SUStAIN-ING: SUpervision, Support & Advocacy for Improvement in Nursing:

A study to understand the impact that PNAs have on patient outcomes and patient experience, through quality improvement projects they lead.

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Abbreviations

Abbreviation	Full Form
A-EQUIP	Advocating and Educating for Quality Improvement
AI	Artificial Intelligence
CEBIS	Clinical Education Based Information Services
EI	Expert Involvement Group of PNAs
HEI	Higher Education Institution
JISC	Joint Information Systems Committee
MeSH	Medical Subject Headings Index
NHSE	NHS England
PI	Principal Investigator
PWR	Provider Workforce Return
PMA	Professional Midwife Advocate
PNA	Professional Nurse Advocate
PRISMA	The Preferred Reporting Items for Systematic Review and Meta Analyses
QI	Quality Improvement
RAYYAN	Systematic Review Screening Software
RCS	Restorative Clinical Supervision

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Executive Summary

Introduction

The Professional Nurse Advocate (PNA) programme is a clinical and professional leadership initiative that prepares nurses in England to provide restorative clinical supervision (RCS) to their colleagues. The national PNA Programme was devised and commissioned by NHS England in 2021 and since that time Higher Education Institutions (HEIs) have been delivering PNA courses across the country (NHSE, 2021). On becoming a qualified PNA, nurses have worked in different ways within their organisations to implement the various elements of the role.

During 2022-23, Coventry University was commissioned to evaluate the roll out of the national PNA programme. This highlighted positive impacts on nurse morale through RCS and career conversations. However, it also identified areas needing further development, particularly in quantifying improvements in patient care derived from Quality Improvement (QI) work.

In May 2024, NHS England commissioned Coventry University to evaluate the impact of PNAs on patient outcomes and experience through QI projects. This report presents the resultant methods, findings, and recommendations.

Background

Quality Improvement (QI) is essential in NHS leadership roles, with ward leaders and clinical staff crucial in identifying and addressing care issues. The NHS employs a range of resources and methods to ensure continuous quality improvements, plus support is often typically provided via in-house training.

The PNA role is structured via the Advocating and Educating for Quality ImProvement (A-EQUIP) model which includes RCS, quality control, personal action for improvement, and education. In 2023, the Royal College of Nursing's educational standards for PNA programmes further defined the 'personal action for quality improvement' function.

Standard 3 emphasises the PNA's role in fostering continual care development and innovation, making QI integral to practice. It includes supporting staff through continuous improvement processes, applying nursing research to innovate and improve practice, and using quality improvement methodologies to enhance care and services systematically. It is on this element that the evaluation focuses.

Evaluation Design and Approach

This evaluation explored the extent to which successive cohorts of PNA’s have been able to impact patient outcomes and experience through the implementation of QI work. Our primary research question asked: what is the impact of QI work led by PNAs on patient outcomes and experience? The evaluation was delivered using mixed-methods design comprising four work streams:

- Workstream 1: Rapid Review and Expert PNA Group
- Workstream 2: National Survey
- Workstream 3: Case Studies
- Workstream 4: Conference; Workshop; and Case Examples

Laschinger's (2001) Theory of Organisational Empowerment, which expands on Kanter's (1993) theory, was utilised to shape the study questions (interviews, survey, and co-creation workshop) and to direct the interpretation and synthesis of qualitative data. This model identifies three constructs of empowerment within an organisation: Structural Empowerment, Psychological Empowerment, and Positive Work Feelings. Several of the survey questions were also informed by Michie et al.'s (2011) Capability, Opportunity, Motivational and Behaviour framework (COM-B). This evaluation gained research ethics approval via Coventry University (Ref: P174616).

Workstream Activities and Data Collection

Rapid Scoping Review - A systemised rapid review process, aligned with Preferred Reporting Items for Systematic Reviews (PRISMA, 2021), was used to guide data collection and reporting. This aimed to inform the research team's knowledge and reporting, contribute to the work of PNAs, and shape the study questions. The main review question was: What is the scope and nature of quality improvements completed by PNAs?

National PNA Survey - An electronic cross-sectional survey was developed and distributed via JISC Online Surveys to trained PNAs through NHS England's email list between January and March 2025. The survey covered demographics, nursing experience, QI training and support, QI delivery, impact on patient care, and PNA roles related to QI. The survey aimed to evaluate PNA participation and leadership in relation to QI programmes.

Organisational Case Studies - Organisations with exemplary QI work from the PNA Programme were purposively sampled, spanning community, mental health, and acute sectors. Semi-structured interviews with key participants explored the nature of QI work by PNAs in their organisations.

PNA Conference and Co-creation - Entitled "Inspire, Innovate and Impact", the Conference was held at Coventry University on November 13, 2024, to showcase PNA QI work and promote learning on its positive impacts. A co-creation workshop was held where delegates shared experiences and strategies for sustaining QI work. Further activities supported gathering QI case examples, with contributions from conference delegates and other invited participants.

Findings

Rapid Scoping Review:

- A limited number of relevant papers were retrieved, describing the PNA role (Smythe et al. 2023; Pearce 2023a, 2023b), the role of RCS in the PNA model (Scanlan and Hart 2024; Hart and Scanlan 2024), and reflections on being a PNA (Brookes, 2022).
- Sharman et al. (2025) evaluated the implementation PNA programme in a mental health and learning disability NHS trust, finding that only 18% of RCS sessions resulted in identifying a QI project. However, one of the identified signposting areas from RCS was to the continuous quality improvement team. 41% of sessions addressed stress and wellbeing, providing psychological safety for staff to discuss issues. They concluded that PNA training increases confidence to undertake QI, however further CPD was identified as needed as new insights develop regarding the role.

- Within the Professional Midwifery Advocate (PMA) literature, Horler (2020) implemented a QI project to increase home birth rates, using various tools and culminating in an audit, new service proposal, guideline review, and training development. Sterry (2019) introduced the A-EQUIP model to support practice change for PMAs.
- The review highlighted gaps in reporting and quantifying QI projects arising from PNA work and informed potential questions for the expert involvement group and survey.

National PNA Survey:

- There were 105 survey responses. Most respondents (72%) had QI experience before becoming PNAs, and nearly all (92%) were currently engaged in QI work. PNA training was moderately rated as equipping nurses for QI, with 51% receiving additional training.
- PNAs felt 'somewhat confident' in leading QI work and 'somewhat supported' in practice. The perceived impact of QI work was rated higher on patient care outcomes ('high impact') than on patient experience ('moderate impact'), and patients were only reportedly involved 'to a small extent'.
- Over half (54%) reported improvements in patient care outcomes or experience, with only 5% stating no improvement.
- Three main areas of QI work positively impacting patient care or outcomes were identified: interventions and treatment processes; workforce and staff wellbeing issues, and focused clinical projects tailored to specific clinical contexts.

Case Study Interviews:

Eight participants provided case study interviews (October 2024 to December 2024).

Four key themes were identified during the thematic analysis of narrative data, namely; Identifying QI projects and lack of preparedness; Implementing QI projects, related support and collaboration; Monitoring, reporting and disseminating QI work; and the Impact, reach and sustainability of QI work.

Theme 1. Identifiying QI projects and lack of preparedness: PNAs identified potential QI work through RCS sessions, staff feedback, care observations, patient feedback and complaints. Whilst some staff felt unprepared for QI, others felt empowered by the PNA role and emphasised the importance of utilising this to empower others to take forward their own ideas and projects.

Theme 2. Implementing QI work, related support and collaboration: The importance of support, teamwork, and collaboration in relation to QI was emphasised. Time was a major barrier and being released from the clinical duty if this was needed to develop QI work. It was stressed that these barriers needed resolution to successfully implement QI projects.

Theme 3. Monitoring, reporting and disseminating QI work: There was a clear need for robust data collection to demonstrate the impact of QI initiatives. Participants discussed the methods used to gather data (local level), the challenges of measuring outputs/successes (system level), and the value of qualitative feedback as well as its limitations in providing concrete evidence of impact.

Theme 4. Impact, reach and sustainability of QI work: Respondents emphasised the ability of QI to significantly impact both staff wellbeing and patient outcomes. Where successes had been garnered via QI projects, efforts were made to share these within and beyond their organisation. Designing QI projects focused directly on patient outcomes was considered particularly challenging. As such, QI projects focused on staff wellbeing could indirectly improve patient outcomes, by creating supportive environments for staff, leading to better patient care.

PNA Conference and Co-Creation Workshop

The Conference was extremely well attended by 90 delegates, mostly PNAs. At the Conference the Co-Creation Workshop enabled the development of a set of Principles for PNAs, translated into a Toolkit, aimed at helping PNAs to engage in QI; in particular for nurses with minimal nursing experience, or PNAs new to the role of QI work. Additionally, the Toolkit provides nine characteristics of good QI work and a set of 'top tips' for PNAs initiating QI work have been developed.

The toolkit sets out the following principles to support the development of QI work:

1. **ACCESS:** the QI team (or support person) to facilitate further QI training, tools and ongoing support as needed, before commencing any work.
2. **EXPLORE:** the problem (s) to envisage how this could be improved and decided whether or not, to progress with QI work.
3. **UNDERSTAND:** the complexity of the problem through discussing the impact this is having in your area and barriers it potentially creates – it might be more than one problem.
4. **CONTACT:** your Lead PNA to enable identification of other PNAs or ward-based nurses with experience of undertaking QI work, for transitional support.
5. **NEGOTIATE:** Establish if/how other PNAs have negotiated the time to undertake QI work (see Tool 3).
6. **COLLABORATE**: Consider ways to buddy with other PNAs to build your confidence of QI work and enhance your practice. For example, join a PNA network/forum to create inspiration, creativity and support for QI work.
7. **COMMUNICATE:** your QI plans to the Lead PNA and upwards to senior leadership/corporate nursing team/the education/practice development team to facilitate awareness of QI work.
8. **ALIGN:** your QI work to the organisational nursing priorities, to achieve organisational buy in. This will connect your QI work and enable greater traction.
9. **DOCUMENT:** your QI project ready to receive feedback, disseminate or to celebrate success using existing organisational mechanisms, such as team meetings and Newsletters.

Conclusion

Three core elements were identified from the qualitative findings namely, the need for further QI training; to develop confidence in QI and the ambiguity of the PNA role in relation to leadership of QI. Adequate time to conduct QI work within the PNA role was identified as an issue throughout. PNAs report that their QI activities enhance patient outcomes and experiences, with case examples showing benefits for both staff and patients. Improved data capture could lead to more routinely reported patient benefits. While PNAs use QI

methodologies, strengthening training within the PNA programme could aid their transition and support QI efforts. PNAs value the professional growth from QI involvement, but greater organisational commitment is needed to fully realise the benefits of the PNA role in clinical settings.

Recommendations

Eight recommendations were derived from the evaluation:

Provider organisations for the education of PNAs to

1. Enhance the QI element of PNA training: Provider organisations for the education of PNAs should review the QI training as part of the PNA programmes to improve the confidence, skills and capacity of PNAs to undertake QI work.

2. Clarify responsibilities for QI work: Expand upon current education guidance/policy (RCN,2023) regarding the PNA responsibilities in relation to delivering and supporting QI work to ensure the expectations and deliverables are clear.

Provider organisations for the employment of PNAs to

3. Recognise the time required for QI work to be realised: Acknowledge QI work within PNA roles to ensure there is adequate time.

4. Foster a supportive culture for QI work: Encourage empowerment and leadership among PNAs to facilitate QI projects through communities of practice (e.g., Shared decision-making councils).

PNA's to

5. Promote the involvement of patients in QI work: Establish ways of routinely involving patients to represent their voice in addressing issues which required improvement.

6. Improve the quality of data reporting at organisational level: Encourage the development of methods across organisations for data reporting (quantitative and qualitative) to better demonstrate impact from work

PNA Leads regional and system level to

7. Enhance communication and engagement regarding QI work: Promote communications regarding the sharing and dissemination of QI work to highlight successful projects and innovative practices.

8. Ensure sustainability and greater reach of QI projects: Clear mechanisms should be developed to support continuous improvement and the reach across organisations of successful QI work.

1. Introduction

The National PNA Programme was introduced in March 2021 (NHSE, 2023). During 2022-2023 NHS England commissioned Coventry University to undertake an evaluation of the National programme which explored its impact on PNAs and wider organisational teams. Many positive aspects of the PNA programme were identified, such as positive improvements to nurse morale through the provision of RCS and career conversations.

Areas requiring further work were also highlighted to develop and promote all elements of the Advocating and Educating for Quality ImProvement (A-EQUIP) model in practice. In particular, the study identified a lack of quantifiable evidence of improvements in patient care arising from PNA initiated Quality Improvement (QI) work. While some QI work was underway the understanding was that individual QI work lacked robust development and potential longevity, including measures to quantify the difference this had made to patient experience and outcomes.

NHS England sought an evaluation of the impact that PNAs have on patient outcomes and patient experience, through QI projects they lead. During May 2024, a research team from Coventry University were convened to undertake this work. This report sets out the methods, findings and recommendations as requested by commissioners.

2. Background

QI is an integral part of all leadership roles in the NHS; ward leaders and clinical staff are pivotal to understand the problems and best placed nearest to patient care delivery to address these and improve patient care. The NHS draws on a wide variety of resources, approaches, and methods in healthcare organisations to continuously deliver QI (Health Foundation, 2021). Most large NHS organisations offer in-house training for the plethora of multi-professional staff to enable understanding of the QI process, associated tools and how to identify appropriate interventions.

The term ‘quality improvement’ broadly refers to the systematic use of methods and tools to improve quality of care and outcomes for patients (Alderwick, et al. 2017). This said, no one single definition exists with the imperative being, to posses the skills and habits needed to deliver measurable improvements in patient care (Health Foundation, 2021).

The nurse’s role in QI is not new; it is explicit in the Leadership Standard of the revised Nursing Midwifery Code (2018) ‘to improve the experiences of patients’ (NMC:25.1. p,25). The standard aims to augment existing mechanisms by developing a PNA workforce with the abilities to lead QI, in practice. This creates the potential for additional NHS capacity and capability supporting frontline nurses in the delivery of quality improvement initiatives, through the A-EQUIP model (Advocating and Educating for Quality Improvement). Embedded in the model are four key functions:

- Restorative clinical supervision (restorative)
- Monitoring, evaluation and quality control (normative)
- Personal action for QI
- Education and development (formative).

In 2023, the 'personal action for QI function was further defined within the new Royal College of Nursing (RCN) educational standards for PNA programmes and learning modules, as follows:

Standard 3: Critically appraise the role of the PNA in contributing to continual development and innovation in care so that quality improvement becomes part of everyone's practice.

3.1. learners know how to comprehensively support staff through a continuous improvement process that builds personal and professional clinical leadership, improves quality of care, and supports professional revalidation.

3.2: learners can systematically identify and critically apply high-quality nursing research and support to innovate and use evidence in practice; enabling PNAs, and those who work with them, to develop new knowledge, improve nursing practice and transform patient care and experience.

3.3: learners can comprehensively apply quality improvement methodologies enabling them to systematically evaluate, change and improve the quality of care and services as part of every nurse's responsive practice.

Royal College of Nursing, Standards for the Delivery of Professional Nurse Advocate Training Programmes and Modules, Part 2: Page, 12.

Together the NMC (2018), Health Foundation (2021), PNA Programme (NHSE, 2021) and RCN (2023) form supportive mechanisms to develop and engage nurses with QI in daily practice.

3. Aims and Research Questions

3.1. Aim

This evaluation explores the extent to which the successive cohorts of PNAs have been able to impact patient outcomes and experience through the implementation of QI work.

4. Evaluation Design and Methods

4.1. Evaluation Design

The evaluation was delivered using mixed-methods design comprising four work streams namely:

Workstream 1: (Parts a, b): Rapid Review and Expert PNA Involvement Group

Workstream 2: National Survey

Workstream 3: Case Studies

Workstream 4: (Parts a, b, c): Conference; Workshop; and Case Examples (recruitment)

The Expert Involvement of a group of PNAs (EI group) was established to guide the study throughout its development, to member check our interpretations and feedback on work.

4.2. Theory to Inform Study

4.2.1. Laschinger's (2001) Theory of Organisational Empowerment

Laschinger's (2001) Theory of Organisational Empowerment (an expansion of Kanter's (1993) theory) was used to inform the study questions (interviews, survey and co-creation workshop) and to guide the interpretation and synthesis of qualitative data. This model proposes three constructs of empowerment within an organisation, namely Structural Empowerment; Psychological Empowerment and Positive Work Feelings (see Figure 1). Empowering work conditions improve the empowerment of nurses and are assumed to improve patient outcomes; using this model the constructs can be understood and better associated with empowering interventions achieved from QI.

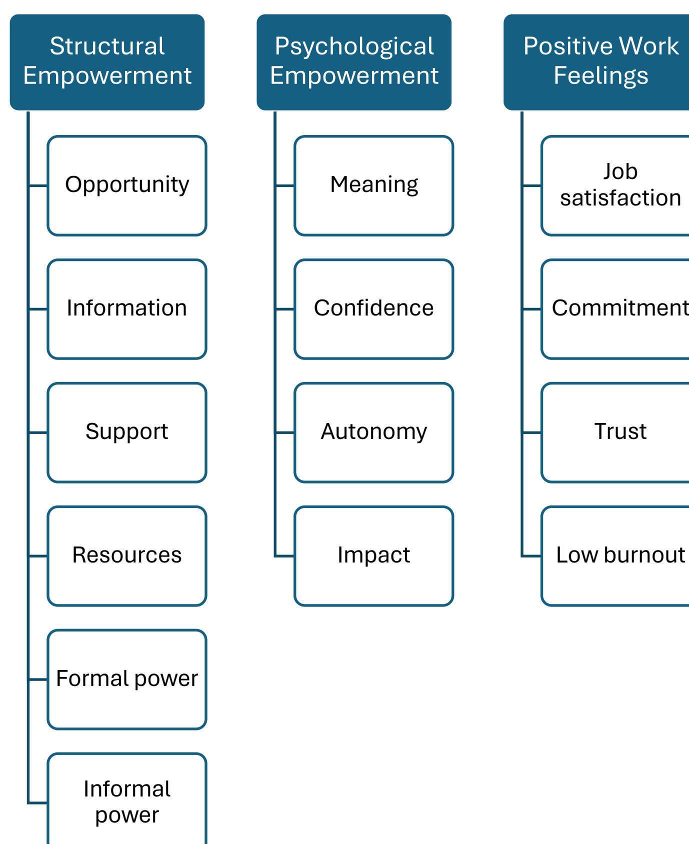


Figure 1: Laschinger's Theory of Empowerment

4.2.2. Theory of Behavioural Change

Several of the survey questions were also informed by Michie et al's (2011) Capability, Opportunity, Motivational and Behaviour framework (COM-B). This framework proposes that existing models related to the issue under exploration, should be combined with the COM-B framework to characterise the context and form a link to Capability, Opportunity and Motivation, to associate the required behaviour changes. The A-EQUIP model is the existing framework providing a structured approach to guide improvements in care; restorative clinical supervision and is a process of continuous improvement. In this study we are not proposing to develop behavioural change interventions, but we are aiming to illuminate the behaviours needed to lead QI interventions as these are introduced by PNAs.

4.3. Research Question

Our primary research question asked: what is the impact of QI work led by PNAs on patient outcomes and experience?

Across the workstreams secondary focused questions were developed.

4.4. Study Assumptions

In the process of developing this study the research team prepared assumptions based on the findings from the 2023 evaluation (Lees-Deutsch et al., 2023). Although the study did not set out to explicitly test these, the process of sharing and understanding our thoughts was important to increase the clarity of approach to the overall design. Our assumptions are listed within a system level Logic Model. The aim of using the Logic Model was to form a graphic display of the system level (NHSE) planned inputs, activities and output components, which are quantifiable (Figure 2).

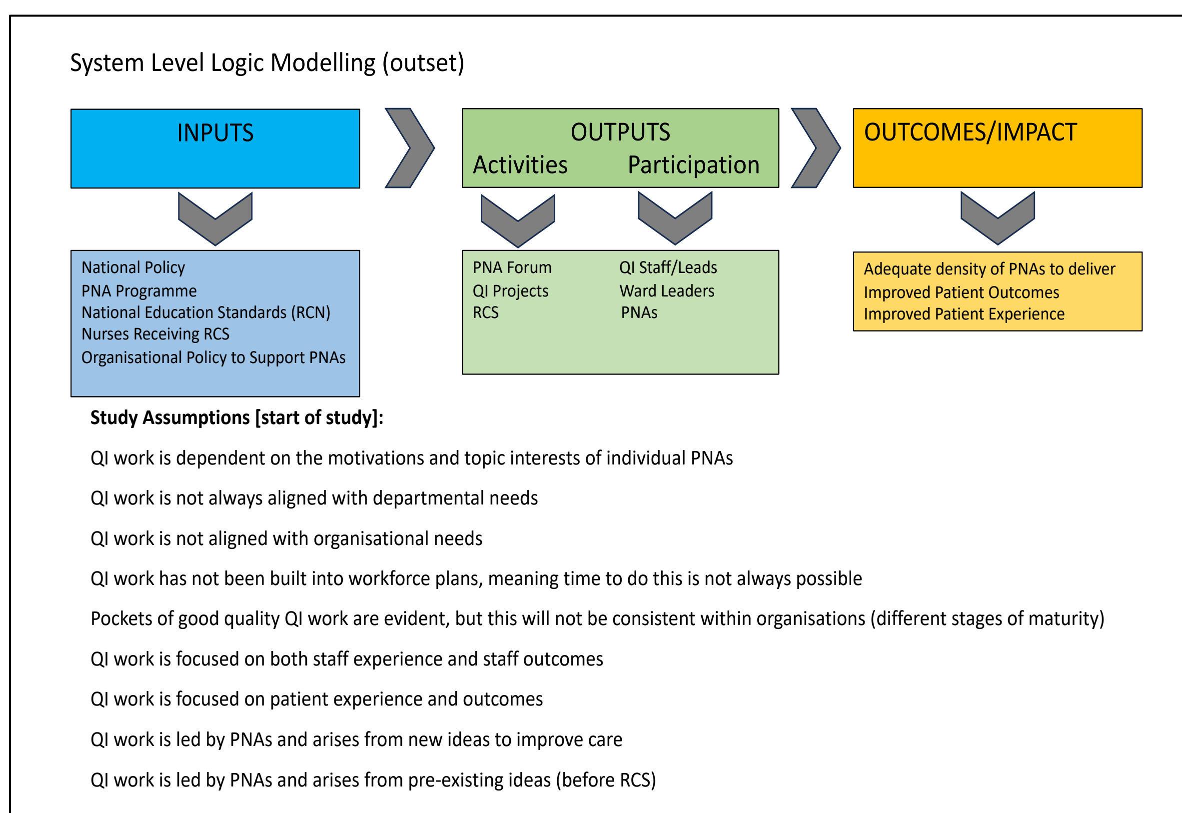


Figure 2: System Level Logic Modelling

The assumptions are revisited at the end of the evaluation and integrated within a Logic Model to understand the extent to which new perspectives have formed.

This evaluation gained research ethics approval via Coventry University (Ref: P174616, Appendix 1).

4.5. Data Collection Methods

An overview of the four workstreams comprising this evaluation are illustrated in

Figure 3.

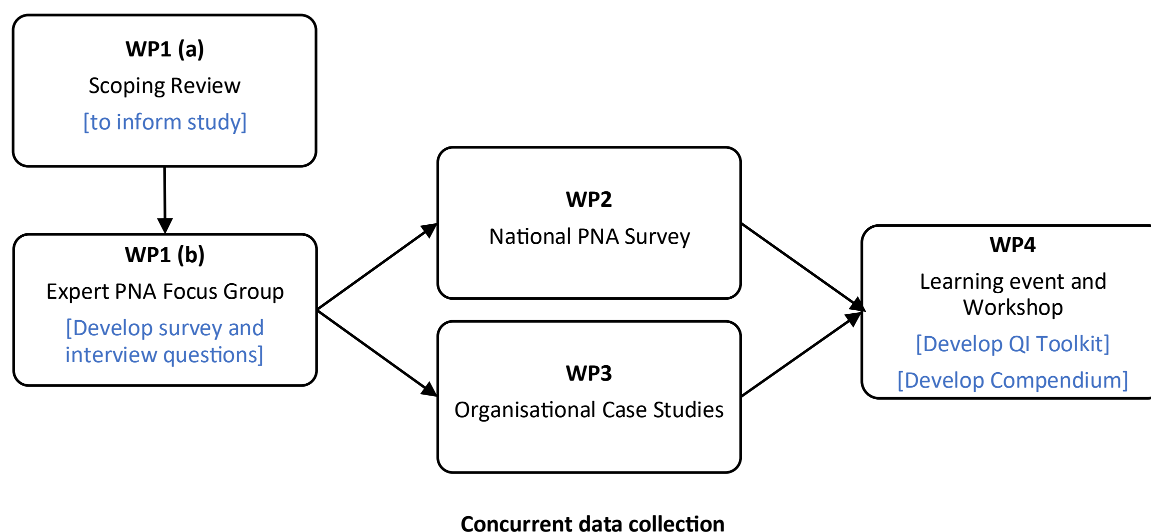


Figure 3: Workflow for the Four Work Packages

4.5.1. Workstream 1a – Rapid Scoping Review

A systemised rapid review process was used to guide the data collection and reporting aligned with PRISMA (2021). This had several purposes:

- To inform the knowledge of the research team and our reporting.
- To contribute to the work required for a group of PNAs.
- To inform the study questions.

Eligibility criteria were developed in accordance with the review question and were iterated following an initial search.

PNAs/PMAs	From 2019 to present
Quality Improvement	Produced in English Language

The overarching review question was: What is the scope and nature of QI completed by PNAs?

4.5.2. Workstream 1b – Expert Involvement Group of PNAs (EI)

NHS England (NHSE) (KT-C) shared an invitation and participant information sheet with PNAs on the database to participate in an expert involvement (EI) group. Interested PNAs completed an online survey (through JISC Online Surveys) to share their contact details to receive the online meeting information. Further meetings (3) were convened throughout the study.

4.5.3. Workstream 2- National PNA Survey

An electronic cross-sectional survey was developed (Appendix 2) and distributed via Joint Information Systems Committee (JISC) Online Surveys, using an account accessible only by the research team. The online survey included the participant information sheet (Appendix 3) and consent form (Appendix 4).

Participants were trained PNAs. An introductory email which included a link to the electronic survey was distributed by NHSE via their relevant email distribution list, thus constituting a convenience sample. A formal sample size calculation was not conducted as the likely variability in response data was unknown. 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. Responses were completely anonymous.

The survey questions were developed iteratively by the research team and the EI group to address the aims of the commissioned evaluation. A draft online survey was piloted with the EI group members and amended based on feedback. The final survey included a mix of quantitative and open text narrative questions and was thoroughly piloted with EI group members before being launched. Answers to all questions were required, although 'Prefer not to say' and 'Other' options were provided as appropriate. The survey opened on 13th January 2025 and closed on 19th March 2025.

The survey was structured to address the following topics: Demographics (age, gender, ethnicity and disability); Experience as a nurse and of doing QI work; Training and support for QI; Delivery of QI in practice; Impact of QI on patient care outcomes or patient experience; Reach, success and sustainability of QI; Capability, opportunity and motivation to engage in QI; and PNA Standards and PNA roles and responsibilities related to QI. The section on capability, opportunity and motivation was based on a generic questionnaire developed and validated by Keyworth et al (2020). The final section contained three questions devised to address each of three specific PNA standards related to QI (RCN, 2023). Four further questions in this section mirrored those asked in a previous evaluation of the PNA programme and were based on published roles and responsibilities of PNAs (Critical Care Networks-National Nurse Leads, 2022). Only statements directly related to QI were selected for the current survey. On the basis of feedback from our EI group, the statement *"I am effective in participating in and leading on quality improvement programmes"* administered in the previous evaluation (Lees-Deutsch et al, 2023) was amended. For the purposes of the current survey, two separate statements were administered *("I am effective in participating in quality improvement programmes"* and *"I am effective in leading on quality improvement programmes"*).

4.5.4. Workstream 3 – Organisational Case Studies

Participants were purposively sampled with selected organisations having exemplar status for achieving QI work from the PNA Programme. Organisations spanning community, mental health and acute care were pre-identified by NHSE (EW). The EI Group supported this process. Those sampled were then invited via an email from NHS England to take part in the case studies.

Details of the study were included in the invitation email from NHSE and participants were asked to complete a digital consent in advance by completing an online consent form (via JISC Online Surveys) which included the participant information sheet (Appendix 5) and consent form (Appendix 6). Following consent, a date and time was arranged via email for the interview. Semi-structured interviews were conducted online via MS Teams. Interviews were recorded and automatically transcribed via MS Teams and checked for accuracy by LW following the interviews. Audio/video recordings were deleted following transcription checking. The researchers asked questions as per interview guide (Appendix 7) to explore what QI work from PNAs looks like at their organisation.

4.5.5. Workstream 4a – National Conference

A 2nd National PNA Conference was organised by the study team (the 1st was held in 2023) to showcase exemplar PNA QI work and to promote learning regarding the positive impacts on patient care; wider adoption for QI sustainability and longer-term impact of PNAs in the

nursing workforce. This was held at Coventry University on the 13th November 2024 and titled: Inspire, Innovate and Impact.

4.5.6. Workstream 4b - Conference Co-Creation workshop (Toolkit of Principles)

A co-creation Workshop with conference delegates enrolled in advance was organised. Delegates interested in taking part in the workshop signed up following conference registration through a JISC Online Surveys link. A participant information sheet (Appendix 8) and consent form (Appendix 9) were provided (maximum registration 20 participants).

The aim was to share experiences and learning regarding wider adoption of ideas from QI work and how to sustain this work. Two members of the study team (RK and LL-D) facilitated the workshop and data collection. Five questions were developed and framed using Laschinger's (2001) framework to guide outputs from delegates:

Question 1 [Structural empowerment]: Within the organisation that you work, what key support do you have to deliver quality improvement work as an individual PNA?

Question 2 [Structural empowerment]: In your organisation, what key methods, tools or techniques do PNAs use to deliver quality improvement work?

Question 3 [Structural and psychological empowerment]: Within your organisation, what are the key success factors and barriers to delivering quality improvement work, either as individual PNAs or groups of PNAs?

Question 4 [Structural and psychological empowerment]: What training have you received to undertake QI work and was this part of the PNA programme?

Question 5: If you could rewind time and advise what is needed to change to achieve QI what would you advise is done differently?

The questions were printed ready for each table of delegates to consider and discuss. Approximately 15 minutes were allocated to each question. Notes were made onto flip charts by the delegates during the workshop and were transcribed (LL-D) into a Microsoft Word file, with flip chart sheets shredded for disposal. Additional summary notes for sense checking were made by facilitators, also transcribed and shredded for disposal.

4.5.7. Workstream 4c - Compendium Development (Case Examples)

Delegates at the Conference (4a) were invited to contribute to a proposed compendium of QI Case Examples. A presentation regarding the compendium was given at the conference (LW). Participants were invited to sign up (and provided consent) via JISC Online Surveys through a link or QR code. NHSE also extended the invitation to PNA lead contacts who were unable to attend the event. After the event, invitations were also extended to case study interview participants and the EI Group.

Following consent, participants were emailed a case study form (Appendix 10) to provide details for their case study and email back to the research team. The case study form included details of QI work and an adapted pre-formatted version of the Seven Lenses of Transformation matrices (Gov, 2018) to provide a framework for contributors to self-assess the maturity of their case example. The original matrices comprised of 5 levels of maturity ((1) being the least mature to (5) being most mature (5), across seven transformation domains namely, Vision, Design, Plan, Transformation/Leadership, Collaboration, Accountability and

People. These were reviewed by the EI group who suggested simplification of the matrices. The resulting maturity matrices included only three levels of maturity (1) least mature to (3) most mature. It had four transformation domains namely, Vision; Transformation/Leadership, Collaboration and People. The submitted responses were checked and edited by the research team. The research team had editorial control and checked back via the submitters email address for clarification if needed.

4.6. Data Analysis Methods

4.6.1. Workstream 1a – Rapid Scoping Review

Data was extracted in accordance with the review question in a systemised manner using the PRISMA principles (Appendix 11).

4.6.2. Workstream 2- National PNA Survey

Demographic data were analysed and reported as total numbers and proportions. Demographic data was used to check for potential multiple entries by participants, but none were identified. Likert scale items were converted to numbers for the purpose of analysis. These were treated as ordinal scale data for the purposes of analysis and median (interquartile range, IQR) values were used to summarise responses. Quantitative analyses were conducted using IBM SPSS Statistics 27. There were no missing data as all data fields were compulsory.

Most open text responses comprised very short responses of several words. Data were extracted into a Microsoft Word document, any identifiable information removed, and familiarised. Further reading of whole content (across all responses, from each question) enabled identification of connections and divergence between response characteristics. For these, relevant vignettes were selected to illustrate the range of responses to explain findings. For data where grouping responses was required (Questions 23, 26, 49 and 66), Microsoft Co-Pilot artificial intelligence tool was used to summarise the groupings described.

4.6.3. Workstream 3 – Organisational Case Studies, via Interviews

Qualitative data was analysed using Reflexive Thematic Analysis (Braun & Clarke, 2022) following the steps outlined in Workstream 4b - Conference Co-Creation workshop (Toolkit of Principles)

During the process of transcription, data were familiarised organised and managed in accordance with the five guiding questions (LLD). Data was sense checked between the facilitators (LLD and RK) and content was analysed using the key principles for QI from the Health Foundation Guide (2021) and COM-B (Mitchie et al, 2011).

4.6.4. Workstream 4c - Compendium Development (Case Examples)

The finding from each case provided by contributors (n = 7) were systematically prepared and standardised. A decision was made by the study team lead (LLD) to summarise the information provided in the case examples, due to some omissions of information. Using the self-assessments of case maturity guided by the abridged matrices these were compiled for comparison.

Table 1. Initially, LW inductively coded transcripts using Microsoft Word to create a codebook. The codebook and coded transcripts were shared with LL-D and RK for ‘sense checking’ and analysis within and across cases, to establish comparisons using Constant Comparison (Boeije, 2002). LW organised the codes into preliminary themes and subthemes which was then

discussed collaboratively (LW, LL-D, and RK) to develop the final themes and subthemes. The themes and subthemes were then triangulated and discussed with the EI Group.

4.6.5. Workstream 4b - Conference Co-Creation workshop (Toolkit of Principles)

During the process of transcription, data were familiarised organised and managed in accordance with the five guiding questions (LLD). Data was sense checked between the facilitators (LLD and RK) and content was analysed using the key principles for QI from the Health Foundation Guide (2021) and COM-B (Mitchie et al, 2011).

4.6.6. Workstream 4c - Compendium Development (Case Examples)

The finding from each case provided by contributors (n = 7) were systematically prepared and standardised. A decision was made by the study team lead (LLD) to summarise the information provided in the case examples, due to some omissions of information. Using the self-assessments of case maturity guided by the abridged matrices these were compiled for comparison.

Table 1: Qualitative Data Analytical Steps

Analysis step	**Researcher**
1. Case study interviews completed	LW, LLD
2. Sampling grid of types of organisations completed	LW
3. **Transcription**	LW
4. **Familiarisation,** sense making and memo making. Summaries created	Team collaboration
5. **Notes and initial coding manual formed** (line by line method)	LW, LLD
6. **Constant comparison** of codes to adapt and develop codes. a. The first transcript forms initial codes, with coding manual and descriptions. b. All subsequent transcripts compared, and codes iterated, or new ones added, if first manuscript does not identify same code. May look like categories. c. Coding manual updated per transcript d. Codes attributed (inserted) into sampling grid	LW first, then to LLD
7. **Team review** (sense check and member review alongside codes and codebook**)** - All transcripts re-read to find vignettes which illustrate similarities and differences between the types of organisations. Themes discussed	LL-D, LW, RK
8. **Preliminary themes developed**	LW
9. **Similarities and differences** in codes/categories noted through sampling grid (overview)	LW
10. **Overlay theory**/ theory-informed (COM-B/Theoretical Domains Framework and Laschinger's)	LL-D, LW, RK
11. **Final themes** and abstraction	LL-D, LW, RK

5. Findings

5.1. Workstream 1a – Rapid Scoping Review

Two separate searches were undertaken of the PNA and PMA literature (see Appendix 12 and Appendix 13 for the PNA and PMA searches respectively).

5.1.1. Search Results

PNA Literature

Two members of the study team (LW and LL-D) independently reviewed 22 of the 82 (27%) titles and abstracts with a 95% concordance on inclusion and exclusion. This process enabled clarification of topic scope, joint understanding and sense checking. Conflicts were resolved with discussion. LL-D screened the remaining titles and abstracts. From 9 full texts reviewed (LW and LL-D) for inclusion none met the eligibility criteria for inclusion (Figure 4).

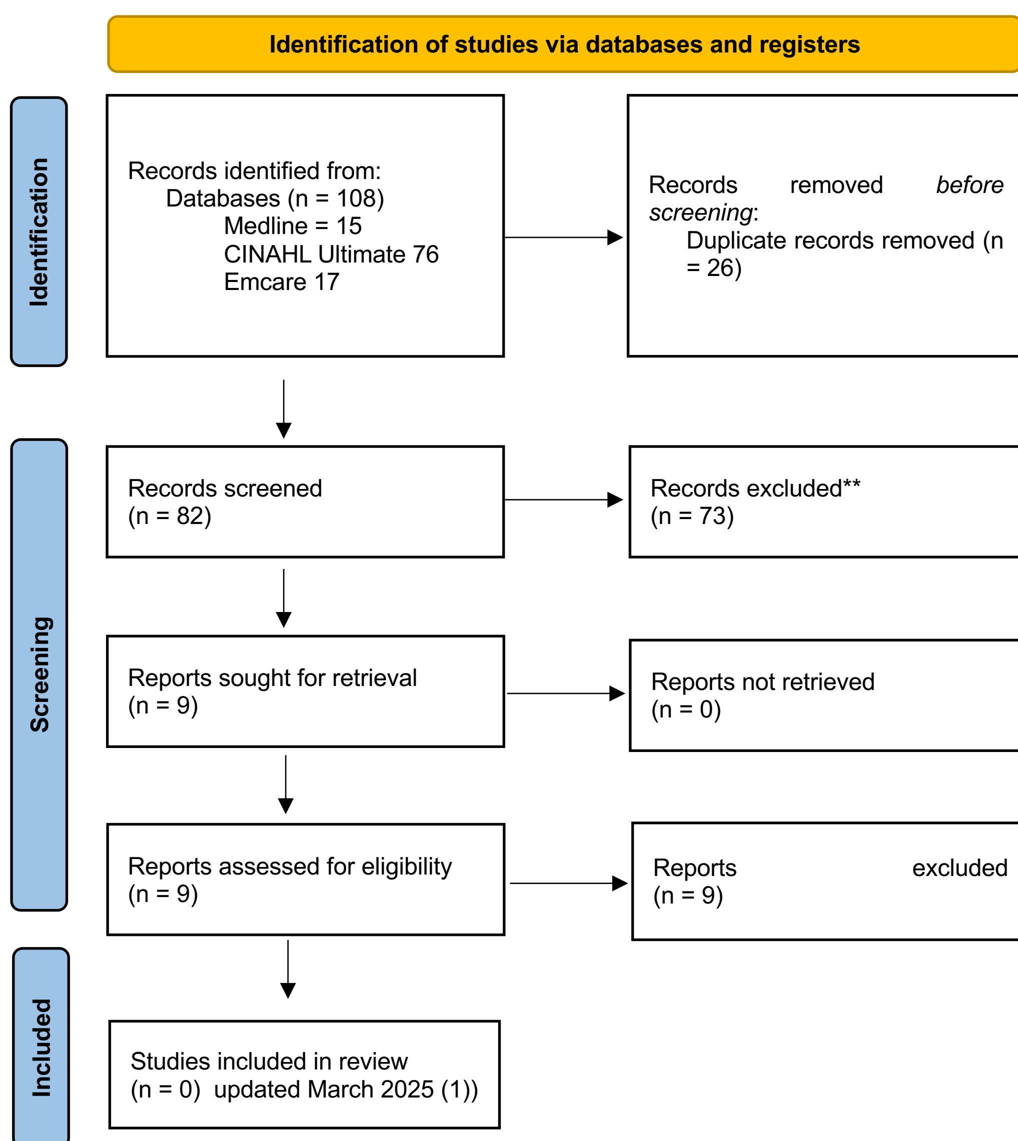


Figure 4: Prisma Flow Diagram (Page et al., 2021) - Professional Nurse Advocate Literature

An exploratory updated search was conducted in CINAHL and Medline on 18th March 2025 and which found **one** paper eligible for inclusion (Sharman et al., 2025). Abstracts of included studies can be found in Appendix 14.

PMA Literature

Due to a lack of results on the PNA literature, a search was also conducted in the midwifery literature to identify any relevant papers to develop our understanding of QI. Of the PMA evidence reviewed (n = 19 full texts) two studies were eligible for inclusion; Horler (2020) and Sterry (2019). See Appendix 14 for the abstracts of included studies. LW and BH reviewed 118 titles and abstracts independently with 95% agreement (see

Figure 5 for the PRISMA flow diagram). Conflicts were resolved with discussion. LW and BH screened 19 full texts for inclusion.

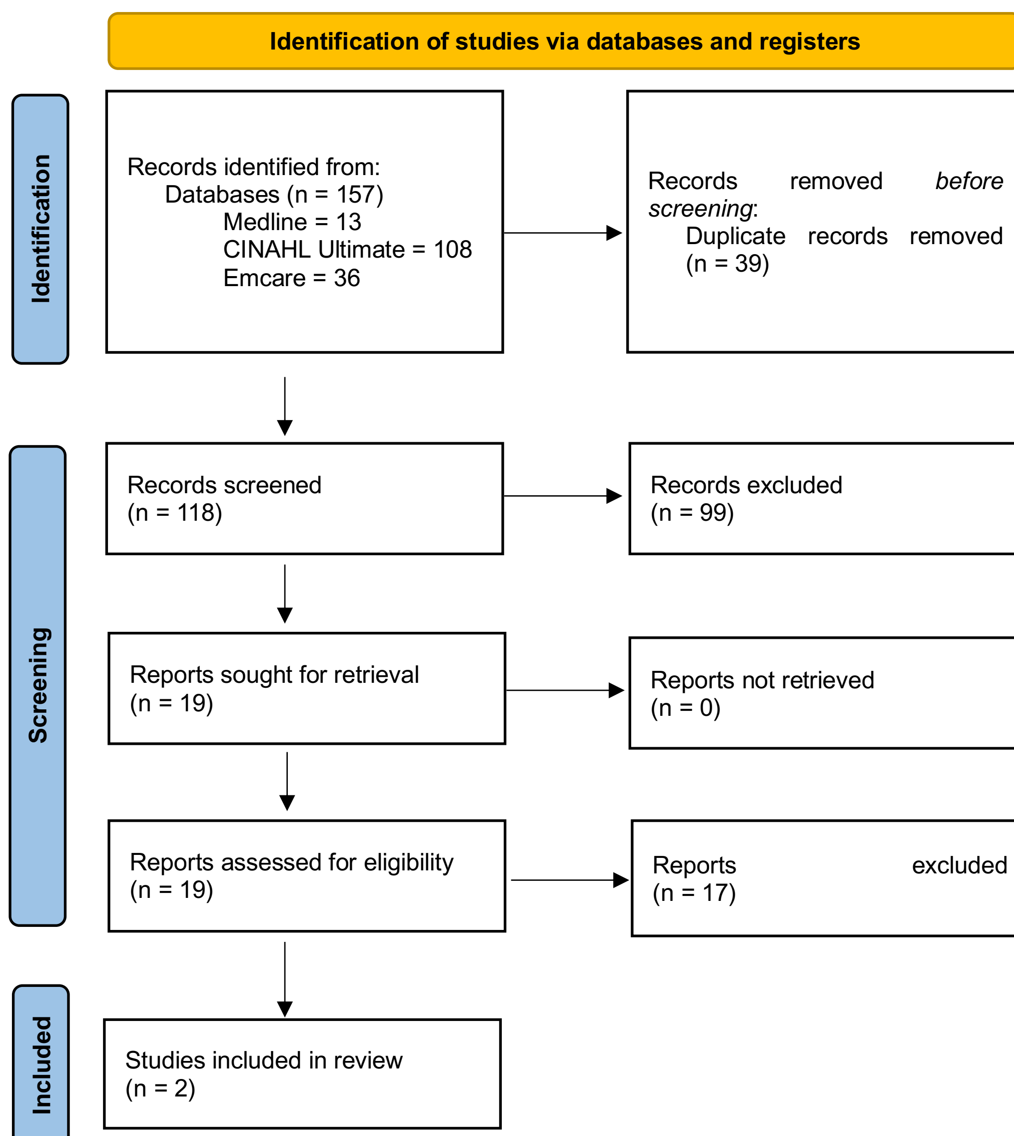


Figure 5: Prisma Flow Diagram for the Professional Midwife Advocate Literature

5.1.2. Findings

PNA Review Findings

The 9 full texts reviewed were descriptions of the PNA role (Smythe et al. 2023, Pearce 2023a, Pearce 2023b), the role of RCS in the PNA model (Scanlan and Hart 2024, Hart and Scanlan 2024) and a reflection on being a PNA (Brookes, 2022).

An exploratory updated search was conducted in CINAHL and Medline on 18th March 2025 and which found **one** paper eligible for inclusion (Sharman et al., 2025). Abstracts of included studies can be found in Appendix 14.

Sharman et al. (2025) conducted a service evaluation to determine the effects of introducing the PNA programme in a mental health and learning disability NHS trust. In their evaluation, they included a single question on QI in their PNA experience survey questionnaire which asked: *"Was a continuous quality improvement project identified?"* From 477 respondents to the survey they reported that *"Only 18% (n = 86) of the Restorative Clinical Supervision sessions identified a quality improvement project."* One of the identified signposting areas arising from RCS, was to the continuous quality improvement team. 41% of sessions addressed stress and wellbeing, providing psychological safety for staff to discuss issues. They concluded that PNA training increases confidence to undertake QI, however further CPD was identified as needed as new insights develop regarding the PNA role.

PMA Review Findings

Horler (2020) implemented a QI project within the student PMA population, in an NHS Trust to increase the home birth rate. Their work used a range of QI tools and culminated in an audit, a proposal for a new service, review of guidelines and development of training. Onward evaluations were continued using surveys to understand which elements were most beneficial to midwives.

Sterry (2019) introduced the A-EQUIP model and PMAs role as a QI initiative to support change in practice. The QI project aimed to introduce RCS to delivery-suite staff. They also used a range of tools to include SMART goals and measurements of small cycles of change with identified data sources and run charts to understand improvements.

5.1.3. Search Limitations

- Given the paucity of papers critical appraisal was not conducted.
- Databases were limited to provide the rapid review.

5.1.4. Conclusion

The findings from this review highlight there are gaps in the reporting and quantification of QI projects arising from RCS and how the PNAs quantify their QI experience. The findings helped to inform thinking about potential questions for the expert Involvement group and survey, with one core question:

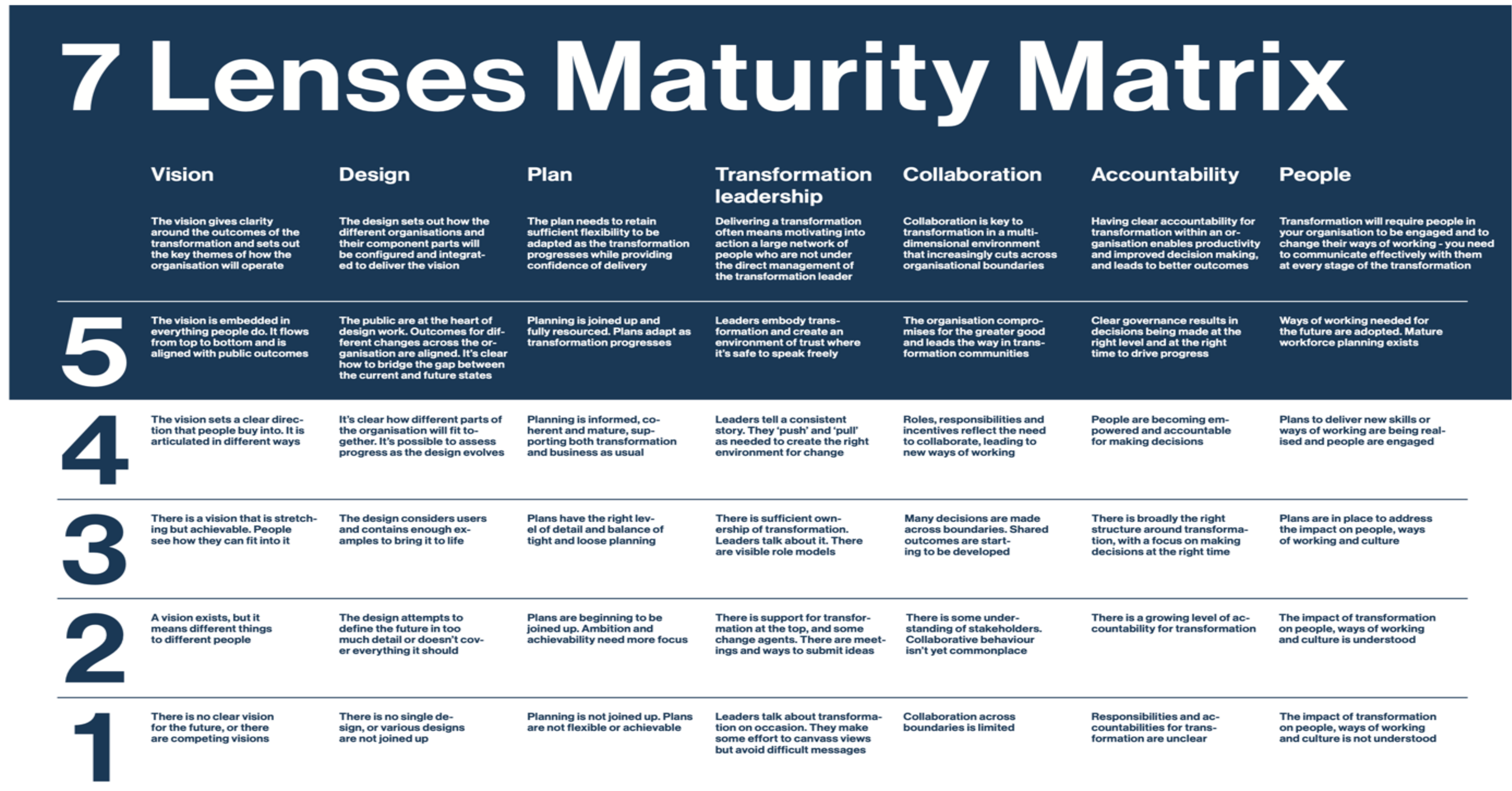
a) How are the commitment to actions, which improve patient care/experience arising from RCS realised?

5.2. Workstream 1b – The EI Group

Three meetings were held through the course of the evaluation. The purpose of the first meeting was; (a) to consider the Seven Lenses Maturity Matrix proposed for the self-

assessment Case Examples; (b) to consider a definition of QI from The Health Foundation (2021) and (c) to assess the accuracy of the study assumptions. The Maturity Matrix is designed to assist with complex transformations, which are likely to require significant organisational and cultural changes. In 2018, this was developed and piloted as one Government major project in their portfolio (GMPP). It was co-created and piloted by a team in the Government during 2028 (See Figure 6).

The Seven Lenses Maturity Matrix



7 Lenses Maturity Matrix

	Vision	Design	Plan	Transformation leadership	Collaboration	Accountability	People
	The vision gives clarity around the outcomes of the transformation and sets out the key themes of how the organisation will operate	The design sets out how the different organisations and their component parts will be configured and integrated to deliver the vision	The plan needs to retain sufficient flexibility to be adapted as the transformation progresses while providing confidence of delivery	Delivering a transformation often means motivating into action a large network of people who are not under the direct management of the transformation leader	Collaboration is key to transformation in a multi-dimensional environment that increasingly cuts across organisational boundaries	Having clear accountability for transformation within an organisation enables productivity and improved decision making, and leads to better outcomes	Transformation will require people in your organisation to be engaged and to change their ways of working - you need to communicate effectively with them at every stage of the transformation
5	The vision is embedded in everything people do. It flows from top to bottom and is aligned with public outcomes	The public are at the heart of design work. Outcomes for different changes across the organisation are aligned. It's clear how to bridge the gap between the current and future states	Planning is joined up and fully resourced. Plans adapt as transformation progresses	Leaders embody transformation and create an environment of trust where it's safe to speak freely	The organisation compromises for the greater good and leads the way in transformation communities	Clear governance results in decisions being made at the right level and at the right time to drive progress	Ways of working needed for the future are adopted. Mature workforce planning exists
4	The vision sets a clear direction that people buy into. It is articulated in different ways	It's clear how different parts of the organisation will fit together. It's possible to assess progress as the design evolves	Planning is informed, coherent and mature, supporting both transformation and business as usual	Leaders tell a consistent story. They 'push' and 'pull' as needed to create the right environment for change	Roles, responsibilities and incentives reflect the need to collaborate, leading to new ways of working	People are becoming empowered and accountable for making decisions	Plans to deliver new skills or ways of working are being realised and people are engaged
3	There is a vision that is stretching but achievable. People see how they can fit into it	The design considers users and contains enough examples to bring it to life	Plans have the right level of detail and balance of tight and loose planning	There is sufficient ownership of transformation. Leaders talk about it. There are visible role models	Many decisions are made across boundaries. Shared outcomes are starting to be developed	There is broadly the right structure around transformation, with a focus on making decisions at the right time	Plans are in place to address the impact on people, ways of working and culture
2	A vision exists, but it means different things to different people	The design attempts to define the future in too much detail or doesn't cover everything it should	Plans are beginning to be joined up. Ambition and achievability need more focus	There is support for transformation at the top, and some change agents. There are meetings and ways to submit ideas	There is some understanding of stakeholders. Collaborative behaviour isn't yet commonplace	There is a growing level of accountability for transformation	The impact of transformation on people, ways of working and culture is understood
1	There is no clear vision for the future, or there are competing visions	There is no single design, or various designs are not joined up	Planning is not joined up. Plans are not flexible or achievable	Leaders talk about transformation on occasion. They make some effort to canvass views but avoid difficult messages	Collaboration across boundaries is limited	Responsibilities and accountabilities for transformation are unclear	The impact of transformation on people, ways of working and culture is not understood

Figure 6: Seven Lenses Maturity Matrix, Government Digital Services, GMPP (2018)

5.2.1. Workshop 1: 17/07/2024

Workshop 1 included 8 participants led by LL-D and LW and lasted 1 hour and 18 minutes. Feedback and suggestions included:

a) ***Maturity Matrix****:* The original matrix (Figure 6) was felt by the EI group to be too complex and detailed. Participants suggested simplifying it to make it more user-friendly and practical. For example, reducing the number of areas to focus on key aspects such as vision, transformational leadership, and collaboration.

b) ***Definition of QI:*** The EI group members felt that the existing definition (below) from the Health Foundation (2021) was *'too strict and potentially off-putting'* for nurses to use.

> "Quality Improvement is a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about measurable improvement"
> *The Health Foundation (2021) - Quality Improvement Made Simple.*

Participants suggested that the language should be simplified, using plain English to make it more accessible and relatable, and include examples to demystify QI and emphasise that QI is something nurses are already doing in their daily work, even if they do not realise it. The PI study lead, led the work to simplify the QI definition, in readiness for the next workshop.

c) ***Assumptions****:* There was mixed agreement on the assumptions (Section 4.4, Figure 2) presented at the workshop. Some participants felt that QI is dependent on the motivations and interests of individual PNAs, while others believed it should be guided by the needs of the service and the issues identified through RCS. Participants suggested that QI projects should align with organisational needs and to consider the time pressures on PNAs and how this affects their ability to undertake QI projects.

5.2.2. Workshop 2: 15/10/2024

Workshop 2 included 8 participants led by LLD and LW and lasted 28 minutes. Feedback and suggestions from the workshops included the maturity matrix and definition of QI.

- ***Maturity Matrix***: Further feedback was requested from participants via email following the Conference Workshop which also presented the Seven Lenses Maturity Matrix (November 2024). The final abridged matrices with three levels of maturity (1 below low and 3 being mature) was indicated by participants to be a 'vast improvement' and deemed suitable for data collection (Table 2).
- ***Participant Materials:*** The draft participant materials (i.e., consent form, participant information sheet and demographic questions), survey and interview questions were shared at the Workshop and subsequently via email for further feedback (December 2024). This feedback highlighted several key points. The interview and survey questions were found to be comprehensive, with minor corrections suggested. Concerns were raised about the survey's ability to capture the impact of multiple QI projects undertaken by PNAs, suggesting that including a definition of QI could help participants better understand and report their activities. Additionally, it was advised that PNAs should be allowed to draw on all QI projects they have supported to provide the most robust feedback, rather than focusing on the most recent or a single project.

Table 2: SUSTAIN-ING PNA Quality Improvement Assessment Maturity Matrix

SUSTAIN-ING PNA Quality Improvement (QI) Study - Maturity Assessment Matrix

	Vision	Transformation leadership	Collaboration	People
	The vision about the QI work gives clarity around the outcomes of the transformation and sets out the key themes of how this will operate.	**Delivering a QI transformation often means motivating into action a large network of people who are not under the direct management of the transformation leader.**	**Collaboration is key to QI transformation in a multidimensional environment that increasingly cuts across organisational boundaries.**	**QI Transformation will require people in your organisation to be engaged and to change their ways of working - you need to communicate effectively with them at every stage of the transformation.**
1	There is no clear QI vision for the future, or there are competing visions (from different departments or wards).	Leaders talk about QI related transformation on occasion. They make some effort to canvass staff views to join with QI work but avoid difficult messages.	Collaboration across organisational boundaries with QI work is limited.	The impact of QI transformation on people, ways of working and culture is not understood.
2	There is a QI vision that is stretching staff but achievable. Staff see how they can fit into it.	There is sufficient ownership of QI transformation. Leaders talk about it. There are visible role models, e.g. PNAs.	Many QI decisions are made across boundaries. Shared patient outcomes are starting to be developed. PNA led QI work incorporates sustainability.	Plans are in place to address the impact on people, ways of working and culture.
3	The QI vision is embedded in everything staff do. It flows from top to bottom and is aligned with public outcomes.	Leaders embody QI transformation and create an environment of trust where it's safe to speak freely.	The organisation compromises for the greater good and leads the way in QI transformation communities.	Ways of working needed for the future of QI work are adopted. Mature workforce planning exists.

- ***Definition of QI****:* Further suggestions to the updated definition included adding 'continuous evaluation' in the to highlight the importance of working with others, such as stakeholders, to make the process less onerous.

The revised definition of QI preferred by the EI Group is:

Quality Improvement is a continuous process used for improving the quality and safety of patient care. It begins with identifying a problem and involves several stages; planning change(s); making change(s); and understanding effectiveness of the change (s), continuous evaluation to improve and maintain patient care.

[These stages are repeated to form continuous cycles of improvement, known as Plan, Do, Study, Act].

While this definition provides relatable language it contains all of the elements considered to be prerequisite in bringing about improvement – Define; Measure; Analyse; Improve and Control (Health Foundation, 2021). As an exercise it was valuable in sharing a joint understanding of what is meant by QI and perhaps how to make this acceptable to share across a large audience of nurses.

5.2.3. Workshop 3: 15/04/2025

Workshop 3 included 7 participants led by LL-D and LW and lasted 56 minutes. The key findings from the evaluation were presented and positively received. Feedback and suggestions from the workshop included:

- ***Positive Reception****:* Participants were impressed by the findings and the amount of QI work shared. They appreciated the thorough presentation and felt that the evaluation effectively described the breadth of QI activities being undertaken. Participants expressed gratitude for the work done, calling it a "great piece of work" which will bring QI to the forefront of PNA discussions.
- ***Support for Teaching:*** Participants mentioned that the knowledge and insights from this project will be helpful in filling gaps identified when teaching the PNA course. They identified areas where knowledge is lacking and suggested linking this evaluation with additional tools that might be helpful. They believed this evaluation could enhance the curriculum by providing practical examples and addressing current knowledge gaps.
- ***Recognition of QI Work***: Participants noted that QI work is often unrecognised in organisations and contextualising it through this evaluation will be beneficial for making changes.
- ***Demystifying QI:*** Feedback indicated that the evaluation will help PNAs and nurses understand QI and its terminology, making it more accessible and less academic. Participants noted that nurses are already doing QI work, even if they do not realise this. This evaluation will help contextualise their efforts and make QI more relatable.
- ***Suggestions for Report:*** Participants suggested including a summary of QI Principles or a Toolkit to facilitate easier access to practical elements for busy PNAs, and consider

developing an infographic. They also recommended developing 'a top 10 QI tips' or a video summary resource, to engage PNAs with the findings.

Workstream 2 - National Survey

There were 105 survey responses (Table 3). Respondents were predominantly women (89%) and identified as 'white' ethnicity (87%). 30% considered themselves to have a disability.

Table 3: Demographic characteristics of survey respondents (n=105).

Survey items		**Responses**
Demographics		
What is your age? [mean ± SD years, Range]		46.3 ± 10.0 25-62
Which of the following best describes your gender? [n (%)]	Man	12 (11%)
	Non-binary	0 (0%)
	Woman	93 (89%)
	Prefer to self-describe	0 (0%)
	Prefer not to say	0 (0%)
What is your ethnic group? [n (%)]	Asian/Asian British	9 (9%)
	Black/African/Caribbean/Black British	5 (5%)
	White	91 (87%)
	Any other ethnic group	0 (0%)
Do you consider yourself to have a disability or long-term condition? [n (%)]	Yes	31 (30%)
	No	74 (70%)
	Prefer not to say	0 (0%)

Table 3 contains data related to QI work. On average, the sample was very experienced (mean 20.4 years since qualification) and had been doing QI work for more than 5 years. A majority (72%) had experience of QI work before becoming a PNA and almost all (92%) were currently doing QI work. There was a median rating of feeling that PNA training 'somewhat well' equipped them to deliver QI work, and just over half (51%) subsequently had additional QI training.

The three most commonly used methods were Plan-Do-Study-Act (PDSA) cycles (73% of respondents), Clinical Audit (59%) and Process Mapping (43%). Only 10% of respondents reported that they did not use specific methods. The methods were rated as 'Very helpful' and repeatability as 'Very repeatable'.

PNAs were slightly less positive about initiating QI work ('To some extent'), their ability to lead QI work ('Somewhat confident') and feeling supported to undertake QI work in practice ('Somewhat supported'). There was a slightly higher median rating for the perceived impact of QI work on patient care outcomes ('High impact') than on patient experience ('Moderate impact') and patients had only been involved 'To a small extent' in QI work. More than half of respondents (54%) stated that their QI had improved patient care outcomes or patient experience, with only 5% stating that it had not.

Table 4: Experience, training and support, delivery and impact of QI (n=105).

*5-point Likert scale, lower values = more positive. The word descriptor associated with the median value has been reported to aid with interpretation.

Survey items		**Responses**
Experience		
How long have you been qualified? [mean ± SD years, Range]		20.4 ± 11.2 Range 2-41
In your current role as a PNA are you involved in any QI work? [n (%)]	Yes	97 (92%)
	No	8 (8%)
How long have you been doing QI work? [mean ± SD years, Range]		5.4 ± 6.7 Range 0-40
Before your role as a PNA did you have experience with QI work? [n (%)]	Yes	76 (72%)
	No	24 (23%)
	Not sure	5 (5%)
Training and support for QI		
How well do you feel your PNA training equipped you to deliver QI work? [median (IQR), descriptor]*		3 (2), Somewhat well
Have you received any additional QI training following your initial PNA training? [n (%)]	Yes	54 (51%)
	No	46 (44%)
	Not sure	5 (5%)
Delivery of QI work in practice		
In your role as a PNA to what extent have you initiated QI work? [median (IQR), descriptor]*		3 (1), To some extent
Do you use any specific methods for your QI work? [n (%)]	Plan-Do-Study-Act (PDSA) cycles	77 (73%)
	Clinical Audit	62 (59%)
	Root Cause Analysis (RCA)	36 (34%)
	Six Sigma	3 (3%)
	Lean Methodology	17 (16%)
	Process Mapping	45 (43%)
	Benchmarking	23 (22%)
	Statistical Process Control (SPC)	5 (5%)
	Ishikawa (Fishbone) Diagrams	21 (20%)
	Failure Modes and Effects Analysis (FMEA)	1 (1%)
	Kaizen (Continuous Improvement)	6 (6%)
	Total Quality Management (TQM)	1 (1%)
	Driver Diagrams	32 (30%)
	Model for Improvement	24 (23%)
	None of these	10 (10%)
	Other (please specify)	4 (4%)
How helpful were these methods? [median (IQR), descriptor]*		2 (1), Very helpful
How confident are you in your ability to lead QI work? [median (IQR), descriptor]*		3 (2), Somewhat confident

How easily could your QI work be repeated by another person? [median (IQR), descriptor]*		2 (1), Very repeatable
How well supported do you feel to undertake QI work in practice? [median (IQR), descriptor]*		3 (2), Somewhat supported
Impact of QI on patient care outcomes or patient experience		
To what extent do you believe your QI work has impacted patient care outcomes? [median (IQR), descriptor]*		2 (1), High impact
To what extent do you believe your QI work has impacted patient experience? [median (IQR), descriptor]*		3 (1), Moderate impact
How involved have patients been in your QI work? [median (IQR), descriptor]*		4 (2), To a small extent
Has your QI work improved patient care outcomes or patient experience? [n (%)]	Yes	57 (54%)
	No	5 (5%)
	Not sure	43 (41%)

Table 5 illustrates that the perceived reach was predominantly at a Department (50%) or Ward (45%) level. The most common QI collaborators were Lead Nurses (76%), Matrons (57%) and AHPs (50%). Professional growth and development were influenced 'To a large extent' by involvement in QI work, although the perceived success ('Somewhat successful') and sustainability ('To some extent') of QI work were slightly less positive. Progress on QI work was most commonly reported monthly (38%), followed by quarterly (23%) and never (17%). 54% reported that there was a central point for logging QI work, whilst 29% reported that they were unsure.

Table 5: Reach, Success and Sustainability of QI Work.

*5-point Likert scale, lower values = more positive. The word descriptor associated with the median value has been reported to aid with interpretation.

Survey items		**Responses**
How would you describe the reach of your QI work? [n (%)]	Ward	47 (45%)
	Department	52 (50%)
	Directorate	34 (32%)
	Hospital/hospitals	36 (34%)
	A business case	6 (6%)
	Other (please specify)	9 (9%)
Who do you collaborate with in your QI work? [n (%)]	Matrons	60 (57%)
	Lead Nurses	80 (76%)
	Doctors	30 (29%)
	Allied Health Professions (AHPs)	53 (50%)
	Other (please specify)	34 (32%)
How successful do you consider your QI work to be? [median (IQR), descriptor]*		3 (1), Somewhat successful
How sustainable are the changes that have been implemented following your QI work? [median (IQR), descriptor]*		3 (1), To some extent

How has your involvement in QI work influenced your professional growth and development? [median (IQR), descriptor]*		2 (1), To a large extent
How often is the progress of your QI work reported? [n (%)]	Weekly	7 (7%)
	Monthly	40 (38%)
	Quarterly	24 (23%)
	Annually	8 (8%)
	Never	18 (17%)
	Other (please specify)	8 (8%)
Is there a central point within your organisation to log information about QI work? [n (%)]	Yes	57 (54%)
	No	18 (17%)
	Not sure	30 (29%)

Table 6 illustrates that PNAs rated their physical capability and reflective motivation to help nurses to engage in QI work most positively (both rated 8 out of 10). Social opportunity (rated 6) and physical opportunity (rated 5) were the two lowest rated components.

Table 6: Capability, opportunity and motivation to engage in QI.

0=strongly disagree, 10=strongly agree. Figures are all median (IQR).

Survey items	**Responses (n=105)**
I am PHYSICALLY able to help nurses to engage in QI work (PHYSICAL CAPABILITY)	8 (3)
I am PSYCHOLOGICALLY able to help nurses to engage in QI work (PSYCHOLOGICAL CAPABILITY)	7 (3)
I have the PHYSICAL OPPORTUNITY to help nurses to engage in QI work (PHYSICAL OPPORTUNITY)	5 (4)
I have the SOCIAL OPPORTUNITY to help nurses to engage in QI work (SOCIAL OPPORTUNITY)	6 (4)
I am MOTIVATED to help nurses to engage in QI work (REFLECTIVE MOTIVATION)	8 (3)
Helping nurses to engage in QI work is something I do AUTOMATICALLY (AUTOMATIC MOTIVATION)	7 (2)

Table 7 shows that PNAs were generally positive about how they met the published PNA standards and PNA roles and responsibilities (all statements were rated as median 'Moderately agree').

Table 7: PNA standards and PNA roles and responsibilities related to QI.

1= strongly agree, 6 = strongly disagree

I know how to comprehensively support staff through a continuous improvement process that builds personal and professional clinical leadership, improves quality of care, and supports professional revalidation	2 (1), Moderately agree

I can systematically identify and critically apply high-quality nursing research and support to innovate and use evidence in practice; enabling PNAs, and those who work with them, to develop new knowledge, improve nursing practice and transform patient care and experience	2 (1), Moderately agree
I can comprehensively apply quality improvement methodologies enabling me to systematically evaluate, change and improve the quality of care and services as part of every nurse's responsive practice	2 (1), Moderately agree
I believe the restorative clinical supervision delivered by PNAs has helped to improve nurses' leadership of quality improvement	2 (2), Moderately agree
I am effective in developing a nurse's ideas and actions for quality improvement and service development	2 (1), Moderately agree
I am effective in participating in quality improvement programmes	2 (1), Moderately agree
I am effective in leading on quality improvement programmes	2 (1), Moderately agree

Qualitative Survey Findings

Some questions within the survey required a narrative response. Answers given have been analysed, with main categories extracted (using AI) and vignettes selected, to explain findings.

Question 18 asked: "What is your current role?"

30 of the 105 respondents were working in clinically facing roles ranging from staff nurses, sisters, senior sisters to consultant and specialist nurses. PNAs also occupied a range of educator roles (practice developers, clinical educators, education leads) which featured significantly. The remainder were working in lead roles such as, corporate nurses, research nurses, directors, governance and workforce roles.

Question 23 asked: "What types of quality improvement work are you involved with?"

Types of QI work were broad ranging and included non-clinical and clinically focussed work. Many responses, however, described the role of a PNA in supporting, implementing, and signposting staff to QI support, as needed. These are displayed in Table 8 in summary format.

Table 8: Examples of the range of QI work being undertaken by PNAs

Clinical	Non-Clinical	PNA role
Mouthcare	Communications	Supporting staff to generate ideas from issues.
End of Life	Cost savings	Implementation of QI and development leading to embedding QI
Lymphoedema	Workforce Standard Operating Procedure	Signposting staff to other services such as, Audit.
Multidisciplinary Team (introduction of)	Policy/Process Review	

Question 26 asked: Please describe any additional QI training you have received?

Many forms of additional QI training had been undertaken by respondents. Although we did not ask over what period of time courses were undertaken and the immediacy of this in relation to their PNA Programme, it was evident most respondents had received training which is presented in four key groups:

1. Trust-Specific Training:
    - Many respondents mentioned completing various in-house QI training programs provided by their Trusts, including modules on Lean Principles, Six Sigma, Gemba Walks, Process Mapping, and Recording QI activity.
    - Specific courses mentioned include Quality Service Improvement and Redesign (QSIR) Fundamentals, QSIR Practitioner, QI Bronze Academy, and Continuous Improvement Practitioner courses.
2. External Training and Certifications**:**
    - Several respondents had completed external training programs and certifications such as Yellow Belt, Project Management Technician, Level 7 module on leadership in QI, and Level 4 apprenticeship in QI.
    - Training from organisations like Quality Improvement in Healthcare (AQUAH), Florence Nightingale Foundation, and NHS England were also noted.
3. Specialised Workshops, Sessions and E-learning:
    - Bespoke sessions for PNAs run by QI Practitioners, including content on organisational approaches to QI and how to apply QI as a PNA.
    - Workshops and training sessions provided by the Trust's QI team, including coaching systems courses, Institute of leadership and Management (ILM) Level 3 course, and Lean Enterprise ‘KATA’ Improvement training.
    - E-learning courses such as Leading Change Adding Value (LCAV) via E-learning for Health and virtual teaching sessions like PNA Boost sessions.
    - Leadership and management modules, change management training, and East of England leadership course.
4. Conferences and Network Groups:
    - Some respondents have attended conferences and PNA network groups to further their QI knowledge, often in their own time.

The responses indicate a wide range of QI training experiences, both within healthcare organisations and through external trainers. The emphasis on continuous learning and development is evident, with respondents actively seeking out opportunities to improve their QI capabilities.

Question 37 asked: “How have you involved patients in your QI work?”

The most prevalent response was related to staff actively seeking patient feedback through a variety of surveys. The changes made to services were in response to the issues described. In

this regard patients were not necessarily involved in the QI work, but had proposed ideas of things which could be improved. Some areas described stakeholder groups to enable patient involvement in a range of activities, such as consultation and listening exercises, following formal care complaints. In this model patients are more likely to be linked into reviewing the resulting action plan (QI) and potentially see improvements progress, depending on how often groups were held. It was also noted that while a series of actions may arise, they may not be measured as QI. To this end, QI may be interwoven within many pieces of work, while not explicitly viewed as QI.

Question 39 asked: "Please describe how patient care or outcomes have improved"

Three principal areas of QI work were described which positively impacted upon patient care or outcomes, namely;

- Processes of care: interventions and treatment
- Workforce and staff wellbeing issues: recruitment, retention and support for staff
- Focused clinical projects: wide ranging according to clinical context.

Vignettes of responses are given to illustrate each area:

1. *Processes of care:*

"Staff described feeling that patients were engaged and motivated in their recovery more and progressed well with the interventions. Staff found this satisfying and felt connected to their purpose more, which was likely to be a better experience for patients".

"Improved patient experience by encouraging them to express how they feel and want their treatment plan to look. Looking at outcomes in relation to best practice and identification of variances in practice…"

"Increased screening and preventative work. Adapted practices to support families and carers. Increased use of advanced care plans. Improved pathways of care and collaborative working with allied health professionals for greater access to services".

2. *Workforce issues:*

"Staff retention, reduced sickness and increased support and training has led to increased capacity for patient care and subsequent reduction in errors"

"When involved with QI from a PNA perspective it usually is to do with the staff health and wellbeing. I have seen that if staff's health and wellbeing improve, their moral improves and the care they provide to the patient is on another level, giving the patient a better experience".

"I find the supportive element of the PNA model also useful, which I understand isn't within the scope of this research. The benefits of this can be far reaching in supporting staff to stay within the profession and start to develop better support mechanisms for themselves. It enables staff to feel valued"

3. *Focussed clinical projects:*

"Patients engaging in my QI project have found … solutions to loneliness which is one of the major projects for the population I am serving. Moreover, they seem ready to engage in more activities and commit to engaging more. We have also seen all of them ….becoming more vocal about their needs, implementing health changes that improve their wellbeing"

"The Q.I initiated was to improve patient's environment and improve activities on the ward which led to a reduction in the incidents of violence and aggression"

These responses highlight the various ways patient care outcomes and patient experience have improved through QI initiatives, emphasising the importance of evidence-based changes, process improvements, staff training, patient engagement, and more.

Question 49 asked: "How do you collect feedback about patient care/outcomes?"

Receiving feedback from patients takes place through formal / organised methods as well as frequent informal verbal feedback, received through ward staff. Respondents identified using many sources of feedback, depending on the issue or project being undertaken.

1. Surveys and Questionnaires:
    - Patient surveys and satisfaction questionnaires are commonly used to collect feedback. Surveys can be paper-based, electronic, or conducted via mobile apps.
2. Focus Groups and Interviews:
    - Feedback is gathered through focus groups with patients and their families.
    - Regular interviews and one-on-one interviews are conducted to assess patient experience.
3. Electronic Feedback Forms:
    - Electronic feedback forms are used for patients to fill out after their visit.
    - Online feedback platforms and mobile apps including iPad allow patients to provide feedback in real-time.
4. Suggestion Boxes:
    - Suggestion boxes are placed in facilities for patients to leave comments and suggestions.
5. Follow-Up Calls:
    - Follow-up phone calls are made to patients after their discharge to collect feedback.
6. Clinical Audits:
    - Patient care outcomes are monitored through clinical audits and patient feedback forms.
7. Community Forums and Advisory Councils:
    - Feedback is gathered through community forums and patient advisory councils.
8. Post-Visit Emails:
    - Post-visit emails with links to online surveys are sent to patients to gather feedback.

Also reported was work underway to improve feedback mechanisms, especially where they had identified as not receiving any form of feedback from patients. An example is given here:

"There has not been paid time to progress the QI process further which is very disappointing. It would have been so powerful to collate patient surveys and outcome measures. PNA role is yet to be supported with time"

Question 51 asked: "How the progress of QI work is reported?"

The responses were relatively ambiguous and limited, ranging from being unable to determine which systems were used to log activity and progress, to completing monthly PNA activity reports and feeding QI work into the existing QI work within the hospital.

Question 66: Finally, we gave the opportunity to add "any other feedback" that may prove useful in this study. The responses were comprehensive and ranged across 4 areas, described here:

1. Focus on Restorative Clinical Supervision (RCS)**:**
    - The PNA programme is perceived to focus too much on RCS, neglecting other aspects like QI and career coaching.
    - The PNA role is still being embedded within organisations, with a strong emphasis on RCS, staff wellbeing, and leadership.
2. Organisational Support**:**
    - Organisational cultures are seen to support QI work through existing mechanisms pre-PNA, but there is a lack of support for PNA development and QI activities in some organisations.
3. Time Constraints**:**
    - Competing demands and lack of protected time are significant barriers to undertaking QI work.
4. Staff Wellbeing**:**
    - The supportive element of the PNA model is valued for its role in helping staff feel valued and stay within the profession.
5. Patient Experience**:**
    - There is a strong focus on patient experience within QI, but many QI ideas are about improving efficiency rather than involving patients directly.
6. Impact of PNA Role**:**
    - The PNA role has increased the profile of QI in organisations and strengthened relationships to support QI projects.
    - Some PNAs have successfully led large-scale QI projects and implemented PNA services.

In summary, QI work is being conducted as part of PNA activities, whether this is through signposting and supporting staff or, getting involved and leading work. If a clinical area is already pressured through inadequate staffing, the PNA role is appropriately used to support the staff, but may not achieve implementation of QI work, with lack of time being the most reported, influencing factor. When issues relating to patient experience and outcomes are amenable to QI, we heard some are highly successful and have increased in scope beyond the clinical area where they were implemented. QI work conducted by PNAs could be viewed as

an add-on to existing QI workload, often conducted by QI specialists, which means it is not always acknowledged in the 'QI system'. More organisational infrastructure (termed as support) is needed for training, reporting processes, and to create organisational cultures which value the enhancement of patient outcomes or patient experiences through QI, led by nurses and PNAs.

5.3. Workstream 3 – Case Study Interviews

5.3.1. Participant Details

Eight participants consented to take part in the case study interviews and all were interviewed (between October 2024 and December 2024). Participants were aged between 33 and 61 years (mean = 43 years). Three participants described themselves as a Man and five as a Woman. All participants reported their ethnicity as 'White English / Welsh / Scottish / Northern Irish / British'. Participants reported their current role was Matron (n = 2), Director of Workforce (n = 1), Lead PNA (n = 2), Nurse Education Manager (n = 1), Lead for Nurse Retention (n = 1), PNA Emergency Department LTHTR (Band 6) (n = 1). Participants has been registered between 12 and 37 years (mean = 21.5 years). Two participants reported to have a disability or long-term condition. The types of organisations participants worked for, included Acute (n = 3), Community (n = 1), Community mental health (n = 1), Acute paediatric (n = 1), Emergency Department (n = 1) and Mental health (n = 1).

5.3.2. The Themes

Four themes, each with three subthemes were identified during the coding and comparative thematic analysis of narrative data namely; Identifying QI projects and lack of preparedness; Implementing QI work, related support and collaboration; Monitoring, reporting and disseminating QI work and; Impact, reach and dissemination of QI work, these are illustrated in the overview of themes (Figure 7). See Appendix 15 for an overview of initial thematic categories from case study interviews.

Seven case examples provided by conference delegates punctuate the themes, with the most appropriate cases included at relevant stages throughout the qualitative findings (e.g., the cases are **not** presented in numerical order), these bring together and illustrate different aspects of QI work across several healthcare contexts. A short summary of contributor details and the self-assessed maturity of the case examples is provided in workstream 4c (page 54).

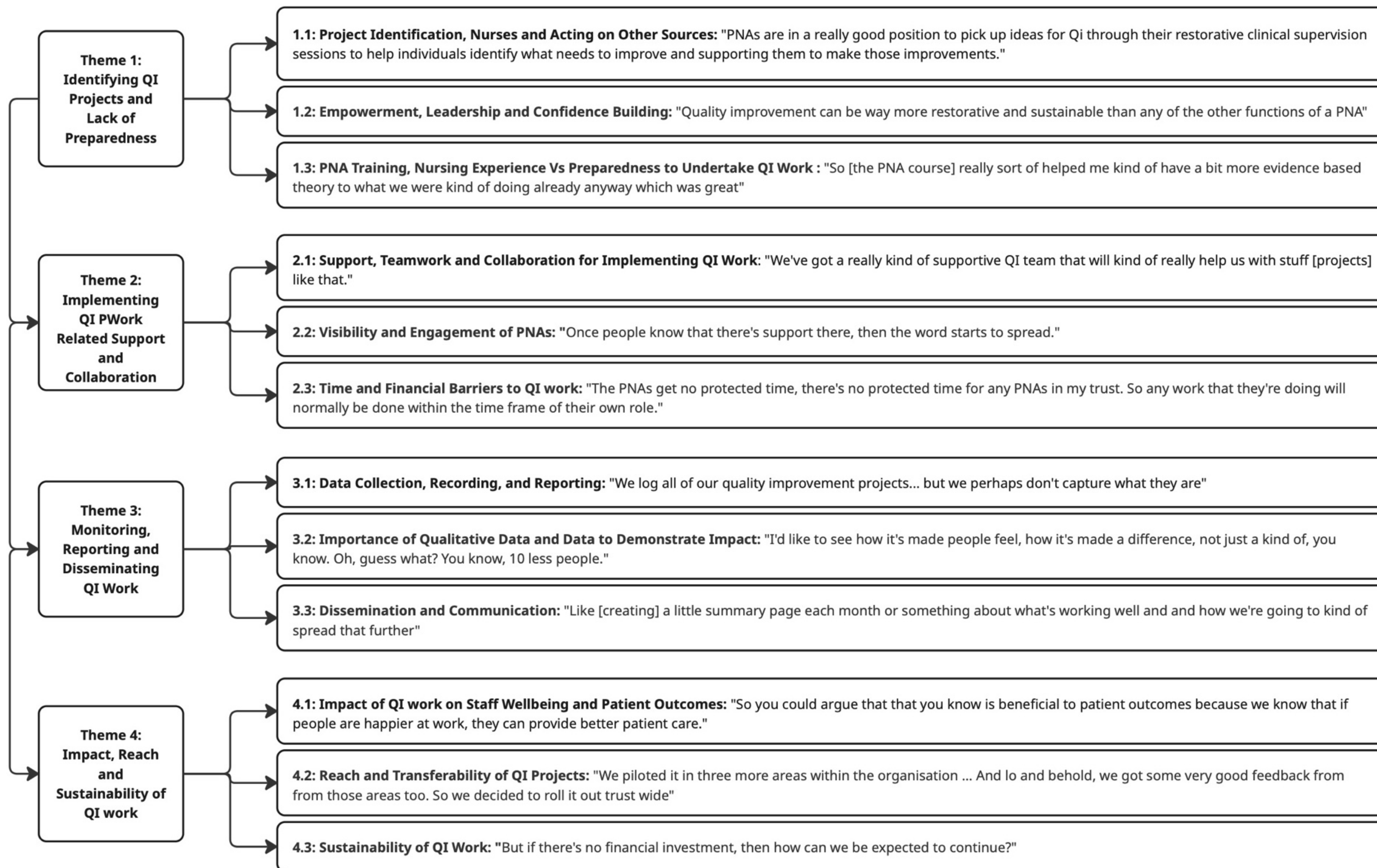


Figure 7: Overview of Themes

5.3.3. Theme 1: Identifying QI Projects and Lack of Preparedness

This theme identified how PNAs identify potential QI work and how prepared they feel for developing the ideas for QI. In the generation of ideas participants described several main sources, such as RCS sessions, staff feedback, observations of care, alongside patient feedback and complaints. RCS also aided a wide variety of purposes namely; staff wellbeing, empowerment and demonstrative leadership to engage in QI work. Finally, challenges were revealed arising from feeling unprepared to conducting QI (some staff) plus the need for continual professional development to sustain the QI knowledge to underpin ongoing work.

Subtheme 1.1: Project Identification, Nurses and Acting on Other Sources

The essence of being able to generate QI ideas revolved around PNAs taking time to listen to nurses and act upon issues discussed in RCS, from which ideas stemmed.

…. I think PNAs are in a really good position to pick up ideas for QI through their restorative clinical supervision sessions to help identify what needs to improve and supporting them to make those improvements. (P8)

At times, other valuable sources of routinely collected feedback from patients, such as, the ‘Family and Friends survey’ and opportunities for engagement with the ‘Patient Advice and Liaison Service’ (PALs) following complaints, were also pro-actively developed into QI work.

….we have a friends and family test… But what we try and do is encourage patients to feedback about their experience. And, what we found is when we've done the restorative days [for staff], we've seen a significant improvement in friends and family tests results. (P3)

While most of the study participants were involved in leading/supporting QI projects, several felt that QI was perhaps the ideal outcome, rather than expecting this routinely through RCS. To achieve QI through this route depended on the wellbeing of nurses receiving restorative supervision.

….there is a restorative element to QI, but most staff are coming through for emotional well-being, support…..because they're broken. Do you know what I mean? And they're not kind of in a place to be considering QI. We want to get them to that place, I guess. (P5)

Whereas some clinical areas discussed QI being in their ethos throughout routine care delivery.

…the department is committed to constantly quality improving. We're always looking constantly looking for ways that we can do things differently and better. It's just our language. It's the only thing we do really, it's. (P6)

The catalyst for ideas is undoubtedly achieved through the RCS sessions nurses have with their PNAs. RCS seems to be a mechanism which improves wellbeing and can create a culture of QI work being everyone’s business; part of everyday work. Ultimately here, it seems to generate an improvement loop where restoration sessions improve other nursing metrics, such as the Family and Friends surveys.

Case Example 1: Implementation of Restorative Clinical Supervision in Berkshire Healthcare NHS Trust

Organisation: Berkshire Healthcare NHS Trust
Type of Example: Mental health/community NHS trust
Lead Contact: Carrie Ord

The implementation of RCS in a Criminal Justice Liaison and Diversion Service aimed to improve recruitment and retention, reduce sickness levels, and enhance staff satisfaction. Fortnightly RCS sessions were conducted via MS Teams due to the remote team structure. The team included health professionals working in criminal justice settings, management, and non-clinical staff. Key measures of success included the stability index, recruitment and retention data, and sickness data. The project utilised the Plan-Do-Study-Act model to implement and refine the RCS sessions. Outcomes included increased staff satisfaction, fewer gaps in clinical cover, more time for professional development, and safer patient care. Staff reported feeling more empowered and experienced less "incivil" behaviour in meetings. Key learning points emphasised the importance of maintaining a positive team culture, inclusivity, and regular RCS sessions to reduce work-related stress and sickness. The project demonstrated the value of restorative practices in improving team dynamics and staff well-being, particularly in remote and challenging work environments.

Key Details:

- **Objective**: To improve team cohesion, professional development, and patient safety through fortnightly RCS sessions via MS Teams.
- **QI Methods**: Plan-Do-Study-Act (PDSA) to implement and refine the RCS sessions.
- **Participants**: The team included health professionals working in criminal justice settings, management, and non-clinical staff.
- **Outcomes**: Increased staff satisfaction, fewer gaps in clinical cover, safer patient care, and reduced work-related stress.
- **Learning Points**: Importance of team culture, inclusivity, and regular RCS sessions.

Subtheme 1.2: Empowerment, Leadership and Confidence Building

Most participants felt empowered by the PNA role and emphasised the importance of utilising this to empower others to take forward their own ideas and projects. Engaging in QI created a sense of achievement, which was empowering and gradually built confidence. Through this process they improved their leadership skills, built resilience learnt ways of not taking things personally.

….I'm a much more confident leader. (P1)

So those active conversations are stopping staff escalating or spiralling, so it's a proactive approach to supporting them. ….if there's staff who are needing support, I work with them on a one-to-one basis so that we can work through whatever challenges may be happening and I can support them through any decisions they may be coming to. (P4)

While for some, the lack of focus on QI training in their PNA programme led to a lack confidence in undertaking QI projects.

I don't feel like I came out [from the PNA programme] feeling particularly confident in [quality improvement], but I guess it's been exposure to initiatives with the guidance of the Qi coaches that helps…. It's just reassuring to know in the RCS training, I didn't feel like I learned anything hugely new… It was just making sure that I was doing what I thought was the right thing to do. It was right, if you know what I mean. So, I guess it was a confidence thing for me. And it's the same with the quality improvement …now I've had a general understanding of different quality methodologies (P3)

This subtheme showed that empowerment, leadership and confidence were linked to both PNA role and QI work. The opportunity to reflect back to understand how confidence was built was essential for delivering QI work and to view constructive feedback about issues in the wider context of everyday clinical issues beyond any individual reflections.

Subtheme 1.3: PNA Training, Nursing Experience vs Preparedness to Undertake QI Work

Participants reflected on their experiences of the PNA programme and the elements of QI training. They discussed the benefits and shortcomings of this in relation to, their lack of preparedness for the QI role, with the need for ongoing learning and professional development. Participants' confidence with methods and models of QI varied; with some relying on QI teams for support. Whereas, others relied on their experience of doing QI prior to their PNA course to support their current work.

So PNAs don't feel confident in doing the role because they go online for their ten-week course, which is absolutely brilliant [for RCS training]. They come out and they're not quite sure …how to get involved in quality improvement. And some of the methodologies around that. …. I am familiar with quality improvements. I've done it in previous roles, so it wouldn't necessarily have been anything particularly new to me, but it was not the focus of my training. (P3)

You do things all the time as nurses that we just don't recognise as a quality improvement and I think its [the PNA QI role] about strengthening awareness, from a practice perspective, will be really beneficial because nurses just 'do things' because they just need to be done, you know, within the realms of governance, policy, process and procedure. But actually, they're doing things probably on a daily basis and we're just not recognising it and therefore we're just not pooling that together and reporting on it. (P4)

This subtheme illustrated the benefits of having experience in nursing to support the PNA role in delivering QI work and understanding that quality of healthcare is inextricably linked to wider mechanisms within healthcare delivery.

Case Example 6: LEARNING WITH WILF: Improving Practice through Cohesively Incorporating the PSIRF Strategy and PNA Principles of the A-EQUIP Model into a Regular Learning Opportunity for Staff at Oxford University Hospitals NHS Foundation Trust

Organisation: Oxford University Hospitals NHS Foundation Trust
Type of Example: Acute Hospital Trust
Lead Contact: Paul Gardner-Smith

The Ward Incident and Learning Forum (WILF) project to combine the PNA role and Patient Safety Incident Response Framework (PSIRF) strategy in a learning model for staff aimed to create a proactive learning culture to reduce patient safety incidents and support staff. Two one-hour group sessions per month were conducted using RCS, focusing on incident reports, PSIRF incidents, after-action reviews, and staff concerns. Key measures of success included incident reporting data, staff engagement, and qualitative feedback. Outcomes included reduced patient safety incidents, increased staff engagement, and improved patient care. Key learning points emphasised the importance of combining strategies, continuous learning, and staff support. The project highlighted the importance of continuous learning and support to sustain QI initiatives and improve patient safety. The initiative demonstrated the potential for similar collaborative learning models to be implemented in other departments and healthcare settings.

Key Details:

- **Objective**: To reduce patient safety incidents and support staff through two one-hour group learning sessions per month using Restorative Clinical Supervision.
- **QI Methods**: Plan-Do-Study-Act (PDSA) was used. The initial cycle is completed, demonstrating the effectiveness of WILF. The group are now entering the second cycle to improve staff engagement and sustainability.
- **Participants**: PNAs, MDT members, and other stakeholders.
- **Outcomes**: Reduced patient safety incidents, improved staff engagement, and better patient care.
- **Learning Points**: Importance of combining strategies, continuous learning, and staff support.

5.3.4. Theme 2: Implementing QI Work, Related Support and Collaboration

This theme focuses on the implementation of QI projects, emphasising the importance of support, teamwork, and collaboration. Study participants highlighted the value they place on having access to QI coaches, multidisciplinary teamwork, and the support they receive from nursing colleagues and senior management. The visibility and engagement of PNAs were also discussed, noting (at times) the need for better communication and engagement with staff to realise work. Barriers to QI work, were typically ‘time’ and the effect of ‘financial constraints’, were identified. Time was a major feature in the data and financial constraints were related to being released from the clinical duty if this was needed to develop work. It was stressed that these barriers needed resolution to successfully implement QI projects.

Subtheme 2.1: Support, Teamwork and Collaboration for Implementing QI Work

Adequate support was essential for PNAs to implement QI work. Most indicated that they had support from other members of nursing staff or organisationally based QI teams - through to varying levels of engagement and support. QI coaches, multidisciplinary teamwork, and the support they receive from colleagues and senior management were stressed. Nevertheless, throughout the organisational mechanisms identified there were challenges and successes of working together to implement QI initiatives. An example of success is described here:

I think we've got a supportive QI team that will help us with stuff like that. I think the trust overall, [see this as] a big drive forward. …QI [provide an opportunity for] celebration around the things that …go well and QI conferences... (P5)

Participants described working with QI coaches, senior management and other stakeholders to drive QI. All participants emphasised the importance of collaboration in the implementation of QI projects. Examples were given where they worked with MDT teams and more to achieve QI, an example is given here:

Because it's all about teamwork. Everything is [..] teamwork. (P6)

Case Example 5: MDT: Teaching, Sharing & Learning based upon PNA Feedback within Critical Care at Liverpool Heart & Chest Hospital
Organisation: Liverpool Heart & Chest Hospital
Type of Example: NHS Foundation Trust
Lead Contact: Laura Newman and Anna York

The initiative to implement weekly MDT meetings in Critical Care to enhance teaching, learning, and sharing among staff aimed to improve patient safety, care, and experience by enhancing staff knowledge and collaborative practices. Weekly MDT meetings were conducted where all members could deliver and attend sessions, fostering collaboration and teamwork. Key measures of success included data collection on session topics, qualitative feedback from staff, and the application of the PDSA model to expand the audience of staff within the MDT. Outcomes included improved staff knowledge, defined roles and responsibilities within the MDT, regular learning opportunities, and increased collaboration. Key learning points emphasised the importance of creating a forum for teaching, learning, and sharing, and enhancing skills and practices through collaborative learning. The project demonstrated the transferability of successful QI initiatives, with the potential to extend beyond the local level and make a difference nationally.

Key Details:

- **Objective**: To enhance teaching, learning, and sharing among MDT members through weekly MDT meetings with collaborative sessions.
- **QI Methods**: PDSA was applied to expand the audience of staff within the MDT and the A-EQUIP model was used for the focus on QI.
- **Participants**: MDT members including doctors, nurses, physiotherapists, pharmacists, and other specialists.
- **Outcomes**: Improved staff knowledge, teamwork, and patient care.
- **Learning Points**: Importance of structured schedules, collaborative learning, and continuous improvement.

Subtheme 2.2: Visibility and Engagement of PNAs

Study participants felt that [at times] more staff awareness was needed about the PNA role and visibility of PNAs within the organisation needed to be increased. Linked to this, the need for improved communication and engagement with staff, describing different strategies for achieving this.

Once people know that there's support, then the word starts [about PNAs) to spread. (P4)

For some PNAs we heard they made a concerted effort to be visible and accessible to staff, such as walking around the department/ward and reminding staff of the support available. They also discussed the importance of face-to-face promotion and peer support.

….it's just making sure that I'm visible and also, I suppose just finding ways of raising awareness of the [PNA] role. [I hold] a designated drop-in session that everybody's aware of, but before that happens, I walk around our department and speak to everybody on duty and just remind them that I'm here if they want to drop in, or if it's not convenient, they can contact me anytime and I sit in a room that everybody has to walk past when they're coming in and out of work. Well, when I arrive and I come in []to overlap the night shift. (P6)

Case Study 3: Implementing the PNA service into GP surgeries within Primary Care in Northamptonshire

Organisation: Northamptonshire Primary Care Training Hub
Type of Example: Primary Care
Lead Contact: Georgina Callard, Melanie Mullin, and Clare Rogers

The implementation of the PNA service in GP surgeries within Northamptonshire aimed to support staff and improve patient care through the PNA service. The Training Hub offered one day a week to implement the service, and a Roadshow was organised to visit each of the 69 GP surgeries in the county, presenting hampers to nursing teams and promoting the PNA service. A Lead Nurse Steering Group (LNSG) was established for nurse team leaders to provide peer support and facilitate QI work. Key measures of success included feedback forms, PDSA cycles, and qualitative feedback from staff. Outcomes included increased staff satisfaction, better professional development, and enhanced patient care. Staff reported feeling supported, less isolated, and better equipped to handle work-related stress. Key learning points emphasised the importance of face-to-face promotion, peer support, and collaboration. The project demonstrated the transferability of the PNA service across multiple GP surgeries, providing a model for similar initiatives in other primary care settings.

Key Details:

- **Objective**: To support staff and improve patient care through the PNA service by implementing roadshow visits, Career Clinics, Wellbeing Weeks, and LNSG meetings.
- **QI Methods**: The Kotter's 8-step model was used to introduce the service. The PDSA model was and is used 6-monthly for the LNSG to reflect and plan forward.
- **Participants**: PNAs, nursing teams, practice managers, and other stakeholders.

- **Outcomes**: Increased staff satisfaction, better professional development, and enhanced patient care.
- **Learning Points**: Importance of face-to-face promotion, peer support, and collaboration.

Subtheme 2.3: Time and Financial Barriers to QI Work

The lack of protected time and financial constraints were common barriers to QI work discussed by all study participants. This was expressed as, having to fit QI work into their busy schedule and existing role, as described here:

….the quality improvement projects that the PNAs may be doing and I need to be really clear about this, the PNAs get no protected time, there's no protected time for any PNAs in my trust. So, any work that they're doing will normally be done within the time frame of their own role. (P4)

Nevertheless, some participants noted that QI was seen as additional work and suggested that sometimes it was about 'working smarter, not harder'.

This said financial barriers to QI, including being released to do work, having effective systems in place to gather data to enable QI to be valued as a cost-effective intervention, financial support for sustaining QI initiatives, and funding for QI training.

But what's quite interesting is the organisation has seen the benefit of it and I do really feel like the organisation has backed the PNA, certainly up to this point. Financially at the moment we're having some discussions about how that looks …. [designated role].

It's been beneficial in where we are in our [improvement] journey compared to perhaps some people who have had a PNA lead as tagged on to their other hugely challenging roles [portfolio of work]. I've been very fortunate to have a designated role as just being the PNA lead. (P3)

Participants highlighted that without investment, it is challenging to maintain and expand QI work.

There are challenges with funding it [QI work] because there's challenges with PNA funding and I think NHSE need to know that if I'm being really honest because it's needed, staff need the support.

If we want to retain staff, we need, to support our staff. … So effectively my role could end in March next year. Because there may not be funds available to continue to support me to do what I do, therefore then the quality improvement work that's already been established will stop. (P4)

Case Example 2: The Implementation of the Professional Nurse Advocate role in Tees, Esk and Wear Valleys NHS Foundation Trust
Organisation: Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust
Type of Example: Mental Health and Learning Disabilities
Lead Contact: Lianne Jamfrey

The implementation of the PNA programme in TEWV NHS Foundation Trust aimed to support staff and improve patient care by establishing a governance framework, policy, and implementation guide. A live register of qualified, studying, and awaiting allocation PNAs was created, and a PNA council was formed for peer support and sharing best practices. The project secured funding for PNA training and ensured sessional PNAs had protected time to deliver RCS sessions. Key measures of success included the increase in the number of PNA sessions delivered, the number of qualified PNAs, and progress towards achieving the target ratio of PNAs to staff. Outcomes included indirect improvements in patient care due to staff feeling valued and supported, leading to better skilled and confident staff. Positive feedback from staff accessing the PNA service highlighted increased confidence, support in career progression, and feeling valued. Key learning points emphasised the importance of maintaining momentum, clearly communicating the purpose of the model, engaging senior leaders, and collecting both soft and hard data to demonstrate impact. The project demonstrated the importance of strategic planning and support in implementing a new role within an organisation.

Key Details:

- **Objective**: To support staff and improve patient care through the PNA programme.
- **QI Methods**: The strategic plan was created using the PDSA model.
- **Participants**: PNAs, Chief Nurse, senior management, and other stakeholders.
- **Outcomes**: Increased number of qualified PNAs, improved staff satisfaction, and better patient care.
- **Learning Points**: Importance of governance, inclusivity, and continuous improvement.

5.3.5. Theme 3: Monitoring, Reporting, and Disseminating QI Work

This theme describes the need for robust data to demonstrate the impact of QI initiatives. Participants reflected on the importance of data collection and reporting when conducting QI work. They discussed the methods used to gather data, the challenges of measuring outputs/success, and the value of qualitative feedback. Participants emphasised the significance of recording QI projects and the challenges associated with reporting and capturing qualitative data. The theme also explores the importance of demonstrating success and proving worth for business cases, including strategies used to share and disseminate QI work.

Subtheme 3.1: Data Collection, Recording and Reporting

Data to inform QI work was primarily collected from RCS sessions, staff feedback, and patient complaints. QI plans were often related to nurse wellbeing, measured before and after issues were addressed, in this case improved results were demonstrated through patient feedback. For example, participant 3 collected data from staff to assess the impact of self-rostering:

… in one particular area I can't remember if the average score for the few months before the restorative [sessions] was either 78 or 83% […] so it wasn't horrendous, but it wasn't brilliant. But actually, when they [ward nurses of unknown number] had made changes in the duty rostering, during the months after they'd scored 100% in their friends and family tests. (P3)

Participants described challenges with recording and capturing data on QI work. Systems are in place to record QI work – but are not always adequate detail to quantify impact. For example, it was difficult to understand the number of referrals made to PNAs to support nurses because systems such as Datix were not set up to capture this. While they could observe that retention of nurses had improved, and believe it was likely to be attributed to PNA support, it was not easy to evidence.

We log all of our quality improvement projects through our provider workforce return data, but they log how many projects they're supporting, but we don't capture what they are. So it's something to think about as a team, how we actually share all the different quality improvement projects. I could [..] name a few, … but I wouldn't be able to name all. (P3)

While the quantity of QI projects is routinely reported through provider work force return (PWR) and upwards to the NHSE, it seems QI work also requires the active engagement with a QI team to assist other processes and connections within an organisation.

I reached out to my QI team. We do have a really good QI team in this trust and it's now mandatory to do the basics in QI training. So, I'll be having some kind of governance and oversight that my PNAs are completing that [training] and I've also asked the QI team to attend our monthly PNA forum. (P5)

Subtheme 3.2: Importance of Qualitative Data and Data to Demonstrate Improvement

Most participants emphasised the importance of collecting qualitative data to capture the depth of QI work related to staff and patients. Although the qualitative data was viewed as valuable, for identifying improvements, it was believed this may not translate into increased financial support where needed.

All of the feedback, all […] qualitative data is exemplary, but it still doesn't boil down into the finances. (P4)

Participants also added that qualitative feedback from staff is valuable for understanding the impact of QI projects and should be better integrated into organisational reporting and decision-making and shared widely within the organisation/trust.

Again, I'd like to see the qualitative data I'd like to see how it's made people feel how it's made a difference……… (P5)

Some participants used the data collected from their QI projects to build business cases which had the potential to secure more financial support for initiatives or, change patient services delivered. For others, they were keen to garner a specific focus on the PNA agenda, by trying to gather the evidence needed to 'prove their worth.' There was a clear urgency to demonstrate through being a PNA, how and where they had achieved successful improvements. In many cases, the hard evidence required did not exist and this proved frustrating.

Data's challenging. Really, really challenging…
I do use the NHSE provider workforce portal, which is really interesting and gives me some national and regional comparative data. …I do put in information, so I link with our well-being community and the organisation.

I can utilise soft data they've got and then it's all about that qualitative rather than quantitative, so it's really difficult with data to demonstrate this, and actually a lot of the information is soft. ….but from a trust perspective, they want the finances that are connected with that. That's not easy to demonstrate because you can't necessarily identify that PNA, even though I know the impact it's had personally on the individuals, that you don't have anything that's tangible to go "it was because PNA, it was because [name] did an RCS session with that individual". The data isn't there to support that (P4)

Examples of improvements regarding patient safety, improved sickness, improved staffing and culture were broadly described. However, they added that was challenging to attribute this to PNA activities.

The difficulty being is in the climate we're working is we need to produce evidence; we need to produce work. And show basically making that we're making bang for our buck essentially because we're expensive people in an organisation that's currently going through financial issues. (P7)

Subtheme 3.3: Dissemination and Communication

Participants described their efforts to share and disseminate successful QI projects. They discussed the importance of communication, project sharing, and feedback. The narratives illustrate the strategies used to ensure that QI work is recognised and adopted across the organisation. Participants noted great work was being done but not always shared and more could be done to recognise and report the QI work by PNAs. Ideas were suggested to enable this across organisations:

This is what's happening over here, …..you know, [produce] like a little summary page each month or something about what's working well and how we're going to kind of spread that further. …..[I could see] Oh, they're doing that really well over in [place]. I'm going to give them a ring and say what, what you doing? (P5)

Participants shared successful QI projects and practices with colleagues during CPD days and PNA forums and presented to the trust board and senior nurses.

Case Study 4: Catheter Quality Improvement project in Hertfordshire Community NHS Trust

Organisation: Hertfordshire Community NHS Trust (HCT)
Type of Example: Community health care provider
Lead Contacts: Rebecca Harlow, Suzy Fitch, and Sharon Freeman
HCT initiated a QI project to improve catheter management in HCT. The project aimed to ensure consistency and high quality of care in catheter management for all patients using Trust services. The project team conducted stakeholder mapping, patient observations, and process mapping sessions to identify challenges in catheter care. Key issues identified included challenges with nursing documentation, overreliance on doctors, and the need for regular clinical update training. Key measures of success included incident reporting data, patient stories, and feedback from staff. The team worked with the performance team to build codes in the online record system for data collection. Outcomes included improved nurse competencies, better patient outcomes, and a sense of ownership and engagement among staff. Key learning points emphasised the importance of data reporting, nurse empowerment, and collaboration. The project highlighted the challenges of data reporting and the importance of robust data collection methods to demonstrate the impact of QI initiatives.

Key Details:

- **Objective**: To ensure consistency and high quality of care in catheter management through stakeholder mapping, patient observations, and process mapping.
- **QI Methods**: Fishbone diagram and stakeholder mapping.
- **Participants**: PNAs, QI lead, frontline staff, and patients.
- **Outcomes**: Identified key issues in catheter care, improved nurse competencies, and better patient outcomes.
- **Learning Points**: Importance of data reporting, nurse empowerment, and collaboration.

5.3.6. Theme 4: Impact, Reach and Sustainability of QI work

This theme explores the impact and reach of QI projects from staff wellbeing to patient outcomes. Improved staff wellbeing leads to the generation of positive work feelings and by proxy, to patient experience/ outcomes. The theme also describes the reach and transferability of QI work, with some initiatives being shared within the organisation and beyond. Participants emphasised the need for ongoing support and investment to ensure the sustainability of QI work as this relates to continuous improvement.

Subtheme 4.1: Impact on Staff Wellbeing and Patient Outcomes

Participants noted that designing QI projects to focus on patient outcomes was challenging. Instead, the psychological safety of nurses was recognised to have the biggest impact on better patient outcomes. For example, projects which had an indirect impact on patient outcomes were those where happy and supported staff provide better patient care.

…..you could argue that … because staff have a better work life balance therefore they're more likely to be happier at work …. So you could argue that that you know is beneficial to

patient outcomes because we know that if people are happier at work, they can provide better patient care. (P3)

Few participants QI projects related directly to improving patient outcomes and reported they had indirectly impacted patient safety and outcomes as well as creating more supportive environments for both staff and patients.

[our project] delivered safe transfers, it made it meant that the nurses felt better. That they had the [patient] information and they knew they could keep the patient safe. The staff on the wards receiving the patient […] is completely embedded now in our practise. So that's been over a number of years now. (P6)

Participant 4 noted that although patients were '*not necessarily the key objective* of QI work', they would be the central beneficiary of QI work; they believed a creating a positive culture where staff feel supported leads to better patient care and safety.

So this is actually in relation to patient outcomes. It's not, it's not necessarily the key objective, but if you've got a stabilised workforce that where the culture is more positive than it may have been previously, then patient safety increases. So even though it's not one of my key objectives in relation to patient outcomes, it is a subsidiary to that and it does absolutely help patient safety and patient outcomes because if you've got happy staff, you've got happy patients. And that sounds a little bit- a little bit jazz handy and a little bit woolly. But if we take care of our staff and we get them into a position where staffing is where it needs to be, that people feel secure within that staffing environment, that people are able to ask those questions because we've created a culture we're questioning, is it accepted and asked for, then our patient safety and our patient outcomes improve as part of that. So yes, it's not a direct ask from the work that I've been doing, but it is absolutely part of what is being seen now within our department. (P4)

Case Study 7: Launching and implementing professional advocacy service in The Princess Alexandra Hospital
Organisation: The Princess Alexandra Hospital NHS Trust
Type of Example: NHS Acute Hospital Trust
Lead Contact: Silpa Dhaneesh

The initiative to introduce PNAs to improve staff morale, engagement, and professional resilience was prompted by a significant decline in staff engagement and morale revealed in a 2020 staff survey, attributed to pressures faced during the COVID-19 pandemic. The project involved various stakeholders, including the Health and Wellbeing team and Freedom to Speak Up Guardians. Key measures of success included staff surveys, feedback from Wellbeing Weeks, and the implementation of a structured framework for PNAs. Outcomes included improved staff morale and engagement, enhanced professional development, and better patient care. Key learning points emphasised the importance of staff feedback, stakeholder involvement, and communication. The project demonstrated the indirect impact of QI work on patient outcomes through improved staff wellbeing, highlighting the importance of creating a supportive environment for staff.

Key Details:

- **Objective**: To improve staff morale, engagement, and professional resilience through structured framework for PNAs, including Career Clinics, Wellbeing Weeks, and a buddy system.
- **QI Methods**: Kotter's 8 Stage Change Management Model was used to launch and implement the service. The PDSA Cycle and Strengths, Weaknesses, Opportunities and Threats Analysis were applied during each stage, especially for sustainability. John Fisher's Transitional Curve was used to analyse and support staff behaviour throughout the change management.
- **Participants**: PNAs, Health and Wellbeing team, Freedom to Speak Up Guardians, and nursing staff.
- **Outcomes**: Improved staff morale and engagement, enhanced professional development, and better patient care.
- **Learning Points**: Importance of staff feedback, stakeholder involvement, and communication.

Subtheme 4.2: Reach and Transferability of QI Projects

Participants explored the impact and reach of QI projects. They discussed pilot projects, the transferability of successful initiatives, and the wide-reaching effects of their work on staff and patient care. Some participants described QI projects which had become completely embedded into individual wards or departments, or throughout the trust/organisation, while others, had extended the reach of their project across the UK. Successful QI projects on a local level have the potential to extend beyond and make a difference nationally (and even internationally).

….I did log it as a as an official project, and we piloted it in three more areas within the organisation - we knew that it worked in critical care […], but I wanted to check about

working it in different sort of areas of the organisation. And lo and behold, we've got some very good feedback from those areas too. So, we decided to roll it out trust wide. We had a project plan that was about two years to roll this out with the whole of the organisation, but we've been really busy as we've kind of gone through different cycles of improvement, we've managed to do the whole hospital within nine months. So basically, it was a really good quality improvement project. So that is just one of the examples of perhaps quality improvement that's come out of some of the restorative conversations. (P3)

Subtheme 4.3: Sustainability of QI Work

Participants discussed the sustainability of QI initiatives, emphasising the need for ongoing support and investment. They considered the driving forces behind sustaining QI work, the importance of continuous improvement, and the challenges of maintaining momentum. Some participants had successfully secured support from HR, senior management and/or external networks for their projects. Sustainability however was viewed as needing someone with energy and support to encourage PNAs to think about QI.

I suppose with sustainability, you do need to have someone driving it, don't you? … So I guess the sustainability is, is the person driving it, how much they want to sort of create that change and then I'm I guess that's the good thing about having the PNA, is I've spoken a bit about quality improvement projects that I've run, but also ones that we support. (P3)

For sustainability of QI initiatives and the PNA role, most participants noted that financial investment in the PNAs and support is required. Without funding, the role and QI work may not continue, which would negatively impact staff retention and patient outcomes.

But if there's no financial investment, then how can we be expected to continue? (P4)

This brings in retention if we get it right, what the NHS will be looking much healthier and better. But if it's not part of that that 10-year plan then I can't see where the investment will come from and therefore, I can't see how the PNA role will be able to be sustained. So for me personally, very challenging. (P4)

These findings across the themes underscore the importance of enhancing PNA training, clarifying responsibilities for QI work, recognising the time required for QI work, fostering a supportive culture for QI, improving data reporting, enhancing communication and engagement to ensure the sustainability of QI projects.

5.4. Workstreams 4a, 4b and 4c

5.4.1. 4a – The National Conference

A 2nd National PNA Conference, was held on Wednesday 13th November 2024 at Coventry University. The aim was to showcase exemplar PNA quality improvement work to promote learning regarding the positive impacts on patient experience and outcomes. The Conference programme (Appendix 16) featured a range of presentations highlighting positive changes arising from PNAs across NHS organisations. In the afternoon, two workshops were held concurrently (1) to present examples of PNA QI work from abstract submissions and (2) opportunity to participate in an interactive research workshop aimed at developing QI principles for PNAs. A QR code was displayed during the conference to enable those delegates who wished to provide a case example of their work to be featured in this report. Feedback from the conference was received from delegates, with several examples given here:

"A brilliant, well-organised and interesting conference that I thoroughly enjoyed. I felt inspired by all the presenters and posters at the conference and motivated for the future." (conference delegate)

"A really inspiring conference, meeting other PNAs, understanding more about how to engage with the quality improvement side and seeing and hearing about work happening nationally" (conference delegate)

"Hearing other PNAs talk about their QI projects was inspiring. It shows that so much hard work is being done to implement the PNA role and so many nurses are benefitting from this positive change in nursing culture." (conference delegate)

5.4.2. 4b - Co-Creation Workshop

16 participants signed up for the Workshop Programme (Appendix 17) via a QR code, of these 11 were in attendance. During the Workshop three groups of participants self-selectively formed according to the seating arrangements chosen. Each group of participants were guided by a key question (see data collection methods), using Laschinger's Framework. Each group rotated around three tables to answer one question, thus giving equal opportunity to build on the responses provided, until all questions were completed. The findings from this workshop (Appendix 18) were analysed with the data from the case examples (4c) to form a small QI Toolkit for PNAs, to include:

Introduction and list of resources

TOOL 1: Set of Established QI Principles

TOOL 2: A QI Deliberation and Decision-Making Tool

TOOL 3: A set of QI principles for PNAs

TOOL 4: Time as prerequisite for QI

TOOL 5: Characteristics of good QI work

TOOL 6: Case Study Form

TOOL 7: Seven Lenses Maturity Matrices

TOOL 8: Top Tips for success

List of Case Examples

The set of QI principles for PNAs from the Toolkit are provided here:

1. **ACCESS:** the QI team (or support person) to facilitate further QI training, tools and ongoing support as needed, before commencing any work.
2. **EXPLORE:** the problem (s) to envisage how this could be improved and decided whether or not, to progress with QI work.
3. **UNDERSTAND:** the complexity of the problem through discussing the impact this is having in your area and barriers it potentially creates – it might be more than one problem.

4. **CONTACT:** your Lead PNA to enable identification of other PNAs or ward-based nurses with experience of undertaking QI work, for transitional support.
5. **NEGOTIATE:** Establish if/how other PNAs have negotiated the time to undertake QI work (see Tool 3).
6. **COLLABORATE**: Consider ways to buddy with other PNAs to build your confidence of QI work and enhance your practice. For example, join a PNA network/forum to create inspiration, creativity and support for QI work.
7. **COMMUNICATE:** your QI plans to the Lead PNA and upwards to senior leadership/corporate nursing team/the education/practice development team to facilitate awareness of QI work.
8. **ALIGN:** your QI work to the organisational nursing priorities, to achieve organisational buy in. This will connect your QI work and enable greater traction.
9. **DOCUMENT:** your QI project ready to receive feedback, disseminate or to celebrate success using existing organisational mechanisms, such as team meetings and Newsletters.

The PNA QI Toolkit is provided separately: https://doi.org/10.18552/CHC/2025/0005

4c – QI Case Examples

Following the Conference, case examples provided (n=7) were constructed using the proforma sent to participants (Appendix 10), summarised here in Table 9 and each are detailed p throughout the qualitative interview data (Section 5.3, page 38). Each case example also was self-assessed for maturity of development and this information is presented in Table 10. Finally, the data is also systematically displayed within summary tables in Appendix 19.

Following the Conference, a press release was issued at Coventry University (Appendix 20).

Table 9: List of Case Examples Provided

Case	Title	Lead	Organisation Type	Organisation
1	Implementation of Restorative Clinical Supervision in Berkshire Healthcare NHS Trust	Carrie Ord	Mental health/community NHS trust	Berkshire Healthcare NHS trust
2	The Implementation of the Professional Nurse Advocate role in Tees, Esk and Wear Valleys NHS Foundation Trust	Lianne Jamfrey	Mental Health and Learning Disabilities	Tees, Esk and Wear Valleys NHS Foundation Trust
3	Implementing the PNA service into GP surgeries within Primary Care in Northamptonshire	Georgina Callard, Melanie Mullin, Clare Rogers	Primary Care	Northamptonshire Primary Care Training Hub
4	Catheter Quality Improvement project in Hertfordshire Community NHS Trust	Rebecca Harlow, Suzy	Community health care provider	Hertfordshire Community

		Fitch, Sharon Freeman		NHS trust (HCT)
5	MDT: Teaching, Sharing & Learning based upon PNA Feedback within Critical Care at Liverpool Heart & Chest Hospital	Laura Newman, Anna York	NHS Foundation Trust	Liverpool Heart & Chest Hospital
6	LEARNING WITH WILF: Improving Practice through Cohesively Incorporating the PSIRF Strategy and PNA Principles of the A-EQUIP Model into a Regular Learning Opportunity for Staff	Paul Gardner-Smith	Acute Hospital Trust	Oxford University Hospitals NHS Foundation Trust
7	Launching and implementing professional advocacy service in The Princess Alexandra Hospital	Silpa Dhaneesh	Acute Hospital Trust	The Princess Alexandra Hospital

The abridged Maturity Matrices (Table 10) provided a practical tool for contributors to reflect and consider key areas as this related to the maturity of their QI work. It has been employed to assess the current state according to four lenses namely Vison, Transformation, Collaboration and People. The Vision provides clarity around the outcomes and sets themes of how QI will operate. The Transformational Leadership, relates to motivating action, often for people (in this case healthcare workers) who may not be under direct control of the project lead. Collaboration relates to the extent of how people work together to achieve QI. Finally, People related to how many people and how they will be engaged in the work proposed.

Table 10: Abridged Seven Lenses Maturity – Self Assessment of Case Examples

Key: Level 1 least maturity to Level 3 greatest maturity.

Case study	Vision	Transformation Leadership	Collaboration	People
1	2	2	2	2
2	2	3	2	2
3	2	2	1	2
4	1	2	2	2
5	2	3	2	2
6	2	2	2	2
7	3	3	3	3

The greatest level of maturity (3) across the cases is demonstrated in leadership transformation, which demonstrates that PNAs felt motivated to lead QI work. The vision, collaboration and people elements are showing a mid-level of maturity scoring 2, with the exception of cases 3 and 4, where they were assessed at level 1. Only one case example was

self-assessed at greatest maturity (3) across all lenses. Further details regarding the case examples can be located in Appendix 19.

5.5. Synthesis of Mixed Methods Findings

Two theoretical models were employed to guide and interpret the study findings, namely Laschinger's Organisational Empowerment (2001) framework and Michie et al (2011) COM-B model.

5.5.1. Revisiting Laschinger's Organisational Empowerment Framework

Throughout the analysis many elements have resonated and aided an understanding of the issues as they relate to the structures within organisational and psychological empowerment and the extent to which positive work feelings were expressed. Three core elements were identified from the qualitative findings namely, the need for further QI training; to develop confidence in using QI methods in practice and the ambiguity of the PNA role in relation to leadership of QI. Adequate time to conduct QI work within the PNA role was identified as an issue throughout. Using constructs from Laschinger's Framework (2001), these core findings have been overlaid with red, amber and green colour to signify red as the potential to stop the QI process, amber as needing to be built and green to move forward (Figure 8). The same elements were extracted from the quantitative data (survey) and overlaid (see Key). This showed that despite being described in the interviews and qualitative survey data, as core issues, e.g., needing more training in QI and lacking in confidence to undertake QI work – each scored moderate or highly helpful as positive indicators of ability.

Key: Two Likert Scales:

A. 5-point Likert Scales – where a lower score indicates more positive results
B. 6-point Likert Scales - 1= strongly agree, 6 = strongly disagree

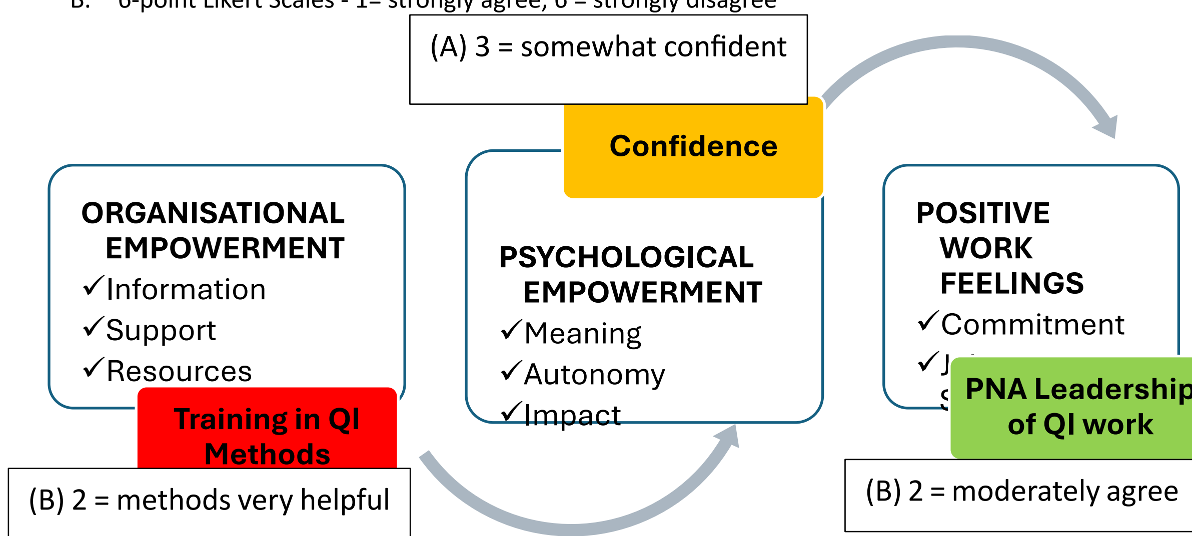


Figure 8: Theory Overlay using Laschinger's Organisational Empowerment Framework

In summary, this shows the elements within each part of Laschinger's Framework (2001) and how these relate to delivering the QI aspect of the PNA role (red, amber and green boxes) with qualitative and quantitative findings synthesised.

5.5.2. Revisiting Michie et al., Capability, Opportunity and Motivation to Change Behaviour

COM-B is used to establish behavioural change interventions to achieve goals, in this study we have overlaid the model to understand whether there is sufficient capability, opportunity and motivation for QI work to be undertaken as described throughout qualitative data and quantified in the survey (Figure 9).

Key:

Capability: Physical (PURPLE) Psychological (BLUE)

Opportunity: Social (PURPLE) Physical (BLUE)

Motivation: Automatic (PURPLE) Reflective (BLUE)

Numerical Scores – 10-point Likert Scale 0=strongly disagree, 10=strongly agree

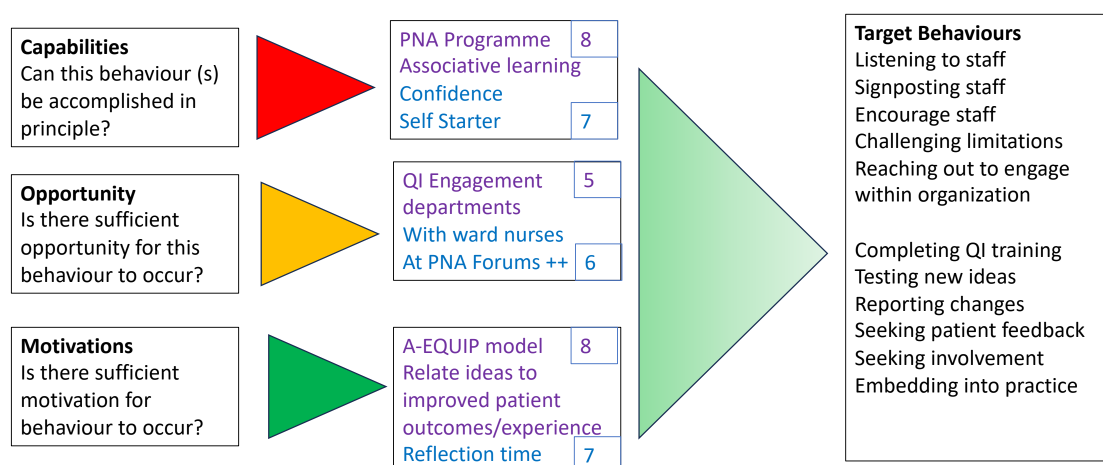


Figure 9: COM-B Model overlaid with Qualitative and Quantitative Findings

Elements of Capability, Opportunity and Motivation were identified from the qualitative data and quantified using matched survey data [from COM-B responses], which were both interpreted within the COM-B model (Michie et al, 2011). This enabled qualitative and quantitative findings to be synthesised and to understand concordance and differences. *Physical Capability* to help nurses undertake QI was scored very highly (8/10) albeit through associative learning after undertaking the PNA programme. *Psychological Capability* related to being able to self-start and the level of confidence associated with this, scored above average (7/10). *Social Opportunity* was identified as being able to engage with QI departments and other people who undertake QI work, which was rated the lowest score (5/10). This aligns with findings that relate to the lack of availability of time (being freed from clinical or other duties) to enable this. *Physical Opportunity* was rated similarly (6/10), although those PNAs that are able to engage in forums described these as very useful experiences and empowering.

Automatic and Reflective Motivations were rated higher (7-8/10); here the A-EQUIP model provides the framework which links the elements of the PNA role in its entirety and, where reflection, is integral in the restorative elements of supervision and career conversations. We anticipate the ***Target Behaviours*** identified will require many interventions depending on the size of an organisation, the maturity of QI systems/processes and density of PNAs within organisations. In terms of behaviour change theory (COM-B), this indicates that nursing policy and practice need to change to better support PNAs in terms of their physical and social opportunities to help nurses to engage in QI work.

6. Discussion

The findings revealed that most PNAs play an active role in identifying issues and from these some are implementing and sustaining clinical and non-clinical QI projects, in their work areas. To achieve this, PNAs are working with nurses in their teams to deliver RCS, which impacts on nurse wellbeing. We heard that when the wellbeing of nurses is improved this naturally contributes to delivering improved patient experience and outcomes. For example, associated nursing quality metrics improve in those areas. This was confirmed in the survey findings, where respondents rated ‘highly’ their impact on patient care and outcomes, indicating they feel they are making a positive difference. In this regard, the impact of the whole PNA role is being considered rather than the specifics of delivering or measuring QI work. Consequently, QI was viewed by some as an integral aspect of their nursing role, where data was routinely available, gathered and reported, for example, through nursing quality boards. In these cases, nurses had considerable years of experience and some occupied senior positions. This was substantiated in the survey where participants were representative of Nursing and Midwifery Council (2024) register data in terms of age (mean 46.3 years in our survey, versus 44 years and 1 month for NMC registrants) and gender (89% versus 88.8% women respectively). Nurses who were experienced in QI (prior to completing the PNA Programme) were able to relate to a broader scope of QI activities, discerning whether to signpost QI work to QI colleagues or deciding what systems could be engaged to build the QI work into existing routinely collected Trust/Organisational metrics. In some cases, it seems to remain unclear regarding the scope of QI work PNAs should undertake. QI work is not a small undertaking; it is likely that small projects will mature into larger pieces of work with substantial reach – and for this reason, however commendable the reach and maturity of QI work might be, some PNAs felt this is not sustainable within full time clinical roles and it may better align with QI staff or departments. Ongoing support is therefore necessary to sustain QI work to ensure continuous improvement.

The most difficulty in undertaking QI work was expressed by PNAs as they started out on their PNA journey. We heard commencing QI projects requires a level of confidence outside of the typical range of skills. PNAs go through a period of transition into understanding the role once they have completed the PNA programme. Part of this process involves understanding if/how much additional training they need to accomplish QI work. This factor is inextricably linked to their substantive role, their years of experience as a nurse and possessing a range of skills prior to being a PNA. For some PNAs completing the PNA programme may only signify achievement of a basic understanding of QI methods, which requires consolidation over time after PNA Programme completion. Overall, PNAs perceive that the relevant education standards are being met and that they are also meeting their roles and responsibilities. These

were also assessed in our previous evaluation (Lees-Deutsch et al., 2023) and the ratings are comparable. Nurturing ongoing skills will inevitably support the growth and sustainability of QI related work, such as the ability to self-start, along with a deeper understanding of how to engage the many QI methodologies. It takes time, some of those who are participated in this study were new to the PNA role and their responses reflected this. Part of the process of learning to undertake QI as a PNA, involves getting to know people who can support them within their employing organisations.

The issue of 'lack of time' was a consistently factor reported throughout this study – it is multifaceted and poses the most significant challenge for PNAs delivering the role. We heard some PNAs feel under organisational scrutiny arising from the cost of releasing them to do aspects of the role. Some organisations are concerned about needing to increase the number of PNAs to be effective; others about ongoing development for PNAs and ultimately needing evidence to prove value of the PNA role. This generates frustrations and anxiety regarding the immediate and prospective long-term sustainability of QI through the A-EQUIP model. The way in which the PNAs engage within their organisations, such as actively reaching out for support from other PNAs/forums, will also limit or expand their ability to initiate/undertake and learn from QI work. This means that while QI work is an essential element of the PNA role, it must be manageable within time constraints; meaning that teamwork and collaboration [often outside of individual clinical areas] are essential for successful implementation.

Through our proforma, we have collated examples of QI work which has improved patient experience and benefits. Data collection and reporting however, is sometimes lacking in refinement across organisations participating in this study. For example, digital systems to capture quantitative information from QI improvements undertaken by PNAs lack maturity. Nevertheless, reporting remains a vital component for demonstrating the patient outcomes/impact. Qualitative data was viewed as particularly valuable to deepen understanding of clinical issues and the patient voice, which participants felt even more precarious to report and were worried about exposing confidentialities. PNAs believed that their QI work is having a high impact on patient care outcomes which is also encouraging. However, a mismatch was noted between the answer to *"Has your QI work improved patient care outcomes or patient experience?"* (54% answered 'Yes' and 41% 'Not sure') and the perceived extent of impact on these factors ('High' for patient care outcomes and 'Moderate' for patient experience). The reach of QI work is quite insular (predominantly at Department/Ward level) hence there is scope for improving dissemination and scale. This might be related to the observation that 46% of PNAs reported either that there was no central point within their organisation to log information about QI work, or they were not sure. This seems like a missed opportunity for institutional learning from QI work.

PNAs, however, are positioned well to inform the development of new data collections systems at local and hospital level, which are capable of demonstrating the range of QI work being undertaken enabling interrogation, demonstrating progress of QI and sharing of valuable work. The organisational structures which exist to support data collection and reporting and feed into the nursing metrics should be linked to capture any PNA led QI work to demonstrate patient experience and benefits to outcomes. Successful QI work initiated at ward or departmental level may have greater reach and transferability for broader organisational impact, if staff were aware of their existence.

A summary illustration of the findings as they relate to the characteristics of good QI work is shown in Figure 10.

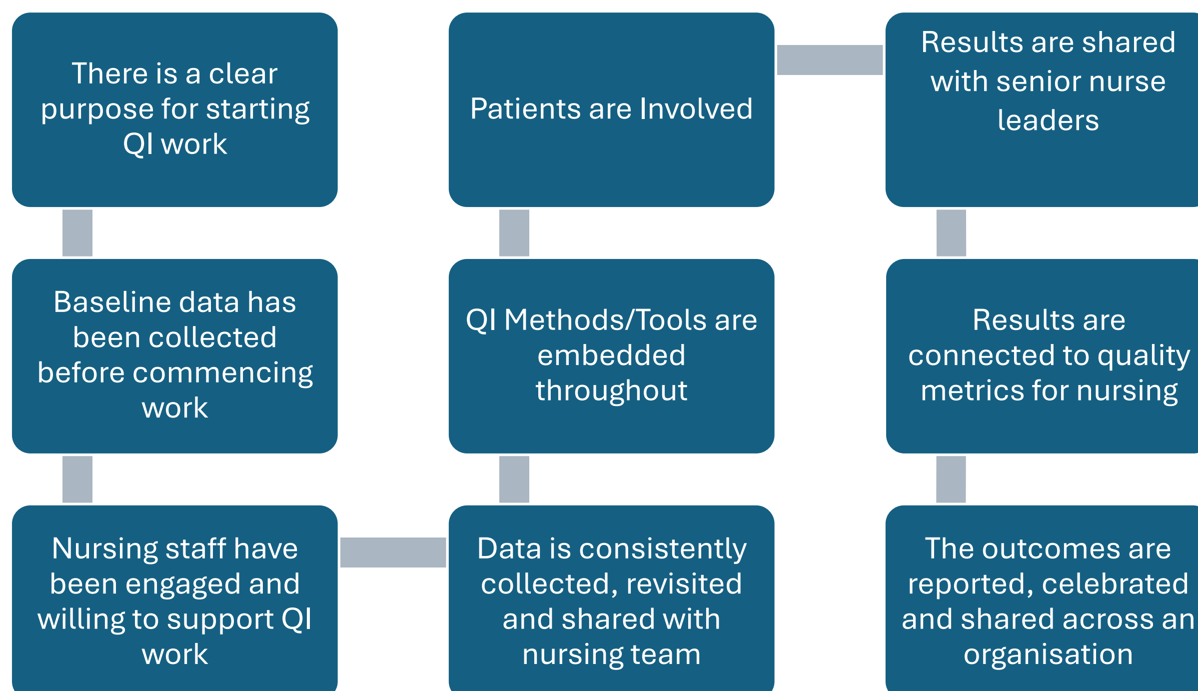


Figure 10: Characteristics of Good QI Work

6.1. Limitations and Strengths

Only 'exemplar' organisations were suggested to take part in the case study interviews. Therefore, experiences of where QI work is not undertaken well, were not represented. We may have missed some of the challenges experienced in other organisations.

Case examples for compendium were only collected from delegates who attended the conference and cascaded among contacts and networks of the Expert PNA Involvement Group. This meant that a smaller number of cases than anticipated were generated. We decided not to develop a compendium owing to missing information. Instead, these were written as summaries in a standardised format.

The survey invitation was recirculated twice to improve recruitment and an additional month was allowed for participants to complete the survey. Despite these actions we only received 105 responses. This caused a delay for reporting this evaluation and an extension was granted by the NHSE PNA Nursing Team.

The strengths of this study are from the expertise of the team and their knowledge of delivering mixed methods evaluation. PNA Education Standards from the RCN (2023) and theoretical frameworks (COM-B, Michie et al, 2011; Laschinger's Framework, 2001) were used to aid interpretation and generalisability. Throughout an expert PNA group was invited to give feedback and to shape the outputs of the work, described as usefulness and application of the study. This is the first study to report on QI within the A-EQUIP model as part of the PNA role.

7. Conclusion

PNAs are reporting QI activities which improve patient outcomes and experience. The case examples illustrate a small collection of QI work to benefit staff and patients. In benefitting staff this impacts positively (by proxy) upon patients. QI work is often conducted outside of existing mechanisms employed for reporting routine nursing quality metrics; with improved data capture, more patient benefits would be routinely reported. While PNAs expressed using QI methodologies, the training for this within the PNA programme could be strengthened which would assist PNAs in their transition into the PNA role and support the QI deliverable. This said, PNAs were really positive about the effects that being involved with QI work had on their professional growth and development. Time allowed for the PNA role, within clinical facing roles, needs greater organisational commitment to realise the full benefits PNAs can bring to staff and ultimately patient care.

Assumptions were made at the outset of this study which have been revisited and revised through the interpretation of the findings using a system level Logic Model (Figure 11).

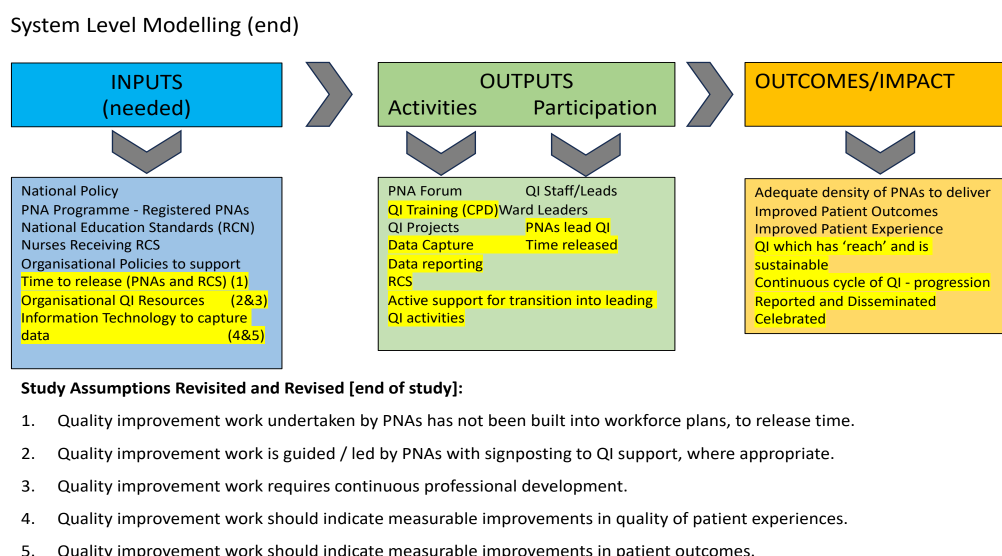


Figure 11: Logic Model at System Level

The system level logic modelling demonstrates the core inputs to develop the PNA programme [Policy, Programme, Education Standards and Organisational Policies]. Analysis of the findings shows that there is immaturity in systems at the point of the connection with NHS organisations and provider training organisations. Adequate time to release PNAs to undertake QI work is needed to realise the role fully. Resources to support QI development are also needed beyond the PNA programme. Introducing the PNA training programme into the NHS is a huge intervention and requires further continued development to support and capture QI outcomes. For example, a key "Input" change relates to the development Information Technology to improve the data collection and improve the quantification of the outcomes and impact of QI work, e.g., in relation to patient outcomes and patient experience.

8. Recommendations

Eight recommendations were derived from the evaluation:

Provider organisations for the education of PNAs to

1. Enhance the QI Element of PNA Training: Provider organisations for the education of PNAs should review the QI training as part of the PNA programmes to improve the confidence, skills and capacity of PNAs to undertake QI work.

2. Clarify Responsibilities for QI Work: Expand upon current education guidance/policy (RCN) regarding the PNA responsibilities in relation to delivering and supporting QI work to ensure the expectations and deliverables are clear.

Provider organisations for the employment of PNAs to

3. Recognise the Time required for QI Work to be realised: Acknowledge QI work within PNA roles to ensure there is adequate time.

4. Foster a Supportive Culture for QI work: Encourage empowerment and leadership among PNAs to facilitate QI projects through communities of practice (e.g., Shared decision-making councils).

PNA's to

5. Promote the Involvement of Patients in QI work: Establish ways of routinely involving patients to represent their voice in addressing issues which required improvement.

6. Improve the Quality of Data Reporting at organisational level: Encourage the development of methods across organisations for data reporting (quantitative and qualitative) of QI work to better demonstrate impact from work

PNA Leads regional and system level to

7. Enhance Communication and Engagement regarding QI work: Promote communications regarding the sharing and dissemination of QI work to highlight successful projects and innovative practices.

8. Ensure Sustainability and Greater Reach of QI Projects: Clear mechanisms should be developed to support continuous improvement and the reach across organisations of successful QI work.

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Appendices

Appendix 1. Certificate of Ethical Approval

Certificate of Ethical Approval

Applicant:	Dr. Laura Wilde
Project Title:	SUSTAIN-ING: A study to understand the impact that Professional Nurse Advocates (PNAs) undertaking quality improvement work have on patient outcomes and patient experience.

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 Medium Risk

Date of approval:	10 Sep 2024
Project Reference Number:	P174616

Appendix 2. Survey (delivered via JISC online surveys)

Demographics

Thank you for participating in this survey. To begin, we ask for some demographic information. We understand that this can feel personal, but please rest assured that we are only collecting the minimum details necessary. This information will help us ensure the study reflects diverse perspectives and supports our commitment to Equality, Diversity, and Inclusion (EDI). Your responses will remain anonymous, and data will be reported in aggregate form (e.g., 'X% of participants were between the ages of 25-34').

6. What is your age? (please enter a number in years) *

7. Which of the following best describes your gender? (please select one) *

Man

Non-binary

Woman

Prefer to self-describe

Prefer not to say

8. Please describe your gender in your own words*

What is your ethnic group? (please select all the options that best describe your ethnicity or background e.g. you could select Black African and White British if this best reflects your identity)

9. Asian / Asian British

Bangladeshi

Chinese

Indian

Pakistani

Any other Asian background, please describe

10. Please describe your other Asian background in your own words

11. Black / African / Caribbean / Black British

African

Caribbean

Any other Black / African / Caribbean background, please describe

12. Please describe your other Black / African / Caribbean background in your own words13.

13. White

English / Welsh / Scottish / Northern Irish / British

Gypsy or Irish Traveller

Irish

Roma

Any other White background, please describe

14. Please describe your other White background in your own words

15. Any other ethnic group

Arab

Hispanic

Latina/Latino/Latinx

Any other ethnic group, please describe

Prefer not to say

16. Please describe your other ethnic group in your own words

17. Do you consider yourself to have a disability or long-term condition? (such as dyslexia, diabetes, arthritis, a heart condition, or a mental health condition) (please select one) *

Yes

No

Prefer not to say

Introduction and Experience

18. What is your current job role? (please describe in your own words) *

19. How long have you been qualified? (please enter a number in years)*

'Quality Improvement' (QI) is a continuous process used to improve the quality and safety of patient care. It begins with identifying a problem and involves several stages: planning change(s); making change(s); and understanding effectiveness of the change(s) to improve patient care. These stages are repeated to form continuous cycles of improvements, such as within a model of Plan-Do-Study-Act.

20. In your current role as a PNA are you involved in any Quality Improvement (QI) work? (please select one) *

Yes

No

21. How long have you been doing QI work? (please enter a number in years) *

22. Before your role as a PNA did you have experience with QI work? (please select one) *

Yes

No

Not sure

23. In your current role as a PNA what kinds of QI work are you involved in? (please describe in your own words)*

Training and Support

24. How well do you feel your PNA training equipped you to deliver QI work? (please choose one) *

Extremely well

Very well

Somewhat well

Slightly well

Not at all well

25. Have you received any additional QI training following your initial PNA training? (please choose one) *

Yes

No

Not sure

26. Please describe any additional QI training you have received (please describe in your own words)*

Delivery of QI work in practice

27. In your role as a PNA to what extent have you initiated QI work? (please select one) *

To a very large extent

To a large extent

To some extent

To a small extent

Not at all

28. Do you use any specific methods for your QI work? (please select as many as relevant) *

Plan-Do-Study-Act (PDSA) cycles

Clinical Audit

Root Cause Analysis (RCA)

Six Sigma

Lean Methodology

Process Mapping

Benchmarking

Statistical Process Control (SPC)

Ishikawa (Fishbone) Diagrams

Failure Modes and Effects Analysis (FMEA)

Kaizen (Continuous Improvement)

Total Quality Management (TQM)

Driver Diagrams

Model for Improvement

None of these

Other (please specify)

29. Please describe any other specific methods that you have used for QI work (please describe in your own words)*

30. How helpful were these methods? (please select one) *

Extremely helpful

Very helpful

Somewhat helpful

Slightly helpful

Not at all helpful

31. How confident are you in your ability to lead QI work? (please select one) *

Extremely confident

Very confident

Somewhat confident

Slightly confident

Not at all confident

32. How easily could your QI work be repeated by another person? (please select one) *

Extremely repeatable

Very repeatable

Somewhat repeatable

Slightly repeatable

Not at all repeatable

33. How well supported do you feel to undertake QI work in practice? (please select one) *

Extremely supported

Very supported

Somewhat supported

Slightly supported

Not at all supported

Impact of QI on Patient Care Outcomes or Patient Experience

The following questions relate to both measurable patient care outcomes (e.g. safety incidents, falls, wound care, nutrition, hospital stay, mortality) and also to experiences reported by patients (e.g. patient satisfaction or feedback)

34. To what extent do you believe your QI work has impacted patient care outcomes? (please select one) *

Very high impact

High impact

Moderate impact

Low impact

No impact

35. To what extent do you believe your QI work has impacted patient experience? (please select one) *

Very high impact

High impact

Moderate impact

Low impact

No impact

36. How involved have patients been in your QI work? (please select one) *

To a very large extent

To a large extent

To some extent

To a small extent

Not at all

37. Please describe how you have involved patients in your QI work (please describe in your own words)*

38. Has your QI work improved patient care outcomes or patient experience? (please select one) *

Yes

No

Not sure

39. If yes, please describe how patient care outcomes or patient experience have improved (please describe in your own words) *

40. Please describe how you collect feedback on patient care outcomes or patient experience (please describe in your own words)*

Reach, Success and Sustainability of QI Work

41. How would you describe the reach of your QI work? (please select as many as relevant) *

Ward

Department

Directorate

Hospital/hospitals

A business case

Other (please specify)

42. If you selected 'Other', please describe the reach of your QI work (please describe in your own words)

43. Who do you collaborate with in your QI work? (please select as many as apply) *

Matrons

Lead Nurses

Doctors

Allied Health Professions (AHPs)

Other (please specify)

44. If you selected 'Other', please describe who else you collaborate with in your QI work (please describe in your own words)

45. How successful do you consider your QI work to be? (please select one) *

Extremely successful

Very successful

Somewhat successful

Slightly successful

Not at all successful

46. How sustainable are the changes that have been implemented following your QI work? (please select one) *

To a very large extent

To a large extent

To some extent

To a small extent

Not at all

47. How has your involvement in QI work influenced your professional growth and development? (please select one) *

To a very large extent

To a large extent

To some extent

To a small extent

Not at all

48. What data do you collect to monitor the progress of your QI work? (please select as many as relevant) *

Patient outcomes (e.g., clinical results, recovery rates)

Process measures (e.g., time taken for tasks, adherence to protocols)

Staff feedback/surveys

Patient feedback/satisfaction surveys

Safety incidents or near misses

Cost data (e.g., savings, budget adherence)

Quality indicators (e.g., infection rates, readmission rates)

Audit results

Benchmarking against national or local standards

Statistical process control (SPC) charts

Resource utilisation (e.g., staffing, equipment)

Compliance with guidelines or policies

Other (please specify)

49. If you selected 'Other', please describe the other data that you collect yo monitor the progress of your QI work (please describe in your own words)

50. How often is the progress of your QI work reported? (please select one) *

Weekly

Monthly

Quarterly

Annually

Never

Other (please specify)

51. If you selected 'Other', please describe how often the progress of your QI work is reported (please describe in your own words)

52. Is there a central point within your organisation to log information about QI work? (please select one) *

Yes

No

Not sure

These questions ask about your perceived CAPABILITY, OPPORTUNITY and MOTIVATION to help nurses to engage in QI work

53. I have the PHYSICAL OPPORTUNITY to help nurses to engage in QI work (please select one)

What is PHYSICAL OPPORTUNITY?

The environment helps me to engage in the activity concerned (e.g. I have sufficient time, the necessary materials, reminders) *

0 Strongly disagree

1

2

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9

10 Strongly agree

54. I have the SOCIAL OPPORTUNITY to help nurses to engage in QI work (please select one)

What is SOCIAL OPPORTUNITY?

Interpersonal influences, social cues and cultural norms help me to engage in the activity concerned (e.g. I see other colleagues engaged in QI activities, I have support from managers) *

0 Strongly disagree

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10 Strongly agree

55. I am MOTIVATED to help nurses to engage in QI work (please select one)

What is REFLECTIVE MOTIVATION?

Conscious planning and evaluations (beliefs about what is good and bad) help me to engage in the activity concerned (e.g. I have the desire to, I feel the need to) *

0 Strongly disagree

1

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10 Strongly agree

56. Helping nurses to engage in QI work is something I do AUTOMATICALLY (please select one)

What is AUTOMATIC MOTIVATION?

Doing something without thinking or having to consciously remember help me to engage in the activity concerned (e.g. it is something I do before I realise I’m doing it) *

0 Strongly disagree

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10 Strongly agree

57. I am PHYSICALLY able to help nurses to engage in QI work (please select one)

What is PHYSICAL CAPABILITY?

Having the physical skill, strength or stamina helps me to engage in the activity concerned (e.g. I have sufficient physical stamina, I can overcome disability, I have sufficient physical skills) *

0 Strongly disagree

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10 Strongly agree

58. I am PSYCHOLOGICALLY able to help nurses to engage in QI work (please select one)

What is PSYCHOLOGICAL CAPABILITY?

Knowledge and/or psychological skills, strength or stamina to engage in the necessary thought processes helps me to engage in the activity concerned (e.g. I have the knowledge, cognitive and interpersonal skills, and I have the ability to engage in appropriate memory, attention and decision making processes) *

0 Strongly disagree

1

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10 Strongly agree

The following questions relate to the relevant Professional Nurse Advocate Standards for Education and Training Programmes and Modules (RCN 2023). Specifically Standard 3. Enabling nurses to undertake personal action for quality improvement. The standard: critically appraise the role of the PNA in contributing to continual development and innovation in care so that quality improvement becomes part of everyone's practice.

59. I know how to comprehensively support staff through a continuous improvement process that builds personal and professional clinical leadership, improves quality of care, and supports professional revalidation (please select one) *

Strongly agree

Moderately agree

Slightly agree

Slightly disagree

Moderately disagree

Strongly disagree

60. I can systematically identify and critically apply high-quality nursing research and support to innovate and use evidence in practice; enabling PNAs, and those who work with them, to develop new knowledge, improve nursing practice and transform patient care and experience (please select one) *

Strongly agree

Moderately agree

Slightly agree

Slightly disagree

Moderately disagree

Strongly disagree

61. I can comprehensively apply quality improvement methodologies enabling me to systematically evaluate, change and improve the quality of care and services as part of every nurse's responsive practice (please select one) *

Strongly agree

Moderately agree

Slightly agree

Slightly disagree

Moderately disagree

Strongly disagree

The following question replicates one posed in a previous evaluation of the PNA programme

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

…improve nurses' leadership of quality improvement (please select one) *

Strongly agree

Moderately agree

Slightly agree

Slightly disagree

Moderately disagree

Strongly disagree

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

63. I am effective in…

...developing a nurse's ideas and actions for quality improvement and service development (please select one) *

Strongly agree

Moderately agree

Slightly agree

Slightly disagree

Moderately disagree

Strongly disagree

64. I am effective in…

...participating in quality improvement programmes (please select one) *

Strongly agree

Moderately agree

Slightly agree

Slightly disagree

Moderately disagree

Strongly disagree

65. I am effective in…

...leading on quality improvement programmes (please select one) *

Strongly agree

Moderately agree

Slightly agree

Slightly disagree

Moderately disagree

Strongly disagree

66. Please use this space to add anything else you would like to tell us (please describe in your own words)*

Please click submit for your responses to be recorded!

Thank you!

Appendix 3. Survey Participant Information Sheet (delivered via JISC online surveys)

Professional Nurse Advocate (PNA) Survey

Participant Information Sheet

SUStAIN-ING: A study to understand the impact that Professional Nurse Advocates (PNAs) undertaking quality improvement work have on patient outcomes and patient experience

Contact: liz.lees-deutsch@nhs.net

You are being invited to take part in a national research survey to evaluate the Professional Nurse Advocate (PNA) programme in relation to the nature and scope of Quality Improvement (QI) activity being undertaken. Liz Lees-Deutsch, Professor for Nursing at Coventry University is leading this evaluation, in collaboration with a team of researchers from Coventry University. Before you decide whether to take part, it is important that you understand why the evaluation is being conducted and what it will involve. Please take the time to read the following information carefully.

What is the purpose of this research?

The purpose of the research is to evaluate (using a national survey) the nature and scope of quality improvement activity being undertaken by PNAs in their workplaces . Your voice and experiences are important within this research project because it will help us to understand the quality improvement work and how it can be further improved in the future.

Who is organising and funding the research?

The research is being organised by Coventry University and funded by the National Health Service England (NHSE). The research has ethical permission from Coventry University Research Ethics Committee [10th September 2024, No: P174616].

Do you have to take part?

No – your participation is entirely up to you. You are free to withdraw your data from the project at any time until the data are fully anonymised in our records up to one month after the interviews have taken place. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the lead researcher at the earliest opportunity should you wish to withdraw from the study (contact details are provided below). You do not need to provide a reason for withdrawing. A decision to withdraw, or not to take part, will not affect you in any way.

What will happen if I decide to take part?

You will be asked to complete an online survey on the next few pages (using JISC Online Surveys, which is a platform approved by Coventry University). The questions will explore a range of topics around quality improvement, such as your experiences, understanding and perceptions of quality improvement within the PNA programme (e.g., benefits and limitations), as well as what you believe are the barriers to quality improvement. You can complete survey online via JISC Online Surveys at a time that is mutually convenient for you. It will take approximately 20 minutes to complete.

Your responses will be anonymised. We will remove the names and identifying features and replace them with unique identifier codes and/or pseudonyms. In rare cases where data could possibly still be identifiable through being a very unusual case, anonymity will be protected by minor modification of the case before inclusion in analyses. All data will be kept anonymous.

Why have you been invited to take part?

You have been invited to participate in this research because you are a lead PNA or PNA, having completed the PNA Programme.

What are the benefits and potential risks and benefits in taking part?

By taking part you will help to shape the development of the way in which Quality Improvement initiatives are executed at workplaces. No direct incentives are being offered, including payments or other inducements.

There are no significant risks associated with participation in the survey.

You do not have to answer any questions that makes you feel uncomfortable or respond to any questions that you simply would not like to respond to. You are able to freely withdraw and exit the survey while completing it at any time without giving a reason or after completion up to one month until the data are fully anonymised in our records up to one month after the completion of the survey. Information will be provided at the end of the survey which gives helpline numbers and websites for support.

What information is being collected in the research?

Your experiences and thoughts regarding quality improvement within the PNA programme will be collected during this evaluation, so that we can explore a deeper understanding of, and further improve/develop, the quality improvement element of the PNA programme.

Lawful basis of processing

Under the UK General Data Protection Regulation (UK GDPR) 2016 we must have a lawful basis to process your personal data and for the purpose of this research, our lawful basis is that of Legitimate Interests.

What will happen to the results of the research?

The results of this evaluation will be reported to the NHSE commissioners. It is anticipated that following any embargo, the report will be publicly accessible via the NHSE website.

Following completion of the NHSE commission work, data from this research project may be summarised in conference abstracts, published journal articles, and presentations. Presentations will be made to PNA Leads via their Communities of Practice at agreed times following the dissemination of the Report. All data, including quotes and key findings, will always be anonymised in any future outputs.

Who will have access to the information?

Your anonymous data will only be accessed and discussed by the research team for this project. In cases where the Open Access Policy has been instigated, all anonymised data with unique ID codes and pseudonymisation may be shared upon adequate written request.

Where will the information be stored and how long will it be kept for?

Your data will be processed in accordance with the UK General Data Protection Regulation 2016 (UK GDPR) and the Data Protection Act 2018 (DPA). All information collected about you will be kept strictly confidential. Your data will be referred to by a unique participant number rather than by name.

Data collected through JISC online surveys will be stored on a saved, double-authenticated, password protected account of the researchers. Data will be downloaded and stored on Coventry University secure OneDrive servers. All electronic data will be stored in password protected online folders, on password protected computers, on Coventry University. The lead researcher (see below) will take responsibility for data destruction. Any identifiable data (e.g., email addresses) that will be needed to organise a convenient time for the data will be destroyed at the end of the SUStAIN-ING research project (expected to be March 2025). All collected data will be destroyed within 10 years of the research project concluding.

For further information about how Coventry University will handle your personal data, please read our Privacy Notice for Research Participants.

What will happen next?

If you would like to take part, please complete the consent form at the bottom of this page or contact the lead researcher (details below) if you have any questions. On the next few pages you will be asked some questions for the research project.

Lead researchers contact details:

Professor Liz Lees-Deutsch, email: liz.lees-deutsch@nhs.net

Who do I contact if I have any questions or concerns about this research?

If you have any questions or concerns about this research, please contact Professor Liz Lees-Deutsch using the contact details above. If you still have concerns and wish to make a complaint, please contact the University's Research Ethics and Integrity Manager by e-mailing ethics.uni@coventry.ac.uk. Please provide information about the research project, specify the name of the researcher, and detail the nature of your complaint.

Thank you for taking the time to read this information and for considering participating in this research. Your help is very much appreciated.

Appendix 4. Survey Consent form (delivered via JISC online surveys)

Consent Form

SUStAIN-ING: A study to understand the impact that Professional Nurse Advocates (PNAs) undertaking quality improvement work have on patient outcomes and patient experience

You are invited to take part in the SUStAIN-ING research project. We will be collecting data (using a survey) regarding quality improvement as part of the Professional Nurse Advocate (PNA) programme.

Before you decide to take part, you must read the accompanying Participant Information Sheet [information on previous page] and Privacy Notice

Lead researcher: Professor Liz Lees-Deutsch
Department: Centre for Healthcare Research (Coventry University) and University Hospitals Coventry and Warwickshire
Contact details: Liz.Lees-Deutsch@nhs.net.

This consent form is to confirm that you understand what the purposes of this research project are, what will be involved, and that you agree to take part.

Please do not hesitate to ask any questions if anything is unclear or if you would like more information about any aspect of this research project. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

If you are happy to participate, please select each box [yes] to indicate your agreement.

1. I confirm that I have read and understood the Participant Information Sheet [information above] for the SUStAIN-ING research project and have had the opportunity to ask questions.*

Yes

2. I understand that all of the information I provide will be held securely and treated confidentially. *

Yes

3. I understand who will have access to any personal data provided and what will happen to the data at the end of the research project.*

Yes

4. I understand that my participation is voluntary and that I am free to withdraw my participation and data, without giving a reason, by contacting the lead researcher at any time until the date specified in the Participant Information Sheet.*

Yes

5. I understand that the anonymised results of this research project will be used in academic papers, reports, and other formal research outputs.*

Yes

Appendix 5. Case Study Interviews Participant Information Sheet

SUSTAIN-ING PNA Study: Case Study Interviews

A study to understand the impact that Professional Nurse Advocates (PNAs) undertaking quality improvement work have on patient outcomes and patient experience.

You are being invited to take part in a **case-study interview** in relation to the nature and scope of Quality Improvement (QI) activity being undertaken as part of your role as PNA. **Liz Lees-Deutsch, Professor for Nursing at Coventry University** is leading this evaluation, in collaboration with a team of researchers from Coventry University.

Before you decide whether to take part, it is important that you understand why the evaluation is being conducted and what it will involve. Please take the time to read the following information carefully.

What is the purpose of this research?

The purpose of the research is to evaluate the nature and scope of quality improvement activity being undertaken because of the PNA programme. Your voice and experiences are important within this evaluation because it will help us to understand the quality improvement work that is happening as part of the PNA programme, if any, including how it can be further improved in the future.

Who is organising and funding the research?

The research is being organised by Coventry University and funded by the National Health Service England (NHSE). The research has ethical permission from Coventry University Research Ethics Committee [10/09/2024 - Ref: P174616].

Do you have to take part?

No - your participation is entirely up to you. You are free to withdraw your data from the project at any time until the data are fully anonymised in our records up to one month after the interviews have taken place. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the lead researcher at the earliest opportunity should you wish to withdraw from the study (contact Professor Liz Lees-Deutsch: liz.lees-deutsch@nhs.net). You do not need to provide a reason for withdrawing. A decision to withdraw, or not to take part, will not affect you in any way.

What will happen if I decide to take part?

You will be asked to participate in an online one-to-one interview. These will explore a range of topics around quality improvement, such as your experiences, understanding and perceptions of quality improvement within the PNA programme (e.g., benefits and limitations), as well as what you believe are the barriers to quality improvement. The interview

will take place online via a digital video platform, such as Microsoft Teams, at a time that is mutually convenient for you and the research team. You can choose whether to keep your video on or off. Only audio data will be used for analysis.

The interview will take approximately one hour depending on how much there is to talk about. We would like to audio record your responses to create a transcript (i.e., a written record of the conversation that was had during the interview). This is important to ensure the accuracy of the conversations. Confidentiality for the interview process will be assured. We will ask that you choose a location to do the interview where you will not be disturbed, including the use of signage on the door in cases of shared office spaces. The timing of the interview will also be organised to suit your individual preferences. If the interview is conducted away from your usual place of work (e.g., at home) we will ask that you choose a place where you are not disturbed during the interview.

Anonymity will be ensured for the interview (i.e., data will not be identifiable), such that we will remove the names and identifying features relayed to us and replace them with unique identifier codes and/or pseudonyms. In rare cases where data could possibly still be identifiable through being a very unusual case, anonymity will be protected by minor modification of the case before inclusion in analyses. All data will be kept anonymous.

Why have you been invited to take part?

You have been invited to participate in this research because you are part of a selected organisation having exemplar status for achieving QI work from the PNA Programme.

What are the benefits and potential risks and benefits in taking part?

By taking part you will help the NHSE to better understand the PNA programme in terms of quality improvement moving forward. No direct incentives are being offered, including payments or other inducements.

Although there are no significant risks associated with participation, it is possible that through discussion, sensitive matters relating to practice may arise. You do not have to answer any questions that make you feel uncomfortable or respond to any questions that you simply would not like to respond to. If the interview causes you distress, or you require a break at any time, this will be facilitated, and you will be able to freely withdraw or leave the interview/focus group at any time without giving a reason. If you require any further support, you can:

- Visit the following website (https://www.practitionerhealth.nhs.uk/wellbeing-and-mental-health- for-nurses)
- Call The Samaritans (phone number: 116 123)
- Call the Royal College of Nursing (phone number: 0345 772 6100, active between 08:30-20:30, 365 days/year)

What information is being collected in the research?

Your experiences and thoughts regarding quality improvement within the PNA programme will be collected during this research project, so that we can explore a deeper understanding of, and further improve/develop, the quality improvement element of the PNA programme.

Lawful basis of processing

Under the UK General Data Protection Regulation (UK GDPR) 2016 we must have a lawful basis to process your personal data and for the purpose of this research, our lawful basis is that of Legitimate Interests.

What will happen to the results of the research?

The results of this research project will be reported to the NHSE commissioners. It is anticipated that following any embargo, the report will be publicly accessible via the NHSE website. Following completion of the NHSE commission work, data from this research project may be summarised in conference abstracts, published journal articles, and presentations. All data, including quotes and key findings, will always be anonymised in any future outputs.

Who will have access to the information?

The interview will be audio recorded and transcribed by either automatic closed captioning/transcription within the audio/video software (e.g. Microsoft Teams) by a member of the research team for this project. This interview data will be saved on the CU Microsoft Teams account, which is password protected and only accessible to the researchers. The audio recording will be transcribed and anonymised as soon as possible. Your transcribed, anonymous data will only be accessed and discussed by the research team for this project. In cases where the Open Access Policy has been instigated, all anonymised data with unique ID codes and pseudonymisation may be shared upon adequate written request.

Where will the information be stored and how long will it be kept for?

Your data will be processed in accordance with the UK General Data Protection Regulation 2016 (UK GDPR) and the Data Protection Act 2018 (DPA). All information collected about you will be kept strictly confidential. Your data will be referred to by a unique participant number rather than by name. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed.

All electronic data will be stored in password protected online folders, on password protected computers, at Coventry University. Your consent information will be kept separately from your responses. The lead researcher (see below) will take responsibility for data destruction. Any identifiable data (e.g., email addresses) that will be needed to organise a convenient time for the interview/focus group will be destroyed at the end of the SUStAIN-ING research project (expected to be March 2025). All other collected data will be destroyed within 10 years of the research project concluding.

For further information about how Coventry University will handle your personal data, please read our Privacy Notice for Research Participants.

What will happen next?

If you would like to take part, complete the consent form or contact the lead researcher (details below) if you have any questions. On the next few pages you will be asked some questions to check you are suitable to take part in this research and then a few questions about yourself so we can understand more about you. Please provide details of how the research team can contact you to take part in the interview.

Lead researcher's contact details:

Professor Liz Lees-Deutsch, email: liz.lees-deutsch@nhs.net

Research team

Dr Laura Wilde, email laura.wilde@coventry.ac.uk Professor Rosie Kneafsey, email: aa9398@coventry.ac.uk

Dr Laura Wilde will contact you to make arrangements for the interview.

Who do I contact if I have any questions or concerns about this research?

If you have any questions or concerns about this research, please contact Dr Liz Lees-Deutsch using the contact details above. If you still have concerns and wish to make a complaint, please contact the University's Research Ethics and Integrity Manager by e-mailing ethics.uni@coventry.ac.uk. Please provide information about the research project, specify the name of the researcher, and detail the nature of your complaint.

Thank you for taking the time to read this information and for considering participating in this research. Your help is very much appreciated.

Appendix 6. Case Study Interviews Consent form

CONSENT FORM

For case study compendium

SUSTAIN-ING: A study to understand the impact that Professional Nurse Advocates (PNAs) undertaking quality improvement work have on patient outcomes and patient experience.

You are invited to take part in the SUStAIN-ING research project. We will be collecting data using case study data collection form, ready to compile organisational case studies, regarding quality improvement as part of the Professional Nurse Advocate (PNA) programme.

Before you decide to take part, you must **read the accompanying Participant Information Sheet [information above] and Privacy Notice**

Lead researcher: Professor Liz Lees-Deutsch, Professor for Nursing and Clinical Academic Nurse
Department: Centre for Healthcare Research (Coventry University)
Contact details: Liz.Lees-Deutsch@nhs.net.

This consent form is to confirm that you understand what the purposes of this research project are, what will be involved, and that you agree to take part. Please do not hesitate to ask any questions if anything is unclear or if you would like more information about any aspect of this research project. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

If you are happy to participate, please **select** each box [yes] to indicate your agreement.

		YES
1	**I confirm that I have read and understood the Participant Information Sheet [information above] for the SUStAIN-ING research project and have had the opportunity to ask questions.**	
2	**I understand that all the information I provide will be held securely.** **Information I provide regarding my organisation's case study will not be anonymised and that my work contact details (email) will be included in the compendium of information.**	
3	**I understand who will access any personal data I have provided and what will happen to the data at the end of the research project.**	
4	**I understand that my participation is voluntary and that I am free to withdraw my participation and data, without giving a reason, by contacting the lead researcher** at any time **until the date specified in the Participant Information Sheet.**	
5	**I understand that the information I provide [on the data collection form], regarding my organisational case study will be reported within a compendium of other national case studies.**	
6	**I agree to gain appropriate permission from my employing organisation to provide a case study for this research to be included in a national compendium of case studies.**	
7	**I agree to take part in providing a case study for the SUStAIN-ING research.**	
8	**I am happy for a researcher to contact me about by email about the case study.**	

Appendix 7. Case Study Interview Schedule

Introduction and Experience

1. Organisation?
2. Number of nurses?
3. Number of PNAs?
4. Tell us a little about yourself.
    a. Prompts:
        i. How long have you been registered as a nurse?
        ii. When did you complete PNA Programme?
        iii. Describe Setting where they work
5. Can you tell me about your involvement/experience with development quality improvement (QI) work?
    a. Prompts:
        i. As a PNA?
        ii. Any experience before PNA role?
        iii. Over what time period?
        iv. How are things progressing now?

Training and Support

BEFORE:

6. How well do you feel the PNA programme (training) equipped you to commence quality improvement work?
    a. Prompts: Why is this the situation?

AFTER PROGRAMME:

7. Did you feel confident to start QI developments after you had completed the programme?
    a. Prompts:
        i. Ideas (practical)
        ii. Updating (modules etc)
8. How do you stay updated on best practices and delivery of QI work?
    a. (e.g. online training, peers, others)

Delivery of QI work in practice

9. Tell us about the QI projects you have developed in your PNA role, if any?

If projects to discuss:

10. How are ideas for QI work typically generated?
    a. Prompts:
        i. From RCS
        ii. Problems from practice (costs, infections, mortality, readmissions, complaints, patient safety)
11. Describe ways in which you have set about the delivery of QI work?
    a. Prompts:
        i. Tools used/process used

      ii. PDSA
      iii. Gathering service data
      iv. Setting a standard
12. How would you describe your project in terms of the ability to repeat it again?
13. Which staff are involved in the QI work?
    a. Prompts:
        i. Just PNAs
        ii. Ward Nurses or multi- disciplinary
        iii. How did you choose these people to be involved? Nominated?

For all

14. How well supported in practice do you feel to undertake QI work in practice?
    a. Prompts:
        i. What support?
        ii. Availability of experienced staff
        iii. Access to Training
    iv. QI departmental support
    v. Constraints
    vi. Peers (PNAs)

Impact of QI on Patient Care Outcomes

15. If/how does your QI work relate to improvements in patient outcomes and experience?
    a. Prompts:
        i. Quality of Care
        ii. Safety of Care
        iii. Improve service
16. If/How have patients been involved in making the changes?
    a. Prompts
        i. Patient satisfaction survey results
        ii. Patient complaints
        iii. Patient Involvement groups (ppi)

Reach, Success and Sustainability of QI work

17. How would you describe the reach of your project?
    a. Prompts: -ward, department, directorate, hospital/hospitals....
    b. A business case?
18. Are you collaborating with (or being supported by) an experienced QI team to progress work?
    a. Prompts: Difference this makes
19. What do you consider to be the wider benefits of QI work?
    a. Prompts: (staff satisfaction, morale, workflow efficiency, cost-effectiveness)?
20. Can you give examples of QI projects that have had a lasting impact over time?
21. What are the factors within your organisation that positively or negatively influence the QI work?
    a. Prompts:
        i. Positively (training/experience)

            ii. Negatively (confidence)

22. What (if any) organisational learning has been sustained from the QI work?
    a. Prompts:
        i. PNAs share their learning
        ii. Other wards following suit
        iii. Changes made impacting on patient care
23. If/How has your involvement in QI work influenced your professional growth and development?

Implementation and Monitoring

24. What data do you collect from QI work in practice?
25. Could this be improved?
26. Where/how does this get reported?

Closing questions

27. Is there anything else you would like to add to what we have spoken about today
28. Do you have any questions for me?

Thank you

Appendix 8. Workshop Participant Information Sheet

Workshop 13th November 2024 - Participant Information Sheet

Introduction

The national learning event which you have registered for is being held to feedback findings of research, disseminate work and showcase best QI practice from PNAs and staff they have worked with, to demonstrate positive impacts on patient care and outcomes. The national learning event will also include a workshop (see Programme) with delegates who are attending the learning event being given the option to join this workshop. There will be a maximum of 20 places for this workshop.

Workshop details

The purpose of the workshop is: to share experiences and learning regarding wider adoption of ideas from QI work and how to sustain this work.

Recruitment to the workshop: As you have already registered to attend the learning event, you are also invited to join the workshop. The information has been sent to you by email from NHSE. If you are interested in the workshop you can give consent here/below/through the online surveys link.

The workshop involves: a round table open discussion to explore the key areas below, phrased into open questions, to guide the outputs of the workshop.

- Key success factors for Quality Improvement (QI) work
- Tools used by PNAs for QI work
- Methodologies used/devised by PNAs for delivery of QI work
- Sign Posting to QI training

What data is collected?

Notes from round table discussions will be made onto flip charts by the facilitators during the workshop – which will be transcribed and organised into a document following the session. Member sense checking of the document will be facilitated through email dissemination, following the workshop.

The final product envisaged from this workshop is a Toolkit of QI Principles [with final name and content determined by participants from the round table discussions] which will be hosted digitally on NHS England Futures platform.

Do I have to take part?

No – your participation is entirely up to you. You are free to withdraw your data from the project at any time until the data are fully anonymised in our records **up to one week after the interviews have taken place**. You are advised to contact the lead researcher at the earliest opportunity should you wish to withdraw from the study. To withdraw contact Professor Liz Lees-Deutsch: liz.lees-deutsch@nhs.net. You do not need to provide a reason for withdrawing. A decision to withdraw, or not to take part, will not affect you in any way.

Appendix 9. Workshop Consent Form

Workshop 13th November 2024 – Consent form

You are being invited to participate in a workshop (single event), as part of the SUStAIN-ING evaluation. The purpose of the workshop is to enable the research team to create a toolkit of principles for Quality Improvement (QI) work. Brief notes of the round table discussions will be scribed by the research team which will be anonymised, aggregated and stored securely in a password-protected file. This Workshop will finalise the evaluation and points or topics raised in this workshop will enable different perspectives regarding QI to be heard through joint discussion.

Lead researcher: Liz Lees-Deutsch, Professor for Nursing

Department: Centre for Healthcare Research (Coventry University) and University Hospitals Coventry and Warwickshire

Contact details: Liz.Lees-Deutsch@nhs.net

This consent form is to confirm that you understand what the purposes of this workshop are, have received information regarding what will be involved, and that you agree to take part. If you are happy to participate, please **initial** each box to indicate your agreement, sign and date the form, and return it to the researcher.

Please do not hesitate to ask any questions if anything is unclear or if you would like more information about any aspect of this evaluation. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

1	**I confirm that I have read the participant information and understand the purpose of the workshop.**	
2	**I understand that all of the information I provide as part of the workshop will be held securely and treated anonymously.**	
3	**I understand that my participation is voluntary and that I am free to withdraw my participation and data, without giving a reason, by contacting the lead researcher at any time up to one week after the workshop has taken place.**	
4	**I am happy to receive the aggregate notes from the workshop to sense-check following the discussions and to provide feedback to the researchers by email.**	
5	**I understand that the finalised data collected from this workshop will be used to inform the SUStAIN-ING Toolkit of Quality Improvement principles.**	
6	**I agree to take part in the workshop for the SUStAIN-ING evaluation.**	

___________________________ ________________________ _________________

Name of Participant **Signature** **Date**

___________________________ ________________________ _________________

Name of Researcher **Signature** **Date**

Appendix 10. Case Study Example Data Collection Form

Title of the Quality Improvement:
Organisation Name:
Type of Organisation:
Name of PNA Lead:
Name of lead person submitting the case study (if part of a team include all names):
Contact email address (in case of queries pre-publication):
Overview of Quality Improvement Work *(what was the improvement, why and when started, where was this based, who involved, how it was carried out)*
Key measures used to assess success: *(e.g., do you have any data before, during, or following QI work?)*

Key QI methods used: (e.g., PDSA, 5 whys)
Patient Outcomes (indirectly or directly):
Staff Outcomes (indirectly or directly):
Key Learning Points: (up to three; those others could learn from)
Transferability: (points that could be used elsewhere)
Has this work been published/shared? (if yes, please describe)

SUSTAIN-ING PNA Quality Improvement (QI) Study - Maturity Assessment Matrix

	Vision	Transformation leadership	Collaboration	People
	The vision about the QI work gives clarity around the outcomes of the transformation and sets out the key themes of how this will operate.	**Delivering a QI transformation often means motivating into action a large network of people who are not under the direct management of the transformation leader.**	**Collaboration is key to QI transformation in a multidimensional environment that increasingly cuts across organisational boundaries.**	**QI Transformation will require people in your organisation to be engaged and to change their ways of working - you need to communicate effectively with them at every stage of the transformation.**
1	There is no clear QI vision for the future, or there are competing visions (from different departments or wards).	Leaders talk about QI related transformation on occasion. They make some effort to canvass staff views to join with QI work but avoid difficult messages.	Collaboration across organisational boundaries with QI work is limited.	The impact of QI transformation on people, ways of working and culture is not understood.
2	There is a QI vision that is stretching staff but achievable. Staff see how they can fit into it.	There is sufficient ownership of QI transformation. Leaders talk about it. There are visible role models, e.g. PNAs.	Many QI decisions are made across boundaries. Shared patient outcomes are starting to be developed. PNA led QI work incorporates sustainability.	Plans are in place to address the impact on people, ways of working and culture.
3	The QI vision is embedded in everything staff do. It flows from top to bottom and is aligned with public outcomes.	Leaders embody QI transformation and create an environment of trust where it's safe to speak freely.	The organisation compromises for the greater good and leads the way in QI transformation communities.	Ways of working needed for the future of QI work are adopted. Mature workforce planning exists.

Appendix 11. Framing the Review Question

PICO framework (Population, Intervention, Comparison and Outcomes):

Framework PICO+C	**Descriptors**	**Search term/key words**
Populations (P)	Nurses from a variety of clinical settings who have completed the PNA (Nurse) programme in England	"Professional Nurse Advocate" OR international Nurse OR Midwife AND Nurses (registered practitioners) & International nurses
Interventions (I)	Quality Improvements in clinical practice through the AEQUIP model of delivery	Quality Improvement methodology Needs Eligibility Criteria due to breadth of terms.
Comparison (C)	Samples, similarities, and differences between organisations before PNAs	Midwives and PMA programme Care improvements.
Outcomes (O)	Leading quality improvements in NHS care by Nurses	Pathway to Excellence nurse model: Shared decision making; local accreditation; meaningful staff recognition; distributed staff leadership; continuous quality improvement; research and innovation. Safety of care; Quality of care.
Context (C)	NHS settings only	Sample populations are Acute Hospitals, Mental Health Trusts, Primary Care PNA and PMA (midwife) programmes

Search Strategy

Three databases (CINAHL Ultimate, Medline and Emcare) were searched for the PNA and PMA literature using the strategy in Table 11 (see Appendix 12 and Appendix 13 for database specific searches for the PNA and PMA searches, respectively).

Table 11: PNA and PMA search strategy

PNA	PMA
("nurse advocates" OR "nurse advocate" OR "professional nurse advocate" OR “professional nurse advocates").	(Professional midwifery advocate OR professional midwife advocate OR (professional AND midwi* AND advocat*)).

Screening Process and Eligibility Criteria

Search results from the databases were uploaded to Rayyan web application (Ouzzani, Hammady, Fedorowicz, & Elmagarmid, 2016). Title, abstract and full text screening was conducted using Rayyan. Each reviewer screened using the ‘blind on’ facility until first screening was completed.

Eligibility criteria were established to guide the screening process as set out in Table 12.

Table 12: Eligibility criteria

PNAs/PMAs	From 2019 to present
Quality Improvement	Produced in English Language

Appendix 12. Rapid Scoping Search Strategy - Professional Nurse Advocates (PNA)

Emcare

Search date: 04/06/2024

Search	Term	Results
1	"nurse advocates".mp.	18
2	"nurse advocate".mp.	29
3	"professional nurse advocate".mp.	7
4	"professional nurse advocates".mp.	3
5	1 or 2 or 3 or 4	44
6	limit 5 to yr="2019 -Current"	**17**

Medline (Ovid)

Search date: 04/06/2024

Search	Term	Results
1	"professional nurse advocate".mp.	6
2	"professional nurse advocates".mp	3
3	"nurse advocate".mp.	37
4	"nurse advocates".mp.	22
5	1 or 2 or 3 or 4	55
6	limit 5 to yr="2019 - 2024"	**15**

CINAHL Ultimate

Search date: 05/06/2024

Search	Term	Results
1	professional nurse advocate	26
3	"professional nurse advocates"	12
4	"nurse advocate"	76
5	"nurse advocates"	111
6	S1 or s2 or s3 or s4	159
7	Limit from 2019 to current	**76**

Appendix 13. Rapid Scoping Search Strategy - Professional Midwifery Advocates (PMA)

CINAHL Ultimate

Search date: 16/07/2024

Search	Term	Results
1	Professional midwifery advocate or professional midwife advocate	30
3	professional AND midwi* AND advocat*	246
4	S1 OR S2	246
5	Limit from 2019 to current	**108**

Emcare

Search date: 16/07/2024

Search	Term	Results
1	"midwife advocates".mp.	0
2	(midwi* adj3 advocat*).mp	54
6	limit 2 to yr="2019 -Current"	**36**

Medline (Ovid)

Search date: 16/07/2024

Search	Term	Results
1	"professional midwi* advocate".mp.	0
2	(midwi* adj3 advocat*).mp	36
6	limit 2 to yr="2019 - Current"	**13**

Appendix 14. Abstracts of Included Review Papers

Horler, A.L. (2020) 'A report on a quality improvement initiative to increase midwives' confidence in attending home birth', ***British Journal of Midwifery*****, 28(4), pp. 260–267. doi:10.12968/bjom.2020.28.4.260.**

Abstract: Since the dissolvement of the 'supervisor of midwives' role, NHS England has introduced a new midwifery role: the professional midwifery advocate (PMA) via the advocating for education and quality improvement (A-EQUIP) model. The author undertook the long course PMA study, which is a six-month module. A requirement of the module was to implement a quality improvement project within the student PMA NHS Trust. As part of a wider project under the 'Better Births Maternity Transformation Programme' (2016) to increase the home birth rate for the trust, the author chose to implement a quality improvement project to improve the (shared) home birth equipment available to community midwives, aiming to increase midwives' confidence in attending home birth. Through the use of quality improvement tools and utilising a compassionate leadership model, the project aim was met: 75% of midwives reported they felt increased confidence in attending home birth with the new equipment offering.

Sharman, V.L., Gadher, A. and Shipperlee, F. (2025) 'Benefits and challenges of implementing the professional nurse advocate programme: a service evaluation', ***Mental Health Practice*****, 28(2), pp. 14–21. doi:10.7748/mhp.2024.e1721**.

Abstract: Why you should read this article: • To enhance your awareness of the professional nurse advocate (PNA) programme • To read about the introduction of the PNA programme at one mental health and learning disability trust • To learn about the benefits and challenges that PNAs may experience when delivering supervision. The professional nurse advocate (PNA) programme aims to equip nurses with the skills to provide restorative clinical supervision, thereby enabling then to support other staff members. This article details a service evaluation to determine the effects of introducing the PNA programme in a mental health and learning disability NHS trust. Data on the PNA supervision sessions were collected using trust records, supervisee evaluations and a PNA experience survey questionnaire. The evaluation found that the PNA sessions primarily supported staff well-being and retention. The PNAs found the experience of delivering supervision rewarding, but they expressed challenges such as having insufficient time to facilitate sessions and a lack of ongoing development. This suggests that protected time for supervisees and PNAs needs to be provided, and that it may be beneficial to establish a continuing professional development programme for PNAs.

Sterry, M. (2019) 'Midwives matter: developing a positive staff culture using restorative clinical supervision An evaluation of a professional midwifery advocate quality improvement project', ***MIDIRS Midwifery Digest*****, 29(2), pp. 162–166. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,sso&db=cul&AN=137589763&site=ehost-live (Accessed: 3 April 2025).**

Abstract: The two-year anniversary of the legislative change that heralded the cessation of statutory **supervision** of **midwifery** is approaching. The NHS England (2017) Advocating for Education and **Quality Improvement** (**A**-EQUIP) model has been developed to provide **a** framework for ongoing support, and the promotion of the continuous **improvement** for practising **midwives** that will ultimately impact on the delivery

of safer care and enhance the maternity experience for women (NHS England 2017). The **A**-EQUIP model is deployed through **professional midwifery advocates** (PMAs) who are performing **a** new leadership and advocacy role which is now becoming embedded into NHS organisations across England. Whilst university courses provide excellent preparation for PMAs, there has been no defined pathway guiding integration of their role into the existing maternity services and embedding the **A**-EQUIP model as mandate into the employing organisation. Trusts across England have developed their own strategies whilst NHS England, universities and regional peer networking have supported some consistency in implementation and promoted sharing of innovative examples of good practice (NHS England 2018).

Appendix 15. Overview of Initial Thematic Categories from Case Study Interviews

	Participant							
	1	2	3	4	5	6	7	8
Theme 1: Preparedness for QI Projects and Identifying Projects								
Subtheme 1.1: Ways of identifying QI Projects	x	x	x	x	x	x	x	x
Subtheme 1.2: Importance of Restorative Clinical Supervision (RCS) and Staff Wellbeing for QI	x	x	x	x	x	x	x	x
Subtheme 1.3: The PNA role and Responsibility for QI		x		x				x
Subtheme 1.4: Empowerment and Leadership for Engaging with QI	x	x	x			x	x	
Subtheme 1.5: Confidence to Engage with QI work	x	x	x	x	x	x	x	x
Subtheme 1.6: Challenges with PNA Training and Lack of Preparedness for Implementing QI	x	x	x	x	x	x	x	x
Subtheme 1.7: Awareness and Understanding about QI Methods and Models	x			x				x
Theme 2: Implementing QI Projects								
Subtheme 2.1: Support, Teamwork and Collaboration for Implementing QI Work	x	x	x	x	x	x	x	x
Subtheme 2.2: Visibility and Engagement of PNAs		x	x	x		x	x	
Subtheme 2.3: Time and Financial Barriers to QI work	x	x	x	x	x	x	x	x
Theme 3: Monitoring, Reporting and Disseminating QI Work								
Subtheme 3.1: Data Collection and Reporting	x	x	x	x	x	x	x	x
Subtheme 3.2: Logging QI Projects and Challenges With Reporting and Capturing QI	x		x	x	x		x	x
Subtheme 3.3: Importance of Qualitative Data	x	x		x	x	x	x	x
Subtheme 3.4: Demonstrating Success and Proving Worth for Business Cases	x		x	x		x	x	x
Subtheme 3.5: Dissemination and Communication	x	x	x	x	x	x	x	x
Theme 4: Impact and Reach of QI Projects								
Subtheme 4.1: Impact of QI work on Staff Wellbeing and Patient Outcomes	x	x	x	x	x	x	x	x
Subtheme 4.2: Reach and Transferability of QI Projects	x	x	x	x	x	x	x	x
Subtheme 4.3: Sustainability of QI Work	x	x	x	x	x	x	x	x

Appendix 16. Conference Programme

2nd National Conference – 13 November 2024

National Professional Nurse Advocate Conference

Inspire, Innovate and Impact

Conference Aims: are to showcase exemplar PNA quality improvement work to promote learning regarding the positive impacts on patient care; wider adoption for QI sustainability and longer-term impact of PNAs in the nursing workforce.

09:30 Arrival, Networking and Coffee

10:00 **Conference Opens:**

Welcome to Coventry and Centre for Care Excellence

Professor Rosie Kneafsey

10.10 National PNA Programme Update

Jacky Vincent, Director of Nursing – East Region and Interim PNA Lead: NHS England

10.30 **National Study Preliminary (incomplete) Findings –**

SUStAIN-ING: Impact of PNAs on Patient Outcomes through Quality Improvements

Professor Liz Lees-Deutsch and Dr Laura Wilde

Centre for Care Excellence and Centre for Healthcare Communities.

11.15 **Comfort, Networking and Poster Viewing**

11.45 The perceived impacts of becoming and being a PNA: A qualitative secondary analysis

Dr Wendy Walker and Dr Analisa Smythe

The Royal Wolverhampton NHS Trust

12.10 PhD PNA Studentship (NHS England) Early Ideas and Engagement

Bethany Hall - Coventry University

12.35 PNA Research Impact Accelerator (making research outcomes tangible)

Mr Nicolas Aldridge – Head of Research Delivery and Impact

University Hospitals Coventry and Warwickshire NHS Trust

13.00 **Concurrent Afternoon Workshops A and B**

Registration, Research, and Reminders

Dr Laura Wilde, Research Fellow, Centre for Healthcare Communities

13.15 **LUNCH, Networking and Poster Viewing**

14.15 **Choose Workshop A or B** *(Refreshments in rooms)*

Workshop A (Main room)	**Workshop B (Registered in advance in breakout room)**
14.15 Oral Presentations: QI Case Studies Facilitator: Dr Laura Wilde **14.20** Laura Newman **14.35** Sarah Squire and Alice Kershaw **14.50** Jenny Hunt and Kate Carney **15.05** Sophie Mayes **15.20** Final questions and thanks	**14:15** Research Workshop Toolkit Development: A facilitated engagement activity [round table] Facilitators: Professor Liz Lees-Deutsch and Professor Rosie Kneafsey **Back to main room**

15.30 Prize Giving – Coventry University and Certificates of Participation

15.45 **Closing Words:** Professor Liz Lees-Deutsch

Centre for Care Excellence and Centre for Healthcare Communities.

Appendix 17. Workshop Agenda

SuStAIN-ING: Supervision, Support, & Advocacy and Improvement in Nursing

November 13th 2024

Breakout Room

Conference Workshop Agenda - 2.30 – 3.30pm

2.30pm Introductions

The purpose of the workshop is: to share experiences and learning regarding wider adoption of ideas from QI work and how to sustain this work to create a Toolkit to support Quality Improvement (QI) work.

2.35pm Consent

We propose that core principles underpinning QI will be the main outcome, but the data may lead us differently. Our ground rule is to remain open-minded and to provide a safe space for data to evolve. We are adopting the principles of co-define, co-design and co-refine:

In this workshop we will seek your involvement to co-define the data for analysis to inform the Toolkit: QI training; support; tools and techniques, key success factors.

Organisation of the workshop activities:

1. There are four key questions
2. On each table you will see a question and flip chart paper for responses
3. Take the opportunity to have discussions and make notes onto flip charts
4. Each table activity will move around every 10 minutes

Following this workshop, we will seek your involvement in co-design and refining of the outputs by inviting feedback.

Very many thanks for your participation in this workshop.

Liz Lees Deutsch and Rosie Kneafsey

Coventry University

Appendix 18. Data from Conference Workshop – creating the QI Principles

Q1: Within the organisation that you work, what key support do you have to deliver quality improvement work as an individual PNA?

- Additional QI training from a QI team for all qualified PNAs.
- A QI resource pack is provided on SHAREPOINT for all qualified PNAs
- E-Learning package for Continuous Improvement methods.
- A PNA Roadmap
- Monthly quality improvement meetings/group meetings
- QI task and finish groups for PNAs
- Leadership – 1st and 2nd line.
- PNA Leads x3
- PNA Strategy and Communications
- Regional and National connections and access to support via these groups
- Clinical Psychologist access
- Role Recognition
- Knowledge, Skills and Confidence
- PNA forums/working groups/community of practice as a collaborative emotional support.
- Corporate Education Teams/Project Teams

Q2: In your organisation, what key methods, tools or techniques do PNAs use to deliver quality improvement work?

30. 60, 90 days model

Start with a good understanding of the problem using: themes from Datix, RCS and patient feedback* survey

- The 5 Whys
- QI Fundamentals
- NHS Improvement Model (LEAN, Six Sigma) x3
- UHCWi
- Linking with local hospital QI departments x2
- Action plans from existing complaints etc*
- Circles of Influence x3
- Fishbone Model
- 6 s model
- SWOT analysis
- PDSA model
- SMART
- Communication Matrix
- 7 step model with roadmap methodology
- Alignment with Trust Values
- Being clear on the problem before starting out *
- Encourage Identification of a QI team prior to commencing Qi work
- Using a Waste Cycle

- Reflective Practice
- Reflective cards

Q3: Within your organisation, what are the key success factors and barriers to delivering quality improvement work, either as individual PNAs or groups of PNAs?

Success Factors for QI	Barriers to delivery of QI
Leadership and understanding of QI. The leadership involves director level buy-in; line managers. It needs a positive and open culture to learning and improving	Time – with distinct barriers cited regarding study leave or time allocated on the duty rota which is not study leave but accepted as part of being a PNA
Needs access to QI training at site level	Rota's – the person doing the rota or having oversight of team needs to know who the PNAs are.
Protected time out of clinical work x6	No visible PNA lead
Space and time out x3	Unmanageable clinical workload and impossible to fit in being a PNA
Championing success with ideas given as (Newsletters, Intranet, celebrating project of the month).	Confidence and Skills to be a PNA and all that involves, especially straight after training – needs a transition period
Accepting and understanding feedback on the work completed	Funding for PNAs for ongoing training to develop the role and sophistication of QI work
Confidence supported by education after training to support and sustain skills.	Poor quality of information reported upwards through the organisation
Dissemination of the knowledge gained	Lack of feedback on own work and that of others x2
Good stakeholder engagement	Too much emphasis on starting projects which are fledgling and not likely to be successful (x2)
PNA leads who are the Champions	
QI teams at site level must support PNAs to deliver	
Buddies who support us after training x3 repeated statement	
Planning for QI at ward level – all staff should be involved and priorities decided together as a team	
Oversight of all projects and the stage they are at would greatly help to motivate a starting point.	
Writing up projects would help us to share these with others	Poor training is a key factor because work doesn't start up quickly and is often halted quickly

Transitionary support after PNA programme. PNA programme leaves everything up in the air otherwise.	

Q4: What training have you received to undertake QI work and was this part of the PNA programme?

Training as part of programme	Since the programme
2 self-directed sessions only as part of the programme	
Completed PNA course in 2021 –	none offered since this.
2 lectures only as part of PNA Programme	
	Became part of QI forums after the training.
Very little and the projects were made up.	QI fundamentals as part of the CNO research fellowship
It wasn't linked to reality.	Joined a Qi improvement hub
Describe as light touch, overview only – nothing specific.	QI department and linked up with QI work
We need to raise the bar of training to deliver on the expectation of delivering QI	QI practitioner training
E-learning only – rushed through	Change management programme
E-Learning module only	Project management training

A fifth and final supplemental question was asked based on the discussions in the room:

Q5. If you could rewind time and advise what is needed to change the QI aspect of the PNA role what would you advise is done differently?

Standardisation of training across HEIs would make it easier to understand the baseline knowledge each PNA should have and to support educational needs.

National PNA competencies for after return from PNA programme – with a time limitation to complete these – proficiency test

To enable a transition period of time after completion of QI training and return to practice to get to know staff, understand issues, decide priorities, share these, create a feedback loop and to incentivise changes made.

A welcome pack in each organisation which stated QI networks and support available

To commence QI work as soon as qualified by buddying with QI fellow/department

Recognition that this work takes time out of a clinical role. RCS with nurses identifies issues, but it does not include time to do QI work.

I would ask for training in the practical application in the principles of QI in practice.

PNA training in QI should be delivered as an Action Learning Group

Provide examples of previous work either to critique on the course or to build on in practice

Ensure senior nurses are educated within leadership teams regarding the art of possible

Communicate with the corporate nursing team to achieve buy into the work and for this to go forward.

Data Familiarisation

The process of understanding the data began with identification of commonalities from each question asked, noted here:

Question 1: Within the organisation that you work, what key support do you have to deliver quality improvement work as an individual PNA?
PNA leads were identified by all three groups
Improvement meetings or groups or PNA forums with focus on QI
Question 2: In your organisation, what key methods, tools or techniques do PNAs use to deliver quality improvement work?
To have a good understanding of the problem (s) before embarking on QI – the planning phase is very important
To establish early links with quality improvement departments for support
Understand the methods of doing QI
To take existing action plans aligned with Trust values to guide core areas of work
Question 3: Within your organisation, what are the key success factors and barriers to delivering quality improvement work, either as individual PNAs or groups of PNAs?
Recognition of the entirety of the PNA role at ward level and using this to enable time on the rota to deliver effective QI work
Leadership at PNA level and above endorsement from director level buy into the PNA work.
Oversight and dissemination of existing QI work across an organisation is needed
Transitionary support into practice as a PNA is needed at Organisation level
Engaging nurses following RCS to understand their experiences of care delivery – QI is not a separate process to RCS.
QI work needs to be staged to understand where to focus efforts in developing Qi work – work is sometimes tackled prematurely and not completed.
Question 4: What training have you received to undertake QI work and was this part of the PNA programme?
In general, poor training was identified by the workshop participants in a variety of forms from E-Learning to self-directed learning and light touch. Participants felt unprepared to move ahead once back in practice
Since the programme participants have undertaken a variety of training opportunities: change management, project management and Qi training.

Appendix 19. Case Examples Summary Table

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
Case 1 - Mental health/ community NHS trust	**Objective**: Improve recruitment and retention, reduce sickness levels, and enhance staff satisfaction. **Method**: Fortnightly Restorative Clinical Supervision (RCS) sessions conducted via MS Teams due to the remote team structure. **Participants**: The team included health professionals working in criminal justice settings, management, and non-clinical staff.	Used the **Stability Index** to measure team stability. Monitored **Recruitment and Retention Data** to assess improvements. **Tracked sickness Data** to evaluate the impact on staff health. **Feedback** and case studies.	**Plan-Do-Study-Act (PDSA)** to implement and refine the RCS sessions.	**Patient Outcomes**: Improved team cohesion led to fewer gaps in clinical cover, more time for professional development, and safer patient care. **Staff Outcomes**: Increased staff satisfaction, more out-of-work team events, successful recruitments, and better induction	**Team Culture**: Consistent effort is needed to maintain a positive team culture, especially for remote teams. **Inclusivity**: Including all staff groups in RCS sessions fosters openness and transparency. **Sickness Reduction**: Regular, well-attended RCS sessions significantly reduce work-	**Remote Delivery**: Lessons learned about delivering RCS in a virtual setting, including the importance of managing the space to avoid negativity while allowing honest sharing. **Publication**: The work has not been published yet, but there are plans to explore this.

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
				periods. Staff felt more empowered and reported less "incivil" behaviour in meetings.	related stress and sickness.	
Case 2 - Mental Health and Learning Disabilities	**Objective**: Implement the Professional Nurse Advocate (PNA) programme to support staff and improve patient care. **Start Date**: March 2024. **Challenges**: Initially, only 3 out of 18 trained PNAs were practicing	**Session Delivery**: Increase in the number of PNA sessions delivered. **Qualified PNAs**: Increase in the number of qualified PNAs. **Progress Towards 1:20 Ratio**: Improvement in achieving the target ratio of PNAs to staff.	**Plan Do Study Act (PDSA)** to consider how to effectively embed the PNA programme	**Patient Outcomes**: Indirect improvements in patient care due to staff feeling valued and supported, leading to better skilled and confident staff. **Staff Outcomes**: Positive feedback from staff who	**Momentum**: Maintain momentum when developing and promoting a service. **Purpose**: Clearly communicate the purpose of the model to ensure understanding and support. **Engagement**: Use influence to engage senior	**Policy Sharing**: PNA policy shared on NHS futures platform. **Evaluation Process**: Referral and evaluation process can be shared. **PDSA Model**: Example of how the PDSA model worked for this QI project.

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
	regularly, highlighting the need for a strategic approach. **Method**: A PNA lead was appointed, and a strategic plan using the Plan-Do-Study-Act (PDSA) model was developed to embed the PNA programme.			accessed the PNA service, reporting increased confidence, support in career progression, and feeling valued.	leaders and gain organisational buy-in. **Data Collection**: Collect both soft and hard data to demonstrate impact. **Patience**: Be patient as projects take time and may not always go as planned.	**Publication**: The work has not been published yet.
Case 3 - Primary Care	**Objective**: Implement the Professional Nurse Advocate (PNA) service in GP surgeries within Northamptonshire. **Start Date**: Georgina Callard	**Feedback Forms**: Collect data via feedback forms to evaluate the impact of the PNA service.	**Kotters 8-step model**[a] was used to introduce the service. The **PDSA model** was and is used 6-monthly for the Lead Nurse	**Patient Outcomes**: Though not yet measured, indirect improvements in patient care as staff feel better equipped to	**Diverse Methods**: Utilise various methods to connect with people effectively in a non-hospital trust environment	**Resource Sharing**: Encourage sharing of resources, such as templates for policies, to help lead nurses work smarter.

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
	was the first to qualify as a PNA in Northamptonshire primary care. **Method**: The Training Hub offered one day a week to implement the service. A Roadshow was organised to visit each of the 69 GP surgeries in the county, presenting hampers to nursing teams and promoting the PNA service.		Steering Group (LNSG) to reflect and plan forward.	work with patients, enhancing the quality of care. **Staff Outcomes**: Positive feedback from staff who accessed the PNA service, reporting feeling supported, less isolated, and better equipped to handle work-related stress.	with a wide geographical reach. **Continuous Evaluation**: Continuously evaluate and revise work and outcomes, even if formal data collection is challenging.	**Microsoft Teams Group**: Set up a group with folders to share useful resources accessible to everyone. **Publication**: The work has been shared at Best Practice Shows in 2024 (London and Birmingham) and featured in the Independent Nurse magazine.
Case 4 - Community health care provider	**Objective**: Ensure consistency and high quality of care in catheter management for	**Data Collection**: Working with the performance team to build codes in the online record system to collate data.	**Fishbone diagram** and **stakeholder mapping**	**Patient Outcomes**: Not fully implemented yet, but initial patient visits	**Data Reporting**: Lack of data reporting on catheter care has been a significant challenge.	**PNA/Staff and Patient Visits**: These reflections have been useful in identifying challenges and

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
	all patients using trust services. **Start Date**: Summer 2024. **Reason**: Concerns raised from patient safety reports of safety incidents and patient deaths related to catheter care. **Method**: The project team, including two PNAs and a QI lead, conducted stakeholder mapping, patient observations, and gathered patient stories to identify challenges in catheter care.	**Patient Stories**: Obtained through PNA observations with staff. **Monitoring**: Patient compliments/complaints, data on infections, and catheter prescriptions.		allowed nurses to reflect and review patient care holistically. **Staff Outcomes**: Staff were involved in every step of the project, leading to a sense of ownership and engagement.	**QI vs. Transformation Projects**: QI projects require full staff engagement and a slower, more thorough approach compared to transformation projects. **Project Impact**: The project could impact approximately 1500 patients in community care services.	could be beneficial for other QI projects. **Publication**: The project is ongoing and has not been published yet.

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
Case 5 – NHS Foundation Trust	**Objective**: Enhance teaching, learning, and sharing among staff in Critical Care based on feedback from Professional Nurse Advocate (PNA) sessions. Implementing weekly Multi-Disciplinary Team (MDT) enabled a collaborative approach to teaching and learning. **Start Date**: Weekly Multi-Disciplinary Team (MDT) meetings commenced in September 2024.	**Data Collection**: Topics to explore in the sessions were gathered using MS Forms before and after the implementation of the MDT sessions. **Qualitative Feedback**: Feedback was also captured verbally during sessions. Suggestions and ideas were collected to improve and expand the sessions.	**Plan-Do-Study-Act (PDSA) a**pplied to expand the audience of staff within the MDT. **A-EQUIP Model** used to focus on quality improvement.	**Patient Outcomes**: Indirectly improved patient safety, care, and experience by enhancing staff knowledge and collaborative practices. **Staff Outcomes**: Defined roles and responsibilities within the MDT, regular learning opportunities, and increased collaboration.	**Forum Development**: Develop a forum for teaching, learning, and sharing among MDT members in Critical Care. **Knowledge Expansion**: Enhance skills and practices of the MDT through collaborative learning.	**Structured Schedule**: Implement a routine and structured delivery of sessions. **Collaborative Approach**: Foster openness and collaboration in learning and sharing on the unit. **Publication**: Plans to share at the Chief Executive's QI Meeting and with the PNA and Staff Health & Wellbeing Team in Critical Care. Developing an A3

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
	Method: Implement weekly MDT meetings where all members can deliver and attend sessions, fostering collaboration and teamwork.					poster based on PNA feedback.
Case 6 - Acute Hospital Trust	**Objective**: Combine the Professional Nurse Advocate (PNA) role and Patient Safety Incident Response Framework (PSIRF) to create a proactive learning culture aimed at reducing patient safety incidents. **Start Date**: The Ward Incident and	**Incident Reporting Data**: Used to identify themes and trends, generating topics for sessions. Data is revisited monthly to assess reductions in incidents and report on learning opportunities. **Staff Engagement**: 188 staff members engaged over twelve months, with 99% recommending the sessions to colleagues.	**Plan-Do-Study-Act (PDSA)**: Initial cycle completed, demonstrating the effectiveness of WILF. Entering the second cycle to improve staff engagement and sustainability.	**Patient Outcomes**: Indirect improvements in patient care and safety, recognised by a local coroner as a positive learning opportunity. **Staff Outcomes**: Increased staff engagement, with 20% stating	**Coverage of Staff**: Expand access to ensure those working nights or weekends can benefit. **Sustainability**: Demonstrate sustained post-session data and reductions in incidents before expanding across the trust.	**Multi-Disciplinary Team (MDT) Engagement**: Open to all staff across the orthopaedic surgical hub, fostering greater depth of discussion and shared strategies. **Flexible Delivery**: Adaptable to different areas,

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
	Learning Forum (WILF) sessions began in 2024. **Method**: Two one-hour group sessions per month using Restorative Clinical Supervision, focusing on incident reports, PSIRF incidents, after-action reviews, and staff concerns.			it directly impacts patient care, 20% assisting others, and 60% noting other improvements in practice.	**Adaptability**: Implement more flexible sessions, including "hot debrief" styles for significant issues.	sites, and trusts based on priorities and structures. **Collaborative Working**: Showcases the implementation of two national strategies (PNA and PSIRF). **Publication**: Presented at various conferences and meetings, including the National PNA Conference and the RCN Education Forum. Currently being written up for publication as a

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
						Service Evaluation.
Case 7 - NHS Acute Hospital Trust	**Objective**: Introduce Professional Nurse Advocates (PNAs) to improve staff morale, engagement, professional resilience, career development, and quality improvement. **Start Date**: The initiative was launched in August 2022. **Reason**: Project was prompted by a significant decline in staff engagement and morale revealed in	**Staff Morale and Engagement**: Improved since 2022 The "**Wellbeing Week" Project** showed 99% of staff feel value, and 97% believe PNA can improve staff retention.	**Kotter's 8 Stage Change Management Model**[a] was used to launch and implement the service. **PDSA Cycle and SWOT Analysis** was applied during each stage, especially for sustainability. **John Fisher's Transitional Curve** was used to analyse and support staff behaviour throughout the	**Patient Outcomes**: Improved staff wellbeing directly affects staffing, retention, and reduces sickness, positively impacting patient experience. **Staff Outcomes**: Improved staff survey results. Enhanced professional development across the organisation.	**Staff Feedback**: Essential and always needs to be acknowledged. **Internal Network and Stakeholder Involvement**: Crucial for implementation and sustainability. **Communication and Buy-In from Senior Leadership Team (SLT)**: Important for success.	**Wellbeing Initiatives**: Should be based on identified gaps and aligned with the Trust Vision. **Stakeholder Support**: Significant for implementation and sustainability. **Publication**: The work has not been published yet.

Case Study Number and Type of Organisation	Overview of Quality Improvement Work	Key Measures of Success	Key Quality Improvement Methods	Outcomes	Key Learning Points	Transferability
	a 2020 staff survey, attributed to pressures faced during the COVID-19 pandemic. **Stakeholders** included the whole team of 32 PNAs, Health and Wellbeing team, 6 Freedom to Speak Up Guardians, Library services, the "Here for You" initiative and Nursing staff within the organisation.		change management.	Empowerment among internationally recruited nurses.		

Appendix 20. Conference Press Release

Coventry University Hosts 2nd National Professional Nurse Advocate (PNA) Conference

Coventry University recently welcomed nurses, healthcare professionals and researchers from across England to the 2nd National Professional Nurse Advocate (PNA) Conference, 2024. The event showcased the SUSTAIN-ING Research, which aims to understand how PNAs working on quality improvement projects can positively impact patient care outcomes and experience.

The conference, held on Wednesday 13th November 2024, featured a range of presentations and workshops highlighting the positive changes PNAs are making within the NHS. Key speakers included Professor Liz Lees-Deutsch, Professor Rosie Kneafsey and Dr Laura Wilde from Coventry University's Centre for Healthcare and Communities, who shared early findings from the national study, showing promising impacts on patient outcomes.

Jacky Vincent, Director of Nursing for the East Region and Interim PNA Lead for NHS England, opened the conference with an update on the National PNA Programme. Later in the day, Dr Analisa Smythe from The Royal Wolverhampton NHS Trust shared insights from her research on the perceived impact of becoming a PNA. Bethany Hall, a PhD student from Coventry University, also presented her plans and hopes for her research, funded by NHS England. Her study investigates the cultural dimensions and their influence on developing and implementing QI work. Another thought-provoking session was delivered by Mr Nicolas Aldridge, Head of Research Delivery and Impact at University Hospitals Coventry and Warwickshire NHS Trust, who spoke about how PNA outcomes can be made tangible through the Research Impact Accelerator work.

One of the event's highlights was the presentation of prizes. The prize for best presentation went to Laura Newman, from Liverpool Heart & Chest Hospital, presenting "Health and Wellbeing in Critical Care - Utilising the PNA Role". The best poster prize was awarded to Tina Kitcher, Liverpool John Moores University and The Royal Marsden NHS Foundation Trust presenting "Introducing Restorative Clinical Supervision for Theatres and Quality Improvement Project". These prizes recognised the outstanding and innovative quality improvement projects by PNAs.

In addition to the presentations, the day featured a research workshop, an interactive session designed to help nurses drive lasting change in their workplaces.

"A brilliant, well-organised and interesting conference that I thoroughly enjoyed. I felt inspired by all the presenters and posters at the conference and motivated for the future." (Conference attendee)

A national report on the SUSTAIN-ING study, summarising the research findings and recommendations, is expected to be published in March 2025. Other key outputs from this work include a Compendium of Case Studies to be hosted on NHS England, Futures Platform and a Set of Principles in Practice for undertaking Quality Improvement work.

Coventry University is proud to host such an inspiring event, showcasing the vital role PNAs play in improving patient care across the country.