



National Evaluation Report of the Professional Nurse Advocate Programme in England.

SUSTAIN – Supervision, Support, Advocacy for Improvement in Nursing, Mixed Methods study.

Authors [alphabetical order]

Dr Amanda Adegboye
Dr Natasha Bayes
Dr Aiden Chantry
Associate Professor Liz Lees-Deutsch
Mariam Khan
Professor Rosie Kneafsey
Professor Shea Palmer

Key Contact:

Associate Professor Liz Lees-Deutsch
Coventry University
Aa6611@coventry.ac.uk

Contents

ABBREVIATIONS	5
ILLUSTRATIONS	6
ACKNOWLEDGEMENTS.....	7
EXECUTIVE SUMMARY	8
RECOMMENDATIONS	13
1. INTRODUCTION.....	14
2. BACKGROUND.....	15
3. AIM.....	15
4. OBJECTIVES	15
5. EVALUATION DESIGN	16
5.1 Empowerment Theory	16
5.2 Programme Theory	17
5.3 Ethical Approval	18
6. DATA COLLECTION METHODS	18
6.1 RAPID LITERATURE REVIEW	18
6.2 SURVEY.....	19
6.3 CASE STUDIES.....	19
6.4 ALL INTERVIEWS.....	19
6.5 MAPPING ONTO THE LOGIC MODEL	20
6.6 DEVELOPMENT OF THE EVALUATION QUESTIONS FOR EACH WORK PACKAGE.....	20
7. DATA ANALYSIS	23
8. RECRUITMENT.....	23
8.1 THE APPROACH	23
8.2 RECRUITMENT STAGES	23
8.3 EXPRESSIONS OF INTEREST.....	24
8.4 Project Management	24
9. FINDINGS.....	25
(1) THE RAPID REVIEW.....	25
9.1.1 Introduction	25
9.1.2 Methods.....	26
9.1.3 Initial topic scoping:	26
9.1.4 Key Medical Subject Headings (MeSH) terms	26
9.1.5 Search Strategy and Databases	26
9.1.6 Search Limitations.....	27
9.1.7 Screening and Selection of Papers:	29

9.1.8 Strengths and Limitations	30
9.1.9 Critical Appraisal	30
9.1.10 Bottom Line Evidence	30
9.1.11 Conclusion.....	31
(2) THE SURVEY.....	32
9.2.1 Introduction	32
9.2.2 Methods.....	32
9.2.3 About you	32
9.2.4 About RCS	32
9.2.5 Perceived effectiveness in meeting roles & responsibilities	33
9.2.6 Additional evaluation.....	33
9.2.7 Data analysis	33
9.2.8 Results.....	34
9.2.8.1 About you.....	34
9.2.8.2 About RCS	36
9.2.8.3 Perceived effectiveness in meeting roles & responsibilities	37
9.2.9 Additional evaluation.....	40
9.2.10 OPEN ENDED QUESTIONS.....	40
9.2.10.1 Theme 1: Conditions necessary for RCS	41
9.2.10.2 Adequate Time:	41
9.2.10.3 A Safe Space:.....	42
9.2.10.4 Adequate communication regarding RCS:.....	44
9.2.10.5 Theme 2. Nurse Participation, Engagement & Organisational Commitment to RCS in the A-EQUIP Model:.....	44
9.2.10.6 Growing Appreciation of the Benefits of RCS:.....	44
9.2.10.7 Issues regarding local frameworks for delivery at site level:	45
9.2.10.8 Theme 3: Reflection and Reinvigoration from RCS	47
9.2.10.9 A reflective process.....	47
9.2.10.10 RCS is a Reinvigorating Experience	47
9.2.10.11 DISCUSSION	48
9.2.12 CONCLUSION.....	50
(3) THE CASE STUDIES	51
9.3.1 Introduction	51
9.3.2 Methods.....	51
9.3.3 Results.....	51
9.3.3.1 Geographical locations:	51

9.3.3.2	Healthcare sites	52
9.3.3.3	Health Education Institutes	52
9.3.4	Introduction to the qualitative data findings	53
9.3.4.1	A personal commitment to implement the PNA Programme	54
9.3.4.2	PNA Module Characteristics & Gradual Evolution:	55
9.3.4.3	Programme Evolution and Outputs:.....	57
9.4	THE INTERVIEWS.....	59
9.4.1	Introduction	59
9.4.2	Methods.....	59
9.4.3	The Themes	59
9.4.3.2	Awareness, Experience and Provision of Clinical Supervision.....	60
9.4.3.3	The potential benefits of good clinical supervision	61
9.4.3.4	Perceived Value of Supportive Restorative Services	63
9.4.3.5	Time, staffing, and approach used to deliver Clinical Supervision	63
9.4.3.6	Delivering the PNA Programme	65
9.4.3.7	Challenges to Overall Programme Delivery	65
9.4.3.8	Benefits of Restorative Clinical Supervision	66
9.4.3.9	Challenges to the delivery of restorative clinical supervision in practice.....	70
9.4.3.10	Future Sustainability of the Programme.....	73
10.	CONCLUSION.....	77
11.	RECOMMENDATIONS	81
12.	LIMITATIONS	83
13.	APPENDICES.....	85
14.	REFERENCES.....	128

ABBREVIATIONS

Alphabetically listed abbreviations

A-EQUIP	Advocating and Educating for Quality Improvement
CEBIS	Clinical Education Based Information Services
HEI	Higher Education Institution
JISC	Joint Information Systems Committee
MeSH	Medical Subject Headings Index
NHSE	NHS England
PI	Principal Investigator
PMA	Professional Midwife Advocate
PNA	Professional Nurse Advocate
PRISMA	The Preferred Reporting Items for Systematic Review and Meta Analyses
RAYYAN	Systematic Review Screening Software QCRI
RCS	Nurses receiving Restorative Clinical Supervision

ILLUSTRATIONS

Figures

- Figure 1: Laschinger's Model of Empowerment
- Figure 2: The Programme Theory – Logic Model
- Figure 3: Participant Approach
- Figure 4: Preferred Reporting Items for Systematic Reviews Flow Chart
- Figure 5: Case Study Locations – geographical map
- Figure 6: Characteristics of Successful Organisations
- Figure 7: Summary of benefits of RCS identified by PNAs
- Figure 8: Benefits of PNA model expressed by RCS nurses
- Figure 9: Challenges of PNA model expressed by RCS nurses
- Figure 10: Experience of RCS and transition through a maturing RCS model
- Figure 11: Revisiting Laschinger's model of empowerment
- Figure 12: Original assumptions of the Logic Model - restated
- Figure 13: Revisiting the assumptions of the Logic Model

Tables

- Table 1: Data collection methods and participant groups
- Table 2: Programme Theory Logic Model
- Table 3: Gantt Chart – Projected Timescale
- Table 4: Eligibility Criteria [rapid review]
- Table 5: Demographic characteristics of survey respondents
- Table 6: Median (Interquartile Range) ratings of questions related to impact of RCS
- Table 7: Median (Interquartile Range) ratings of questions related to other impacts of RCS.
- Table 8: Median (Interquartile Range) rating of the overall effectiveness of RCS.
- Table 9: Median (Interquartile Range) rating of questions related to RCS Nurses' roles and responsibilities.
- Table 10: Median (Interquartile Range) rating of questions related to PNAs' roles and responsibilities.
- Table 11: Median (Interquartile Range) rating of questions related to Trust Leads' roles and responsibilities.
- Table 12: Examples of Healthcare Sites and PNA workforce
- Table 13: HEI delivery of PNA Programme
- Table 14: Participants Interviewed from each Population Group

ACKNOWLEDGEMENTS

We would like to thank the PNA programme management team at NHS England for their responsive and reliable dissemination of study information.

The study team would like to thank each of our participants who gave their precious time to help to inform and shape the future of the PNA programme. We appreciate your support in these challenging times.

We would also like to thank those participants who encouraged other colleagues to take part in this study ensuring we achieved a maximum variation of participants.

Special thanks are extended to Abby Kendrick from Clinical Evidence Based Information Services (CEBIS) at University Hospitals Coventry and Warwickshire NHS Trust who kindly guided us through the intricacies of pragmatic database searching and using RAYYAN software to support the Rapid Review.

Dr Liz Lees-Deutsch extends special thanks to the study team for their hard work to achieve the scale and pace of this evaluation in 9 months, enabling the production of a first draft Report by March 2023.

EXECUTIVE SUMMARY

INTRODUCTION:

The Professional Nurse Advocate (PNA) programme is a clinical and professional leadership programme delivered by Higher Education Institutions (HEI) which equips nurses with the skills to deliver restorative clinical supervision to colleagues in England. The programme has been gradually rolled out across England during 2021/22 with the aim of ensuring there will be PNAs in place to support colleagues in the following specialties: Critical care, Mental Health (Adult Acute & Children and Young Peoples inpatient settings) Community, Learning Disabilities (Adult), Children and Young People, Safeguarding, Health & Criminal Justice settings (HCJ), and International Nurses. In February 2022, NHSE sought an evaluation of the PNA programme. A research team from Coventry University was commissioned to undertake this work. This Executive Summary Report sets out the methods, activities, findings, and recommendations as requested by commissioners.

BACKGROUND:

Launched towards the end of the third wave of the Covid-19 pandemic, the PNA programme was introduced at the start of a critical point for recovery in the NHS. Whilst the pandemic had added complexity to care delivery and stretched the capacity of the nursing workforce, the PNA programme provided an opportunity to re-build resilience within the profession and promote workforce retention. The A-EQUIP (Advocating for Education and Quality and Improvement) Model with restorative clinical supervision, career conversations is integral to PNA training and starts as soon as their time on the programme begins. The HEI education programme equips PNAs to listen and to understand challenges and demands of fellow colleagues, lead support and deliver quality improvement initiatives in response. Course content focuses first and foremost on restorative supervision practices. Beyond this, the focus is on the four functions of the A-EQUIP Model. These four functions are as follows: Clinical Supervision (Restorative); Monitoring, Evaluation and Quality Control (Normative); Personal Action for Quality Improvement; and Education and Development (Formative).

EVALUATION AIM AND OBJECTIVES:

The evaluation aim was to explore the impact of the Professional Nurse Advocates (PNA) programme on PNAs and wider team, with recommendations for improvements. The following objectives were agreed by commissioners:

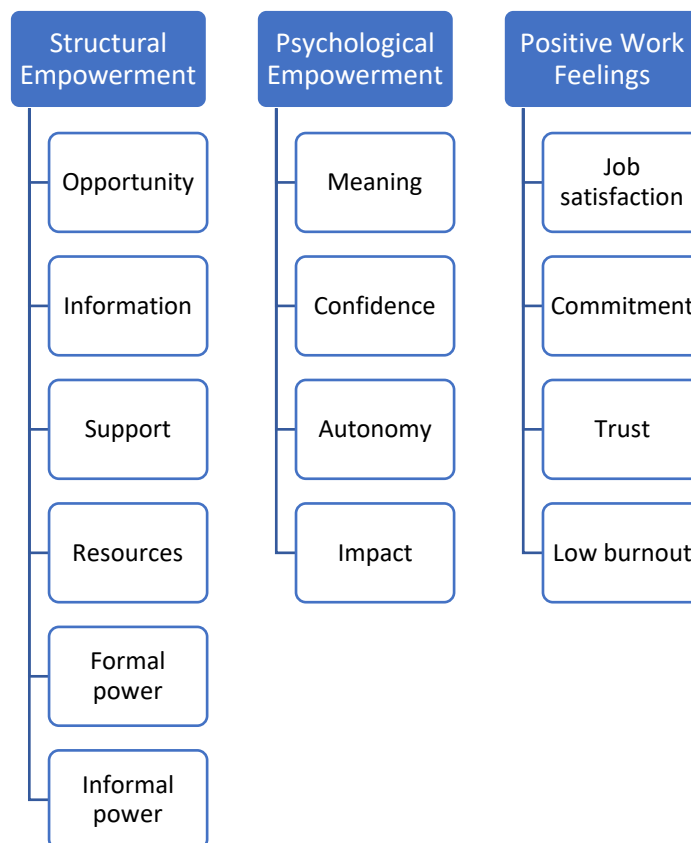
1. Create a logic model [programme theory of change] to explain programme implementation activities
2. Rapid review of the PNA literature as this relates to empowerment
3. Evaluate baseline data across organisations participating in the PNA programme
4. Assess factors impacting on the delivery of the PNA programme
5. Describe individual perceptions of PNAs and influencing contextual factors
6. Describe individual perceptions of nurses receiving restorative supervision
7. Assess the usefulness of the model and establish assumptions essential to delivery
8. Evaluate the perceived benefits of restorative supervision, plus enablers and barriers

- Provide recommendations on how the programme can be effectively embedded, implemented and sustained across a range of contexts.

EVALUATION DESIGN

A mixed methods design was implemented with four work packages. The evaluation was theory driven throughout and we applied the concept of ‘empowerment’ via Laschinger et al, model (2001) and a theory of programme change (Logic Model). Laschinger’s Model enabled the development of study questions, survey design and structured the qualitative phase of the study, including analysis, enabling exploration of structural and psychological empowerment in the workplace and the indicators of positive work feelings (Fig, 1). The Logic Model was used to map the inputs, activities, and outputs of the national programme, with our clearly stated assumptions to guide our questions.

Figure 1: Laschinger’s Empowerment Model (2001)



DATA COLLECTION METHODS

Quantitative and qualitative data were collected via a survey, case studies, semi structured interviews, and a final workshop with commissioners. A Rapid Review of the available literature was used to inform our understanding of the topic and contributed to formation of questions alongside the Laschinger’s empowerment model. A survey was designed to explore the impact on perceptions and levels of empowerment with all PNAs and nurses who have delivered or received restorative clinical supervision. Case study organisations in different

settings provided the opportunity to undertake a deep dive of pertinent information at individual sites/areas. Semi-structured interviews (single and joint) were completed with the following staff groups: Higher Education Institute leads for the PNA course (HEI); regional lead PNAs; site lead PNAs; nurses in PNA roles (PNAs); and, nurses who have received restorative clinical supervision (RCS Nurses). We adopted a sampling approach to achieve maximum variation so that we were able to access a wide range of views and perspectives. We included staff working in District General Hospitals, Community trusts, large Acute Trusts and Mental Health Trusts and many speciality areas.

FINDINGS

Survey An electronic survey was distributed by NHS England between August and December 2022, via email to three constituent groups: Nurses who received RCS (known as RCS Nurses); PNAs; and Trust PNA Leads. There were 302 responses to the survey (RCS Nurses n=73, PNAs n=214, Trust Leads n=15). Most respondents worked in adult nursing, were female and mainly identified as 'white'. RCS Nurse respondents were more ethnically diverse than PNAs and Trust Leads. Trust Leads and PNAs tended to be qualified for longer and were more likely to have been educated in the UK than RCS Nurses.

Of the 214 PNA respondents, 175 (81.8%) had delivered RCS and 39 (18.2%) had yet to do so. Overall, RCS was rated very positively in terms of enhancing structural empowerment, psychological empowerment, and positive work feelings. These items were all rated at a median of 'moderately agree' by all three groups, illustrating strong beliefs in the effectiveness of RCS in having a positive impact on these aspects. All groups provided a median rating of 'strongly agree' to the statement "*I believe that restorative supervision is effective*", illustrating strong support for the effectiveness of RCS. The ability of RCS to improve the support available to nurses at work and nurse confidence was rated as a median of 'strongly agree' by all three groups.

Open text comments highlighted the importance of adequate time provision to undertake the role and to secure staff release for RCS. A safe private space, in a calm area to create a relaxed environment for the planned RCS session was overwhelmingly identified as a pre-requisite factor in which to discuss confidential matters. Most RCS Nurses were fundamentally satisfied with their experience of RCS which left them feeling positive and looking forward to continuing the process. One example of this relates to being challenged:

'...matters related to work are opened up, that could either hinder [] or push me to improve, but they do push me to improve the way I approach work'.

It seemed there was a growing appreciation of the benefits of RCS. RCS was described as a reflective process that legitimises the time and the necessity for nurses to understand and process difficult experiences in their roles. This could only be done with the support and underpinning of a trusting relationship. Participating in RCS was described as a positive and constructive experience by many RCS nurses which had boosted their self-confidence, leaving them restored and reinvigorated.

Case Studies were conducted with eight sites, spanning Healthcare and HEI settings across England to provide in-depth, contextually based information regarding the implementation of the professional nurse advocate programme. For most HEIs, the PNA training module was established at great speed in the context of the covid-19 pandemic, aided through experienced teaching staff, amidst a great sense of urgency. The case studies revealed that a personal commitment to implement the PNA programme was important but in the early waves, a lack of communication hampered initial strategic efforts. For example, nurses undertaking the course in the early days often self-selected and returned to organisations without a strategic lead in place to then implement the programme. In later waves, this became less common. Learning was facilitated online using Microsoft team or zoom, via a level 7 (Masters) module, requiring attendance one day per week over approximately 10 weeks. However, it was noted that there was little parity regarding module content or assessment strategy across the many HEIs delivering the programme in the initial stages. This created some frustrations and barriers to access for training amongst some PNAs due to inadequate entry credentials at the appropriate level to enable this study at level 7. This was rectified in later course iterations.

A general appreciation was reflected that the PNA programme has opened opportunities for nurses at any stage of their career to engage in further study and to combine this with experience, which served to make nurses feel valued and empowered in their roles. For the most part QI activities focused on delivering the restorative aspect of the PNA role. We asked participants about their understanding of RCS delivery outputs regarding the frequency and types of sessions offered. Some participants described the workforce returns and counting activities, but at the same time, not being sure what counted as RCS. Respondents in the case studies identified key aspects which enabled more effective joint working to achieve programme role out. For example: they operated a planned and strategic roll out with careful selection of nurses to complete the PNA training; existing forums were used to drive the progress of the PNA work; the PNA role was linked with others in similar domains (e.g., practice educators, speak up guardians, psychological first aiders); PNAs were given adequate time to functionalise this aspect of their role; a wider interpretation of the PNA role was adopted and linked with existing clinical supervision mechanisms; PNAs were enabled through CPD and this was facilitated through Personal Development Plans; PNAs were supported to do their role through wellbeing mechanisms; PNA leads were linked effectively to support via the NHS England PNA office.

All these elements enabled PNS leads to celebrate achievements and generated a sense of sustainability – that this is not a project – it is here to stay.

Interview data were collected from 63 individuals, with 59 individual interviews and 4, two-person interviews. This included Regional PNA leads (6), Trust PNA leads (13), PNAs (32) and RCS Nurses (7) and HEI Leads (5). Individuals were recruited from a range of specialties (such as, the criminal justice system, primary care, and the ambulance service), from a range of ages (25-62 years), males (N = 3) and females (N = 60) and those who completed PNA training via different course providers ranging from the first cohort to complete the course to the most recent cohort (in total N = 18 different course providers).

It was evident that when the PNA programme was implemented, clinical supervision was seen as a new thing for nursing - the idea of nurse-to-nurse support was valued but had not really been experienced before for many respondents. Clear differences were identified between clinical supervision and restorative supervision. Nurses who had experienced RCS wanted the process to be 'normalized' and more mainstream as there were still some concerns about the negative connotations associated with 'supervision.' Follow up after initial RCS was seen as important, but there were barriers to this occurring. Time and being freed from the duty were the chief issues. Nurses who had completed the PNA course praised the content and experience of the studying for this qualification. Online learning was the core approach due to covid restrictions, and whilst many benefits were identified (e.g. no travel) some respondents' felt more practical experience and assessment of their skills was needed. However, there were challenges in implementing what had been promoted during the programme within the workplace context. This was largely related to short staffing, and a lack of space and time to undertake RCS.

Most PNA respondents were very clear on the benefits of RCS in restoring, supporting and enabling nurses, and in some cases enabling nurses to stay in the profession. Feeling valued, supported and listened to, were the over-riding perspectives. There appeared to be confusion about data collection and RCS as many respondents did not report their data to a lead PNA. The process of receiving restorative clinical supervision and careers conversations required more clarity to understand if, when and how progress was being made throughout the process. For example, some nurses indicated their first-time experiences of RCS were surrounded with uncertainty, especially if they were asked to attend supervision, with little explanation beforehand. This left some nurses describing their 'offloading of issues' rather than being active participants in a process leading towards greater resilience. We have suggested that this is an area for further research.

CONCLUSION:

The support of experienced nurses (PNAs) in practice helps nurses feel valued and empowered; in some cases, RCS and career conversations are enabling nurses, who might otherwise leave the profession, to stay. The programme has opened opportunities for nurses to engage in further study and development following the programme. These factors are important in the context of a global workforce retention crisis. The A-EQUIP model can be accomplished through good Nursing leadership at site level to assist the implementation of the model, with PNAs supporting this role-out. The intention to implement requires a solid commitment and not contingent on the perfect conditions. The prerequisite conditions must be considered and well-thought-out during implementation to include time for RCS and PNAs to carry out the role; private space to conduct the RCS sessions and good communication regarding the plans to involve the key people. Finally, despite some of the issues identified, the creation of a 'PNA movement' through the development of the national programme, has created much needed support for nurses and is the transformative element of nurse empowerment and greater satisfaction at work.

RECOMMENDATIONS

1. Prior to the PNA Programme, the delivery of restorative support and clinical supervision for nurses was not well developed, despite some pockets of good practice. Learning from the areas good practice developed through the programme must be adopted across England.
2. Regional and site Lead PNAs require more time to drive the PNA Programme strategy, juggling 'many other' priorities which create challenges for implementation at site level. There is much learning that could be shared across each wave of roll out to avoid replication in the development of work and the energy needed to deliver the programme.
3. Disparity in the PNA Programme assessment strategy across HEIs and, the requirement for work-based learning in current NHS pressures, requires an agreement for parity for of assessments at Level 7.
4. Adequate '*time*' release of nurses, and access to '*office space*' [privacy] is needed for PNAs to facilitate RCS and career conversations, these elements at site level are critical to sustain the programme delivery.
5. More work is needed to develop and promote all elements of the A-EQUIP model in practice, particularly quantifiable improvements in patient care arising from QI work.
6. Further understanding regarding if/how progress is enabled through the RCS model, is needed. This we suggest is an important area for further research to clearly articulate the benefits to the individuals and teams, over time.

1. INTRODUCTION

The Professional Nurse Advocate (PNA) programme is a clinical and professional leadership programme delivered by Higher Education Institution (HEI) which equips nurses with the skills to deliver restorative clinical supervision to colleagues across England. The programme has been gradually rolled out across England during 2021/22 with the aim of ensuring there will be PNAs in place to support colleagues in the following specialties: Critical care, Mental Health (Adult Acute & Children and Young Peoples inpatient settings) Community, Learning Disabilities (Adult), Children and Young People, Safeguarding, Health & Criminal Justice settings (HCJ), International Nurses.

The Professional Nurse Advocate (PNA) is a leadership and advocacy role designed to support nurses to deliver safe and effective practice. A key aspect of this model is to teach nurses to deliver restorative clinical supervision in their areas of practice. The implementation of this program across nursing aims to support delivery of the long-term plan for the NHS and enable recovery and restoration following the COVID-19 Pandemic. It also supports delivery of the following CNO objectives: 1) to support health and wellbeing of Nurses, 2) Compliance with IPC procedures, 3) Nursing workforce - attract, retain and celebrate nurses.

PNA training provides those on the programme with skills to facilitate restorative supervision to their colleagues and teams, in nursing and beyond. A version of this programme exists already for maternity colleagues, where outcomes point to improved staff wellbeing and retention, alongside improved patient outcomes.

Restorative supervision was first introduced in the health visiting workforce in the UK at a time of fragile professional identity (Wallbank, 2012). Throughout the literature it is described broadly as a safe space to express professional anxieties and share new ideas to improve roles and coping in the workplace. The restorative supervision process acknowledges personal emotions and helps staff to work through containment strategies, to restore their thinking in practice situations.

The restorative supervision that PNAs deliver is integral to their training and starts as soon as their time on the programme begins. The training equips them to listen and to understand challenges and demands of fellow colleagues, and to lead support and deliver quality improvement initiatives in response. The course content of PNA training focuses first and foremost on restorative supervision. Beyond this, the focus is on the four functions of the Advocating for Education and Quality and Improvement (A-EQUIP) Model. These four functions are as follows:

- Clinical Supervision (Restorative)
- Monitoring, Evaluation and Quality Control (Normative)
- Personal Action for Quality Improvement
- Education and Development (Formative)

Benefits of the A-Equip model include providing a framework for the consistent delivery of effective and psychological safe clinical supervision, delivering professional development at

level 7 (Masters level), with recognised national qualification in leadership and advocacy, equipping Nurses to ensure continuous quality improvement in practice.

During February 2022, NHSE sought an evaluation of the PNA programme. A research team from Coventry University were commissioned to undertake this work. This report sets out the methods, activities, findings, and recommendations as requested by commissioners.

2. BACKGROUND

The PNA programme launched in March 2021, towards the end of the third wave of COVID-19. This was the start of a critical point for recovery in the NHS: for patients, for services and for the nursing workforce. The covid pandemic added complexity to care delivery through new ways of working and by stretching the capacity of the nursing workforce. The PNA programme provided an opportunity to re-build resilience and promote retention through adequate support in the form of the A-EQUIP model.

The evaluation specified four separate work-packages to include the following stages:

1. Document the baseline before the PNA programme
2. Evaluate the PNA model
3. Assess the usefulness of using one or all elements of the model and the perceived impact and outcomes
4. Restorative clinical supervision – specifically evaluation of the perceived benefits.

The evaluation is theory-driven throughout; all evaluation activities incorporate elements to develop and refine the programme theory. This process will explicate the role of programme implementation activities and describe assumptions about how these are intended to achieve specific intermediate and distal outcomes.

3. AIM

To undertake an evaluation of the impact of the Professional Nurse Advocates (PNA) programme on the PNAs and wider impact of PNAs in a team with recommendations for improvements.

4. OBJECTIVES

10. Create the logic model [programme theory of change] to explain the programme implementation activities
11. Conduct a rapid review of the emerging PNA literature
12. Evaluate baseline data across organisations participating in the PNA programme
13. Assess factors impacting on the delivery of the PNA programme
14. Describe individual perceptions of PNAs and influencing contextual factors

15. Describe individual perceptions of nurses receiving restorative supervision
16. Assess the usefulness of one or all elements of the model implementation activities and describe assumptions essential to delivery
17. Evaluate the perceived benefits of restorative supervision, plus enablers and barriers
18. Provide recommendations based on the findings about how the programme can be effectively embedded, implemented and sustained across all nursing contexts, settings and services

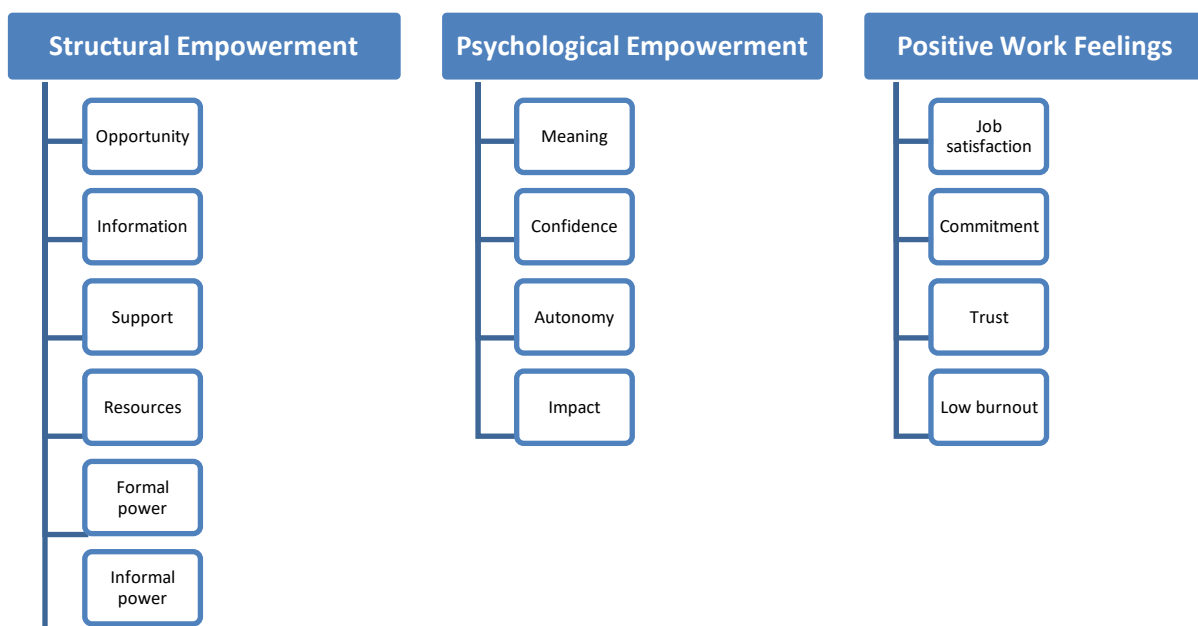
5. EVALUATION DESIGN

A mixed methods approach was deployed to assess the impact of the PNA programme on PNAs, nurses receiving restorative supervision and the wider impact of the PNAs within a team and across healthcare organisations. To provide a theory-based approach we applied the key concepts of Empowerment via the Laschinger et al Model (2001) and the Logic Model theory of programme change (McCawley, 2001). The study team met weekly and used a participatory, action learning approach to adjust approaches as indicated throughout the evaluation.

5.1 Empowerment Theory

Laschinger's Model (Figure, 1) enabled the development of study questions and survey design aimed at the exploration of structural, psychological empowerment and indicators of positive work feelings. It also helped to achieve a balance of questions across each element of the Laschinger's framework and to align with programme inputs, activities, and outputs. We examined the impact of restorative clinical supervision on nurse empowerment at both the individual and nursing community level.

Figure 1: Laschinger's Model of Empowerment



This framework for understanding workplace empowerment was proposed by Laschinger et al., (2001) after expanding an existing model by Kanter (1993) through the addition of psychological empowerment. This helps to explain some the intervening processes necessary to achieve positive work feelings.

Laschinger's work states:

'...workplace empowerment structures, employees experience feelings of personal empowerment that in turn reduces job strain and increases job satisfaction. The strong relationship between structural empowerment and psychological empowerment supports Kanter's claim that social structural factors in the workplace are important conditions for empowering employees to accomplish their work'.

Laschinger et al, 2001, p268

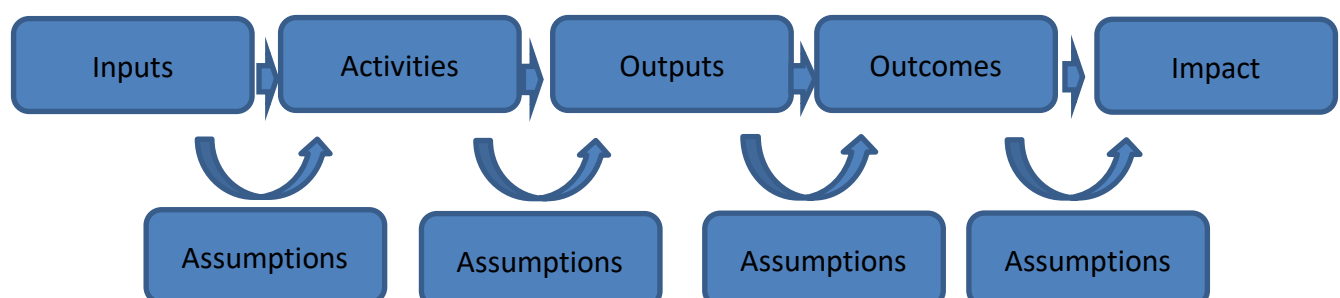
Empowerment theory is imperative for this evaluation to enable understanding of if/how the PNA programme with its information, resources through the A-EQUIP model supports PNAs participation and the delivery of restorative clinical supervision for nurses.

We also considered Christen's model of empowerment (2012) to further understand the possible relational elements also at play through the introduction of the PNA programme, within the social structures/contexts of the workplace. Being 'connected with other people', the collective engagement generated by being 'part of a social movement' [the programme] are recognised in this model to develop greater fulfilment and empowerment. This was considered throughout our analysis to understand if/how any relational aspects between PNAs and RCS nurses help to empower staff in the workplace.

5.2 Programme Theory

The aim of the Programme Theory (Logic Model) is to describe the major features required to implement the PNA programme and if/how these influence the achievement of the change (Figure, 2). To evaluate the features of the PNA programme, how this is envisaged to work and works in practice, we applied the Logic Model at the outset, to guide key areas for our development of evaluation questions. Following data collection and interpretation we mapped the multiple programme inputs and outputs to revisit our assumptions and pathways.

Figure 2: The Logic Model of Programme Change



By understanding the likely assumptions of the programme theory and the interdependencies, we can determine which factors or elements supported or hindered the implementation / outcomes of the PNA programme.

5.3 Ethical Approval

This evaluation gained research ethics approval via Coventry University (Ref: P139411, Appendix 1, page 84).

6. DATA COLLECTION METHODS

Quantitative and qualitative data were collected throughout the following work packages, with members of the evaluation team assigned according to their skillset (Table 1).

Evaluation work package	Data collection methods					Participant groups engaged				
	Rapid review	Case studies	Interviews	Survey	Workshop	RCS	PNA	Lead PNA	Reg PNA	HEIs
1	X					--	--	--	--	--
1		X						X		X
2			X			X	X	X	X	X
3				X		X	X	X	X	X
4					X				X	X

Table 1: Data Collection Methods and Participant Groups across the Work Packages

Table Key:

RCS	A nurse who has received restorative clinical supervision
PNA	A nurse who has completed the professional nurse advocate programme training and delivers restorative clinical supervision via the A-EQUIP model
Lead PNA	A senior nurse with responsibility for leading the implementation of the PNA Programme at NHS Healthcare Facilities
Regional PNA	A very senior nurse with responsibility for leading the implementation of the PNA Programme across a defined geographical regions of NHS Healthcare Facilities
HEI Lead	Higher Education Institution with responsibility for delivering the education of the professional nurse advocates

6.1 RAPID LITERATURE REVIEW

The review is focussed on empowerment and nurses, with the aim of informing the evaluation and the study team to deepen understanding of the concept of empowerment, in the context of nursing workforce, through the PNA role. The review scope and protocol were produced (LLD) and refined by study team (AC, NB, MK) with further review/feedback by NHSE commissioners (Appendix 2, pages 85-90). The Rapid Review was conducted using a group methodology with study team members to expedite the process. This was a pragmatic process which sought to establish the bottom-line evidence most useful for the purposes set out in the protocol. Typical systematised review techniques/tools (PRISMA, RAYYAN software) were engaged with expertise of information services (CEBIS) to systematically search relevant evidence databases (MeSH) and identify the highest quality evidence (Appendix 3, pages 91-92).

6.2 SURVEY

Using the Model of Empowerment, a survey (Appendix 4, pages 93-98) was designed (SP) in collaboration with team to explore the impact on perceptions and levels of empowerment with all PNAs and nurses who have delivered or received restorative clinical supervision. The survey was created using Jisc Online Surveys <https://www.onlinesurveys.ac.uk/>

6.3 CASE STUDIES

Case study organisations in different settings provided the opportunity to undertake a deep dive of pertinent information at individual sites/areas related to PNAs, PNAs in training, delivery of restorative supervision and nurse workforce, retention issues. These were conducted using mixed methods, in two parts. Firstly, an analysis of baseline data collected via a short survey to generate insight into their starting point before implementation of the PNA programme and inputs leading to PNA implementation. Access to the survey was created through a QR code using free online software <https://www.qr-code-generator.com/>. Secondly, invitations were extended to HEI Leads and PNA Site Leads for interview, using a brief protocol and interview schedule (Appendix 5, pages 109-110). Interviews were audio recorded and conducted using two study team members (LLD and RK).

6.4 ALL INTERVIEWS

We explored the implementation of the PNA programme from multiple stakeholder perspectives to understand views on the successes, challenges and learning for future implementation and sustainability. This was an in-depth qualitative phase, involving semi-structured interviews (single and joint) with the following staff groups:

- Higher Education Institute leads for the PNA course (HEI)
- Regional Leads PNAs
- Site Lead PNAs
- Nurses in PNA roles (PNAs)
- Nurses who have received restorative clinical supervision (RCS)

Sampling across settings and contexts – we adopted a sampling approach to achieve maximum variation so that we were able to access a wide range of views and perspectives.

We included staff working in District General Hospitals, Community trusts, large Acute Trusts and Mental Health Trusts and speciality areas (Appendix, 6, page 111).

For the PNAs we explored:

- Perceptions of the PNA programme (benefits, limitations)
- Expectations of the PNA programme (personal, organisational, strategic)
- Experiences of being a PNA
- Enablers and barriers to the PNA role (using theory of change to explore)

For the nurses receiving restorative clinical supervision we explored:

- The perceived benefits and usefulness of the supervision
- Barriers and facilitators in the model used
- Contextual factors
- How their experience could be improved

6.5 MAPPING ONTO THE LOGIC MODEL

Discussions with the National PNA team helped the study team to establish the necessary detail for the Logic Model. Inputs, activities, outputs, and desired outcomes were then mapped, with the indicators anticipated to best judge success using the overall structure created by the PNA team at NHS England (Table, 2). For simplicity of the mapping, envisaged pathways of the PNA are displayed as high-level and linear. The reality is of complex interactions, between different organisational pathways and at different levels throughout. On the logic model, blue arrows indicate interactions, involving two or more parties [sometimes from different health and education settings] working in partnership together. Finally, assumptions underpinning the model have been stated which are critical to the achievement of the outcomes. This model has been used to aid the development of all study questions and to decide the data collection stages. It was revisited during data analysis to aid the interpretation of our findings from the viewpoints of the groups of stakeholders/pathways, to fully explore the transactional and interactive elements. This enabled appreciative reporting of the real-world factors involved in delivery of the PNA programme, to show successful pathways and where adjustment would be indicated for long term sustainability.

6.6 DEVELOPMENT OF THE EVALUATION QUESTIONS FOR EACH WORK PACKAGE.

Evaluation questions were developed for all groups of participants with each aligned to the evaluation objectives and empowerment theory. This process served to demonstrate differences and overlap in questions and to align with topics for each participant group. Oversight and feedback were provided by the PNA management team (Appendix, 7, pages 112-114). Extensive background reading of literature (MK and LLD) from the Professional Midwife Advocate programme expanded our understanding of Empowerment and its Agency, regarding how this might relate to the realisation of the PNA programme. Questions were piloted with volunteers [known to the evaluation team] representing two participant groups namely, nurses and PNAs. Several questions were adjusted, in accordance with the team member's expertise to make the questions acceptable (AC and NB). The questions were

developed into comprehensive interview schedules for the five participant groups, an example of a schedule for the PNA group (largest group of participants) is included (Appendix, 8, pages 115-118). Interviews were audio recorded and transcriptions were conducted via a professional transcription service commissioned from Coventry University called Just Delegate. Member checking of a sample (10%) of transcripts were conducted by study team members. All files were password protected on transfer and return, and stored in a secure study site server with CU.

Table 2: Logic Model Programme Theory

INPUTS	ACTIVITIES	OUTPUTS	DESIRED OUTCOMES		
Finances to establish PNA Team at NHSE	Establish Regional Leads	NHS Regions enlisted	Short-term [3-6 months]	Medium-term [7-12 months]	Long-term [13 -24 months]
<u>Workstream 1 (P1):</u> PNA Team at NHSE.	Establish contracts / partnerships with HEIs, agree module	Materials, training assessment and structure for delivery defined	Developed PNA programme material proof of concept	Awareness of and PNA Programme structure working well	Achieve indicator of success 1:20 PNA ratio
<u>Workstream 2 (P2):</u> Member Expertise / Concept	Establish partnerships with NHS Trusts	Lead PNA contacts in NHS Trusts	Identified trainees (registered nurses) are completing the PNA Programme	Recruited to second wave and learning from wave 1 and 2	Improving retention of nurses
<u>Workstream 3 (P3):</u> Stakeholders	HEIs and NHS working partnerships	Recruitment to PNA Programme ↓ National Network for PNA Leads	PNA's working in NHS Trusts to deliver A-EQUIP Model Learning from others to refine programme	Spread the word nationally, seminars, commission national evaluation.	Increased clinical supervision sessions delivered compared to baseline A-Equip Model promotes continuous improvement in care delivered.

Assumptions [political, financial, organisational] spanning inputs, activities, outputs and outcomes:

- P1: NHSE finance is stable and secure for PNA Programme Implementation
- P1: PMA [Midwife] Programme is suitable base AEQUIP model for RCS and can be applied to a workforce of Nurses.
- P2: The concept of the PNA Programme is adequate to engage early support from partners (HEIs and NHS)
- P2: Changes to the PNA programme are an incentive to engage further stakeholders
- P3: NHS Trusts can recruit sufficient nurses to become PNA's
- P3: The mechanisms for delivery of the restorative clinical supervision model are adequately identified and understood by stakeholders

7. DATA ANALYSIS

DATA ANALYSIS

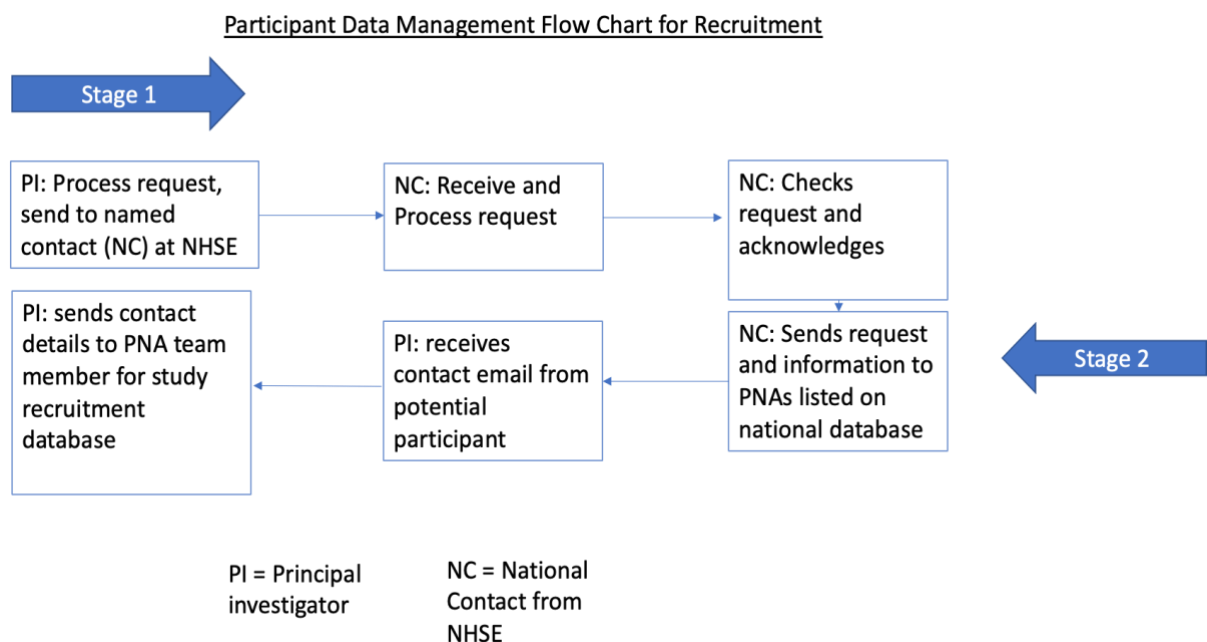
Methods relating to each aspect of this evaluation are described at the beginning of each chapter.

8. RECRUITMENT

8.1 THE APPROACH

Initial contact with PNAs on the NHSE database was made through the PNA Management team at the NHSE. Confidentiality was maintained; PNA details were not shared directly with the study team, the process for making contact was agreed during the study set up (Figure, 3).

Figure 3: Approach Used to Contact Participants



8.2 RECRUITMENT STAGES

We used a range of approaches to recruit participants to the study:

- I. A Study Poster circulated to all database contacts. This generated expressions of interest from PNAs, whose details were transferred to a secure expressions of interest database.

- II. Study information with contact details was sent by email to all PNAs.
- III. A national communication was developed by the study team and shared by the NHSE PNA team shared with all NHS Trusts and HEIs.
- IV. The survey link was shared by email.
- V. The Case Study Survey Link and Information was shared.
- VI. Study information was re-sent to all PNAs [5,000 on NHSE database at time]
- VII. Social Media [Twitter] was used to generate further interest.
- VIII. Study information was sent to all NHS Trusts reporting high workforce returns for nurses receiving restorative clinical supervision sessions.
- IX. Presentation at a PNA meeting with invitation from NHSE.

8.3 EXPRESSIONS OF INTEREST

All expressions of interest were received by the PI (n= 303) and assigned to a study team member (MK) for screening, database entry, organization, management, and oversight. Details were retrieved by study team members to establish contact.

8.4 PROJECT MANAGEMENT

The evaluation team managed work in accordance with the agreed timescale over 12 months to study reporting (Table, 3). The team met weekly throughout and their individual expertise [qualitative and quantitative] enabled each work package to be commenced and, to work at pace. Oversight and guidance were provided at regular intervals from the PNA office at NHS England.

Table 3: Project Overview Gantt Chart.

9. FINDINGS

The findings from each work package of the evaluation are presented in section 9 of this report commencing with the rapid review of empowerment literature, the survey, case studies and qualitative findings from interviews.

(1) THE RAPID REVIEW

9.1.1 Introduction

The purpose of the rapid review was to strengthen understanding of the NHSE PNA programme and to support understanding and analysis in relation to the descriptors of empowerment. The review is organized through presentation of the question and the bottom-line evidence at the outset. All methods and literature reviewed plus references are reported subsequently.

The Review Question:

Set Up Activities	2022						23					
	Mar ch	Ap ril	M ay	Ju ne	July	Aug	Se p	Oc t	No v	De c	Jan	Feb
Study Initiation Recruit Study Team	Awa rd	Sta rt										
Study Set Up												
NHSE Meetings												
Ethics				Awarded August								
Participant Recruitment												
Work Package 1												
Rapid Review of Evidence												
Case Studies												
Analysis of Findings												
Work Package 2												
Interviews												
Preliminary analysis												
Work Package 3												
Design Survey												
Distribute Survey												
Analyse findings												
Dissemination												
Co-design workshop												
Feedback Workshop												
Report Write up												

What do PNAs and Nurses who have received Restorative Clinical Supervision (RCS) on the PNA programme describe as the factors which contribute to, and influence their empowerment at work?

9.1.2 Methods

The formal rapid review process was established through a critically appraised topic (CAT) group Stevenson et al, (2021) to enable members of the evaluation team (LLD, AC, NB, and MK) to work collaboratively and to expedite this review. The CAT approach is well-established to identify best evidence to use in practice settings. Good practice stems from the volume of people involved in the process, discussion and sense checking throughout to determine a consistent review process. CEBIS expertise employed enabled the judicious choice of databases and platforms used to conduct the rapid review and for eligibility criteria to be carefully considered to inform decisions.

9.1.3 Initial topic scoping:

Google Scholar was used to identify the likely breadth of Empowerment literature (LLD) with the following empowerment related terms located:

Morale Boosting
 Positivity
 Productivity [increase]
 Feeling Secure
 Autonomy [in role]
 Retaining [in role]

This located 50 articles with a potential fit to nurses and empowerment.

The rapid review protocol (Appendix 2, pp 85-90) including eligibility criteria (Table 4) were drafted by LLD and iteratively progressed thereafter by the evaluation team, through three online meetings. Additional initial reading of related papers was undertaken for topic familiarization, from the literature for Midwife Advocates and empowerment.

9.1.4 Key Medical Subject Headings (MeSH) terms

Empowerment [described as power or psychological informal or formal or autonomy] and Clinical Supervision [nursing 'supervisory' and preceptorship] were located as MeSH terms (Baumann, 2016).

9.1.5 Search Strategy and Databases

The expertise of a Clinical Evidence Based Information Services (CEBIS) librarian (AK) guided the question development, using MeSH terms and live-literature search process. In line with rapid review protocols, we started by selecting one database. Decisions regarding how many more would be included, were based on the results from the first database search. Four, databases were searched namely: PubMed, then Embase, CINAHL Plus, and PsycInfo (pp 10-11).

9.1.6 Search Limitations

In line with the protocol our search parameters were:

- Limited to 5 years
- English translations only
- Exclude British Library requests.
- Enable proximity word searches with 5 words
- Supplementary searches of word list

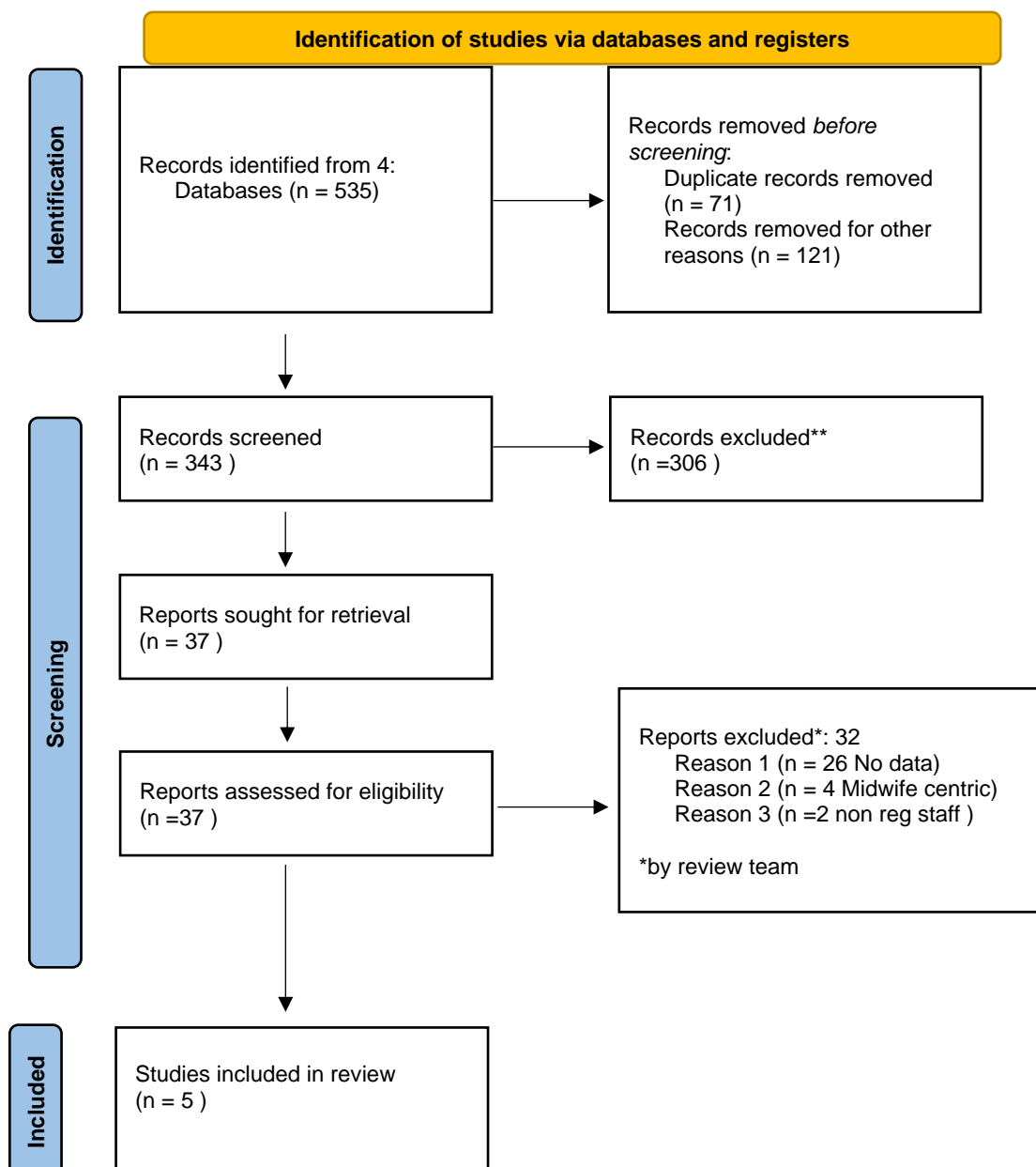
Eligibility Criteria		
	Inclusion	Notes or examples, if appropriate
1	Nurses [registered nurses or registered practitioners]	But could include the supervision or spread of practice to other healthcare professionals (e.g. Nurses AND Anaesthetists, doctors, midwives....)
2	Clinical + Supervision [all features of: Supervisory roles, Preceptorship]	Must include this feature within the paper, so must state this explicitly. Must be evidence of a formal model of Clinical Supervision. Must be a main part of the work delivered in the paper and link to empowerment.
3	Empowerment [did the paper report features of this, as per Laschinger's model] Examples or features of empowerment may be: Training; Confidence; Building of Resilience (nurses); Patient empowerment. Empowerment and survivorship Delivering compassionate care	<ul style="list-style-type: none"> • Must be because of the clinical supervision process • Empowerment must be included as a core part of the work to achieve this • Empowerment will sometimes be implicit rather than explicitly described. NB: keep an eye on 'features' of empowerment, such as those mentioned in Laschinger's model (plus others), or even methods to improve empowerment (such as mindfulness), rather than focus on finding 'empowerment' explicitly
4	Application of a model of change / quality improvement stated [e.g. A-EQUIP]*	Clearly discusses the model– quality improvement. Other models, are ok– but must report the potential to be used for care or actual improvement of a patient focused service/clinical change with empowerment – must be constructive and for benefit of nurses
5	PNA Programme	Benefits should come from this NHSE programme – but other organisations (Health Foundation and RCN have previously run programmes)
6	Health care settings [acute, community, mental health, learning difficulties, prisons] Include Ambulance Trusts	We have noted healthcare setting may not be explicit/mentioned. Types of settings will typically mention: Ward; Department; Clinic; Virtual care; Theatre; Area; Ambulatory care; Intermediate care; Primary care or Clinical Work; in conjunction with a specific specialty
Notes	*Quality Improvements made in practice [outcomes] examples are:	<ul style="list-style-type: none"> • Improve quality of patient mealtimes • A decrease in infection rates • Set up improved communication systems for relatives • Co-Design rehabilitation programmes for patients • Improve drug rounds • Improve patient safety for falls risks • Building compassionate care • To empower patients through new care delivery

Table 4: Eligibility Criteria

9.1.7 Screening and Selection of Papers:

The team were taught to use Rayyan Software Ouzanni et al, (2016) which facilitated the multiparty organisation, and collaboration for screening/eligibility/inclusion decisions to aid the selection of literature. Ten papers were selected from the search results (n=343), which were used to pilot the eligibility criteria and test the interrater reliability across the reviewers (McHugh,2012). Complete concordance to criteria was achieved for 5 of the 10 papers, with variance in the remainder, giving an overall interrater reliability of 82.5%. The area providing most variance and discussion concerned empowerment and its description, and if/how this related to a PNAs or Nurses receiving restorative supervision. Retrieval and access to full text literature was facilitated by CEBIS. The literature flow is illustrated using PRISMA (2020) (Figure 4).

Figure 4: The Preferred Reporting Items for Systematic Review and Meta Analyses (PRISMA, 2020)



9.1.8 Strengths and Limitations

There was a dearth of evidence regarding empowerment, the PNA Programme, PNAs and RCS for Nurses. The available literature showed a lack of fundamental data to critically appraise. Nevertheless, this review has demonstrated the gaps in the evidence base and enabled us to fulfil our intention of building our understanding and a framework to aid our analytical process.

9.1.9 Critical Appraisal

Appraisal of the papers was conducted as follows:

Individual critical appraisal by AC and LLD, using the Critical Appraisal Skills Programme (CASP) Qualitative Review Tool. During this stage, a decision was taken not to exclude papers due to the dearth of literature. A quality review was undertaken by AC using a quality review tool for disparate papers, by Hawker et al., (2002). Scores for papers ranged from 10-20, out of a possible maximum of 36 (Appendix, 9 pages 119-222). Given the dearth of literature, no cut off point for exclusion [e.g. due to poor quality] was applied. The most limiting factor of this review of quality stems from no primary data through research being available.

9.1.10 Bottom Line Evidence

Five papers shaped the findings relating to empowerment with PNAs and RCS Nurses. Empowerment is an extensive term; in this review it broadly relates to knowledge gained from the PNA Programme and enablement of support strategies and learning through A-EQUIP model with RCS nurses. Laschinger's Model encompasses structural, psychological, and positive work feelings. Laschinger states:

'Psychological empowerment is defined as the psychological state that employees must experience for empowerment interventions to be successful'
(Laschinger et al., 2001, p. 261)

It is posited that empowerment is experienced through the PNA Programme and A-Equip model. Thereafter the model creates the opportunity for a relationship between PNAs to form and to promote empowerment of Nurses receiving RCS through the delivery of restorative interactions.

Factors contributing to structural empowerment arise from supportive mechanisms taught on the PNA Programme and taking the opportunity for RCS. Having enough 'time' is an important factor related to individual empowerment experience and the delivery of restorative clinical supervision and is referred to throughout. Hence, although not explicit, it would be disempowering if time were not available. Encouraging positive work feelings are reported as 'feeling motivated by PNAs and the RCS process' and 'being able to help others', in a reciprocal relationship which involves the whole team. The presence of a model for clinical supervision is empowering and makes nurses feel valued. Supervisory relationships on an individual level, create a sense of person-centeredness and being listened to. Moreover,

this process may help to empower nurses to remain in practice. Psychological empowerment was reported as 'raising self-awareness' to regulate less positive 'learnt' nurse behaviours and encourage more positive interactions. Although, the PNA programme and empowerment is not reported in sufficient detail to draw conclusions, empowerment is a feature n referred to individually and structurally as a positive influence upon well-being. Notable by its absence was any reporting related to empowerment as it relates to improved patient care by nurses (Muscat et al, 2021), Mahati (2020), Foster (2021), Griffiths, (2022) and Pearce (2022)..

9.1.11 Conclusion

This review is limited to the experiential and anecdotal published evidence available, which indicated that RCS delivered through the PNA Programme should be able to decrease stress and burnout. Empowerment arises from RCS to support nurses, time to contemplate different perspectives of issues and helps inform their onward decision making. These results were founded through discussions, reflective conversations, supportive challenge, and open and honest feedback. Empowerment can be expressed as: as improved knowledges of collective leadership and the power of being involved in quality improvement, has given them a better understanding and appreciation of the PNA role, with its many benefits. While the quality of evidence is weak it provides justification for evaluating the impact of the programme and the potential for empowerment as a derivative.

(2) THE SURVEY

9.2.1 Introduction

This section describes the methods and findings of the online survey. The survey was designed to address key aspects of the evaluation requirement document. It aimed to evaluate key stakeholders' perceptions of restorative clinical supervision (RCS) and their perceived effectiveness in meeting their published roles and responsibilities.

9.2.2 Methods

An electronic survey was developed and distributed via Joint Information Systems Committee (JISC) Online Surveys (Appendix, 4, pages 93-108). An introductory email which included a link to the electronic survey was distributed by NHS England via email to three constituent groups:

- I. Nurses who received RCS
- II. PNAs
- III. Trust PNA Leads

For the purposes of brevity, these groups will be referred to as 'RCS Nurses', 'PNAs' and 'Trust Leads' throughout the remainder of this chapter. Study information, a privacy notice, and explicit informed consent was integrated into the survey. Participants were unable to progress to the main survey without confirming their consent.

There was an initial under-representation of RCS Nurses responding to the survey, so an amendment to ethical approval was secured to ask PNAs to advertise the survey to RCS Nurses that they had supervised. The survey was also advertised during an online event hosted by NHS England. These steps were successful in securing more responses from RCS Nurses. The survey opened on 31st August 2022 and closed on 12th December 2022. A copy of the survey is available in Appendix X.

The survey was developed and amended in collaboration with members of the evaluation team and the NHS England (NHSE) team who commissioned the evaluation, and it was thoroughly piloted before being launched. The main sections of the survey were as follows:

9.2.3 About you

Basic demographic information was collected to provide context to the analysis. This included the region of England and field of nursing in which respondents worked; age, gender, ethnicity and disability; and time since completion of their nurse education and whether their nurse education was conducted outside of the United Kingdom (UK). Answers to all questions were required, although all had 'Prefer not to say' and 'Other' options where appropriate.

9.2.4 About RCS

Answers to all questions in this section were compulsory. Questions were constructed to address the different components of the Model of Empowerment by Laschinger et al. (2011).

Laschinger et al.'s model was the key framework selected for the wider evaluation and was used as the basis for understanding the effectiveness of RCS. The model contains a total of 14 items, arranged in 3 domains and is summarised in Figure 1 (page 16). A positively worded statement related to each of the 14 items was constructed and respondents were asked to state their level of agreement with each of the statements on a 6-item Likert scale, ranging from 'Strongly agree' to 'Strongly disagree'. This section was prefaced with a definition and explanation of RCS, as described by NHS England & NHS Innovation (2021).

An additional five statements were added to this section in response to suggestions from the research and NHSE&I teams during development and piloting. These addressed the effectiveness of RCS in helping to improve the safety of patient care delivery; the ability to make changes to care delivery; networking with others; the influence nurses have in their practice; and the leadership of quality improvement. Answers to all questions were required.

A second section about RCS was presented at the end of the survey. This asked respondents to indicate their level of agreement with the statement "*I believe that restorative clinical supervision is effective*", using the same 6-item Likert scale as before. This provided an overall rating of the effectiveness of RCS. Finally, respondents were asked to indicate the main benefits of RCS, what could be improved about RCS, and how those improvements could be implemented using open text responses. Again, answers were required to all questions, although responses could be brief.

9.2.5 Perceived effectiveness in meeting roles & responsibilities

The questions in this section were based on the published roles and responsibilities relevant to each of the three groups (RCS Nurses, PNAs and Trust Leads). Statements related to the respondent's perceived effectiveness in meeting each of their published roles and responsibilities (Critical Care Networks-National Nurse Leads, 2022) were created. Respondents were then asked to state their level of agreement with each statement, using the same 6-item Likert scale as before. All questions in this section were compulsory.

9.2.6 Additional evaluation

The final section provided an optional open text box for any other comments that respondents wanted to add and an opportunity to leave their contact details if they were happy to be contacted by the evaluation team to discuss the PNA programme in more detail.

9.2.7 Data analysis

Demographic data were analysed and reported as total numbers and proportions for each group. Likert scale items were converted to numbers for the purpose of analysis, as follows: 6 = Strongly agree, 5 = Moderately agree, 4 = Slightly agree, 3 = Slightly disagree, 2 = Moderately disagree, 1 = Strongly disagree. These were treated as ordinal scale data for the purposes of analysis and median (interquartile range, IQR) were used to summarise responses for each of the groups.

Open text responses were analysed from RCS Nurses, PNAs and Trust PNA Leads who responded to the evaluation survey providing their insights regarding the benefits, improvements and how the improvements identified for the RCS process could be implemented. Most data comprised very short responses of several words. Data were extracted into a Microsoft Word document, and through reading, familiarised. Each response was open coded and a list of characteristics for each made to form descriptions and coding book. Further reading of whole content [across all responses, from each question and participant group] comparing between RCS Nurse, PNA and Trust PNA Lead’s data, enabled identification of connections and divergence between characteristics. Synthesis was guided according to the emergent characteristics to form overarching themes. This analytical process was used to keep an open mind regarding the possibilities, particularly in relation to the development of potential adaptations to the A-EQUIP model delivery or enriching the Empowerment Theory as this relates to the PNA Programme.

Three central themes were identified as: Conditions necessary for RCS; Nurse participation, engagement and Organisational commitment to RCS in the A-EQUIP Model; and Reflections on and Reinvigoration from RCS. As such, they represent three phases of delivery namely, before, during and afterwards.

9.2.8 Results

9.2.8.1 About you

There were 302 responses to the survey (RCS Nurses n=73, PNAs n=214, Trust Leads n=15). The demographics of respondents in each group are detailed in Table 1. There was a fairly even representation from the different English regions and most respondents worked in adult nursing. There was a greater proportion of RCS Nurses in the younger age categories, compared to PNAs and Trust Leads, although the proportions in the 50-60 years of age category were similar across all three groups. The samples were predominantly female and mainly identified as ‘white’ ethnicity. RCS Nurse respondents were more ethnically diverse than PNAs and Trust Leads. The proportions declaring a disability were similar across the three groups. Trust Leads and PNAs tended to be qualified for longer and were more likely to have been educated in the UK than RCS Nurses. Indeed, none of the Trust Leads reported that they had received their nurse education outside of the UK.

Survey items		RCS Nurses (n=73)	PNAs (n=214)	Trust Leads (n=15)
In which of the following regions do you work?	East of England	5 (6.8%)	32 (15.0%)	1 (6.7%)
	London	9 (12.3%)	17 (7.9%)	3 (20.0%)
	Midlands	5 (6.8%)	32 (15.0%)	3 (20.0%)
	North East & Yorkshire	23 (31.5%)	40 (18.7%)	2 (13.3%)
	North West	4 (5.5%)	25 (11.7%)	3 (20.0%)
	South East	14 (19.2%)	26 (12.1%)	2 (13.3%)
	South West	13 (17.8%)	41 (19.2%)	1 (6.7%)
	Prefer not to say	0	1 (0.5%)	0

In which field of nursing practice do you work?	Adults	58 (79.5%)	154 (72.0%)	10 (66.7%)
	Children	7 (9.6%)	27 (12.6%)	2 (13.3%)
	Learning Disabilities	1 (1.4%)	4 (1.9%)	0
	Mental Health	7 (9.6%)	26 (12.1%)	3 (20.0%)
	Prefer not to say	0	3 (1.4%)	0
What is your age?	Under 20 years	0	0	0
	20 – 29 years	16 (21.9%)	17 (7.9%)	0
	30 – 39 years	27 (37%)	57 (26.6%)	2 (13.3%)
	40 – 49 years	4 (5.5%)	80 (37.4%)	8 (53.3%)
	50 – 60 years	24 (32.9%)	54 (25.2%)	5 (33.3%)
	Over 60 years	2 (2.7%)	5 (2.3%)	0
	Prefer not to say	0	1 (0.5%)	0
What is your gender?	Male	8 (11.0%)	21 (9.8%)	1 (6.7%)
	Female	64 (87.7%)	191 (89.3%)	14 (93.3%)
	Prefer not to say	1 (1.4%)	2 (0.9%)	0
	Other	0	0	0
What ethnic group do you identify as?	Asian/Asian British	16 (21.9%)	17 (7.9%)	1 (6.7%)
	Black/African/Caribbean/Black British	7 (9.6%)	9 (4.2%)	0
	Mixed/Multiple ethnic groups	1 (1.4%)	3 (1.4%)	0
	White	48 (65.8%)	175 (81.8%)	14 (93.3%)
	Prefer not to say	1 (1.4%)	3 (1.4%)	0
	Other	0	7 (3.3%)	0
Do you consider yourself to have a seen or unseen disability?	Yes	3 (4.1%)	21 (9.8%)	2 (13.3%)
	No	65 (89.0%)	191 (89.3%)	13 (86.7%)
	Prefer not to say	5 (6.8%)	2 (0.9%)	0
If yes, how would you describe your disability or impairment? *	Developmental	0	0	0
	Learning	1	3	0
	Mental health	1	5	0
	Physical	1	5	1
	Sensory	0	1	1
	Neurodiverse	0	3	0
	Not applicable	6	25	2
	Prefer not to say	3	2	0
	Other	0	2	0
How many years ago did you complete your nurse education?	Less than 1 year	3 (4.1%)	3 (1.4%)	0
	1-5 years	15 (20.5%)	24 (11.2%)	0
	6-10 years	16 (21.9%)	29 (13.6%)	0
	11-15 years	11 (15.1%)	36 (16.8%)	1 (6.7%)
	16-20 years	9 (12.3%)	27 (12.6%)	4 (26.7%)
	21-25 years	4 (5.5%)	44 (20.6%)	3 (20.0%)
	26-30 years	4 (5.5%)	22 (10.3%)	3 (20.0%)
	More than 30 years	10 (13.7%)	28 (13.1%)	4 (26.7%)

	Prefer not to say	1 (1.4%)	1 (0.5%)	0
Did you receive your nurse education outside of the UK?	Yes	17 (23.3%)	32 (15.0%)	0
	No	55 (75.3%)	181 (84.6%)	15 (100.0%)
	Prefer not to say	1 (1.4%)	1 (0.5%)	0

Table 5. Demographic characteristics of survey respondents. PNA = Professional Nurse Advocate; RCS = Restorative Clinical Supervision. *Respondents could select more than one option, so % has not been calculated.

9.2.8.2 About RCS

Of the 73 RCS Nurse respondents, 31 (42.5%) reported that they were currently receiving RCS and 42 (57.5%) reported that they had completed RCS. Of the 214 PNA respondents, 175 (81.8%) had delivered RCS and 39 (18.2%) had yet to do so. Of those PNAs who had delivered RCS, they had supervised a mean number of 15 RCS Nurses (Standard Deviation 25, Range 1-217).

The median figures in Tables 6-11 should be interpreted using the following key:

Key											
6	Strongly agree	5	Moderately agree	4	Slightly agree	3	Slightly disagree	2	Moderately disagree	1	Strongly disagree

Table 6 presents the median (IQR) ratings for each of the questions related to the model of empowerment by Laschinger et al (2001). This illustrates generally very positive ratings across all components and for each of the three staff groups, with a median rating of ‘moderately agree’ for almost all statements. The ability of RCS to improve the support available to nurses at work was rated as a median of ‘strongly agree’ by all three groups. Trust Leads also rated the ability of RCS to improve the confidence nurses have in their roles as a median of ‘strongly agree’. The only median rating of ‘slightly agree’ was by PNAs for the ability of RCS to improve the opportunities available to nurses at work. Overall, however, RCS was rated very positively in terms of enhancing structural empowerment, psychological empowerment, and positive work feelings.

	RCS Nurses (n=73)	PNAs (n=214)	Trust Leads (n=15)
Structural Empowerment			
Opportunity	5 (4,6)	4 (4,5)	5 (5,6)
Information	5 (4,6)	5 (4,6)	5 (4.5,5.5)
Support	6 (5,6)	6 (5,6)	6 (5,6)
Resources	5 (4,6)	5 (4,5)	5 (5,5)
Formal power	5 (4,6)	5 (4,5)	5 (5,5)
Informal power	5 (4,6)	5 (4,6)	5 (4.5,5)
Psychological Empowerment			
Meaning	5 (4,6)	5 (4,6)	5 (5,6)

Confidence	5 (5,6)	5 (4,6)	6 (5,6)
Autonomy	5 (4,6)	5 (4,6)	5 (5,6)
Impact	5 (5,6)	5 (4, 5.75)	5 (5,6)
Positive Work Feelings			
Job satisfaction	5 (4,6)	5 (4,6)	5 (5,5.5)
Commitment	5 (4,6)	5 (4,6)	5 (5,5.5)
Trust	5 (4,6)	5 (4,5)	5(5,6)
Low burnout	5 (4,6)	5 (4,6)	5(5,5.5)

Table 6. Median (Interquartile Range) ratings of questions related to the impact of RCS on elements of the model of empowerment by Laschinger et al (2001). PNA = Professional Nurse Advocate; RCS = Restorative Clinical Supervision.

The responses to the additional five questions about RCS are summarised in Table 7. These items were all rated as a median of ‘moderately agree’ by all three groups, illustrating strong beliefs in the effectiveness of RCS in having a positive impact on these aspects.

Other	RCS Nurses (n=73)	PNA's (n=214)	Trust Leads (n=15)
Safety of patient care delivery	5 (4,6)	5 (4,6)	5 (5,6)
Ability to make changes to care delivery	5 (4,6)	5 (4,5)	5 (4.5,6)
Networking with others	5 (4,6)	5 (4,6)	5 (5,6)
Influence in practice	5 (4,6)	5 (4, 5.75)	5 (5,5)
Leadership of quality improvement	5 (4,6)	5 (4,5)	5 (5,5.5)

Table 7. Median (Interquartile Range) ratings of questions related to other impacts of RCS. PNA = Professional Nurse Advocate; RCS = Restorative Clinical Supervision.

Finally, each of the groups were asked about their overall opinion about the effectiveness of RCS and the median scores are summarised in Table 8. All groups provided a median rating of ‘strongly agree’ to the statement “*I believe that restorative supervision is effective*”, illustrating strong support for the effectiveness of RCS.

	RCS Nurses (n=73)	PNA's (n=214)	Trust Leads (n=15)
Based on my overall experience of restorative supervision...			
I believe that restorative supervision is effective	6 (5,6)	6 (5,6)	6 (5,6)

Table 8. Median (Interquartile Range) rating of the overall effectiveness of RCS. PNA = Professional Nurse Advocate; RCS = Restorative Clinical Supervision.

9.2.8.3 Perceived effectiveness in meeting roles & responsibilities

Tables 9-11 summarise the responses of each group to questions related to their published roles and responsibilities (Critical Care Networks-National Nurse Leads, 2022).

Table 9 illustrates that RCS Nurses generally disagreed with the statement about completing the e-learning module on the A-EQUIP model (Q1., median ‘moderately disagree’). There was median agreement with all other statements, although agreement was slowly lower for Q2. related to accessing a PNA and discussing arrangements with line managers (median ‘slightly agree’).

RCS Nurses (n=73)	
<i>“BEFORE my restorative clinical supervision (RCS) sessions, I ...”</i>	
Q1. Completed the e-learning module on the A-EQUIP model	2 (1,5)
Q2. Accessed a PNA in line with their role and responsibility, and discussed with my line manager the timeframe for RCS sessions and implementation of the A-EQUIP model	4 (1,5)
Q3. Thought about and identified issues for discussion	5 (4,6)
<i>“DURING my restorative clinical supervision (RCS) sessions, I ...”</i>	
Q1. Identified issues, particularly those relating to seniority, gender or culture, in myself or my PNA that may impede communication	5 (4,6)
Q2. Actively participated in RCS sessions, was open and shared information, and was responsible for learning	6 (5,6)
Q3. Accepted appropriate responsibility for performance and was active in the pursuit of education and development	6 (5,6)
Q4. Gave and accepted constructive feedback and participated in problem-solving	6 (5,6)
<i>“AFTER my restorative clinical supervision (RCS) sessions, I ...”</i>	
Q1. Reflect, think through and explore options for quality improvement	6 (5,6)
Q2. Promote the best interests of patients	6 (5,6)

Table 9. Median (Interquartile Range) rating of questions related to RCS Nurses’ roles and responsibilities. PNA = Professional Nurse Advocate; RCS = Restorative Clinical Supervision.

Table 10 illustrates strong median agreement of PNAs with statements about their effectiveness in meeting their roles and responsibilities. The median rating was 6 (equating to ‘strongly agree’) for 8 of the 20 statements, and none were rated below 5 (equating to ‘moderately agree’).

PNAs (n=214)	
<i>“I am effective in...”</i>	
Q1. Advocating for patients	6 (5,6)
Q2. Creating care plans collaboratively with patients and/or families	5 (5,6)

Q3. Demonstrating inspirational, motivational and visible leadership in the workplace	6 (5,6)
Q4. Supporting change in clinical area(s)	6 (5,6)
Q5. Acting as a role model promoting psychological safety and situational awareness in my own practice	6 (5,6)
Q6. Discussing any professional issues, including clinical incidents, team dynamics, stress, burnout, instances of bullying, career progression, interviews and quality initiatives, as well as personal issues	6 (5,6)
Q7. Allowing (or creating) the opportunity for reflection to reduce stress and enable learning, limit compassion fatigue and improve confidence following a traumatic or stressful event	5 (5,6)
Q8. Portraying an understanding of personal and professional resilience and developing this attitude in others	6 (5,6)
Q9. Developing a nurse's ideas and actions for quality improvement and service development	5 (5,6)
Q10. Holding reflective discussions about revalidation and career development, preparation for appraisal	6 (5,6)
Q11. Coaching staff through reflection on incidents they may have experienced, with a focus on the system and processes	5.5 (5,6)
Q12. Supporting aspirant PNAs and PNAs in training, including by providing support and supervision	5 (4,6)
Q13. Collating data on the effectiveness of restorative clinical supervision (RCS) for staff, and the benefit of the PNA role.	5 (4,5)
Q14. Arranging any individual meetings at a mutually convenient time	5 (4,6)
Q15. Identifying a private and confidential meeting place	5 (4.25,6)
Q16. Mutually agreeing how long the session will last	5 (5,6)
Q17. Agreeing ground rules for the session and documenting these	5 (5,6)
Q18. Retaining and confidentially storing any notes taken at the meeting	6 (5,6)
Q19. Participating in and leading on quality improvement programmes	5 (5,6)
Q20. Engaging in booster sessions following PNA training	5 (4,6)

Table 10. Median (Interquartile Range) rating of questions related to PNAs' roles and responsibilities. PNA = Professional Nurse Advocate; RCS = Restorative Clinical Supervision

Trust Leads were also asked to rate their agreement with statements regarding their effectiveness in meeting their published roles and responsibilities. Their responses are summarised in Table 7, illustrating median ratings of 'moderately agree' for most statements. Two questions (Q3. regarding access of nurses to PNAs and Q4. regarding allocation of time

to PNAs and release of nurses for meetings) were rated slightly lower at a median of 4 (equating to 'slightly agree').

Trust leads were also asked to indicate 'Yes', 'No' or 'Unsure' in relation to the following statement: *"My organisation's chief nurse has identified a senior registered nurse lead for PNAs to oversee allocation, implementation and oversight of PNAs in practice"*. 86.67% (13/15) responded 'Yes' and 13.33% (2/15) responded 'Unsure'.

Trust Leads (n=15)	
<i>"I am effective in..."</i>	
Q1. Identifying the number of PNAs the service needs to implement the A-EQUIP model (based on a 1:20 ratio)	5 (5,6)
Q2. Selecting and training nurses to fill the required number of PNA roles	5 (4.5,6)
Q3. Ensuring arrangements are in place for all nurses within every service to have access to a PNA	4 (4,5.5)
Q4. Ensuring that PNAs have allocated time to deploy their role and that nurses are released to meet their PNA as required	4 (2.5,5.5)
Q5. Establishing supervision arrangements for PNAs	5 (4,6)
Q6. Ensuring there are robust governance and assurance measures in place to monitor the implementation and contribution of the PNA role	5 (4.5,6)
Q7. Identifying, collating, analysing and interpreting quantitative and qualitative data to inform reports about the process for, and impact and outcome of, the PNA role	5 (5,6)

Table 11. Median (Interquartile Range) rating of questions related to Trust Leads' roles and responsibilities. PNA = Professional Nurse Advocate; RCS = Restorative Clinical Supervision

9.2.9 Additional evaluation

A consistently high proportion of respondents in each group indicated that they were happy to be contacted by the evaluation team to discuss the PNA programme in more detail (RCS Nurses 46/73 63.0%; PNAs 132/214 61.7%; Trust Leads 10/15 66.7%).

9.2.10 OPEN ENDED QUESTIONS

Three primary themes were identified within the open-ended questions in the survey each having three interconnected characteristics most identified by RCS Nurses, PNAs and Trust Leads:

Theme 1: Conditions necessary for RCS

Theme 2: Nurse Participation, Engagement & Organisational Commitment to RCS in the A-EQUIP Model

Theme 3: Reflection and Reinvigoration from RCS

9.2.10.1 Theme 1: Conditions necessary for RCS

This theme comprised of three characteristics namely, adequate time provision; a safe space and adequate communications. Three perspectives of safe space related to the provision of offices, using Microsoft Teams and engaging in group supervision. The density of responses throughout each is focussed on time and a provision of a safe space.

9.2.10.2 Adequate Time:

Most RCS Nurse respondents indicated they were given adequate time to participate in RCS. This was described as 'having time' or 'being given time' [many RCS responses]. This meant that the process of establishing a time for RCS whilst on duty had been successfully facilitated by the ward managers and PNAs. For some RCS Nurses frustrations were expressed regarding '*not having time allocated*' and '*not being released*' from their clinical shift or duties, or '*with adequate cover provided to allow them to leave the clinical area*'. Rostered time to participate in RCS, needs adequate cover. Together with this, needing identified '*protected time*' [many RCS responses] was a frequently cited. Once in RCS sessions, on occasions the time allocated was '*not sufficient to enable issues to be explored or conducive to the topics being discussed*'. Being released from duties to participate was not reflective of all responses and seems contingent on the model used e.g., ad hoc sessions, scheduled sessions and regularly scheduled sessions. Hence, most satisfaction was expressed where RCS was a regular activity and '*dates were in place for future sessions*' [RCS Nurse].

Some RCS nurses recommended an increase in PNA provision was needed, although this was not generalised across the data:

'.....that increased PNA capacity was needed to deliver enough RCS sessions and would enable nurses to book as / when needed'. [RCS Nurse]

One RCS Nurse expressed

'.....that with so few PNAs [on one site], this [delivering RCS] might overload and add stress for PNAs'. [RCS Nurse]

Nevertheless, emotional labour was not a feature described by PNAs. It seems that the system for identifying nurses or enabling nurses to book RCS in some areas, requires further refinement.

In contrast to RCS Nurses, relatively few PNAs felt they were satisfied with having enough time to deliver RCS.

Different perspectives of time were described by PNAs regarding contingent conditions such as, pressures of day job and unmanageable, competing priorities alongside their clinical roles;

'....time to undertake this [role], as currently PNA role is secondary to my main clinical role and trust [hospital] still have not allocated any time identified to undertake role, unless in own time'. [PNA]

And this situation was similarly reflected by PNA site leads;

' RCS can't be done when overwhelmed with current workload, covering sickness or shortages [of staff] on other wards. [PNA Lead]

Satisfaction was expressed by PNAs regarding being able to support *'career development'* [PNA] and for being able to carry out *'structured planning'* to address issues raised through *RCS sessions'* [PNA] in relation to the A-EQUIP Model.

Having enough time is a hugely important factor in relation to the delivery of the PNA model and one of the key conditions identified. This is epitomised by some PNAs who felt without adequate time they were losing their skills and confidence to deliver RCS. This situation is also familiar to sites leads:

'Many PNAs are not using valuable knowledge and skills acquired through their training to support colleagues [...] we will lose our PNA skills! Furthermore, PNAs are always in the numbers like other clinicians because their role is not formally recognized'. [PNA Lead]

PNAs were very keen to deliver a service for their nurses through the A-EQUIP Model. They were enjoying the role of being a PNA, but this was outweighed by the significant volume of responses which indicated issues in the delivery of the model. Some issues relate to having protected and recognised time, or freeing of time, for example,

'Been given the time and space to do the supervision. I no longer do it because my trust doesn't give me any time and, having done it in my own time for a year I refuse to do so any longer.....'. [PNA]

PNAs were concerned that they could not always deliver the service and balance this with their current work demands:

"Staff are keen to access the service, but it is not always possible due to my working commitments and demands with patients, so staff need time to be able to access the RCS and we need more time to deliver this'... [PNA]

9.2.10.3 A Safe Space:

A private space, in a calm area to create a relaxed environment for the planned RCS session was overwhelmingly identified as a pre-requisite factor. This enabled nurses to speak openly during the RCS sessions and for most this was expressed as *'a very positive experience'* [many RCS Nurses]. The nurse's privacy and confidentiality were articulated as *'being paramount to engagement in the RCS process'* [RCS Nurse]. On occasions, for some, RCS was interrupted *'through pagers'* or *'other staff needing the office space'* [RCS Nurse] which made the circumstances unsuitable and left some nurses feeling *'vulnerable and reluctant to*

participate' [RCS Nurse]. Hence, a safe space was not always guaranteed and depended on the availability of rooms, often on the day.

Confidentiality and trust were raised as important benefits of RCS and related to safe space;

'...being able to speak to someone who is not necessarily in a line manager position and have confidence in the confidentiality of the conversation'. [RCS Nurse]

Several nurses suggested RCS should always be delivered by PNAs that are *'not familiar to themselves'* [several RCS responses] to ensure authenticity and confidentiality. Again, this associates the need to 'feel safe' in the safe space. Nevertheless, other RCS nurses described being familiar with PNAs from their ward team and the issue regarding familiarity was not cited. The solution is possibly to have the choice of PNA, regardless of the where they are based and this requires organisation and communication in advance of RCS sessions.

While using Microsoft Teams (and other digital platforms) were necessary to enable participation during the COVID-19 pandemic, this did not suit some RCS Nurses. Preference for face-to-face sessions was expressed by several nurses who had experienced RCS via Microsoft Teams, stating this *'was not conducive to feel real and purposeful'* [RCS Nurse]. Assumptions were made by some PNAs regarding RCS Nurse's access to personal computers or work offices, or privacy if working remotely. Consequently, inadequate access to computers and lack of privacy diminished finding a safe space and undermined delivery of some RCS sessions. Using Microsoft Teams for RCS needs careful consideration to take account of these factors.

Some RCS nurses indicated that group supervision was favoured, which is described as providing a *'structured opportunity to share ideas and make suggestions'* [several RCS Nurses]. RCS nurses enjoyed being with other nurse colleagues in a similar position, and *'listening to others was a process of realisation'*. One nurse stated that:

'...things that had bothered me and I hadn't looked at them, were able to be examined by others with similar experience.' [RCS Nurse]

The ideal group situation was described as *'where mutual feelings can be expressed in a safe environment'* [RCS Nurse]. Group reflection was sometimes structured through clinical and management scenarios from practice where the discussion unpacked a different perspective;

'.....helped to see what other colleagues would have done differently or what I saw differently in the scenario and sometimes thinking about this afterwards'. [RCS Nurse]

Once again, safe space was cited, but this time as needing a *'safe open space, established with trusted ground rules'*. [RCS Nurse]. Skilled facilitation and trust is a critical success factor for group supervision.

Finding a safe space was mentioned relatively little by PNAs - it seemed to be a minor irritation for some, and particularly where *'space cannot be booked in advance'* [PNA]. A safe space was presented as beneficial in the context of its purpose to constructively use time;

'.....safe convenient space conducive for staff [RCS] to explore their thoughts and form a plan.'
[PNA]

PNAs reflected that they appreciated the need for safe space and that this was a pre-requisite when arranging RCS sessions.

9.2.10.4 Adequate communication regarding RCS:

Most RCS Nurses were fundamentally satisfied with their experience of RCS which left them feeling positive and looking forward to continuing the process. Information was generally disseminated from PNAs via email or face to face contacts. For these RCS Nurses, they felt very well informed.

'I was told it [RCS] was booked about three weeks in advance, it was on the e-roster and I knew it was something different to the usual pop into the office with my manager' [RCS Nurse]

Some RCS Nurses, however, were apprehensive about RCS because there was little or no communications about sessions. Consequently, these nurses were left *'unclear about what RCS entailed'* or *'what was expected from them during RCS'*. Several RCS Nurses describe *'being sent for supervision'* and that using this approach changes perspective of RCS from *'a supportive activity, to management'*.

Suggestions to improve this included being told in advance and given information, using NHS Trust communications briefings via the Intranet and Newsletters to promote the benefits of RCS and the production of information leaflets.

9.2.10.5 Theme 2. Nurse Participation, Engagement & Organisational Commitment to RCS in the A-EQUIP Model:

In this theme nurses describe their understanding of participation in restorative clinical supervision, how mechanisms and structures for this are enacted at site level. Two key characteristics of this theme were identified as 'growing appreciation' of the benefits of RCS and, 'issues with local frameworks for delivery at site level.

9.2.10.6 Growing Appreciation of the Benefits of RCS:

The A-EQUIP model is starting to spread throughout healthcare organisations and become recognised by Nurses as a structured emotional supportive mechanism through RCS. Where needed, Nurses are accessing PNA support to resolve practice issues they find difficult to address. RCS enables openness [in safe space] to generate discussion and potential self-related actions, and others, which could improve their practice. Depending on the level of confidence and experience, practice solutions could be actioned by the nurse receiving RCS or PNA's and Lead PNAs.

Nurses receiving RCS state that the process legitimises access to support, especially when needed. The RCS model is viewed as a positive benefit to support nurses in clinical practice. A RCS Nurse explained;

'[] 'can help you see things from a different perspective [] when discussing the tough issues.'

While another RCS Nurse appreciated the challenge, for example;

'...matters related to work are opened up, that could either hinder [] or push me to improve, but they do push me to improve the way I approach work'.

Some PNAs compared the A-EQUIP Model to their previous supervision roles of 30 years ago and expressed clear support and understanding stating for the difference, stating;

'...this is different to the traditional formal learning and development of clinical supervision' [PNA].

The PNAs suggested their role is focussed on constructive behaviours and a restorative approach for nurses who are experiencing significant emotional demands. The A-EQUIP Model has made Lead PNAs and PNAs more aware of the need to take time to consider the wellbeing of staff:

'Helping colleagues to have good work /life balance, helping colleagues to offload their anxiety, enabling colleagues to feel emotionally restored after and contribute to job satisfaction in the workplace. [Lead PNA]

The PNAs reported positively throughout regarding the benefits of the model and their personal realisations about using the model. The responses relate to passion for being part of the programme and being able to use their experience in nursing through the RCS process.

9.2.10.7 Issues regarding local frameworks for delivery at site level:

This theme is represented by characteristics which relate to being able to make changes in their role, having enough time, feeling valued and respected, taken seriously by management, and supported to implement the model of A-EQUIP. Amongst the responses which indicated many improvements are needed in local delivery, there is much positive feedback from RCS Nurses and PNAs, coupled with a sense of needing to test out processes, especially for newcomers.

RCS Nurses indicated that although they were very satisfied with the sessions they attended, making changes in practice was an aspect they felt to be lacking and would benefit from being followed up after supervision to give reassurance that, for example;

'something will change to make it better' [RCS Nurse].

Some RCS Nurses apportioned their suggestions to improve matters regarding change to

Managerial level of staff, for example;

'[..] Managers need to fix things' [RCS Nurse]

and similarly, some PNAs felt managers were not as well engaged as they should be;

'...managers should be better engaged with the process and purpose of RCS'. [PNA]

While the type of manager needed to effect change is not indicated, a reasonable assumption is, of ward managers or matrons. Taking ownership and responsibility is part of the RCS process, but this is also a learning process and for most, RCS is relatively new. If RCS is relatively infrequent, this increases the anxiety that nothing will change. Notwithstanding, making change happen following RCS, requires confidence, agency and the authority to act, and may need further support from more senior staff in the process to effect change.

PNAs are keen to see the engagement of middle, senior, and corporate level Nurses to improve the strategy for delivery of A-EQUIP. There was a huge proliferation of responses to indicate that although the model is working in some areas, very many PNAs felt unsupported in its implementation:

....we've been left to set up the service on our own, which wasn't what I signed up for when I did the course'... [PNA]

Despite this, some Lead PNAs cited enjoying setting up the service and that had dedicated time to do this:

'I don't have much time, but I am following the example of others to set up the service as best as I can, I could always do more with more time' [Lead PNA]

Some PNAs expressed their frustrations about senior management supporting them and the difficulties in keeping a service going at busy times:

'Time to attend [RCS] should be mandated as when its busy it's the first thing to be cancelled...' [PNA]

There were many references to needing more visibility of very senior Nurses and needing to feel that they understand and value the PNA and RCS function of their role, one person stated:

'Senior Nursing management not taking the role seriously, they seem to be paying lip service and switching the RCS on and off, according to how busy we are. Surely if we are busy and pressure is on, this is when we need to ensure continuity of the delivery of RCS and investing in the role to support our nurses.' [PNA]

Finally, some PNAs cited not 'feeling valued' and 'not respected for what they do by the Trust management'. This is illustrated by a quote from a PNA:

[...]effective leadership within Trust, they need to support this and respect us - currently undertaken in addition to other roles with no allocated time'. [PNA]

In summary, in cases where time was not given to PNAs along with the support needed to set up and deliver the A-EQUIP model, PNAs felt devalued or overlooked by the most senior nurses where they work.

9.2.10.8 Theme 3: Reflection and Reinvigoration from RCS

The process of RCS legitimises the time and necessity for Nurses to be enabled to reflect and understand difficult perspectives in their roles, it seems this process gradually changes thinking about individual work-based issues, or those which are affected by team members or personal matters. This is a rewarding activity for RCS nurses and PNAs. Many described RCS as a time to offload or unload issues and this alone helped them to feel relieved. To key characteristics of this theme are the reflective process needed and the reinvigoration possible.

9.2.10.9 A reflective process

Some RCS Nurses describe being less able to instantaneously offload issues and 'needing time to reflect on the process of RCS', to prepare them for the next time. Others indicate they are learning about what 'RCS entails and how to make it beneficial to them and their practice afterwards'. The development of trust is also a prerequisite to authenticity in the RCS process:

'To really benefit from RCS, I need to have confidence that the person I am sharing things with is going to keep my confidences' [RCS Nurse]

Being able to begin reflection as part of RCS however, is contingent on having a safe space, which enables open conversations and issues to be explored. Hence, RCS cannot be assumed to be an 'instant hit' - engagement in the process is contingent on satisfaction regarding the necessary conditions, underpinned by a trusting relationship.

9.2.10.10 RCS is a Reinvigorating Experience

Participating in RCS was described as a positive and constructive experience by very many RCS Nurses and is where the density of responses is concentrated. These respondents expressed that '*no changes*' were needed to RCS and '*that they were very happy*' or '*want more*'. RCS Nurses described their experience as facilitated structured conversations, with debriefs towards solutions. None of the respondents provided negative feedback about their RCS experience. For a very small minority, they identified '*it was not for them*' and that '*it is what it is*'. And, some respondents were unsure about the process, expressing that '*they have only had limited access to RCS*' or '*they will see how they feel next time*'. RCS Nurses enthusiastically described how RCS has encouraged them to think differently about problems. This boosted their self-confidence during and had an impact after sessions, leaving them to feel more restored.

Final remarks provided by RCS Nurses offered a proliferation of positive feedback regarding PNAs' support, knowledge and experience. The following example is provided as representative of the feelings expressed;

'My PNA is based in [...], they are someone I know and trust deeply. They made me feel valued and empowered to change things I have control of and to take the positives out of situations where they are not always obvious. It [RCS] has been a fabulous experience so far'. [RCS Nurse]

The leadership perspective to support RCS and PNAs stems from the awareness of what could be achieved when the number of PNAs reach the optimum level to deliver RCS;

'There needs to be more opportunities for RCS and this can only be addressed as more PNAs are trained' [Lead PNA]

9.2.10.11 DISCUSSION

Many of the characteristics of survey respondents seem to be broadly representative of the wider Nursing workforce. However, it should be noted that it was particularly difficult to recruit RCS Nurses, and alternative recruitment strategies had to be implemented to try to access this group. This was eventually effective in recruiting Nurse respondents, but it is not known if those responding differed from the wider population of Nurses who have received RCS. It was also notable that we recruited considerably fewer RCS Nurses (n=73) than PNAs (n=214). Given the focus of the PNA programme on supporting Nurses in their roles, RCS Nurses would ideally have been the largest cohort recruited. The initial gate-keeping role of NHSE in approaching potential survey participants may have hindered access to this group, as those who initially received details of the survey are likely to have been at a more strategic level (i.e. Trust Leads). The information may, therefore, not have been effectively cascaded to PNAs to reach RCS Nurses. Indeed, evidence from some of the interviews conducted as part of the evaluation suggested that survey details were specifically not disseminated more widely due to factors such as service demands and other ongoing staff surveys. It is recommended that future evaluations of the PNA programme should develop and implement an additional range of recruitment strategies to specifically target Nurses receiving RCS (see (Appendix 10, pages 123-125) for explanation of recruitment strategies implemented in this study).

Nursing and Midwifery Council membership data (NMC, 2022) has reported that 70.8% of registrants were of 'White' ethnicity; 26.0% were of 'Asian', 'Black', 'Mixed race' or 'Other' ethnicity; and 3.2% didn't declare or preferred not to say. Across all hospital and community services in 2018 (NHS England, 2019), 75.4% of the nursing, midwifery and health visitor workforce reported being from a 'White' ethnicity, 20.5% 'BME' (black and minority ethnic) and 4.1% 'Unknown'. Our data is likely to have been broadly representative of these figures, although it was noticeable that ethnic diversity differed across the three groups. For example, 32.9% of RCS Nurses who responded to our survey reported being from an Asian/British Asian, Black/African/Caribbean/Black British, or Mixed/Multiple ethnic groups background, but this proportion fell to 13.6% of PNAs and just 6.7% of Trust Leads. This change in ethnic diversity with seniority has been identified previously. For example, the proportion of nurses, midwives

and health visitors from a BME background was reported to drop from 26.0% at Agenda for Change (AfC) Band 5, to 13.4% at Band 7 and 3.8% at Band 9 (NHS England, 2019). The PNA programme team, Regional Leads, Trust Leads and others should reflect carefully on these trends and implement strategies to enhance equality, diversity, and inclusion regarding appointment to PNA and Trust Lead roles.

NMC (2022) data reported that 10.9% of registrants reported their gender as 'Male', which is very comparable to the proportions reported in the Nurse group in the current survey (11.0%). It was interesting that the proportion of males fell to 9.8% of PNAs and 6.7% of Trust Leads. NMC (2022) also reported that 77.6% of registrants were in adult nursing, 7.5% in children's, 2.3% in learning disability and 12.6% in mental health. These proportions are again very comparable to the figures in each of the three samples recruited to our survey. The samples are therefore likely to be broadly representative of the wider Nursing workforce on the basis of these characteristics.

In 2021, 3.7% of the NHS workforce were registered as having a disability on the Electronic Staff Record. The proportion self-reporting a disability on the 2020 NHS survey was much higher, however, at 20.2% (NHS England 2022). The proportion of respondents reporting a disability in our survey ranged from 4.1% of RCS Nurses to 13.3% of Trust leads. Given the anonymous nature of our survey, it might be expected that the reported disability rate might be closer to that of the NHS survey. This may, therefore, indicate an under-representation of respondents with disabilities in our survey, although that cannot be verified.

RCS was generally viewed very positively by all three groups. It should be noted however, that more than 18% of PNAs had yet to have experience of delivering RCS, and this was reflected in some of the open text comments about 'not using skills'. Of those who had delivered RCS, there was a very wide range of experience, although the mean value of 15 RCS Nurses supervised suggested good levels of experience. It should be noted that this mean value will include both active and completed supervision, so it is not clear from the survey results what the level of ongoing supervision might be. The positivity around RCS was evident in terms of high median ratings for statements related to the model of empowerment (Table 2), and for the additional questions (Table 3). Respondents were particularly positive regarding their overall impression of the effectiveness of RCS, with the median rating for this statement at the highest level of 6 ('Strongly agree') in all three groups (Table 4). Only one statement across all aspects of RCS received a median rating of 4 ('Slightly agree') and this was by PNAs in relation to 'Opportunity'. In conclusion, however, the overriding impression of RCS was very positive.

In general, all three groups were also very positive about their perceived effectiveness in meeting their published roles and responsibilities (Tables 5-7). The only exception was RCS Nurses' completion of the e-learning module before their RCS sessions (this was given a median rating of 2, 'Moderately disagree'). RCS Nurses were also slightly less positive (median rating of 4, 'Slightly agree') about their effectiveness in accessing a PNA and discussing with their line manager the timeframe for RCS sessions and implementation of the A-EQUIP model. It was notable that 5 of the 9 statements presented to RCS Nurses reached a maximum level of agreement of 6 ('Strongly agree'), meaning that most respondents awarded this maximum rating for their perceived effectiveness. PNAs were also very positive about their perceived

effectiveness, rating 13 of 20 statements at this highest level of agreement. None were rated lower than 5 ('Moderately agree') by PNAs. Finally, Trust Leads were also positive about their perceived effectiveness. The only items that were rated slightly less positively (median rating of 4, 'Slightly agree') by Trust Leads related to ensuring arrangements for all nurses to have access to a PNA, that PNAs have allocated time and that nurses are released to meet their PNA. These are very important practical and workload-related issues that might require closer consideration by the PNA programme team, Regional Leads, Trust Leads and others. These issues were also very evident in the open text responses to the survey. Overall, however, the three groups were very positive about their perceived effectiveness in meeting their roles and responsibilities.

9.2.12 CONCLUSION

In summary, the respondents to the survey were likely to have been broadly representative of the wider Nursing workforce, although the response rate from RCS Nurses receiving RCS was sub-optimal. Overall, RCS was viewed very positively by RCS Nurses, PNAs and Trust Leads. The three groups were also generally very positive about their perceived effectiveness in meeting their published roles and responsibilities, although further work is required to support RCS Nurses to engage with the A-EQUIP e-learning module prior to RCS. RCS Nurses were slightly less positive about accessing a PNA and discussing timeframes with their line manager. Trust Leads were also slightly less positive about some of the practical aspects of ensuring access of nurses to PNAs, allocated time for the PNA role, and release of RCS Nurses to meet their PNA.

(3)THE CASE STUDIES

9.3.1 Introduction

The perspectives of lead persons at Higher Education Institutes (HEI) and Lead PNAs at NHS settings across eight different geographical areas were sought to provide in-depth, contextually based information regarding the implementation of the professional nurse advocate programme. This provided a view into individual organisational processes and necessary relationships between HEI and Healthcare settings; to establish and recruit to PNA programmes and to deliver RCS. Barriers and facilitators were explored, and practice exemplars characterised.

9.3.2 Methods

Potential participants were located and approached by the NHS England PNA team, where the participant information was sent with our contact details. Once an expression of interest was received by the study team from a prospective site, direct contact was made by the PI. Data collection involved two aspects: a very short survey and semi-structured interviews. The survey link incorporated online consent and was sent via email. This provided participants with the opportunity to share quantitative data regarding number of nurses at site, number of PNAs and PNAs in training. Replies were received to the survey address where selection and recruitment of sites began to ensure a maximum variation of size and geographical location. Several sites cancelled interviews due to site pressures, however a balanced geographical spread across England was achieved. Approach and invitation for an interview was made via email with consent.

Data was collected through joint interviews (RK and LLD) using a selection of questions (Appendix 5, pages 109-110) from the study schedule database (Appendix 7, pages 112-114). Prompting questions were also used to stimulate further information if answers provided were brief. Questions were iterated according to those that best generated most relevant data. Interviews were conducted and recorded using Microsoft Teams each taking between 30 and 60 minutes. During interviews, extensive notes were made by RK, which formed the first stage of sense making. Debrief between RK and LLD followed each interview. Organisation and management of the transcripts took place through framework approach (Ritchie et al, 2003) to enable data to be examined and easily retrieved from the sites. Themes were derived from commonalities between HEI and Healthcare settings.

9.3.3 Results

9.3.3.1 Geographical locations:

Case studies were conducted with eight sites, spanning Healthcare and HEI settings across England. Additional information from other HEI interviews conducted (work package 2) augmented our understanding of roles and responsibilities and these sites are also included on the map [see Figure 5]. The reach of the HEIs [in all cases] extended beyond their geographical location and, in some cases, they were responsible for delivering PNA training across north to south of England.

Figure 5: Geographical locations of case study sites and supplemental information



9.3.3.2 Healthcare sites

For healthcare settings, the size of each Trust is indicated by the number of nurses in the workforce; the number of trained PNAs and PNAs in training (Table, 5). Further information regarding nursing waiting for entry to a programme was not always available (note: at November 2022).

Healthcare Site	Total Nurses at NHS Site (approx.)	Trained PNAs	PNAs in training	Nurses waiting for PNA Programme
1	3,500	42	0	Not known
2	10,000	20	19	1
3	1,500	9	1	Not known
4	4,000	28	8	25

Table 12: Examples of Healthcare sites and PNA workforce

9.3.3.3 Health Education Institutes

Each HEI was responsible for training large numbers of PNAs across multiple Healthcare settings, which ranged from 4 – 10 sites (at November 2022, Table 6).

Site	HEI Provider across	PNA's Enrolled to programme per cohort	Overall Non-Submissions	PNA's trained Over waves 1, 2 or 3
1	8 NHS sites	85	22	63
2	10 NHS sites	250	25	1850
3	4 NHS sites	150	-	-
4	6 NHS sites	200	Average 10%	1,000

Table 13: Examples of Higher Education Institute delivery of PNA Programme

9.3.4 Introduction to the qualitative data findings

For most HEIs, the PNA training [module] was established at great speed, aided through experienced teaching staff. For example, some staff had experience of delivering leadership programmes and the professional midwife advocate programme enabling them to draw upon this knowledge to support the necessary pace and scale. In healthcare settings, the Covid Pandemic reassigned many people's roles with an appreciation of the need to take care of staff in such ill-prepared transitions. A participant described the context and the sense of urgency this created,

'When Covid happened, I realised we needed to do something for staff, so within the first month of redeploying people I took on a central role setting up wellbeing champions, to look after the nurses, working in collaboration with occupation health and the psychology team, to deliver wellbeing support. I was approached to understand where PNAs could fit into this strategy and that's how it all started.....' [Lead PNA - NHS_02]

For others, there was an appreciation of needing to establish if, where and how the PNA programme fitted into existing organisational support, such as coaching and leadership work. This meant understanding if the programme would plug perceived gaps in support and how best to engage staff with the idea, for example,

'I had a member of staff who came forward to test the programme, they were in a leadership role, but it was not until they had done the programme that we saw the uniqueness of it, you know it's not the same as a QI course or management, it's the EQUIP element that provides the difference and strong framework' [HEI_4]

Healthcare organisations initially relied upon speaking to PNAs to understand their impressions of the role. This process cascaded enthusiasm from early adopters of the programme towards the successful national roll out, despite issues encountered.

Three core themes spanned the qualitative data namely; A Personal Commitment to Implement the PNA Programme; PNA Module Characteristics, and Programme Evolution and Outputs.

9.3.4.1 A personal commitment to implement the PNA Programme

The HEI leads and lead PNAs described their roles regarding liaison with each other, and the regional leads. In cases where HEIs worked across multiple healthcare organisations this created vast administration responsibilities to ensure communications were timely and smooth for the enrolment of students. Although clear frustrations were sometimes expressed regarding communications, early adopters networked to share experience and tips. Frustrations regarding the huge scale and pace of roll out created a sense of not being able to keep track of things adequately, as illuminated.

'...there is no one single point of communication [...], which created problems for the University and communications back to the healthcare organisation, especially regarding starters or those who seem to have dropped off the radar, it was a mess initially...'

[HEI_2]

Supportive structures [processes and relationships] to aid the implementation of the programme are emerging in healthcare organisations and being replicated across England, through shared learning networks, as seen in this example.

.....since we started, compared to where we are now, we do have the regional leads, and I would say different regional leads seem to be more engaged than others with regards to being able to be our representative, I will say - I'm concerned, student X isn't attending, you know, and they're kind of like oh no, they should be coming, or I'll speak to their line manager, that kind of level of interaction.

[HEI_03].

Lead PNAs also expressed that there has been a steep learning curve, where they have relied heavily on key members of senior nursing staff to develop their knowledge about how to organise and manage the roll out in healthcare settings. In some areas there were issues regarding the appropriate selection of candidates for the programme, but PNAs shared their insights regarding how to progress at pace, while keeping staff engaged. Three examples demonstrate experiences, the differences and learning between early and a later waves of implementation:

An early wave participant:

'the PNAs were trained and then told to go back to their organisations and implement the programme – they were practice development nurses who did not have the agency in their role.... They were looking to me to provide the structure, to say how to do it – we are still creating that structure'

[NHS_2]

An early wave participant:

Initially it was just self-selection, staff put themselves forward, and that was due to the short turn around for enrolment, literally we said 'by 5pm'. Now we are getting more oversight and support is needed from line managers. We did pause all training at one point due to

operational problems and inadequate information to participants [...] regarding expectations from the training'....

[NHS_3]

A later wave participant:

'I review all the applications to make sure each person is allocated a buddy as they go onto a training place. We are looking at the spread of PNAs across the organisation nowadays, much more than at first when we accepted any application or nomination... As I lead, I am also making sure I let them do their own stuff, letting them get on with what works for them, their teams. We are still relatively early days, but it feels like the right road'.

[Lead PNA – NHS-4]

Throughout each interview participants shared their enthusiasm for the programme and the need to legitimise support for staff, action learning and problem solving to forge forward summarised the situation.

9.3.4.2 PNA Module Characteristics & Gradual Evolution:

The impression we gained is that HEIs needed to respond and react quickly to establish modules using a best fit approach, e.g., to select an existing module and adapt this to the topic of restorative supervision. The essence of training was to support leadership in the workplace. Modules are all fixed at Level 7 (Masters), requiring attendance one day per week and usually delivered over 10 weeks. Students are expected to participate in all the core lectures and the activities.

The PNA programme began during the Covid Pandemic, for this reason most of the training during this period was delivered digitally via Microsoft Teams with enrolment and the content accessed via electronic portals. We have heard for some PNAs, accessing training proved problematic owing to unfamiliarity with such processes. The delivery of training is gradually changing throughout the new waves of implementation and although most remains online, the use of webinars, development of small communities of practice, and, networking of PNAs who have completed training to support others across regions is now commonplace.

Interviewees described in-depth, getting to grips with their student needs' and being responsive to feedback, in some cases, taking time to visit healthcare organisations to gain an understanding of the issues. For some, this resulted in making changes to the module, as described:

'I found that by listening to needs [of the nurses] we were able to actually free up some of the curriculum or some of the taught content, to actually have a little bit more space in it, to be a bit more creative, which again for me was quite exciting really to be able to do that'.

[HEIP_03 – 61]

To date, there is no parity regarding module content or assessment across the many HEIs delivering the programme. This has created some frustrations and barriers to access for

training amongst some PNAs. Barriers to access relate to a lack of adequate entry credentials at the appropriate level to enable this study at level 7. Previous experience gained in professional roles and CPD has sometimes negated academic entry problems, but these are judged on a case-by-case basis. This situation is best illustrated by the following observation:

'A lot of us are unconvinced of the need for the module to be master's level, it is coming from the academic nurses background, but that feels the reality of the workforce nowadays. Not everyone has this ability at this level, but they do have the capabilities, values, experience and skills to be a PNA. We have a very experienced older workforce. It is putting people off and failure is counterproductive'.

[NHS-01]

The characteristics of Level 7 modules and subsequent assessments are different in their delivery according to the HEI. The content of the module must be quality assured and must deliver adequate academic work to be awarded accreditation. Consequently, we heard the academic credits awarded for the module, ranged from 10 to 20, and the types of assessments to be completed varied. It seemed that most issues described by participants, reflected problems encountered [by PNA trainees] regarding being able to write at level 7 and for some, this translated as needing more support than was available to them. Improved communications were also an identified need in some areas to help PNAs prepare for academic readiness to study, and the academic processes required to become a student. In some cases, these issues remained challenging, as described:

'There are challenges with the courses, I really don't know if this is the way to go for this qualification – there is the academic side of this, but the PNA role really lends itself to people who are compassionate, are committed to wellbeing, and these aspects don't always align, and that's ok, but putting this together [in practice] makes it a problem. I had a fantastic nurse she already did clinical supervision, but hadn't done any further education, her name was put forward [...]but she failed the assignment [...]. So, it gives the wrong message – that only the academic part matters ...'

[NHS_3]

Shared learning from programmes was being facilitated through a network meeting and we understand some modifications were made from Wave 1 to Wave 2, for example:

*'Portfolio and poster presentation [...] - first time around...
Now, it is a single essay, but looking at whether this could be changed again to help the students. It is 5,000 words, Level 7 – Masters'.*

[HEI_1]

Nonetheless, we heard on several occasions that there is a desire from some healthcare organisations to work closely with HEIs bring the course in- house, for example;

.... In the future we would like to co-create the training, so it is more appealing, as work-based learning, we could then give staff the options and this would feel more inclusive to ensure nurses have equity of access'

[NHS_2]

Regardless of the content and type of assessment we heard that HEIs were conscious about the academic workload required for the module and agreed that for some nurses new to learning at Level 7 or in particularly challenging or busy clinical roles, or with home life commitments, this could pose a barrier to achievement. Nevertheless, the PNA role has been designated as a post graduate role requiring level 7 study. A number of the HEI participants explained the nature of additional learning support offered such as study skills.

9.3.4.3 Programme Evolution and Outputs:

Outputs described were reflective of the stage of implementation and were discussed by HEI leads and PNA leads in their corresponding roles as an iterative process of growth. A general appreciation was reflected that the PNA programme has opened opportunities for nurses at any stage of their career to engage in further study and to combine this with experience. Participants feel that the combination served to make nurses feel valued and empowered in their roles. The narrative was presented that the PNA programme has created a movement in just 18 months (at point of evaluation) with PNAs being trained and RCS interventions being delivered. The benefits of roundtable meetings were highlighted in providing a forum to share practice that would otherwise not have been accessible from around the length and breadth of England.

We were told about outputs through the types of quality improvement [QI] projects underway, and it was acknowledged that this type of activity could be hard to capture. For the most part QI activities focused on delivering the restorative aspect of the PNA role. One example of QI work was described as follows;

'we only really get to know about these [QI work] from practice reflections as some submit Most are small scale things, such as a way to change the way equipment is used to improve the safety perspective for staff'

[NHS_1]

We asked participants about their understanding of RCS delivery outputs regarding the frequency and types of sessions offered. Some participants described the workforce returns and counting activities, but at the same time, not being sure what counted as RCS. This is illustrated from the remarks of one participant;

'We are working on this, we have moved from a position of nurses not wanting to take it [RCS] up because they felt guilty about taking the time when wards are so short staffed.... So we are still working on this, we report the number of interventions, but we also have career conversations, informal conversations... Also, we are not sure what to count – formal conversations, impromptu conversations or booked in meetings? We are gradually changing our approach based on what is described by the PNAs...'

[NHS-3]

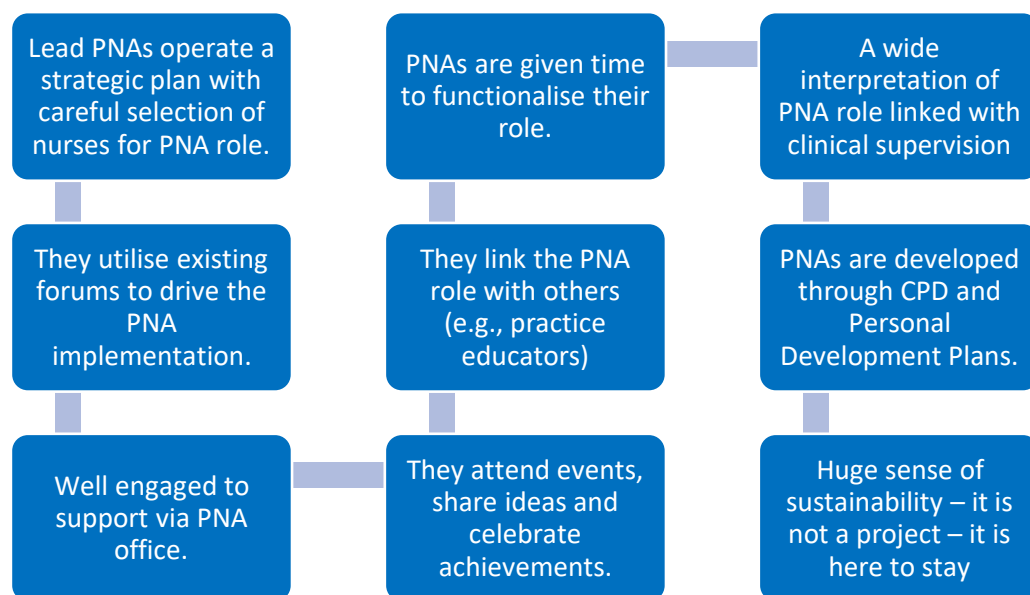
Throughout the many accounts we heard, there was an overwhelming sense of personal commitment and hard work, to ensure a robust roll out of the PNA Programme while recognising opportunities to adjust to do things differently as needed, along the way. HEI and

PNA leads have been developing supportive organisational structures and rewarding opportunities to improve positivity in the workplace. Many great examples were shared, and some of these are listed as:

- Additional Half Day teaching for Quality Improvement methodology (PDSA)
- Staff survey to gather feedback from Lead PNAs, PNAs, RCS nurses
- Clinical Psychologist to support staff (PNAs and RCS nurses)
- Shared in-box for PNAs
- Webpage on Intranet with resources – easy to access
- Librarian resources support
- Monthly celebrations of achievements
- Lanyards and badges to identify achievements
- A reporting structure created to feedback to the Board
- Board to ward, chief nurse involvement with PNAs
- Regular listening workshops
- A time to talk service (with wellbeing officer)
- What’s App group for PNAs

The working relationships between HEI and Healthcare organisations revealed characteristics that exemplify when things are successful and continuing to develop, across the cases these are summarised as (Figure 6):

Figure 6: Characteristics of successful HEI Institutions and Healthcare Cases:



9.4 THE INTERVIEWS

9.4.1 Introduction

In section 4, the interview data from interviews conducted with HEI Leads, regional PNA and site PNA Leads, PNAs and RCS Nurses is presented. In total, data were collected from 63 individuals, with 59 individual interviews and 4 two-person interviews. Focus groups were not conducted due to scheduling difficulties and the lack of joint availability of participants. Table 7 shows the number of participants from each participant group.

Population	Number of participants
Regional PNA leads	6
Trust PNA leads	13
PNAs	32
RCS Nurses	7
HEI Institutes	5

Table 14. Number of participants interviewed from each population group

9.4.2 Methods

All interviews were conducted using Microsoft Teams and transcribed verbatim (mean interview duration was 51 minutes per interview [standard deviation = 11 minutes]). They were transcribed using a service provided by Coventry University and anonymised. Maximum variation sampling was used which ensured that all perspectives from all seven regions of the UK were included. Individuals were recruited across the specialties identified by NHS England, to include the criminal justice system, primary care, and the ambulance service. Participants spanned a wide range of ages (25-62 years), males (N = 3) and females (N = 60) and those who completed PNA training via different course providers ranging from the first cohort to complete the course to the most recent cohort (in total N = 18 different course providers).

Through familiarisation, data were prepared, and summaries made, with a selection of transcripts (10%) member checked. Data were organised and managed using a Framework Approach (Ritchie et al, 2003) informed by the evaluation objectives, questions and theory (Laschinger et al, 2001). Data were retrieved and subsequently analysed from each framework category (Ritchie et al, 2003) throughout the five participants groups, to reveal the range of themes and sub themes.

9.4.3 The Themes

The interviews established (1) the baseline provision of clinical supervision before the programme was introduced; (2) the delivery of the PNA programme, with benefits and challenges; and (3) ideas which would help to sustain the programme.

Nurses described their experience of clinical supervision throughout their careers, for some this was over 30 years. Individual experiences were influenced by the length of NHS service and the different clinical settings they had worked in. For some, their familiarity with

supervision was personified through a traditional managerial model, where clinical supervision, continuing professional development, and appraisal are interlinked. Conversely, for distinct groups of staff, such as health visitors, mental health nurses and children's nurses, supervision was a regular, occurrence, normalised, and integrated into their usual practice. In contrast, some nurses stated that supervision has never been a feature, regardless of their length of nursing career or settings where they worked.

9.4.3 - 1 Baseline Provision of Clinical Supervision before the PNA Programme

During the implementation of the PNA programme, determining a baseline position amongst PNA trainees was an important starting point to understand their experience of participation in supervision. Four sub themes are described here; awareness, experience and provision of clinical supervision; potential benefits of good supervision; perceived usefulness of existing supportive restorative services; and time, staffing and approaches used to deliver supervision.

9.4.3.2 Awareness, Experience and Provision of Clinical Supervision

In general, prior to the PNA programme emerging, supervision featured only marginally in nurses' experience as illustrated below:

"...every presentation [PNA Programme Implementation], every meeting, the question is asked, 'how much clinical supervision have you had since you've qualified?' And it's very little. I've got nurses that are probably in their 40s and 50s that never had clinical supervision. It's not been valued and they never put it in place.

(RPNAL_03)

Whilst educators were experienced in this field, it was often remarked that the concept and delivery of supervision was new for many practising nurses:

"...I've professionally been immersed in this whole area of practice [clinical supervision] really since, well 1999, so way back when, [...] it probably feels new for many people, so none of it's new for me because it's almost second nature, and it's evolved, so it evolved from what it was even within the statutory model, to how it ended before statutory supervision demised".

(HEIP_01 – 46)

It seemed that nurses' exposure to clinical supervision was related to the specific characteristics of the clinical team and the commitment in various settings, which drive the success for this to be embedded as part of practice:

"So my experience of the clinical supervision goes back years and years because I've got experience from district nursing. And years ago clinical supervision, the reflective model, has always been predominantly embedded into district nursing and health visiting. And so we used to run our own clinical supervision groups. I was the lead for that within the trust at the time about rolling out a model and a policy, erm

accessibility for staff into that clinical supervision program sessions. And then more recently with the transitioning to acute, I'd say about nine years ago, acute had never heard of it. So it became obvious it really was a community based reflective model that was known about a lot. But in the acute they'd never heard of it.

(LPNA_02)

Where clinical supervision was delivered by 'management/supervisors', this was described as a "tick box" exercise. Nurses did not feel like they could be truly honest with their superiors for fear of retribution. This led to frustration - nurses felt they were not able to get the most from their clinical supervision sessions and this led to the development of "supervision stigma" as remarked:

"It was more about your bosses, your hierarchy saying 'oh, yes, we'll look after you' and your supervisee thinking 'yeah, sure you will' and being caged in and you didn't feel like you could open up and say how it really is, you didn't feel like your job would be protected you thought 'oh, they'll get rid of me, I'll be sacked if I say too much about... I if I speak up and call people out."

(PNA_15 – 151)

Finally, some PNAs and RCS Nurses reflected on the lack of clinical supervision throughout their careers:

"I've never had clinical supervision, never been offered it, never really spoken about it..."

(PNA_3 – 35)

The scope of experiences indicated demonstrates the contrasting provision and uptake of clinical supervision in nursing prior to the PNA programme.

9.4.3.3 The potential benefits of good clinical supervision

Despite the varied experiences of clinical supervision, nurses reflected a good understanding of the potential benefits of engaging in a process of support, were it available to them. Several nurses described coping without access to support, and adopting undesirable strategies, such as 'shelving or retaining problems', which caused a range of psychological effects and career decisions. One Lead PNA highlighted that a clear need for supervision existed, even though nurses might not always be aware of their own needs in this area:

"I think if people haven't had it they don't miss it, because they don't know what they're missing. But if I think back to people I've worked with over the years, I think there are people who have left who might have stayed if they'd had access to clinical supervision. I think I've worked with people who have called off sick with stress related issues, that probably could have stayed well with clinical supervision."

(LPNA_06)

An extremely positive perspective of the potential of clinical supervision was exemplified by the following nurse:

“I’m a Mental Health Nurse [...] since 1986. I have had supervision ever since I started nursing and I couldn’t have done my job [...] without supervision. The foundations of clinical supervision started in psychiatry, back in the old asylums. So, for me it’s just been there, it’s one of those things. I’m a huge advocate of supervision. I don’t think anybody, particularly clinical staff, can be doing their job without supervision, I think it’s dangerous. So, my experience of supervision, I’ve had some amazing supervisors. I’ve had one or two that haven’t been so amazing and it’s just working with that really. So, I’m a real advocate of clinical supervision.”

(LPNA_08)

Benefits in terms of workforce care quality, staff well-being, staff development were described by the HEI Leads relating to education and development:

“I mean there’s huge variance [regarding benefits], but I’m thinking of a couple of students in particular coming to my mind and their words are ‘I was able to stay, it’s refreshed my career, I’m now using all my skills that I’ve had over the whole of my career and I’m reenergised+’. It’s almost what’s happening with some of our legacy nursing and legacy midwives in terms of keeping people, that end of career bit, but this doesn’t necessarily mean end of as in thirty years down the line, it’s retaining people in a different way”.

(HEIP_03 – 436)

The poignant example below illustrates how supervision, at critical moments in a nurse’s career, could have significant impact in recovering and learning from mistakes in practice:

“I remember after making my first drug error not wanting to give anyone any medications ever again, and actually having someone to talk that through with rather than just working, you know, you speak it through with your friends, but I think in situations like that clinical supervision would have helped me to process it quicker, and hopefully then it wouldn’t have affected me for as long as it did.”

(PNA_03 – 51)

The potential benefits of resolving anxieties through restorative clinical supervision were also reflected upon:

“I think if I had chance to develop and understand what my anxiety was about, I probably would have stayed within the clinical role more than going into the educational role.”

(PNA_05 - 43)

These examples from practice reflect different experiences that positively or negatively influenced nurses’ wellbeing and ultimately, sometimes the choices made throughout their careers. It was evident that many nurses felt that restorative clinical supervision has a role to play in supporting nurses to practice effectively.

9.4.3.4 Perceived Value of Supportive Restorative Services

Prior to the national launch of the PNA programme, it seems the availability of clinical supervision was not widespread and if available uptake was poor. Nurses discussed a range of supportive 'restorative' services that were available to them e.g., access to a clinical psychologist, access to human resources staff and chaplaincy. Nevertheless, for some, these services were perceived as inappropriate, the key reason being the 'lack of relatedness and shared experience of being a nurse' and thereby understanding problems from a nursing perspective, as illustrated:

"The only service that was available for us to go and talk to is this clinical psychologist for half an hour whilst on shift. And it was just not - I can't go and spill my beans and put my beans all back in a box."

(RCS_06 – 24)

"... the hospital we do have psychologists, we do have chaplains and we do have ... I prefer the other one, it's the support for [other] staff as well, wellbeing hub. So we do have that kind of stuff but I don't know, I haven't utilised that very much. I feel more comfortable with the PNA, it's just because she is a nurse as well, I'm a nurse, she can understand me."

(RCS_01 – 371)

"I think there is definitely something around that shared experience and that understanding. So, for example, a nurse to a nurse – well I've walked in your shoes, you know?"

(PNA_01 – 894)

Hence, it would seem there has been a gap in support deemed to be appropriate prior to the introduction of the PNA programme for many nurses who preferred peer-to-peer support from other nurse colleagues.

9.4.3.5 Time, staffing, and approach used to deliver Clinical Supervision

Many participants suggested the main reason that clinical supervision has not been a prominent feature within nursing, has been lack of time to deliver due to insufficient staffing in clinical settings. The way in which clinical supervision was delivered impacted on the spread of provision and equity of access throughout nursing. Regional PNA Leads identified that whilst supervision in nursing has overall, been scarce, it was more embedded for some groups of staff by comparison to others. For example, mental health nursing was identified as more likely to have embedded clinical supervision.

Lead PNAs reflected on one of the biggest challenges in the implementation of the PNA programme related to the time commitment needed:

"Time accessibility is a major barrier. Having time to be relieved. And how does that look? These people still have a job. So you've got nurses in intensive care who might be Sisters. They can't leave and provide an hour. Or, you've got staff working in casualty, so it's very difficult for staff unless they've been given that protected time to

deliver. But also the accessing of it again is down to how good the managers are. So if we've got managers who are supportive of staff to access it. It might be a case of them accessing in their own time. If they do, it's still very unsure, are they getting that time back? So that could be a barrier because you might be thinking, 'why should I when I've got a busy life anyway? And how much sessional time are you gonna support? Is it gonna be an hour a week? An hour a month? What does that look like? Some places are looking at 8 hours a month, but then other places might go I really cannot relieve a PNA for 8 hours a month from existing duties that they have to do, they've employed them to do because actually, I've got 50% vacancy rate. I've got 10% sickness rate. I can't get bank or agency.' (LPNA02)

Depending on the approach used may have meant clinical supervision was subsumed within post graduate programmes, rather than being part of everyday nursing practice:

"So, from my experience working with an acute provider, the majority of nurses that got supervision were predominantly speciality nurses. So, things like clinical nurse specialists, midwifery, they were very much ring-fenced [identified] for clinical supervision. When it came down to the general nursing, registered nursing it was very it was very ad hoc. I think one of the reasons is the time factor. The other reason is that I think a lot of them badge [add this] on to other programmes, like the preceptorship programme or one-to-ones. Whereas the restorative clinical supervision programme is so much more than that."

(RPNA L_02)

Many nurses described the contrasting delivery of clinical supervision across different areas of the nursing workforce:

"Yeah, with me it wasn't a thing when I was working in ITU, I knew about it because I'd got friends that worked in mental health and learning disability nursing, and it was a real big thing with them...."

(PNA_12 – 39)

A number of nurses identified the need to roster in advanced to allow space for clinical restorative supervision. It was noted that this was a challenging aspiration in the context of short staffing:

"I think it's organisational, I think generally we can see that the NHS, whichever hospital you walk in, no-where's adequately staffed. I mean in my Trust they did try about [...] ten to fifteen years ago actually, they did train ward managers, went to local universities and did training for supervision, but when they tried to put that into practice there wasn't the time to pull people off, to sit and talk to them for an hour, it never got done."

(PNA_12 – 71)

"Nursing has always been so busy and most nurses always put their patient first and there's always something else to do. Nursing has never been very good at giving nurses any time out of the clinical work phase".

(PNA_21 – 39)

9.4.3.6 Delivering the PNA Programme

At each level of the PNA programme implementation distinctive challenges were described. The biggest cross cutting themes related to the organisation and administration of the programme. Challenges were broadly expressed by Regional PNAs in relation to the recruitment of PNAs. Lead PNAs described the speed of recruitment required, course content and variations of this across England. PNAs themselves described a mixed response to their training and the realities of implementation in practice. RCS Nurses described frustrations with the difficulty being released from practice for clinical supervision.

Three broad themes emerged as - Challenges to Overall Programme Delivery; Benefits of Restorative Clinical Supervision and Challenges related to the Delivery of Supervision in Practice.

9.4.3.7 Challenges to Overall Programme Delivery

This data related to the Regional PNA and Site Leads with several accounts given regarding issues relating to recruitment and retention of PNAs to the PNA programme. In the following quote, the Regional PNA Lead explains that PNA course recruitment and retention issues occur due to the lack of time for Healthcare Trusts to release staff for the course:

“So administratively, it's been quite a pickle because it's such a short time frame to ask for nurses to be released that we were, we've been scrambling sometimes to get enough to fill cohorts at the right time. Then you'll manage to fill them, but you'll then [...]confirm places with people, then you'll get people pulling out because they just can't get release. So, whether that's more support needed in trust for them to be released when they're given a place. Whether we need to be more forceful with 'no, this is your place, you need to take it and you need to work out how you do that.' I don't know, but that that can be frustrating.”

(RPNAL_03P4)

Some of the Lead PNAs and PNAs described a lack of standardisation in the delivery of the PNA programme assessments across the different HEIs and the issues this created for them:

“My experience was such a differential in each provider. So, you might get some universities [...], wanting 30 credits, some were wanting 15 credits, some were doing 20 credits and, you didn't have a choice. It was a case of, you got sent to the university, and it might be 30 credits for you. It might be 15 credits for you. And I don't think that really was thought through, because then you had some staff who didn't want to 30 credits and do a 4000-word essay as well as everything else, and then you had to staff who do want to do 30 credits. So that caused a bit of mayhem, a bit of extra stress. I am getting different feedback from different universities, well from different people attending different universities because I don't think it's standardised enough.”

(LPNA_02)

“I think it [the assessment] should be standardised because it causes trouble, it causes frustrations, especially those that have the more in-depth assessments.”

(PNA_17 – 200).

It appears that the rush to recruit nurses contributed to some managers ‘nominating’ their staff, rather than staff voluntarily completing the programme. This meant that some nurses and managers were unprepared and did not know what to expect.

“I don't think with hindsight my manager really knew what the role was. So, I don't think there was much awareness of actually what I was signing myself up to.”

(PNA_16 – 29).

While others nurses described the lack of time to apply and prepare themselves for the course:

“We had ten minutes to get our applications forms in. We had no idea what we were letting ourselves in for because, at that point, there really wasn't any information about it and I didn't know about the PMA role at that point, either. So, no. I knew absolutely nothing, other than my matron saying to me, I volunteered you to do this course. I was like, oh, okay then. You've got ten minutes to get your application form in. The course starts in a couple of days, and I don't know what's involved in it. I was like, oh, okay.”

(PNA_25 – 12)

These are important issues to be resolved for each partner in the process of the PNA Programme delivery. In particular, the timing of the recruitment for the prospective PNAs requires adequate readiness to study, such as, arranging the commitment of time, prior reading and as described ‘getting in the zone’. These are regarded as key success factors for post graduate study.

9.4.3.8 Benefits of Restorative Clinical Supervision

Across the participant groups many benefits were described regarding the difference that restorative clinical supervision has made or has the potential to make. Each group gave examples based on their level of involvement with the PNA programme. The RCS group as key benefactors in this model stressed many benefits and outcomes of the PNA model.

In delivering RCS, whether through the ideal model of delivery or the adapted brief model of delivery, the Regional PNA Leads emphasised that the PNA programme is about offering support to professionals, not solutions:

“It's giving people the opportunity to reflect and as a PMA or a PNA you're not there to provide the solution, you're there to listen, and let that person find the...in many ways direct them, well not direct them but get them to come to some sort of solution, some sort of action plan.”

(RPNAL_01)

We learnt about the need to report restorative clinical supervision delivery via workforce returns, we understood from this that there is some confusion regarding what constitutes restorative clinical supervision and whether to count short bursts of contact as illustrated:

“I think people just need to recognise that a corridor conversation can be ‘a contact’. You know if you've had that 5 minutes for somebody who's really distressed, and you've made a difference, then you need to be able to count it, but nurses don't. They think it's, you got to sit down, you got to be away [in privacy] from the [clinical] area. But it's about recognising that it [RCS] comes in different forms really. Some of it, people are doing walk around the wards. You know, so they're taking trolley and they're going around and they're talking about the role and people come up and have a chat to them. And some of those conversations might be a bit more in depth than others.”

(RPNAL_06)

Flexibility of approaches used for supervision, according to circumstance, was echoed by a nurse who had received RCS:

“I think there are some sessions that need to be away from everybody else where that person can ... whether they need to absolutely break down and just lose it and then put that armour back on again. It depends on the situation. But I think you definitely could do a part of your morning huddle with the team, “so what’s going on with your patients today”. It can be brought in like that.”

(RCS_04 – 513).

PNA's described numerous benefits associated with the PNA model but were clear that nurses who were not directly involved with the programme were aware of them. Some nurses identified that effective and timely supervision had retained them in nursing, and had enabled them to overcome significant workplace related wellbeing problems:

“Having some restorative supervision from a really excellent supervisor really helped me remain in work and be effective in my job. Actually, it did give me the insight and confidence to think I’m ready to move on, and that’s how I ended up moving on and coming into this role really. I think that supervision I had at that point was quite a pivotal thing for me”.

(PNA_32 – 61).

We interviewed 32 PNA's, through this we learnt of many other benefits regarding their role in delivering restorative clinical supervision, these are summarised in Figure (7):

Figure 7: Summary of the benefits of RCS delivery identified by PNAs

- Benefits of RCS identified by PNAs
- Improvement in personal self-care
 - Improved work life balance
 - Increased enjoyment at work
 - Improved mental health and well-being
 - Enhanced life satisfaction
 - Improved home life well-being
 - Improved personal and professional development
 - Improved relationships and teamwork whilst at work
 - Enhance NHS's image due to healthier and happier workforce
 - Enhanced resilience
 - A larger number of effective service improvements
 - Improved retention of staff
 - Improvements in nurse empowerment
 - Improved confidence of staff
 - Better job satisfaction
 - Smoother transition for overseas staff coming to the UK
 - Improved delivery of patient care
 - Improved physical and mental health of nurses / lower sickness levels
 - Personal and professional benefits to the PNAs conducting RCS

Almost all RCS nurses interviewed presented their experience of RCS positively, emphasising the restorative element by PNAs and the importance of this, to supporting them in practice:

[...] I think sometimes, we just need that somebody who won't be judging us, like, somebody is just there to listen to us. Somebody who will just accept what we're feeling, rather than saying you do this, you do this, and you do this. It's just a way for you to open up yourselves without being judged."

(RCS_01 – 97)

"It allows you an opportunity to talk about the challenges that you deal with and in fact, you start to work things out for yourself, but that only happens when you express those thoughts. And also sometimes there are shared feelings that you don't realise that perhaps people do experience as well. So I think that's really useful. And just simply a little bit of time out from the usual hustle and bustle is beneficial."

(RCS_03 – 257)

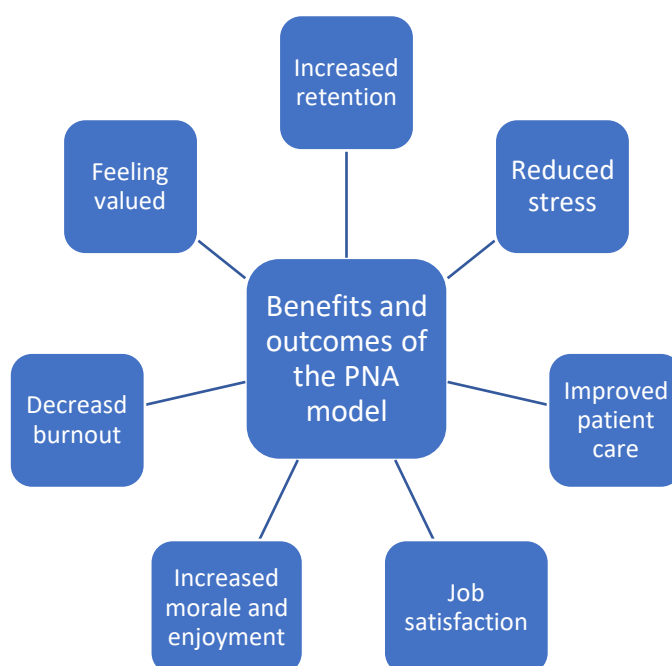
The responsiveness and understanding from individual PNAs tasked with the delivery of the model and following up nurse's post supervision, to develop a supportive relationship rather than supervision being viewed as a one off event was also exemplified:

“Yeah, there’s been follows ups and it’s been very, very informal. It’s mainly been when we’ve been both been stood in the Nero queue for our coffee and it’s like are you alright, how are things, do you want to chat, I’m just upstairs. And I have popped up to see her and I’ve borrowed the odd book off her and things. So, it’s been very, very informal. I know that I felt if I needed a formal session, I could email her and say can we have so and so please, and it would be sorted straightaway.”

(RCS_04 – 245)

Many other key benefits/outcomes of the PNA model, were voiced by the RCS nurses. Notably, many of these align with Laschinger’s model of empowerment, particularly psychological empowerment and the development of positive work feelings (Figure, 8).

Figure 8. The benefits of the PNA model identified by RCS Nurses



Strategies used during supervision by RCS nurses were also identified, which have the potential to strengthen its benefits or outcomes in the future, as listed:

- Having the opportunity to talk through challenges and shared feelings (rather than shelving or retraining them)
- Learning how to work things through for oneself [solutions]
- Learning how to express thoughts and feelings [gaining trust and insight]
- Taking some ‘time out’ from work during periods of high stress
- Validation of how someone is feeling
- Learning how to deal with difficult situations more effectively [insight, experience]
- Ensuring that work issues are not carried outside of work [containment].

9.4.3.9 Challenges to the delivery of restorative clinical supervision in practice

Challenges relating to a lack of hands-on practical experience to deliver RCS were identified by PNAs as problematic. This was recognised by Lead PNAs and feedback to HEI Leads who worked hard to remedy issues raised. Lead PNAs and PNAs were concerned that the content and delivery of PNA module does not always fully prepare them to deliver RCS:

“...nobody’s ever observed me and said, “Yes, that’s how you do it,” or, “No, it isn’t.” You’re just left to get on with it, and that, to me, is the biggest failing of the university course.

(PNA_23 – 141)

Similarly, some PNAs felt the course was too theory-based and the online delivery [only option available during Covid period], prohibited the practical application of delivering the role after the course, as described by this participant:

“What now? What happens now? How do I do restorative clinical supervision? And I think that’s what we’re seeing with some of our PNA’s coming out from university. “Well, I haven’t even done restorative clinical supervision, so I don’t really know what I need ... I don’t really know how to do it”.

(PNA_01 – 299)

A Lead PNA described how the Hospital tried to mitigate this challenge, by offering in-house training opportunities to prepare their nurses to deliver RCS during and after the PNA programme:

“Just attending a piece of training does not make you competent at delivering restorative clinical supervision. [...] But then we also build in access to RCS for about 3 sessions at least with a supervisor. So there’s role modelling, there’s that emotional experience of what it feels like. The appreciation of each other’s roles and contribution, listening to how the supervisor questions and responds. And then we also give them the opportunity of doing a practice run with someone else or one of us. And so they’re actually building up skills, real life skills, rather than just following and watching a video.”

(LPNA_02)

We also heard extremely positive accounts from HEI providers where modules had been modified to reflect PNA feedback, for example; the introduction of role play (recorded) to practice RCS with peer [group] feedback and aspects which aided the communication skills needed in practice, as described:

“...I realised because at first it was a written reflection, and a competency document, and there was a very high failure rate because of the lack of academic skills of the cohort - the first cohort that I ran. So I took my thoughts and ideas to the Major Modifications Board at the university, and said that because of the nature of the role being so hugely dependent on communication skills, hugely dependent on presentation skills, that a written assignment didn’t align with the overall role. So I asked and proposed that we changed it to a

presentation, an individual presentation, alongside the competency document and had to do loads of work to amend that. The value of that was very evident because there was a tremendous increase in pass rates because those nurses were much more proficient at ... communication skills..."

(HEIP_01 – 70)

Nearly all PNAs identified a lack of time to conduct RCS as a significant issue impeding the roll out of the programme. While some PNAs indicated they had protected time, most did not, and they felt they were not able to fulfil the role to their satisfaction. Essentially, even with protected time, some PNAs still were pulled back into clinical practice. It seemed that lower band nurses found it more difficult to get the free time to conduct PNA-related activities. Some nurses found their own solutions and delivered RCS in their own time, although this was considered unfair, and some Trusts have even prohibited this.

"I don't have the allocated time and I am not able to release staff for protected time, paid time to do it. So I haven't been able to run these sort of proper restorative clinical supervision sessions".

(PNA_15 – 285)

Nurses were concerned that the speed of introducing the programme could adversely affect its longer-term sustainability:

"...I just know that sometimes, the NHS can be very quick to put a plaster on a hole, rather than taking the time to actually properly fix it. I'm worried that this is going to turn into a quick fix solution that's going to end up going down the drain and not working because they haven't put the right time and resources into it, and it's just been rushed through. That's my biggest concern, really".

(PNA_18 – 373)

Nurses reflected that altruistic behaviour could make it hard for some nurses to prioritise restorative supervision for themselves and for others, as illustrated by this example:

"I'd say that actually some of the people that I manage, might say it's difficult to get the time out to do this, but I think that's a more of a [organisational] cultural thing and something that we'd have to 'work on' to make people [nurses] realise that it's important that they have [make] time to do things like this."

(RCS_03 – 212)

Despite the obvious tensions in delivering restorative clinical supervision the underlying motivations of the PNAs were embodied through making a difference:

"Even if, I don't know, I only speak to five people a week or five people a month even, and I make a difference, then that was worth it. I don't have to speak to 50 people. Last month I only spoke to one person, but they then haven't now left the profession. I consider that a win".

(PNA_21 – 358)

In this situation it is not about the volume of RCS delivered but the impact of delivery.

Whilst having adequate time to deliver RCS was a predominant challenge, nurses also identified stigma associated with receiving RCS. Some nurses felt that visiting a PNA for RCS could indicate something negative to others e.g., poor mental health or a negative incident that has occurred, as illustrated by the following examples:

“There’s a little bit of stigma when somebody is going for that RCS, because people think that they’re not mentally stable, they’re emotionally not stable. And there is still that stigma that they’re not okay, that’s why they need to go to RCS.”

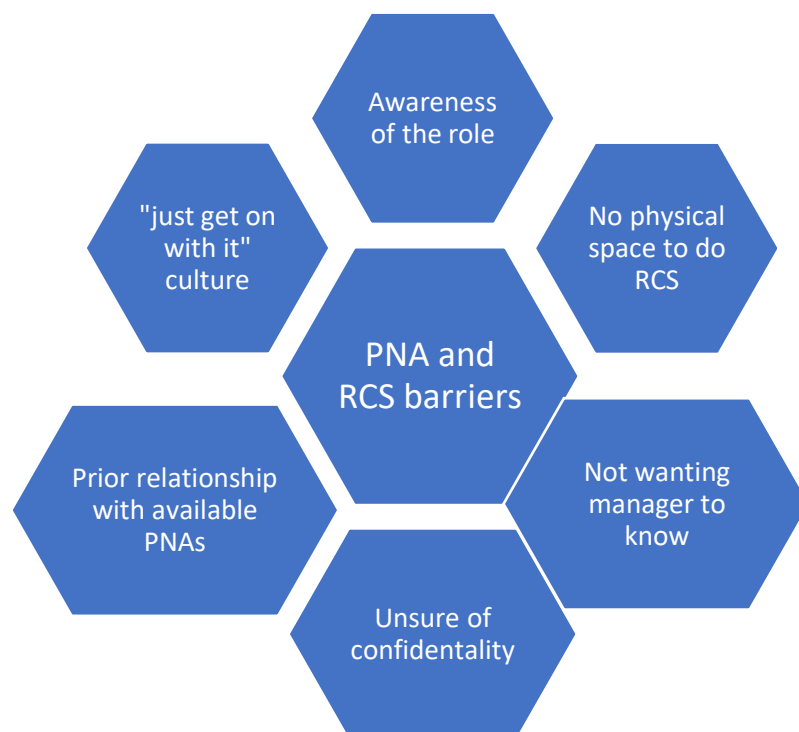
(RCS_01 – 298).

“I always thought clinical supervision was what happens when you're kind of being performance managed or reviewed. So it when I first heard about it, I was like, oh my God, what have I done wrong!”

(RCS_02 – 29)

Although the perception of available time and staffing resources were prominent barriers to the delivery of clinical restorative supervision, other important barriers voiced by the RCS nurses, as illustrated in Figure 9.

Figure 9. Challenges described by the RCS nurses regarding receiving RCS.



Despite some difficulties in delivering and receiving RCS, a willingness to overcome problems and find solutions was evident throughout the interviews.

9.4.3.10 Future Sustainability of the Programme

All staff engaged in the programme believed it was a positive enterprise to benefit nurses. Key aspects discussed were sharing experiences to learn from each other; building and maintaining relationships; the organisational structures required for successful delivery; adapting the programme delivery and continued funding were seen to be crucial to sustain the programme.

The Regional PNA Leads discussed the importance of building and maintaining relationships across the range of key players involved in the implementation of the PNA programme; the national team, lead PNAs, PNAs, and the HEIs. For example, the Regional PNA below reflected on the important ways they worked with and supported each other and how their role drives the programme forward:

“...we’re all on the positive side, we all get on really well.... We meet, when we can every week, we work in a collaborative way. We try, we don’t try and ... do something completely different. so I think there’s a lot of cohesion.... We’re always willing to help [each other] and support... For example - I’ve not been able to fill this cohort, and I’m like, well,.... I’ve got so many on the waiting list can they come on yours? Can they come in your numbers?”

...you know not to underestimate the role of the regional PNA leads both in driving it forward there have been sometimes where you know you got those operational pressures and it’s really tough going, but it’s to keep that sort of momentum and positivity going. And that is so now that it’s become a movement”.

Regional PNA Leads felt their role should continue to feature in the infrastructure of the programme in the future to aid the national oversight:

“[...] I do think you need a regional role. Even if it’s just at one day a week or two days a week, I can’t see it working otherwise. I know that they want, they’re taking about local leadership. Yes, local leadership is fine, but someone’s going to have to inspire them and get them to agree to filling up places and then looking after their colleagues. Otherwise, they’re going to be having, I don’t know how many trusts there are in the country, 400 and something trusts contacting the national team.[..] but the programme needs some sort of regional based leadership just to help coordinate it and keep it together whilst there are funded places. So, there’s only one more year, after that maybe things will be embedded enough that it can sustain itself and the national team can bring it together..”

(RPNALINT01)

If regional roles are to be successfully reduced in line with the long-term national plan it was suggested that Lead PNAs should be available at every Trust. This was seen as an important role in its own right, but it was noted that competing priorities often reduced the capacity to organise and manage the delivery of the programme:

“.....So hopefully, my vision in two years, every provider will have a dedicated PNA lead. That's might not be full time, might only be two or three days a week. So then actually, that person who's got the capacity to push the programme forward within the organisation. So that's my vision.they've all got a PNA lead, but again, it depends, like me, I've got, I'm doing PNA, I'm doing lots of different roles, isn't it? So then they're not all dedicated, they're not all dedicated to the PNA, they're probably juggling the corporate responsibilities.”

(RPNALINT05)

It was identified that the delivery of the programme is generating the potential for research with questions contemplated regarding the effectiveness of current delivery in practice settings:

“It's a reality versus the theory. And in time to come, they'll probably start writing up more research about that actual transition of theory into reality.... because I think, yes, we've got lots of research [data] about an hour and we book them in and we follow them up and things like that, and that's really good. But what about the 15 minutes? What difference does that make? And so that data collection, you know, and we're having discussions now, we're like, how do we collect that data? How do we make it easy so we can collect it and it doesn't get forget forgotten, how can we actually go back to the people that accessed it and ask them, did it make a difference? But actually did it also make a little bit more difference to how you can face your day, your resilience, refreshing, resetting you, you know? So there's a lot of, I think, work around that.”

(LPNA_02)

The HEI Leads offered their perspectives regarding the oversight needed to support and sustain the education of PNAs in practice settings, in this case evolving the programme in line with challenges in healthcare:

“I will always, every cohort, look to improving the module as much as I can, improving the content, updating things, making sure it's contemporary and it reflects contemporary healthcare needs”.

(HEIP_01)

And, in this case one provider reflected about the styles of delivery and how this might need to change to adequately prepare PNAs for their roles:

“I think we could do more restorative clinical supervision activities where it is one to one, and where we can potentially film and feedback and then debrief, so a little bit like that, so they felt a bit more confident to go out and hit the ground running, as I'm not so sure they do at the moment”.

(HEIP_04 – 688).

There was a suggestion of clinical supervision being a mandatory part of every healthcare professional's role:

“Every nurse and midwife healthcare, professional physiotherapist, occupational therapists, paramedic must have restorative clinical supervision or they must have PNA or PMA or whatever, that would make a huge amount of difference. That would make it real”.

(HEIP_02 – 637)

The influence that the programme is already having was also reflected upon positively with the caveat that this will need to be adequately funded:

I hope it continues to get the level of funding to support it. I think even if it didn't, I think there's an appetite now and that's quite exciting, I think as I said there's people that can see their career trajectory going in another way because of it, which is something they'd not thought of really.

(HEIP_03 – 657)

And, finally the ultimate benefits of the programme for the future workforce were encapsulated by this description:

‘This workforce will come out knowing that the professional advocates are there as part of a support network and will utilise them as part of their everyday working life, which is what we want, because then we want them to be more resilient and that's what we aim to do. So hopefully that's what will happen’.

(HEIP_01 – 281)

PNAs frequently discussed the need to learn from PMAs, as well as other PNAs, commenting that the role should not be carried out in isolation. Some respondents felt the role should not be exclusive to nursing, consequently, it was believed that the PNA model had the potential to be implemented across other professions:

“Engaging all professionals, all healthcare professionals within the MDT. I don't think there's one PNA that I know feels like this is exclusive to nursing. It started in midwifery and it was deemed not exclusive to midwifery, it's now in nursing as well and I think midwives and nurses see that this is something to be launched across healthcare generally”.

(PNA_15 – 471)

It was also viewed as having the potential to create greater multidisciplinary relationships:

“You could have a nurse to a paramedic for example, and then you would have shared learning and respect for each other's roles, as well as understanding, which is what we wanted to develop that relationship amongst our workforce as well. So that's why we made it multidisciplinary”.

(PNA_01 – 196)

The value of the PNA role in relation to newly recruited international nurses was mentioned. It was recognised as a transition that could be stressful and where RCS might help support individuals:

“It will be beneficial for the overseas nurses when they come here, for example, they’re newly hired into the hospital, it would be a good time for them to have RCS when they arrive to prepare themselves emotionally and physically because they’re overseas nurses and they can feel that somebody can support them emotionally, especially when you’re in a foreign country and you don’t have family members, like, anxiety and depression can easily strike them.”

(RCS_01 – 269).

The RPNALs emphasised the importance of the programme, and reinforced that the future direction is around nurturing and embedding the programme within the trusts:

“I think it's an absolutely brilliant project. It's something that we needed. It's something we've got to embed and we've got sustain.” (RPNALINT)

10. CONCLUSION

The three aspects of Laschinger's model of empowerment namely Structural empowerment, Psychological empowerment and Positive work feelings are represented throughout the evaluation data. The aspects of the model are never cited in isolation and are interconnected perspectives. Hence making positive changes to improve the PNA Programme is complex and an appreciation of the connections between National, Regional and Site Levels is required.

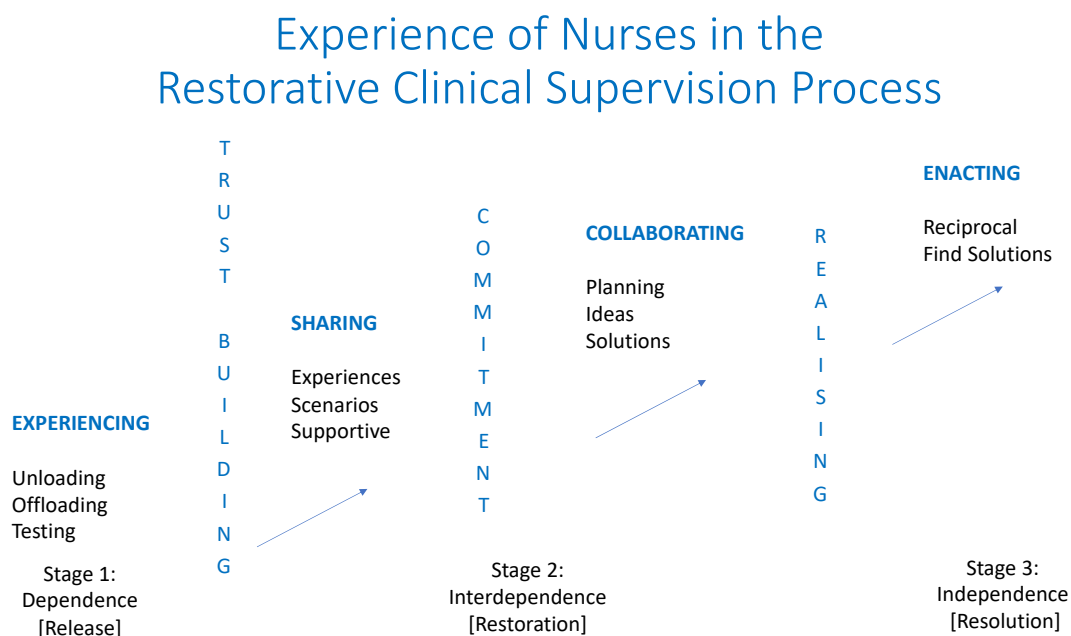
Structural Empowerment: At NHS England programme level, the establishment of the PNA programme and its gradual roll out through the regions of England has been achieved through a centralised, well-organised approach via the PNA office. We heard that regional leads were supporting their site leads, but that further backing was needed from some Directors of Nursing to deliver the programme. For example, wide disparity of approaches was described, with some site lead PNAs juggling many other priorities, limiting the time to invest in implementation of the PNA programme. Nevertheless, sharing of good practice examples through the regional networks was successful and brought cohesiveness to its delivery. HEI Leads worked very closely with partners across all levels and demonstrated flexibility to modify the education modules, following feedback. Their role to support PNAs at the clinical interface was also described positively. At the clinical interface, recruiting nurses to the PNA programme is gradually being achieved but the speed of recruitment and 'last minute reaction' to fill available places may not achieve a consistent approach and good organisational spread of PNAs.

Structural empowerment is reflected through opportunities created to undertake the PNA training and role and, for RCS nurses, to uptake the process. At this level of delivery, the predominant resources called for, are adequate time and a safe space to participate. Information to support implementation and to generate interest and support for the model is featured through good examples of collective supportive local networks. Not everyone involved however in the PNA programme is well-connected, with some PNAs feeling isolated in their roles. Informal power, for some, is enabled through the ability to lead the PNA work and/or RCS sessions and is expressed by the relationships with each other. For example, the building of trust in the RCS relationship is critical to development of informal power. Formal power seems to be dependent on the position the respondent holds, for example, the perception is that more senior nurses (site leads) hold the positional power to support or not adequately support the implementation of the model. The relationships here between the site leads and the PNAs are critical to the successful delivery of RCS. Consequently, the success of the programme at site level requires meaningful commitment of people involved.

Psychological Empowerment: Given at the time of reporting many nurses had only received one or two sessions of RCS, the psychological impact of the PNA role was mostly articulated as a short-term benefit which helped nurses receiving RCS, to feel better. The time out for RCS provided 'release' and on return to the clinical areas, RCS nurses felt more enabled to self-manage and cope in stressful, intense workplace situations. Psychological empowerment is realised from a sense of individual personal control and a critical awareness of the environmental challenges. This will require transition and commitment moving away from an individual perspective of benefit, toward relationships with PNAs to enable engagement in

workplace activities. This process is perhaps currently at an early stage with nurse engagement in RCS necessitating individual transition through several stages. An early appreciation of this transition was described by the nurses, where their experiences of RCS at the outset was dependent on trust building to take this beyond ‘an experience’ towards sharing scenarios where they could visualise and use support. It seems for those who were able to plan future sessions (and these were limited instances) they felt invested and were more committed to the collaboration needed. And finally, there was realisation that RCS could help the enactment of change (s) in the workplace, as illustrated in Figure 10.

Figure 10: Transition and experience of nurses in Restorative Clinical Supervision

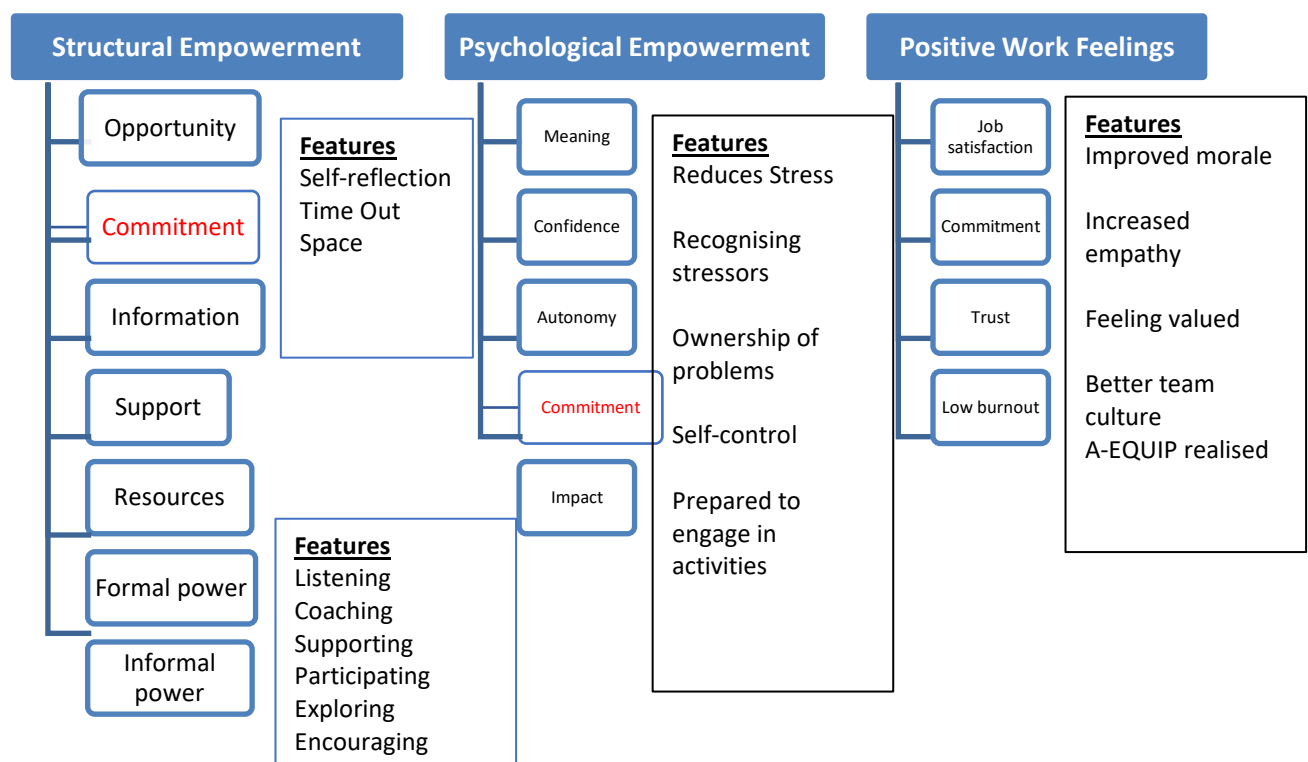


It is evident throughout, that RCS enables release of emotions and through sharing and collaboration provides degrees of restoration.

Positive Work Feelings: RCS is a positive experience, it is welcomed and looked forward to by Nurses who have experienced the process. The immediate outcome of RCS was to feel ‘relieved’ of an issue and to see a way forward, which was always related in a positive scenario. RCS Nurses did express commitment to the A-EQUIP model in the workplace. RCS nurses did not relate the RCS process with job satisfaction but were beginning to express feeling valued in their roles and indicated having less inclination to leave the profession. Some PNAs felt their skills to manage staff situations had been improved, with reductions observed in overall nurse sickness rates in some areas. It is however, too early to comment on whether RCS results in lower levels of staff burnout. The prerequisite conditions must be considered and well-thought-out during implementation to include time for RCS and for PNAs to carry out the role; private space to conduct the RCS sessions and good communication regarding the plans to involve the key people.

Revisiting the theoretical model: Commitment to the PNA Programme was the consistent contingent feature throughout this evaluation, frequently expressed as being able to commit through ‘adequate time’. The implementation of RCS through PNAs requires the unyielding commitment from staff who are delivering the programme and must not be contingent on having ideal workforce conditions e.g., to release staff. It is asserted that over time, this model will become thoroughly embedded in nursing practice and increased engagement in quality improvement activities to improve patient care and workforce wellbeing, will emerge. Hence ‘commitment’ has been added as a necessary agent of change to the Structural and Psychological constructs of Laschinger’s model to support the pre-existing aspect of commitment, which featured in positive work feelings (Figure 11).

Figure 11: Revisiting Laschinger’s Model of Empowerment



Christens (2012) model: This model provided additional insights based on relational aspects of the A-EQUIP model. Progressing from the level of simply completing the PNA training or attending RCS sessions, requires an appreciation of what participation can bring to PNAs and RCS nurses and the organisations. We heard that it could bridge divisions in different areas of practice, through developing PNA communities. For RCS nurses, it can increase the understanding of latent issues, which sometimes exist beneath the surface in the workplace. So, it seems that relational empowerment is inextricably linked to a trust building process, which is ultimately critical to the uptake of RCS from PNAs. This is described by Christens as ‘transformative empowerment’ achieved predominantly through the relationships with others in the programme and the benefits this can bring.

Revisiting our assumptions from the Logic Model Programme Theory: At the outset, assumptions relating to the implementation of the PNA Programme were made at the policy, financial and organisational level (Figure 12).

Figure 12: Original assumptions made regarding the PNA Programme

Assumptions [political, financial, organisational] spanning inputs, activities, outputs and outcomes:

- P1: NHSE finance is stable and secure for PNA Programme Implementation
- P1: PMA [Midwife] Programme is suitable and can be applied to a workforce of Nurses.
- P2: The concept of the PNA Programme is adequate to engage early support from partners (HEIs and NHS)
- P2: Changes to the PNA programme are an incentive to engage further stakeholders
- P3: NHS Trusts can recruit sufficient nurses to become PNAs
- P3: The mechanisms for delivery of the restorative clinical supervision model are adequately identified and understood by stakeholders

These assumptions were based on our early understanding of the mechanisms in place to achieve the inputs, activities, and outputs of the programme. In revisiting these as show below, we have allowed the data to determine the challenges and changes to our assumptions, evident following our evaluation.

Figure 13: Revisiting the original assumptions made regarding the PNA Programme

Assumptions [political, financial, organisational] spanning inputs, activities, outputs and outcomes:

- P1: The level of NHSE finance is being reviewed and revisited for PNA Programme implementation with strategic changes being recommended
- P1: PMA [Midwife] Programme presents a suitable model for the large workforce of Nurses.
- P2: The PNA Programme is learning from first and second wave implementers to further engage early support from partners (HEIs and NHS)
- P2: Changes to the PNA programme are an incentive to engage further stakeholders
- P3: NHS Trusts can recruit sufficient nurses to become PNAs through a more planned cohesive workforce approach to reach 1:20 PNAs to Nurses
- P3: Local structures and reciprocal relationships need to develop to support PNA Programme
- P3: The mechanisms for delivery of the restorative clinical supervision model require further dissemination to ensure greater understanding across the workforce
- P3: Outcomes of the programme will evolve and mature to be quantifiable in the next 24 months

11. RECOMMENDATIONS

An Embedded Approach

Key to the ongoing success of the PNA programme relates to structural support to ensure the ongoing embedding of RCS into nursing practice. To ensure that the restorative clinical supervision and PNA model is sustained it must be prioritised alongside patient care, integrated into practice, and normalised. It is important that RCS is not viewed as something that is event driven and delivered at the point of a crisis, but instead a core element of nursing practice which may prevent such events/crises from occurring.

Education about RCS

The PNA model is currently not well understood by the profession and individual nurses and is perceived as a very formal service that is used to deal with negative events. It is important that the narrative transitions from a formalized, event-driven service to a normalized service that is used for positive events. Education is needed about the PNA model, what it is, how to access it, and what the benefits are.

Reducing Stigma

It is critical to reduce the stigma associated with supervision, and stigma associated with poor mental health. Negative connotations will inhibit uptake of RCS and prevent nurses from engaging in positive help seeking practices. When nurses lack access to support, they are more likely to adopt coping strategies that may be ineffective and harmful. Well supported nurses are more likely to stay in the profession.

Identifying and Supporting PNA's in Training

It is important that sufficient time and thought is given to selecting nurses for the PNA training programme. Nurses need time to reflect on their decision to apply. Potential candidates need adequate information about the PNA role and what the course is comprised of. Given that individual nurses will have a preference regarding teaching style and preferred assessment method candidates would ideally have some choice.

Standardising the Assessment Process

HEIs involved in the delivery of the training module should work together towards standardising the best elements of the assessment process. Nurses are participating in post graduate work-based learning and learning outcomes should focus on what is needed to enable application in practice. Currently, nurses who have completed the programme network with others and hear of disparity regarding the final module assessment. This is dispiriting and reduces engagement in the process.

Support in Practice for PNAs

To ensure sustainability of the PNA model it is important that each Trust has an appropriate Lead PNA. The Lead PNA needs adequate protected time to drive the implementation of the role, manage and support PNA recruitment and training, and monitor implementation and impact at an organisational level. Trusts should continue to work together to share best practice and resources. Due to the difficult topics that may be discussed during RCS, it is also important that PNAs themselves receive RCS and support,

Time to Deliver RCS

PNAs need time in practice to deliver RCS , a quiet and safe space to hold RCS sessions. Without these ingredients, the benefits of the PNA programme will not be fully realised.

Future Research

There is much more that needs to be understood regarding the how RCS is developed and how nurses are empowered through RCS. It is understood that each element of Laschinger 's model are enablers to delivery of the PNA programme, and that relational aspects with developing communities of PNAs are important connections throughout; but it is not understood how RCS is delivered at an individual level and whether a progressive RCS model would help track and support individual a trajectory of growth.

12. LIMITATIONS

This evaluation took place at pace. Contracting, funding and recruitment to study team was finalised in May 2022 and study permission during August 2022. The study team worked hard to minimise any limitations encountered.

Rapid Review of Literature: A protocol guiding the review was established, which focused on empowerment and nurses from the PNA programme. The primary limitation was the focus on nurses, given that much of the literature [April 2022] was generated by the Midwife programme. The second limitation arose from the quality of literature, with a dearth of studies containing data regarding empowerment. This demonstrates that further research regarding empowerment from restorative clinical supervision is warranted.

Case Studies: stage one of the case studies involved short survey. Those returned were incomplete in all cases. It is unclear why information was not completed, but possibilities include not having the information to hand; not having time to locate the information needed and not having access to the information at the time of completing the part one survey. This was mostly remedied during interviews, where information was requested and often provided or sent after the interview. The original ambition was to invite HEI leads and Trust PNA Leads to joint interviews, but the logistics of this proved impossible to negotiate. Nevertheless, our understanding of HEIs and NHS sites to whom they are aligned revealed that our original envisaged colocations for both was incorrect, e.g., HEIs were recruiting PNA trainees from across many sites, not always collocated.

Regional, Site Lead and PNA interviews: these were conducted as planned in accordance with the maximum variation strategy. The study team members (MK, AC and NB) worked together to recruit all participants and interviews were conducted over 7 days of the week accommodating hours to suit. Some interviews were cancelled at short notice by participants and were rescheduled, where possible. Despite tenacious attempts to arrange a convenient time, one participant missed the end of study deadline for data collection.

Nurses Receiving Restorative Supervision (RCS): numerous and consistent attempts were made from August to November 2022 to recruit this group of participants who proved extremely difficult to reach via the agreed mechanisms via NHSE. The initial study communication was distributed via NHSE where responses were received from all groups of PNAs with no responses from RCS Nurses. A poster was also distributed shortly afterwards via NHSE. A study database was commenced and updated by MK. In a follow up to this, NHSE were asked to contact Site Leads and PNAs, who in turn were asked to contact this group by email. We have learnt that clinical nurses are not able to regularly access their emails while on duty negating responses.

During September advice was sought from NHSE regarding recruitment strategies. This was followed by a Risks and Mitigation Paper discussed with NHSE in October 2022 (Appendix 10, pages 123-125). Further information was distributed to NHSE to remind PNAs of the importance of this group of participants, including a poster. At PNA interviews participants

were asked if they would pass on the study information to RCS Nurses for their consideration. The survey was adapted to include participant email address, if they were prepared to participate in an interview. This yielded several from the RCS Nurse group. Three Twitter Appeals were made via NHSE and the study PI. The principal investigator gave a talk about the PNA Evaluation at a national PNA webinar, hosted by NHSE, this yielded many more PNAs, but not nurses receiving restorative supervision from PNAs. Some PNA leads felt uncomfortable forwarding requests to participate RCS nurses.

13. APPENDICES

Appendix 1: Certificate of Approval to Conduct Study	Page 84
Appendix 2: The Rapid Review Protocol	Page 85
Appendix 3: Databases Searched and Results	Page 91
Appendix 4: The Survey	Page 93
Appendix 5: Case Study Data Collection Guide	Page 109
Appendix 6: Maximum Variation Sampling Strategy	Page 111
Appendix 7: Evaluation Questions	Page 112
Appendix 8: Interview Schedule (PNA example]	Page 115
Appendix 9: Quality Appraisal of Literature	Page 119
Appendix 10: Risks and Barriers to Recruitment	Page 123

Appendix 1. Certificate of Ethical Approval

**National Evaluation of the Professional Nurse Advocate Programme (PNA):
SUSTAIN P139411**



Certificate of Ethical Approval

Applicant: Liz Deutsch

Project Title: National Evaluation of the Professional Nurse Advocate Programme (PNA): SUSTAIN

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as High Risk

Date of approval:

Project Reference Number:

22 Aug 2022 P139411

Appendix 2: Rapid Review Protocol [5 pages]

Aim of our rapid review

The purpose of our rapid review is to augment the theoretical base to build a framework, with which to organise and manage the evaluation data. It will also aid the data analysis stage, theoretical development, and the reporting of data from the evaluation.

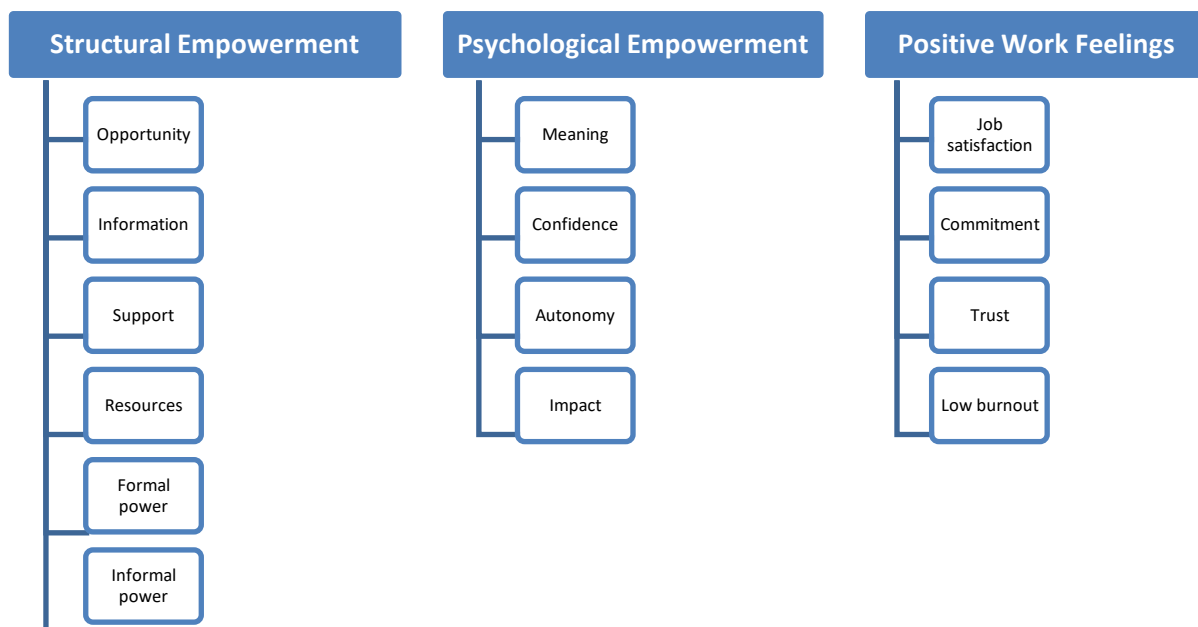
In line with the theoretical approach, we will frame our literature search for literature around empowerment being part of and not separate to clinical supervision, for this Laschinger's model will form a starting point. We do not make any assumptions that our evaluative findings will fit neatly into this model. Hence, we are taking an inductive approach and will be guided by the available evidence to augment theory.

Definition of Empowerment

'Psychological empowerment is defined as the psychological state that employees must experience for empowerment interventions to be successful'

(Laschinger et al., 2001, p. 261)

Laschinger's model of empowerment



Databases:

Prior to the librarian input, google Scholar was used to identify the initial breadth of literature with basic search terms. In line with rapid review protocols (pragmatism) we started by selecting one database, decisions regarding how many more included, were based on the results from the first database search. As an absolute maximum, databases will be limited to five, namely: PubMed, then Embase, Medline, Web of Science and CINAHL Plus, to ensure we capture relevant nursing/midwifery literature.

Data searching:

This took place as a group process together with a librarian (CBIS) from University Hospitals Coventry and Warwickshire. We formed a critically appraised topic group using an approach, where the PNA evaluation team (LLD, MK, AC, TB, (RK)) formed a community of practice to support the pragmatic decisions needed to complete the search.

Search Limitations:

- Limited to 5 years
- English translations only
- Exclude British Library requests.
- Enable proximity word searches with 5 words
- Supplementary searches of word lists

Overarching Review Question

What do nurses who have received clinical supervision/support on the PNA programme state as the factors which influence empowerment in practice settings?

Sub questions:

1. What are the factors that contribute to nurse empowerment?
2. What are factors that contribute to nurse disempowerment
3. What are the factors which form barriers or facilitators to nurse empowerment?
4. What are the features of nurse empowerment described in clinical settings?
5. What are the features of nurse disempowerment described in clinical settings?
6. What resources do nurses need to feel empowered [time, training etc.]
7. What [leadership] strategies best promote nurse empowerment?
8. What difference does empowerment make to [practice] and patient care?

Google Scholar key word search: based on Empowerment

- Morale boosting
- Positivity
- Productivity [increased]
- Safety [patient care]
- Retention [of nurses]
- Autonomy [within role]
- Power [formalised]

Medical Subject Headings: MeSH

Empowerment - Power or Psychological [informal or formal power or autonomy]

Clinical Supervision – Nursing Supervisory and Preceptorship

Step 1 - stage 1: Training and peer review process

- PI met with knowledge expert (AK) to set up the review date in accordance with search strategy (p4)
- Members of the team met with PI and AK for familiarisation with Rapid Review approach
- AK led 'live' search of one database with team – continued off screen to conclude searches
- Agree to meet AK at a mid-point to review

The CBIS Search Strategy

Framework PICO+C	Descriptors	Search term/key words
Populations (P)	Nurses from a variety of clinical settings who have given and/or received clinical supervision via PNA programme	Nurses (registered practitioners) & International nurses & Midwives & Professional Nurse Advocates Nurse OR international Nurse OR Midwife AND "Professional Nurse Advocate" AND ..
Interventions (I)	Clinical Supervision AQUIP model Nurses who have gained empowerment or feel empowered because of the PNA (PMA) programme	Empowerment and to Empower <ul style="list-style-type: none"> • Clinical supervision. • Restorative supervision • Advocacy • Professional Nurse Advocate programme
Comparison (C)	<ul style="list-style-type: none"> • Midwives who have undertaken the PMA programme • Samples, similarities, and differences between nurse groups • Nurses prior to roll out of the PNA Programme 	Midwives and PMA programme Any model of clinical supervision
Outcomes (O)	<ul style="list-style-type: none"> • Contextual aspects of clinical areas • Barrier and Facilitators to implementation of PNA role • Facilitating restorative supervision • Leading quality improvements • Retention etc? 	Setting: NHS Structural, Psychological and Positive work feelings: <i>As listed under model: opportunity, information, support, resources, informal and formal power, autonomy, confidence, impact, job satisfaction, commitment, trust and low burnout.</i>
Context (C)	<ul style="list-style-type: none"> • Clinical Supervision through PNA programme • Experience of nurses (years registered, experience of clinical supervision prior to PNA model) • Sample populations are Acute Hospitals, Mental Health Trusts, Primary Care 	NHS settings only PNA and [PMA programmes]

Search of PubMed

- 1 – Power and Nurses
- 2 – Power and Nurses and Nurses Supervisory
- 3 – Restorative (n= 32)
- 4 – NHS settings (n=2)
- 5 – combined and other databases 465 papers

Data review steps:

Step 1 – stage 2: Interrater reliability: to develop confidence in decision making and process

1. Each reviewer takes the first ten papers from the list (Nos: 1-10)
2. Uses first iteration of the eligibility criteria
3. Made brief notes about each paper – why included, excluded, or thought maybe (using notes Tab)
4. Meet (via Teams) to discuss, sense check and reiterate the criteria.

1 st Iteration of the eligibility criteria		
	Inclusion	Notes or examples, if appropriate
1	Nurses or Midwives [registered nurses and midwives or registered practitioners]	Must include nurses – EW prefers us to limit this to nurses
2	Clinical + Supervision [all features of: Supervisory roles, Preceptorship]	Must include evidence of clinical supervision within the PNA role – so not just clinical supervision without reference to PNAs
3	PNAs (if any papers)	About PNAs Enrolled in the programme (trained)
4	Empowerment [did the paper report features of this, as per Laschinger’s model]	Empowerment may also be listed as an outcome or feature within the ‘improvement (s)’ - as listed
5	Multiple health settings [acute, community, mental health, learning difficulties, prisons]	
6	Must include data - evidence	Needs to be a study – not opinion piece – something quantifiable we can draw from
7	Quality Improvements made in practice [outcomes] Exclude GPs	<ul style="list-style-type: none"> • Improve quality of patient mealtimes • Set up improved communication systems for relatives • Co-Design rehabilitation programmes for patients • Improve drug rounds • Improve patient safety for falls risks To improve patient drug rounds, 90% of patients will receive all their medications within 15 minutes of the prescribed time (e.g., 2pm prescription, received by no later than 2.15pm)!]
	Application of a model of supervision [e.g. AQUIP]	

Using the first iteration of the eligibility criteria, the decisions we made for first 10 papers are recorded as:

Paper No:	MK	AC	NB	LLD	Concordance	No of: Criteria met
1	Maybe	Exclude	Exclude	Exclude	75%	2/5
2	Maybe	Exclude	Exclude	Exclude	50%	3/5 (but weak)
3	Maybe	Exclude	Exclude	Exclude	75%	2/5
4	Exclude	Exclude	Exclude	Exclude	100%	0/5
5	Maybe	Exclude	Exclude	Exclude	75%	1/5
6	Include	Include	Maybe	Include	75%	4/5
7	Maybe	Exclude	Exclude	Exclude	75%	0/5
8	Exclude	Exclude	Exclude	Exclude	100%	0/5
9	Exclude	Exclude	Exclude	Exclude	100%	0/5
10	Exclude	Exclude	Exclude	Exclude	100%	0/5

On this basis we would only include paper 6 in the review with concordance of this across team. Others would be reserved for discussion sections, our own learning or scene setting. Following action learning approach we made a second iteration of the inclusion strategy for papers (as below).

Step 1 –stage 3: testing the second iteration of the eligibility criteria

2 nd Iteration of the eligibility criteria		
	Inclusion	Notes or examples, if appropriate
1	Nurses or Midwives [registered nurses and midwives or registered practitioners]	But could include the supervision or spread of practice to other healthcare professionals (e.g. Nurses AND anaesthetists, doctors, midwives....)
2	Clinical + Supervision [all features of: Supervisory roles, Preceptorship]	Must include this feature within the paper, so must state this explicitly. Must be evident a formal model of Clinical Supervision. Must be a main part of the work delivered in the paper and link to empowerment.
3	Empowerment [did the paper report features of this, as per Laschinger’s model] Examples or features of empowerment may be: Training; Confidence; Building of Resilience (nurses); Patient empowerment. Empowerment and survivorship Delivering compassionate care	<ul style="list-style-type: none"> • Must be because of the clinical supervision process • Empowerment must be included as a core part of the work to achieve this • Empowerment will sometimes be implicit rather than explicitly described. <p>NB: keep an eye on ‘features’ of empowerment, such as those mentioned in Laschinger’s model (plus others), or even methods to improve empowerment (such as mindfulness), rather than focus on finding ‘empowerment’ explicitly</p>
4	Application of a model of supervision stated [e.g. AQUIP]*	Clearly discusses the model of change – quality improvement used. Other models, are ok– but must report the improvement of a patient focused service/clinical change with empowerment – must be constructive not hard to pin down and for benefit of nurses within the health settings stated.
5	PNAs (if any papers) and PMA programme (midwife)	Would be great if this were included, but likelihood is slim
6	Health care settings [acute, community, mental health, learning difficulties, prisons] Include Ambulance Trusts Exclude GP Practices Exclude primary care	Check it is a healthcare setting. We have noted healthcare setting may not be explicit/mentioned. Types of settings will typically mention: Ward; Department; Clinic; Virtual care; Theatre; Area; Ambulatory care; Intermediate care; Primary care or Clinical Work; in conjunction with a specific speciality – such as, anaesthesia
Notes	*Quality Improvements made in practice [outcomes] examples are:	<ul style="list-style-type: none"> • Improve quality of patient mealtimes • A decrease in infection rates • Set up improved communication systems for relatives • Co-Design rehabilitation programmes for patients • Improve drug rounds • Improve patient safety for falls risks • Building compassionate care • To empower patients through new care delivery

Red = Minimum to meet eligibility are criteria 1 + 2 +3

Amber= The application of a model such as AQUIP is nice to have but other models may be mentioned

Green = We are highly unlikely to find examples of PNA – but PMA would substitute as PNA

The healthcare settings are unlikely to be too specific to exclude – we will see!

So, a top-rated paper will meet all 6 criteria. Mark up as 'include' with reason note – 'main review'
But to include, in some cases - this could be as little as the first 3 criteria.

Can also 'include' for background – so mark up as 'include' with reason note – 'background'.

Next step: Using the 2nd iteration of the Eligibility Criteria we will review 20 papers each

Sense checking and good practice:

Our good practice stems from us doing a team 'sense check' at the start and also during the process so that we can reflect on our process, what worked and what was more difficult, and compare our reviews to determine more consistent review process – conducted before we conduct the full review and again at stages during the review process to ensure we are remaining consistent and robust (which may achieve the 10% IRR in the process).

Good practice also stems from the volume of people involved in the process, the databases and platforms used to conduct the rapid review, eligibility criteria carefully considered to inform decisions, and use of Abby to help as external peer review.

Stage 2 - Critical Appraisal:

This will be a three-stage process:

- (1) Individual critical appraisal by PNA team, using CASP or Joanna Briggs tools
- (2) Risk of bias and quality assessment, using abridged Keele tool, by PNA team
- (3) Charting of results into Framework, by AC

*NB: Preferences towards critically appraising studies (methodologies) will be established from the PNA evaluation team to align to skills in reviewing papers.

Stage 3 - Data Synthesis:

Organisation and management of data arising from this rapid review, will be synthesised through using iterative principles to reflect review questions and to augment the Laschinger model. As evaluation data is collected, additions to the Framework will be ongoing through all stages of data collection.

Stage 4 - Data reporting/dissemination:

It is not proposed to report data from this rapid review as a separate entity e.g., published papers. Reporting will be solely limited to the co-production of the overarching organisation and management framework (after Ritchie et al, 2013). We will also map empowerment throughout – useful to inform interview questions and keep us abreast of features of such.

Appendix 3 - Database Search Strategies [2 pages]

A. PubMed search strategy

1. "nurse*" [Title/Abstract]
2. "midwi*" [Title/Abstract]
3. "Nurses" [MeSH Terms]
4. "midwifery" [MeSH Terms]
5. #1 OR #2 OR #3 OR #4
6. "empower*" [Title/Abstract]
7. "power, psychological" [MeSH Terms]
8. "Nursing, supervisory" [MeSH Terms]
9. "Preceptorship" [MeSH Terms]
10. "clinical supervision" [Title/Abstract]
11. "restorative supervision" [Title/Abstract]
12. "nurse advocate" [Title/Abstract]
13. "midwifery advocate" [Title/Abstract]
14. #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13
15. "nhs" [All Fields]
16. #5 AND #14 AND #15
17. y_5 [Filter]

B. EMBASE search strategy (Ovid)

1. nurs*.ab,ti.
2. midw*.ab,ti.
3. exp nurse/
4. exp midwife/
5. 1 or 2 or 3 or 4
6. empower*.ab,ti.
7. (clinical adj5 supervision).ab,ti.
8. (restorative adj5 supervision).ab,ti.
9. (nurse adj5 advocate*).ab,ti.
10. (midwifery adj5 advocate*).ab,ti.
11. exp clinical supervision/
12. exp empowerment/
13. 6 or 7 or 8 or 9 or 10 or 11 or 12
14. nhs.af.
15. 5 and 13 and 14
16. limit 15 to yr="2017 -Current"

C. CINAHL search strategy (EBSCO)

1. TI nurse* OR AB nurse*
2. TI midwi* OR AB widwi*
3. MH "Nurses"
4. MH "Midwives"
5. S1 OR S2 OR S3 OR S4
6. TI empower* OR AB empower*

7. MH "Empowerment"
8. MH "Clinical Supervision"
9. TI (clinical N5 supervision) OR AB (clinical N5 supervision)
10. TI (restorative N5 supervision) OR AB (restorative N5 supervision)
11. TI professional nurse advocate OR AB professional nurse advocate
12. TI professional midwifery advocate OR AB professional midwifery advocate
13. S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12
14. TX NHS
15. S5 AND S13 AND S14
16. 201701-202212

D. PsycInfo search strategy (ProQuest)

1. AB, TI(nurse*)
2. AB, TI(midwi*)
3. MAINSUBJECT.EXACT.EXPLODE("Nurses")
4. MAINSUBJECT.EXACT.EXPLODE("Midwifery")
5. 1 OR 2 OR 3 OR 4
6. AB, TI(empower*)
7. MAINSUBJECT.EXACT.EXPLODE("Empowerment")
8. AB, TI(clinical supervision)
9. AB, TI(restorative supervision)
10. MAINSUBJECT.EXACT.EXPLODE("Professional Supervision")
11. AB, TI(professional nurse advocate)
12. AB, TI(professional midwifery advocate)
13. 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12
14. NHS
15. pd(20170713-20220713)

APPENDIX 4. THE SURVEY [16 pages]

This survey is designed to evaluate aspects of the Professional Nurse Advocate (PNA) programme which delivers training and restorative supervision for nurses right across England. The programme launched in March 2021, towards the end of the third wave of COVID-19. This was the start of a critical point of recovery: for patients, for services and for our workforce.

PNA training provides those on the programme with skills to facilitate restorative supervision to their colleagues and teams, in nursing and beyond. A version of this programme exists already for maternity colleagues, where outcomes point to improved staff wellbeing and retention, alongside improved patient outcomes. The training equips them to listen and to understand challenges and demands of fellow colleagues, and to lead support and deliver quality improvement initiatives in response.

This brief survey has been developed as part of an independent evaluation of the PNA programme, commissioned by NHS England and NHS Improvement. The evaluation is being conducted by a team from Coventry University.

PARTICIPANT INFORMATION STATEMENT

The purpose of this research is to evaluate (using an online survey) the Professional Nurse Advocate (PNA) programme and understand its impact on nurses within the National Health Service (NHS). Your voice, experiences and perspectives are important within this evaluation because it will help us to understand the PNA programme and explore how it can be further improved.

The evaluation is being led by Dr Liz Lees-Deutsch, Associate Professor for Nursing at Coventry University and Clinical Academic Nurse at University Hospitals Coventry and Warwickshire, in collaboration with a team of researchers from Coventry University. You have been invited to take part in this survey because you are one of:

- A local trust nominated Professional Nurse Advocate lead.
- A trained Professional Nurse Advocate.
- A registered nurse who is receiving (or has received) restorative supervision from a Professional Nurse Advocate.

Your participation in the survey is entirely voluntary, and you can opt out at any stage by closing and exiting the browser. If you are happy to take part, please answer the questions in this survey, which aim to gather your views and experiences regarding the PNA role, PNA training, PNA supervision, and the PNA programme in general. This questionnaire will also explore the impact that the PNA programme has on perceptions/levels of empowerment (i.e., the power to accomplish work/tasks in a meaningful way). Your answers will help us to establish the strengths and limitations of the PNA programme, so that it can be further developed and improved. The survey should take no longer than 10 minutes to complete. Your answers will be treated as strictly confidential and the information you provide will be kept completely anonymous (i.e., non-identifiable) in all outputs, including publications, presentations, and reports. All data will be held securely on password protected computers, on a password protected Jisc Online Survey account, and will be viewed by members of the research team. It is possible that we may need to share anonymised and collective feedback about the PNA programme with identified organisations, to enable reasonable adjustments which facilitate the continued success of the PNA programme. All data related to this online questionnaire will be deleted within 5 years of you completing this online survey. The

research was granted ethical approval by Coventry University's Research Ethics Committee (ethical approval number: P139411).

For further information, or if you have any queries, please contact the lead researcher, Dr Liz Lees-Deutsch (email: liz.lees-deutsch@nhs.net), who is an Associate Professor for Nursing at Coventry University and Clinical Academic Nurse at University Hospitals Coventry and Warwickshire. If you have any concerns that cannot be resolved through the lead researcher, please contact ethics.uni@coventry.ac.uk. Thank you for taking the time to participate in this survey. Your help is very much appreciated

CONSENT I have read and understood the above information. I understand that, because my answers will be fully anonymised, it will not be possible to withdraw them from the study once I have completed the survey. I agree to take part in this questionnaire survey. I confirm that I am aged 18 or over * Required

- Yes

About You [All]

In which of the following regions do you work? (select one): * Required

- East of England
- London
- Midlands
- North East & Yorkshire
- North West
- South East
- South West
- Prefer not to say

In which field of nursing practice do you work? (select one): * Required

- Adults
- Children
- Learning
- Disabilities
- Mental Health
- Prefer not to say

Please add any further detail, such as clinical speciality

What is your age? (select one): * Required

- Under 20 years
- 20 – 29 years
- 30 – 39 years
- 40 – 49 years
- 50 – 60 years
- Over 60 years
- Prefer not to say

What is your gender? (select one): * Required

- Male

- Female
- Prefer not to say
- Other

If you selected Other, please self-identify in your own words:

What ethnic group do you identify as? (select one): 1 Required

- Asian/Asian British
- Black/African/Caribbean/Black British
- Mixed/Multiple ethnic groups
- White
- Prefer not to say
- Other

If you selected Other, please self-identify in your own words:

Do you consider yourself to have a seen or unseen disability? We define disability as an 'impairment that has a substantial, long-term adverse effect on a person's ability to carry out normal day-to-day activities' * Required

- Yes
- No
- Prefer not to say

If yes, how would you describe your disability or impairment? Tick all that apply

- Developmental
- Learning
- Mental health
- Physical
- Sensory
- Neurodiverse
- Not applicable
- Prefer not to say
- Other

If you selected Other, please specify:

How many years ago did you complete your nurse education? * Required

- Less than 1 year
- 1-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26-30 years
- More than 30 years
- Prefer not to say

Did you receive your nurse education outside of the UK? * Required

- Yes
- No
- Prefer not to say

Screening Question [All]

I am completing this questionnaire as a... (select one): * Required

- Nurse who has received restorative supervision from a PNA
- Trained PNA
- Local Trust PNA lead

Nurse who has received restorative supervision from a PNA [Nurse only]

ABOUT RESTORATIVE CLINICAL SUPERVISION

The following questions specifically relate to your perceptions of restorative clinical supervision (RCS). RCS is defined as follows:

RCS “involves the development of open discussion space and supporting the professional to undertake reflective conversations and open feedback”. The restorative approach “promotes reflection of personal emotions and practice, has a positive impact on emotional wellbeing, provides a strategy to mitigate workplace stress, enhances retention and assists with the management of personal and professional demands” [NHSE&I (2021). PAR799: Professional Nurse Advocate A-EQUIP model: A model of clinical supervision for nurses].

Tell us about your restorative supervision (select one): * Required

- I am currently receiving restorative supervision
- I have completed restorative supervision

I believe the restorative clinical supervision delivered by PNAs has helped to... * Required

Please don't select more than 1 answer(s) per row.

Please select at least 19 answer(s).

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
...improve the opportunities available to me at work						
...improve the information available to me at work						
...improve the support available to me at work						
...improve the resources available to me at work						

...improve my formal decision-making at work						
...improve my informal decision-making at work						
...improve what my role means to me						
...improve the confidence I have in my role						
...improve the autonomy I have in my role						
...improve the impact I have in my role						
...improve my feelings of job satisfaction at work						
...improve my feelings of commitment at work						
...improve my feelings of trust in others at work						
...reduce my feelings of burnout at work						
...improve the safety of patient care delivery						
...improve my ability to make changes to care delivery						
...improve my networking with others						
...improve the influence I have in my practice						
...improve my leadership of						

quality improvement						
---------------------	--	--	--	--	--	--

PERCEIVED EFFECTIVENESS IN MEETING ROLES & RESPONSIBILITIES

The following questions are based on published roles and responsibilities relevant to the role you selected earlier in this questionnaire [Critical Care Networks-National Nurse Leads (CC3N) (2022) Professional Nurse Advocates in Critical Care: Standard Operating Procedure, Version 1].

BEFORE my restorative clinical supervision (RCS) sessions, I ... * Required

Please don't select more than 1 answer(s) per row.

Please select at least 3 answer(s).

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
Completed the e-learning module on the A-EQUIP model						
Accessed a PNA in line with their role and responsibility, and discussed with my line manager the timeframe for RCS sessions and implementation of the A-EQUIP model						
Thought about and identified issues for discussion						

DURING my restorative clinical supervision (RCS) sessions, I ...

Please don't select more than 1 answer(s) per row.

Please select at least 4 answer(s).

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
Identified issues, particularly those relating to seniority, gender or culture, in myself or my PNA that may impede communication						

Actively participated in RCS sessions, was open and shared information, and was responsible for learning						
Accepted appropriate responsibility for performance and was active in the pursuit of education and development						
Gave and accepted constructive feedback and participated in problem-solving						

AFTER my restorative clinical supervision (RCS) sessions, I ...

Please don't select more than 1 answer(s) per row.

Please select at least 2 answer(s).

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
Reflect, think through and explore options for quality improvement						
Promote the best interests of patients						

Trained PNA [PNA Only]

ABOUT RESTORATIVE CLINICAL SUPERVISION

The following questions specifically relate to your perceptions of restorative clinical supervision (RCS). RCS is defined as follows:

RCS “involves the development of open discussion space and supporting the professional to undertake reflective conversations and open feedback”. The restorative approach “promotes reflection of personal emotions and practice, has a positive impact on emotional wellbeing, provides a strategy to mitigate workplace stress, enhances retention and assists with the management of personal and professional demands” [NHSE&I (2021). PAR799: Professional Nurse Advocate A-EQUIP model: A model of clinical supervision for nurses].

Have you delivered restorative supervision? (select one): * Required

- Yes
- No / Not yet

If you selected 'Yes', please tell us approximately how many nurses you have supervised

--

I believe the restorative clinical supervision delivered by PNAs has helped to...

Please don't select more than 1 answer(s) per row.

Please select at least 19 answer(s).

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
...improve the opportunities available to nurses at work						
...improve the information available to nurses at work						
...improve the support available to nurses at work						
...improve the resources available to nurses at work						
...improve nurses' formal decision-making at work						
...improve nurses' informal decision-making at work						
...improve what nurses' roles mean to me						
...improve the confidence nurses have in my role						
...improve the autonomy nurses have in their role						
...improve the impact nurses have in their roles						
...improve nurses' feelings of job						

satisfaction at work						
...improve nurses' feelings of commitment at work						
...improve nurses' feelings of trust in others at work						
...reduce nurses' feelings of burnout at work						
...improve the safety of nurses' patient care delivery						
...improve nurses' abilities to make changes to care delivery						
...improve nurses' networking with others						
...improve nurses' influence in their practice						
...improve nurses' leadership of quality improvement						

PERCEIVED EFFECTIVENESS IN MEETING ROLES & RESPONSIBILITIES

The following questions are based on published roles and responsibilities relevant to the role you selected earlier in this questionnaire [Critical Care Networks-National Nurse Leads (CC3N) (2022) Professional Nurse Advocates in Critical Care: Standard Operating Procedure, Version 1].

Please don't select more than 1 answer(s) per row.

Please select at least 20 answer(s).

I am effective in...

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
Advocating for patients						
Creating care plans collaboratively with patients and/or families						
Demonstrating inspirational, motivational and visible leadership in the workplace						
Supporting change in clinical area(s)						
Acting as a role model promoting psychological safety and situational awareness in my own practice						
Discussing any professional issues, including clinical incidents, team dynamics, stress, burnout, instances of bullying, career progression, interviews and quality initiatives, as well as personal issues						
Allowing (or creating) the opportunity for reflection to reduce stress and enable learning, limit compassion fatigue and improve						

confidence following a traumatic or stressful event						
Portraying an understanding of personal and professional resilience and developing this attitude in others						
Developing a nurse's ideas and actions for quality improvement and service development						
Holding reflective discussions about revalidation and career development, preparation for appraisal						
Coaching staff through reflection on incidents they may have experienced, with a focus on the system and processes						
Supporting aspirant PNAs and PNAs in training, including by providing support and supervision						
Collating data on the effectiveness of restorative clinical supervision (RCS) for staff, and the benefit of the PNA role.						
Arranging any individual						

meetings at a mutually convenient time						
Identifying a private and confidential meeting place						
Mutually agreeing how long the session will last						
Agreeing ground rules for the session and documenting these						
Retaining and confidentially storing any notes taken at the meeting						
Participating in and leading on quality improvement programmes						
Engaging in booster sessions following PNA training						

Local Trust PNA Lead [Trust Lead Only]

ABOUT RESTORATIVE CLINICAL SUPERVISION

The following questions specifically relate to your perceptions of restorative clinical supervision (RCS). RCS is defined as follows:

RCS “involves the development of open discussion space and supporting the professional to undertake reflective conversations and open feedback”. The restorative approach “promotes reflection of personal emotions and practice, has a positive impact on emotional wellbeing, provides a strategy to mitigate workplace stress, enhances retention and assists with the management of personal and professional demands” [NHSE&I (2021). PAR799: Professional Nurse Advocate A-EQUIP model: A model of clinical supervision for nurses].

I believe the restorative clinical supervision delivered by PNAs has helped to...

Please don't select more than 1 answer(s) per row.

Please select at least 19 answer(s).

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
--	----------------	------------------	----------------	-------------------	---------------------	-------------------

...improve the opportunities available to nurses at work						
...improve the information available to nurses at work						
...improve the support available to nurses at work						
...improve the resources available to nurses at work						
...improve nurses' formal decision-making at work						
...improve nurses' informal decision-making at work						
...improve what nurses' roles mean to me						
...improve the confidence nurses have in my role						
...improve the autonomy nurses have in their role						
...improve the impact nurses have in their roles						
...improve nurses' feelings of job satisfaction at work						
...improve nurses' feelings of commitment at work						
...improve nurses' feelings of trust in others at work						
...reduce nurses' feelings of burnout at work						

...improve the safety of nurses' patient care delivery						
...improve nurses' abilities to make changes to care delivery						
...improve nurses' networking with others						
...improve nurses' influence in their practice						
...improve nurses' leadership of quality improvement						

PERCEIVED EFFECTIVENESS IN MEETING ROLES & RESPONSIBILITIES

The following questions are based on published roles and responsibilities relevant to the role you selected earlier in this questionnaire [Critical Care Networks-National Nurse Leads (CC3N) (2022) Professional Nurse Advocates in Critical Care: Standard Operating Procedure, Version 1].

My organisation's chief nurse has identified a senior registered nurse lead for PNAs to oversee allocation, implementation and oversight of PNAs in practice. * Required

- Yes
- No
- Unsure

I am effective in...

Please don't select more than 1 answer(s) per row.

Please select at least 7 answer(s).

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
Identifying the number of PNAs the service needs to implement the A-EQUIP model (based on a 1:20 ratio)						
Selecting and training nurses to fill the required						

number of PNA roles						
Ensuring arrangements are in place for all nurses within every service to have access to a PNA						
Ensuring that PNAs have allocated time to deploy their role and that nurses are released to meet their PNA as required						
Establishing supervision arrangements for PNAs						
Ensuring there are robust governance and assurance measures in place to monitor the implementation and contribution of the PNA role						
Identifying, collating, analysing and interpreting quantitative and qualitative data to inform reports about the process for, and impact and outcome of, the PNA role						

Restorative Clinical Supervision 2 [All]

Based on my overall experience of restorative supervision... * Required

Please don't select more than 1 answer(s) per row.

Please select at least 1 answer(s).

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
--	----------------	------------------	----------------	-------------------	---------------------	-------------------

I believe that restorative supervision is effective						
---	--	--	--	--	--	--

What do you see as the main benefits of restorative clinical supervision? * Required

What could be improved about restorative clinical supervision? * Required

How could those improvements be implemented? * Required

Additional Evaluation [All]

Please use this space to add any other comments about the PNA programme, including examples of specific benefits or drawbacks.

We are very interested in speaking to participants in more detail about their experience of the PNA programme, either 1:1 or as part of a focus group (this will be online via an online forum such as MS Teams or Zoom). If you would be happy to discuss the programme with the evaluation team, please add your details below:

Are you happy to be contacted by the evaluation team discuss the PNA programme in more detail? * Required

- Yes
- No

Name

Email address

Telephone number

End

Thank you very much for completing this survey

Appendix 5 Case Studies – data collection guide [2 pages]

Case Studies:

A case study comprises one NHS organization (acute trust/community/mental health trust, etc.); the nearest and majority University (HEI) provider) and the Lead PNAs.

Aim:

To evaluate the PNA model - understand the importance of 'context' in determining the extent to which the programme assumptions contribute to expected changes (as per tender).

Objectives for the case studies:

1. To gather descriptive contextual data related to the PNA programme by conducting a deep dive across the landscape and partnerships.
2. To provide a collective overview and understanding of how well the PNA programme is working at an organisational level.
3. To draw out how partners work with each other, how current practices have been created, altered, or refined to accommodate the PNA role.

Selection of Case Studies (organisations of healthcare and education)

Purposive selection to include:

Health and education organisations from each of the 7 NHSE regions to ensure maximum representation across all areas.

NB: HEIs do not link exactly to regions as most have trained PNAs in multiple organisations from across England.

Methods:

Case Studies will be conducted in two parts:

We propose to email a data extraction document to selected individual sites via NHSE to enable sites to collate and prepare their quantitative data which contextualises features of each Case (List A).

We aim to conduct some site visits (depending on available time) or alternatively via Microsoft Team meetings, where we will interview PNA site leads and HEI leads. Proposed possible questions are included (List B).

List A: Data collection proposed for contextualisation for each case:

We will gather demographic data regarding:

- Geographical Location
- Type of organisation
- Size of registered nursing workforce
- Vacancy factors
- Sickness rates
- Which PNA training wave
- Number of PNAs trained by local HEI
- Number of PNAs in post
- Number Nurses who have received restorative supervision
- Review of Trust values and where the PNS program alligns

List B: PNA NHS site leads, and HEI Leads questions

1. As leaders what steer / guidance /timescale were you given to prepare for the PNA role?
2. How do you work together, what / who / which teams are involved to set up the PNA training and roll out?
3. How did you decide which registered nurses from which areas (department or team) to train as PNAs? Eg were people nominated, or did people volunteer, did people have a choice ?
4. What areas did you select and why?
5. If you have more than one area, how are the areas progressing? When did they start ? what data are you collecting on progress/activities ? / monitoring ?
6. What are the key issues you have experienced in the introduction of the PNA Role?
7. What are the key assumptions made of your organisation regarding its capacity to deliver PNA role?
8. Is there any part of the PNA implementation that creates tension across the NHS and HEI partnership?
9. Have you modified the delivery of the PNA programme and if so, please explain?
10. Are there any workforce challenges that the PNA role brings?

To date have any practice improvements have been made as a result of PNAs and nurses receiving restorative supervision?

Appendix 6: Maximum Variation Sampling Strategy

(WP 2)

Hospital Site	Clinical Locations	Age	Gender	Ethnicity Code	Registered Years					
					0-1	2-5	6-10	11-15	16-20	21+

Potential Clinical Locations:

Acute Care, Critical Care, Mental Health, Community Trust, Learning Disabilities, Children and Young People, Children and Young People – mental health, Safeguarding, Health and Criminal Justice, International Recruits and Infection Prevention and Control (Validated with NHSE 22/6/22).

11.

Appendix 7: Study Questions [pp.1/3]

Interview schedule questions mapped together

PNA	NRS	PNA Site Lead	Regional PNA Lead	HEIs
<i>Icebreaker / introductory / contextual</i>				
Can you start by telling me briefly about your job role and how you got involved in the PNA training programme?	Can you start by telling me briefly about your job role?	Can you start by telling me briefly about your job role and how you got involved in the PNA programme?	Can you start by telling me briefly about your job role and how you got involved in leading the PNA programme in your region?	Can you start by telling me briefly about your job role and how you got involved in the delivery of the PNA training course?
How far into the PNA programme are you at the moment?	-----	How long have you been involved with PNA programme?	How long have you been involved with PNA programme, as a regional lead or in any other role?	-----
-----	-----	Were you a PNA prior to becoming a PNA lead?	-----	-----
<i>Before the PNA programme</i>				
Can you tell me a bit about your own experience of supervision prior to your engagement in the PNA programme?	Can you tell me a bit about what your own experience of supervision has been like prior to receiving restorative supervision from a PNA?	Can you tell me a bit about your experience of clinical supervision prior to implementing the PNA programme?	Can you tell me a bit about your experience of clinical supervision prior to leading the implementation of the PNA programme as a regional lead?	Can you tell me a bit about the planning and design of the PNA course in your organisation?
<i>During the PNA programme</i>				

Can you tell me a bit about your experience of the PNA programme?	-----	Can you tell me a bit about your experience of the PNA programme, including your current role of facilitating the implementation of the PNA programme?	Can you tell me a bit about your experience of the PNA programme, including your current role of facilitating the implementation of the PNA programme at regional level?	Can you tell me a bit about your experience with regards to the delivery of the PNA course?
-----	Can you tell me a bit about what you know about the PNA programme?	-----	-----	-----
What has been your experience to date of delivering restorative supervision?	What has been your experience to date of receiving restorative supervision from a PNA?	-----	-----	-----
What do you feel have been the benefits or outcomes of the PNA programme?	What do you feel have been the benefits or outcomes of engaging with restorative supervision with a PNA?	What do you feel are the benefits or outcomes of the PNA programme?	What do you feel are the benefits or outcomes of the PNA programme?	What do you feel have been the benefits or outcomes of the PNA programme?
Can you describe some of the facilitators and barriers you experienced of the PNA programme?	Can you describe some of the facilitators and barriers you experienced in relation to receiving restorative supervision from a PNA?	Can you describe some of the facilitators and barriers to implementing the PNA programme?	Can you describe some of the facilitators and barriers to implementing the PNA programme?	Can you describe some of the facilitators and barriers you experienced in the delivery of the PNA course?
<i>The future of the PNA programme</i>				

What are your thoughts about the future of the PNA programme in your organisation and your career?	What are your thoughts about the future of the provision of restorative supervision in your organisation and your career?	What are your thoughts about the future of the PNA programme in your organisation?	What are your thoughts about the future of the PNA programme in your organisation?	What are your thoughts about the future delivery of the PNA course programme in your organisation?
<i>Concluding questions</i>				
Are there any other ways in which nurse empowerment is supported within (or beyond) your organisation other than the provision of restorative clinical supervision?	Are there any other ways in which nurse empowerment is supported within (or beyond) your organisation other than the provision of restorative clinical supervision?	Are there any other ways in which nurse empowerment is supported within (or beyond) your organisation other than the provision of restorative clinical supervision? If so, how does this compare to the restorative clinical supervision that is part of the PNA programme.	Are there any other ways in which nurse empowerment is supported within (or beyond) the trusts other than the provision of restorative clinical supervision? If so, how does this compare to the restorative clinical supervision that is part of the PNA programme?	Are there any other ways in which nurse empowerment is supported within (or beyond) NHS organisations other than the provision of restorative clinical supervision?
Is there anything else you would like to discuss before we finish?	Is there anything else you would like to discuss before we finish?	Is there anything else you would like to discuss before we finish?	Is there anything else you would like to discuss before we finish?	Is there anything else you would like to discuss before we finish?
Is there anything I haven't asked that I should have asked? Is there anything we should be aware of?	Is there anything I haven't asked that I should have asked? Is there anything we should be aware of?	Is there anything I haven't asked that I should have asked? Is there anything we should be aware of?	Is there anything I haven't asked that I should have asked? Is there anything we should be aware of?	Is there anything I haven't asked that I should have asked? Is there anything we should be aware of?

Appendix 8 Interview Schedule with PNAs [4 pages]

Interview questions

Icebreaker / introductory / contextual question
Can you start by telling me briefly about your job role and how you got involved in the PNA training programme?
How far into the PNA programme are you at the moment?
Main questions
<u>BEFORE THE PNA PROGRAMME</u>
Can you tell me a bit about your own experience of clinical supervision prior to your engagement in the PNA programme?
<p>Prompts:</p> <ul style="list-style-type: none"> • What is it? • Had you participated in it? (Yes/No Why/Why not / describe your experience) • If yes: <ul style="list-style-type: none"> ○ How long did you receive clinical supervision and how often? ○ How did you go about receiving clinical supervision? ○ What mechanisms enabled or prevented you from engaging? (e.g. support from managers, seniors, leaders, organisations in receiving clinical supervision?) ○ What impact did the supervision have on you personally, interpersonally and in practice? • If no: <ul style="list-style-type: none"> ○ Did you want to engage with clinical supervision? ○ What mechanisms enabled or prevented you from engaging? (e.g. support from managers, seniors, leaders, organisations in receiving clinical supervision?) <p>Questions mapped to this overarching question:</p> <ul style="list-style-type: none"> • Prior to the PNA programme had you participated in clinical supervision, if yes - please describe this? [group supervision, clinical assessments] (Q32) • Prior to undertaking the PNA programme (masters level) module had you participated in any type of academic study post registration? (Q33) • Before the PNA programme please describe the corporate (strategic) support for the delivery of clinical supervision in your organisation? (Q34) • Before the PNA Programme can you describe any issues for nurses, wanting to undertake clinical supervision? [optional, adhoc, not important] (Q35) • Prior to the PNA programme how would you best describe the delivery of clinical supervision and support model for staff? (Q36) • Prior to using the AQUIP model how were you empowered (or how did you) to make positive changes to patient care or services? (Q39) • Can you describe how your confidence and autonomy (and so on) were shaped before the PNA programme? (Q7)
<u>DURING THE PNA PROGRAMME</u>
Can you tell me a bit about your experience of the PNA programme?
<p>Prompts:</p> <ul style="list-style-type: none"> • How did you hear about the programme? • What was the recruitment and enrolment process like? • What are your thoughts about the content covered on the programme? • How was the course structured and how did this structure work for you? • Can you describe the delivery methods used in this programme by the HEIs? <ul style="list-style-type: none"> ○ Face to face or online?

- Working alone or as a group?
- Assessment methods used?
- What are your thoughts and experiences of these methods?
- What was your experience of the staff running or delivering the programme?
- What qualifications come from you completing this programme?

Questions mapped to this overarching question:

- What information about the programme during pre-enrolment and the programme was available to you? (Q3)
- What are the aspects of the PNA training that were most useful and least useful in practice? (Q31)

What do you feel have been the benefits or outcomes of the PNA programme?

Prompts:

- What impact has the programme had on you personally? (changes to confidence, autonomy, wellbeing, job satisfaction, career opportunities, etc)
- What impact has the programme had on others and organisationally? (e.g. on nurses receiving restorative supervision, other staff in the organisation; impact on retention)
- What impact has the programme had on your delivery of patient care?

Questions mapped to this overarching question:

Individual impacts:

- What opportunities has completing the PNA Programme enabled for you? For PNAs (Q1)
- Can you describe how personal attributes such as; confidence and autonomy have changed since the PNA programme? (Q8)
- What difference have the changes through PNA Programme made to you on an individual level? (Q9)
- How do you feel your wellbeing has changed, at home and at work by undertaking the PNA programme? (Q19)
- In what way has your job satisfaction changed since being part of the PNA Programme? (Q20)
- Has the process of studying at masters level improved your confidence to study further? (Q41)

Interpersonal impacts / impacts on nurses receiving restorative supervision:

- What difference has the changes made to you in relation to your nursing role - interprofessional relationships? (Q10)
- What if anything has changed about the way you approach nurses needing support now that you are part of the PNA Programme? (Q25)

Impacts on patient care:

- Which aspects of the AQUIP model have the greatest impact [on patient care]? (Q11)
- How has the PNA role and AQUIP Model worked together [has it improved care] (Q12)
- What are the types of quality improvements made as a result of the PNA programme? (Case Study - a general question) (Q56)
- Prior to using the AQUIP model how were you empowered (or how did you) to make positive changes to patient care or services? (Q39) (this Q is asked twice)

What has been your experience to date of delivering restorative supervision?

Prompts:

- How is restorative supervision organised?
 - How does the process of delivering restorative supervision with a nurse begin?
 - How often do meet with a nurse to provide restorative supervision?
 - How many nurses do, or can, you supervise?
- What kind of content or subject areas are discussed in restorative supervision?

- How would you describe the relationships (dynamics) between you and the nurses you supervise? Has this changed compared to before the PNA programme?
- What things work well and what things are challenging when delivering restorative supervision?
- How does restorative supervision fit within your wider role within the organisation?
- What mechanisms support or prevent you in delivering the PNA programme?
- What methods if any are used to evaluate or audit the PNA programme (e.g. are there any measurements in place pre/during/post PNA programme on key individual/interpersonal/patient outcomes? Do you write reflective notes on the delivery or engagement with restorative supervision? Do you have to report back to leaders about the PNA programme implementation)

Questions mapped to this overarching question:

- How well supported do you feel in your delivery of the PNA Programme? For Lead PNAs (Q21)
- What are the key issues that impact upon your ability to implement the PNA role? For Individual PNAs (Q23)
- How would you describe your experience of the PNA role in practice? (Q28)
- Is there any part of the PNA implementation that creates tension in it's delivery? (Q52) (and potentially barriers)
- How would you describe the relationship (dynamics) between you and the nurses who receive your restorative supervision? (PNAs) (Q58)

Can you describe some of the facilitators and barriers you experienced of the PNA programme?

Prompts:

- Individual barriers
- Relational barriers
- Organisational barriers

Questions mapped to this overarching question:

- Do you think the PNA programme and role is well understood by those who are not participating? (Q24)
- What are the barriers [and] facilitators to delivering the PNA role in practice? (Q29)
- How would you describe the benefits of the PNA programme? (Q47)

THE FUTURE OF THE PNA PROGRAMME

What are your thoughts about the future of the PNA programme in your organisation and your career?

Prompts:

- What mechanisms would enable the onward development and sustainability of the PNA programme? (in your organisation and across the country generally)
- What do you hope the PNA programme to look like moving forward in your organisation?
- What are your future career plans?
- What do you envisage your role on the PNA programme in the future?

Questions mapped to this overarching question:

- How would you describe mechanisms to facilitate your onward development since the PNA Programme? (Q6)
- How would you describe your career plans now, beyond the PNA Programme? (Q15)
- What are the things about the PNA programme that you feel could be improved? (Q26)
- If you were to have the opportunity to start all over again with the PNA programme implementation, what would you advise others? (Q27)
- If changes were to be recommended for the PNA role, what would these need to be? (Q30)
- Do you think that the PNA model is sustainable in the longer term? (Q57)

Concluding questions

Are there any other ways in which nurse empowerment is supported within (or beyond) your organisation other than the provision of restorative clinical supervision?

Is there anything else you would like to discuss before we finish?

Is there anything I haven't asked that I should have asked? Is there anything we should be aware of?

Thank you for taking part in this interview, your help is very much appreciated.

TURN OFF RECORDING

Appendix 9: Quality Appraisal of Literature: Hawker et al Appraisal Tool

Ref	Abstract & title	Intro & aims	Method & data	Sampling	Data analysis	Ethics & bias	Results	Transferability/ generalizability	Implications & usefulness	Comments	Total quality score
Foster (2021)	1/4 (no abstract was presented)	2/4 (background was covered but no clear aims were presented)	1/4 (methods were not presented as this was primarily an opinion piece)	1/4 (sampling approach was not presented as this was an opinion piece)	1/4 (no analysis was presented as this was an opinion piece)	1/4 (ethical issues were not discussed)	1/4 (no primary results were presented as this was an opinion piece)	1/4 (transferability/ generalizability was not mentioned as this was an opinion piece)	1/4 (provides no novel insight, does not suggest implications for practice, and does not highlight any future research directions).	An opinion piece with no primary data.	10/36
Foster (2021) presented a reflective piece of work relating to wellbeing interventions that have evolved during the COVID-19 pandemic, with a particular focus on the PNA programme. There was no primary data presented and instead this work summarised the key features of the PNA role/programme.											
Griffiths (2022)	3/4 (informative non-structured abstract was presented)	3/4 (background was covered and the aim of article was briefly)	2/4 (the methods used to deliver and evaluate the PNA session were)	2/4 (the sample were briefly mentioned but with inadequate detail)	2/4 (the analytical strategy was poorly discussed such that it is hard to work out)	2/4 (brief and indirect mention of ethics e.g., explaining)	2/4 (some quotes and basic quantitative data from the survey were presented –)	1/4 (transferability/ generalizability was not mentioned)	3/4 (provides some basic evidence relating to the impact of the PNA programme. Also briefly)	Primarily an opinion piece with some basic data presented, but with little methodological information.	20/36

		mentioned)	inadequately described)		what methodology was used).	reasons why the sessions were being conducted	but very under-developed)		mentions implications for practice, but no future research directions were presented)		
<p>Griffiths (2022) presented a thorough overview of the PNA role/programme and the A-EQUIP model. The article discusses how one nurse delivered RCS sessions and then evaluated whether they were effective using interviews/focus groups (assumed, but not clear) and a snapshot survey. Some very basic data was presented (e.g., quotes mentioning that the RCS sessions were beneficial, and a summary of findings from the survey), however, it is not clear how the data was collected, which makes it difficult to assess rigour.</p>											
Mahachi (2020)	3/4 (informative non-structured abstract was presented)	2/4 (background was covered but no clear aims were presented)	1/4 (methods were not mentioned even though some results were later presented)	1/4 (sampling approach was not mentioned even though some results were later presented)	1/4 (analytical approach was not mentioned even though some results were later presented)	1/4 (ethical issues were not discussed)	2/4 (some very basic data were presented, including a quote indicating that the PNA role had a positive impact on an individual)	1/4 (transferability/generalizability was not mentioned)	3/4 (Some very basic data was presented regarding the impact that the PNA role can have. Basic implications for practice were mentioned. There were no future research directions discussed)	Primarily an opinion piece with some very basic data presented, but it was unclear which methods were used to derive the data.	15/36

Mahachi (2020) discussed how the PNA role might fit into endoscopy. Much of this report discusses what the PNA role is, and the underpinning A-EQUIP model. There was some very basic data presented (with no mention of methodology etc.) which suggests that the PNA model was beneficial in terms of outcomes at work and in one's personal life.

Muscat et al. (2021)	1/4 (no abstract was presented)	2/4 (background was covered but no clear aims were presented)	1/4 (no methods were presented as this was primarily an opinion piece, although some very basic results were later discussed)	1/4 (sampling approach was not presented as this was primarily an opinion piece)	1/4 (no analysis was presented as this was primarily an opinion piece)	1/4 (ethical issues were not discussed)	1/4 (it was mentioned that the PNA course was effective and had benefits, but it was not clear where this data had derived from).	1/4 (transferability/generalizability was not mentioned as this was an opinion piece)	2/4 (some very basic data was provided regarding the usefulness of the course, but implications for practice and future research directions were not discussed)	Primarily an opinion piece with some very basic data presented regarding the outcomes of the PNA training course.	11/36
----------------------	---------------------------------	---	---	--	--	---	---	---	---	---	-------

Muscat et al. (2021) discussed the PNA training course from the perspective of the higher education institutions that deliver the training. The PNA role and the A-EQUIP model were also discussed. Muscat et al. also presented some data (with no indication of where data was derived) summarises the benefits/outcomes that the PNA training has on

Pearce (2022)	1/4 (no abstract was presented)	2/4 (background was covered but no clear aims were presented)	1/4 (methods were not presented as this was primarily an opinion piece, although	1/4 (sampling approach was not presented as this was primarily an opinion piece)	1/4 (no analysis was presented as this was primarily an opinion piece)	1/4 (ethical issues were not discussed)	2/4 (a quote from a PNA was presented which suggests that the PNA role	1/4 (transferability/generalizability was not mentioned as this was an opinion piece)	2/4 (provides some very basic evidence that the PNA role can have tangible benefits. Implications	This was primarily an opinion piece to inform readers of the PNA role. Some very basic data were	12/36
---------------	---------------------------------	---	--	--	--	---	--	---	---	--	-------

			some data was later presented)				reduced stress and increased retention for one nurse receiving supervision)		for practice and future research directions were not mentioned)	presented in the form of a quote from a PNA suggesting that the PNA role reduced stress and increased retention for one nurse receiving supervision.	
--	--	--	--------------------------------	--	--	--	---	--	---	--	--

Pearce (2022) wrote an opinion piece to educate readers regarding the fundamentals of the PNA role. Some very basic data was presented in the form of a quote from a PNA, who argued that the PNA role had a beneficial impact on a nurse receiving supervision, such that it reduced stress levels and prevented her from leaving the nursing profession. However, it is unclear where this data and conclusion was derived from.

APPENDIX 10: Description of Study Recruitment Strategy, Barriers and Risks [3 pages]

PNA Evaluation

Ethics permission to conduct the PNA evaluation was received during August 2022. Strategies in place for the recruitment of participants have been very successful, except for nurses receiving restorative clinical supervision. All work packages are underway and we are completing the workload, aided by a very enthusiastic PNA response.

Participants Recruited:

Across the four work packages [employing the maximum variation sampling strategy to select from the EOI database], we have recruited to each work package, completing the following interviews, to date (Table 1):

Table 1: Participants Recruited across the work packages:

HEI Leads	3
Regional Leads	6
Lead PNAs	11
PNAs	19
Case Studies	8 (mixture of site leads and HEI)
Survey	150

From the survey respondents (n=150), 123 (82%) indicated they have/are undertaking restorative supervision. The number of nurses for each PNA providing restorative supervision ranges from 2 upwards, with an average of 15 nurses per PNA. 17 trained PNAs who responded to the survey were receiving restorative supervision. Some respondents however, indicated they are not supervising any nurses, yet.

Management oversight

The PNA team have met weekly to discuss progress for all work packages of the evaluation, giving good oversight at all levels (Professorial to Research Associates). We have allowed 2/3 weeks for responses to the recruitment strategies employed. Despite support given by NHSE to reach HEI Leads, Regional Leads, Site PNA Leads, PNAs and NRRS we have significant concerns regarding the lack of expressions of interest and subsequent lack of recruitment of nurses receiving restorative clinical supervision (RCS), despite all strategies to recruit (see Table 2).

The following recruitment strategies were adopted during June, August, September and early October to generate expressions of interest from RCS nurses [Survey and Interviews]:

Table 2: Recruitment Strategy and expressions of interest (EOI) to participate in study

Strategy: primary [p] or secondary [s]	EOI from Regional, Lead PNAs, PNAs and HEI	EOI from Nurses Receiving Restorative Supervision
Poster advertising [p]	65	0
Email via NHSE (Comms piece) [p]	32	0
Email via NHSE (Survey) [p]	70	1
Survey – embedded question about receiving supervision	17 (PNAs – receiving supervision)	0
Via PNA Interviews [s]	0	2
Via Site Lead PNA Interviews [s]	0	-
Social Media (Twitter) x2 [s]	0	-

Potential barriers to recruitment:

During our weekly team meeting on 10th October 2022, we discussed perspectives that might be contributing to the lack of success in our recruitment plan, these are summarised as:

- Nurses who have received restorative supervision may not want to revisit the issues/experiences.
- Nurses may be concerned that their privacy will be breached through participation
- Time to be released to participate in an interview is impossible when on duty (stated by PNAs) [time is not protected – evidenced as main theme from survey responses]
- Staff shortages are severe (up to 25% shortage) and nursing staff are feeling burnt out, this is one extra thing to do [evidenced from survey responses]
- Lack of ability to implement the model, in practice, reduces the number of RCS nurses available for interview [evidenced from survey].
- RCS may not recognise restorative elements of supervision, as supervision [informal]
- May not have computer access for MS Teams or Zoom calls
- May not have access to a private area to discuss the restorative supervision process [evidenced from survey].

Remedial action:

1. We will directly contact the PNAs (n=17) who responded giving their email address within the survey, indicating they had received restorative supervision in their PNA role.
2. Within the Case Study (qualitative data – pre interviews) to gain permission approach the Lead PNAs, who indicated they have nurses receiving restorative supervision – to ask for direct support to reach this group of potential participants.

Other actions, where we would value your advice/input:

3. It has been indicated (in the interviews and survey responses) that ‘supervision’ is a rather formal and sometimes intimidating term. It is not always used by the PNAs.

We could consider changing our terminology to frame 'restorative supervision' as 'support in practice' and refer to the PNA interview transcripts to guide us further in the language being used by PNAs.

4. Ask [] to repeat her tweet via Twitter but with specific appeal to nurses receiving restorative supervision.
5. [] can do same Twitter appeal.
6. Ask about the Provider Workforce Return – to understand where RCS nurses are based.
7. Ask NHSE to send a further recruitment email, with information sheet to PNA Site Leads to reach NRRS group:
 - We would ask the site leads to approach PNAs in person, to approach their NRRS – for discussion rather than relying on the email.
 - We would ask the PNA site leads if an office space can be made available for NRRS use for the interviews or telephone calls

We could create some new information to state that:

- We can accommodate much shorter interviews [15 to 30 minutes]
- Interviews are confidential, they will be a safe space to feedback their experience
- Incorporate new terminology replacing the word supervision.
- We can accommodate any time of the day (before or after their shifts)
- Telephone interviews can be accommodated
- We will send the interview questions in advance of the interview

Risks to the PNA Evaluation:

We may need to request an extension to the evaluation to enable us to recruit the NRRS participants, meaning the envisaged finish date 31st January 2023 will not be achievable. We are concerned that the voice of the NRRS will not be present in the final evaluation. Given the huge enthusiasm from the other participants, the risk is this will not be representative of the PNA Programme.

14. REFERENCES

- Baumann, N. (2016), How to use the medical subject headings (MeSH). *Int J Clin Pract*, 70: 171-174. <https://doi.org/10.1111/ijcp.12767>
- Christens, BD (2011) Towards Relational Power, *An J. Community Psychol.* 50: 114-119
DOI: 10.1007/s10464-011-9483-5
- Critical Appraisal Skills Programme (2022) <https://casp-uk.net/casp-tools-checklists/>
[Accessed November 2022, Qualitative Checklist].
- Critical Care Networks-National Nurse Leads (CC3N) (2022) Professional Nurse Advocates in Critical Care: Standard Operating Procedure, Version 1. Available from:
https://www.cc3n.org.uk/uploads/9/8/4/2/98425184/cc3n_pna_sop_final_version_02.22.pdf, Accessed 23/1/23.
- Foster, S. (2021). An intervention for nurse wellbeing. *British Journal of Nursing*, 30(18), 1101-1101.
- Griffiths, K. (2022). Using restorative supervision to help nurses during the Covid-19 Pandemic. *Nursing Times*.
- Hasson F, Keeney S. (2011) *Enhancing Rigour in the Delphi technique research*. Technological Forecasting and Social Change. 78:1695-1704.
- Hawker, S., S. Payne, et al. (2002). Appraising the Evidence: Reviewing Disparate Data Systematically. *Qualitative Health Research* 12(9): 1284-1299.
- Kanter, R.M. (1993). *Men and women of the corporation* (2nd ed.). New York: Basic Books.
- Laschinger, H.K., Finegan, J. and Shamian J. (2001). Impact of Structural and Psychological Empowerment on Job Strain in Nursing Work Settings. Expanding Kanter's Model. *Journal of Nursing Administration*, 1, 260-272. <http://dx.doi.org/10.1097/00005110-200105000-00006>
- Mahachi, L. C. (2020). The Role of Professional Advocate in Endoscopy: The A-Equip Model. *Gastrointestinal Nursing*, 18(8), S18-S24.#
- Mccawley, P. (20021) The Logic Model for Programming Planning and Evaluation
https://www.researchgate.net/publication/237568681_The_Logic_Model_for_Program_Planning_and_Evaluation Accessed 2/8/2022.
- McHugh M. L. (2012) Interrater reliability: the kappa statistic. *Biochemia Medica (Zagreb)*. 22(3):276-282.

Muscat, H., Morgan, L., & Hammond, K. (2021). Staff burnout: how a nurse advocate course can help: Programme uses a model of restorative clinical supervision proven to boost well-being and patient outcomes. *Learning Disability Practice*, 13-14.

NHS Digital (2023) NHS Workforce Statistics, September 2022 Staff Group, Care Setting and Level. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2022>, Accessed 23/1/23.

NHS England (2019) Workforce Race Equality Standard. An overview of workforce data for nurses, midwives and health visitors in the NHS. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/03/wres-nursing-strategy.pdf>, Accessed 23/1/23.

NHS England (2022) Workforce Disability Equality Standard. 2021 data analysis report for NHS trusts and foundation trusts. Available from: <https://www.england.nhs.uk/wp-content/uploads/2022/05/Workforce-Disability-Equality-Standard-2021-data-analysis-report-NHS-trusts-foundations-trusts.pdf>, Accessed 23/1/23.

NHS England & NHS Innovation (2021) PAR799: Professional Nurse Advocate A-EQUIP model: A model of clinical supervision for nurses. Available from: <https://www.england.nhs.uk/wp-content/uploads/2021/12/B0799-national-professional-nurse-advocate-implementation-guide-with-links.pdf>, Accessed 23/1/23.

Nursing and Midwifery Council (2022) Mid-year data report September 2022 Permanent register data tables. Available from: <https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/>, Accessed 23/1/23.

Ouzanni M, Hammady H, Fedorowicz Z, et al. (2016) Rayyan- a web and mobile app for systematic reviews. *Systematic Reviews*. 5:210. DOI 10.1186/s13643-016-0384-4

Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. (2020) The PRISMA statement: an updated guideline for reporting systematic reviews. *BMJ*;372:n71. doi: 10.1136/bmj.n71 <http://www.prisma-statement.org/>

Pearce, L. (2022). What are professional nurse advocates and how do I become one? *Mental Health Practice*, 25:4; 12-13.

Ritchie J, Lewis J (2003) *Qualitative research practice: a guide for social science students and researchers*. London: Sage

Stevenson K, Sarigiannis P, Finney AG, et al. (2021) Development, spread and impact of primary care and musculoskeletal communities of practice to assist rapid translation of evidence into practice. *Musculoskeletal Care*. 1–6. <https://doi.org/10.1002/msc.1552>

Taylor-Powell, E. (1999) *Providing leadership for program evaluation*. University of Wisconsin Extension, Madison Press.

Wallbank S, Woods G (2012) A healthier health visiting workforce: Findings from the restorative supervision programme. *Community Pract* **85**(11): 20–3