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Professional nurse advocates and restorative clinical supervision: national survey of programme implementation and impact

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Abstract

Background In 2021, a new national Programme of clinical nurse leadership, called the Professional Nurse Advocate Programme, was launched across the National Health Service of England. The primary aim was to support nurse wellbeing and resilience in the aftermath of Covid-19 pandemic. Trained nurse advocates offered restorative clinical supervision sessions to nurses, career conversations through the Advocating and Educating for Quality Improvement model, aiming to sustain their motivation at work through improved wellbeing. This paper evaluates the national Programme delivered across England.

Methods Cross-sectional questionnaire, underpinned by Laschinger's model of empowerment, distributed across England in 2022. This explored the effectiveness and impact of Restorative Clinical Supervision on nurse empowerment, and personal effectiveness. The questionnaire sections included demographics and 14 questions to understand restorative clinical supervision in practice; respondents' abilities to fulfil PNA roles and responsibilities; and four open text questions. Demographic data were analysed using descriptive statistics. Open text responses were coded to generate themes.

Results There were 302 questionnaire responses from nurses receiving restorative clinical supervision $n=73$, Professional Nurse Advocates $n=214$ and leads $n=15$, most were female and identified as 'white' ethnicity. Restorative clinical supervision was rated very positively, enhancing structural and psychological empowerment. Three primary themes were identified from open-ended questions; (i) Conditions necessary for restorative supervision; (ii) Nurse engagement and organisational commitment to restorative supervision and (iii) Reinvigoration from supervision.

Conclusion We established that the professional clinical leadership role of the nurse advocates offers individual support through reflective practice and strategies to address resilience. Spaces of safety and adequate time are reported as fundamental to delivering the advocate role, plus time for nurses to be released from clinical duties to participate in restorative supervision. Since the roll out of the Programme 10,933 training places have been funded, representing significant investment. 78,187 restorative clinical supervision sessions; 49,595 career conversations and 2,541 Quality Improvement projects were underway in October 2024. This is the first national evaluation of the

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Programme and findings indicate its potential to address underlying global nursing concerns linked to workforce attrition, wellbeing in the workplace, retention, and recognition of nurse impact.

Public or Patient Contribution Not applicable.

Clinical trial number Not applicable.

Mesh Terms Resilience-Psychological, Quality improvement, Leadership

Keywords Nursing, Professional nurse advocate, Clinical supervision, Workplace empowerment, Wellbeing

Introduction

Attracting new nurses, and preserving an already fragile nursing workforce is a world-wide challenge. In an international review [1] 'intention to stay' was depicted through a theoretical framework of protective factors; environmental, relational, and individual. Within these factors workplace culture, leadership, moral distress, and resilience were identified as key issues affecting the nursing workforce, across different generations, in many countries. Whilst the Covid–19 pandemic added an emotionally charged complexity to nursing care delivery globally and stretched the capacity of the nursing workforce [2]. The Professional Nurse Advocate (PNA) Programme was initiated in the UK to counter this, and to empower nurses, engender professional pride and promote workforce wellbeing and retention [3–5].

Clinical Supervision as a mechanism of support for nurses and midwives in practice predates the PNA Programme by nearly 30 years; however, this received relatively poor uptake except mental health settings [6]. Different approaches were developed for different settings (individual, group), yet difficulties persisted in implementing clinical supervision cited as lack of time, work pressures and inadequate preparation of supervisors in the skills required [7]. Despite the supportive and reflective possibilities through clinical supervision this has remained underused as a resource to support nurses and midwives. Butterworth [7] states the PNA programme offers possibilities for 'more refined and refreshed supervision provision'(p, 20). The proliferation of recent literature focusing on developing individual resilience in nursing in the face of very stressful work conditions indicates this is not a new issue, but one magnified globally by nurse recruitment and retention issues [1, 8, 9].

Professional resilience relates to individual strategies used by nurses to emotionally regulate throughout their daily work [10]. Nevertheless, workplace factors that bolster resilience are influenced beyond the individual remit, extending to environment and organisational levels [1]. Coping mechanisms for work-based stress range from setting personal and professional boundaries, being flexible and adaptable to team needs, and determining overall work commitment. [11] Moreover, Hart et al. [11] asserted that self-beliefs regarding 'professional effectiveness' led to greater nurse empowerment and resilience in the workplace.

Within mental health nursing and the police force the 'promoting adult resilience' programme has been applied to address work-based stress and resilience, involving facilitated group discussions [12]. Early evaluations found that attendees learnt from each other while discussing their experiences and improvements in the ability to self-regulate were reported. Professional responsibility was also emphasised as part of the programme through clinical supervision [10]. Hart et al. [11]identified that nurses who actively sought trusted mentor debriefing sessions experienced improved resilience at work. The need to 'organise work for resilience' was an important factor enabling nurses to take greater control and increase personal autonomy, decision making and overall satisfaction at work [13].

Throughout the literature, 'empowerment' is identified as key to the development of resilience at work and nurse wellbeing [1, 9, 11]. Laschinger's empowerment model [14] illuminates necessary connections between organisational structures and psychological empowerment, to elicit positive work feelings and aids understanding of workplace empowerment. In 2021, a new programme of clinical nurse leadership, called the PNA Programme, was launched and rolled across the National Health Service (NHS) of England, designed primarily to support nurse wellbeing and resilience. As the first national initiative of its kind, a PNA Programme evaluation was commissioned by NHS England and undertaken between 2022 and 23, over a nine-month period by a research team from Coventry University. This paper reports the outcomes from a survey-based evaluation regarding the impact of the PNA Programme on nurses in PNA roles, and those nurses receiving support from a PNA.

The professional nurse advocate programme

The PNA Programme is a nurse-specific clinical professional leadership programme delivered at level 7 by Higher Education Institutions (HEI) in England. It was introduced within the NHS at a critical point in the post Covid-19 recovery of the NHS and its workforce [7]. Programme roll out (Fig. 1) started with registered nurses working in critical care and mental health [13] with the aim of supporting nurse wellbeing and resilience

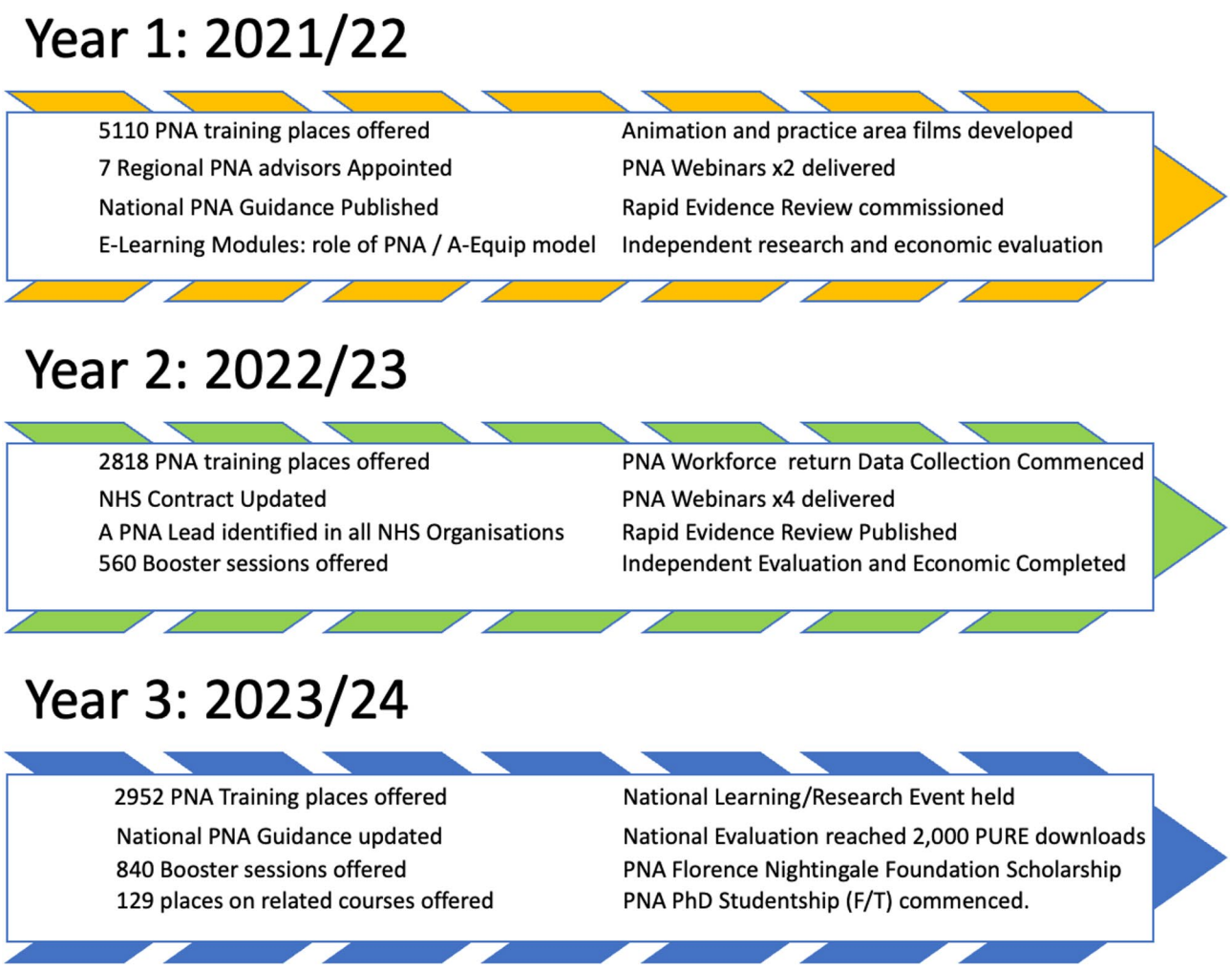

Fig. 1 Roll Out of the professional nurse advocate programme over 3 years. F/T = Full Time

to ensure the delivery of high quality, compassionate, effective care [7, 15]. The Programme itself has been designed to equip registered nurses with skills to deliver Restorative Clinical Supervision (RCS), offer career conversations and through quality improvement activities, improve patient care [16, 17]. A PNA must be a registered nurse in a front facing clinical role, experienced in the NHS at band 5 (junior registered nurse) or above and supported by a line manager, to enable release of time to undertake the PNA role in practice.

The PNA role is underpinned by the A-EQUIP model (Advocating and Educating for Quality Improvement), which comprises three traditional functions of clinical supervision [17]. These functions are *Normative*: - monitoring, management, and evaluation aspects in nursing; *Formative*: - educational aspects: developing knowledge and skills in professional development and self-reflection; and *Restorative*: - supporting the emotional needs of the workforce, to reduce stress, promote self-reflection and action [19]. Bowles and Young [21] stated "nurses greatly benefit from clinical supervision from each of the[se] three functions" and that the model provides a framework for using clinical supervision "to change and critically examine nursing practice". One further function was added by NHS England to the PNA Programme and differentiates it from the A-EQUIP model, namely the delivery of continuous quality improvement (QI) to improve patient care [20].

Specific education standards developed by the Royal College of Nursing [18] (Fig. 2) now underpin the Level 7 PNA Programme education content. These are aligned to the five core standards for education and training from the Nursing and Midwifery Council (NMC) [23]. The collective aim of A-EQUIP within the PNA education is to ensure QI becomes embedded in every nurse's role and gradually enables connections across all functions to contribute to improving nurse-sensitive quality indicators used by organisations [9, 17, 22].

1. Selection, Admission and Progression
2. Facilitating Clinical Supervision Using a Restorative Approach
3. Enabling Nurses to Undertake Personal Action for Quality Improvement
4. Requirements of Educators and Assessors
5. Outcome Requirements for Curricula and Assessment

Fig. 2 Core standards for PNA education (Royal College of Nursing, 2023)

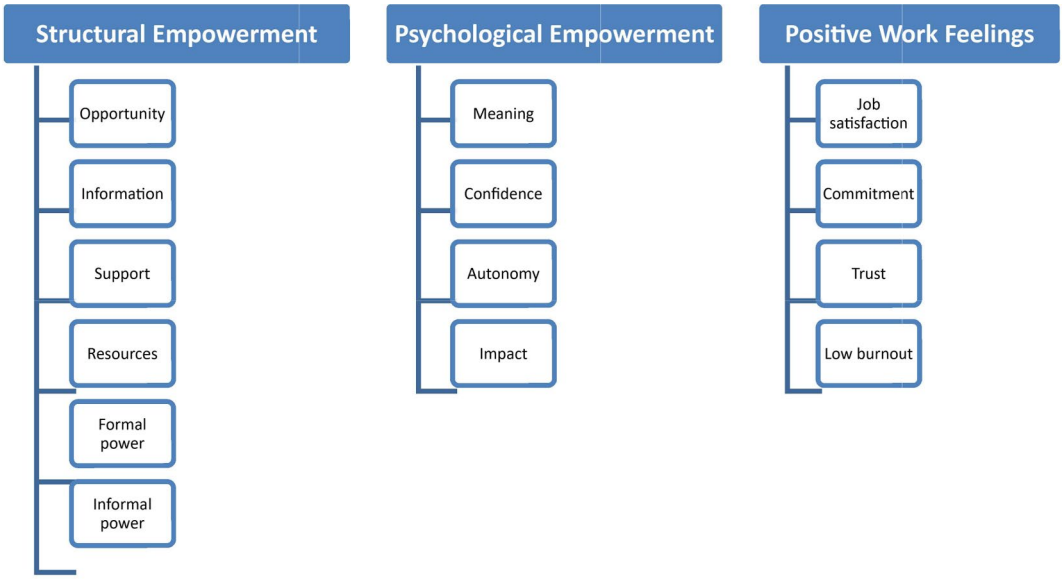

Fig. 3 Laschinger's Model of Empowerment [14]

Methods

Study design

Empowerment theory [14] provided structure to the development of a national cross-sectional questionnaire survey [Supplementary Information File 1]. A multidisciplinary research team undertook this survey study, supported by a clinical advisor. The study received ethical approval from Coventry University, approval number P139411 on 22nd August 2022. Reporting adheres to the Sharma et al. [24] CROSS guidelines for Surveys.

Setting and participants

The survey was aimed at nurses working in NHS settings in England, across three groups: nurses who received RCS (referred to as 'RCS nurses'); nurses in the role of a PNA ('PNAs'); and nurses with responsibility for delivery of the PNA role within their healthcare organisations ('PNA Leads').

Methods of recruitment

Invitations to participate in the survey were distributed by NHS England via their email distribution lists to the three constituent target groups, creating a convenience sample. Study information, privacy notice, and explicit informed consent was integrated into the survey. Participants were unable to progress to the main survey without confirming consent. Responses were completely anonymous. A quick response (QR) code to access the survey was also advertised during an online webinar hosted by NHS England.

Development of tools

The survey was distributed via the Joint Information Systems Committee (JISC) online surveys using an account accessible only by the researcher leading on the survey administration (SP). A formal sample size calculation was not conducted as the likely variability in response data was unknown. Laschinger's Model [14] (Fig. 3) guided identification of relevant topics, research questions and survey items to enable exploration of structural and psychological empowerment and indicators of positive work feelings. The survey was developed, piloted and revised with commissioners, and opened between 31st August 2022 and 12th December 2022 [Supplementary Information File 1].

The survey explored the following characteristics;

i) **Demographic** information: region of England and field of nursing in which respondents worked; age, gender, ethnicity and disability; and time since completion of their nurse education, and whether nurse education was conducted outside the United Kingdom (UK). Answers to all questions were required, although 'Prefer not to say' and 'Other' options were provided where appropriate;
ii) **Impact of RCS on nurse empowerment** with questions constructed to address the 14 items and 3 domains of the Laschinger et al. model [14] (Fig. 3). Respondents were required to state their level of agreement to a positively worded statement related to each of the 14 items using a 6-item Likert scale, ranging from 'Strongly agree' to 'Strongly disagree'.
iii) **Effectiveness of RCS** in helping to improve the safety of patient care delivery; the ability to make changes to care delivery; networking with others; the influence nurses have in their practice; and the leadership of quality improvement. An overall rating of the effectiveness of RCS was captured in the final question which asked respondents to indicate their level of agreement with the statement *"I believe that restorative clinical supervision is effective"*, using the same 6-item Likert scale as before.
iv) **Benefits of RCS** via four open text response questions: (1) *"What are the main benefits of RCS?"*; (2) *"What could be improved about RCS?"*; (3) *"How can these improvements be implemented?"*; and (4) *"How effective are you in meeting PNA roles & responsibilities?"*. Questions here were based on published statements about roles and responsibilities relevant to the three groups - nurses who had received RCS, PNAs and PNA leads.

A final optional text box allowed for any other comments and for respondents to add contact details if they were happy to be contacted by the evaluation team.

Data analysis

Demographic data were analysed and reported as total numbers and proportions for each group. Demographic data was used to check for potential multiple entries by participant but none were identified. Likert scale items were converted to numbers for the purpose of analysis, as follows: 6 = Strongly agree, 5 = Moderately agree, 4 = Slightly agree, 3 = Slightly disagree, 2 = Moderately disagree, 1 = Strongly disagree. These were treated as ordinal scale data and median (interquartile range, IQR) values were used to summarise responses for each group. Quantitative analyses were conducted using IBM SPSS Statistics 27. There were no missing data as all data fields were compulsory.

Open text responses from the three questions were thematically analysed for RCS nurses, PNAs and PNA Leads. Most data comprised short statements. Data were extracted into a Microsoft Word document, with identifiable information removed, and data familiarised. Each response was open coded and characteristics for each response made to a coding book form and descriptions. Themes were compared between RCS nurses, PNAs and PNA Lead data, enabling identification of connections or divergence. Member review of themes was conducted and data synthesis guided by the emergent data characteristics to form overarching themes.

Results

There were 302 survey responses (RCS nurses $n = 73$, PNAs $n = 214$, PNA leads $n = 15$), see Table 1 for respondent demographics (pages 29–31). Initially the RCS nurses proved to be the most difficult to recruit. There was representation from different English regions, and most respondents worked in adult nursing. There was a greater proportion of RCS nurses in the younger age categories, compared to PNAs and PNA leads, although the proportions in the 50–60 years of age category were similar across all three groups. Respondents were predominantly female and mainly identified as 'white' ethnicity. RCS nurse respondents were more ethnically diverse than PNAs and PNA leads. Those declaring disability were similar across the three groups. PNA leads and PNAs tended to be longer qualified and more likely to be UK educated than RCS nurses. None of the PNA leads reported a nurse education outside of the UK.

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

The median figures in Tables 2, 3, 4 and 5 should be interpreted as follows: 6 strongly agree, 5 moderately agree, 4 slightly agree, 3 slightly disagree, 2 moderately disagree and 1 strongly disagree.

Table 2 presents data reflecting nurses' perceptions of the impact of RCS on nurse empowerment and 'other', detailing the median (IQR) ratings for each question. This illustrates very positive ratings across all components and for all three staff groups, with a median rating of 'moderately agree' for almost all statements. The ability of RCS to improve the support available to nurses at work was rated as 'strongly agree' by all three groups. PNA leads also rated the ability of RCS to improve the confidence nurses have in their roles as 'strongly agree'. The only median rating of 'slightly agree' was by PNAs for the ability of RCS to improve the opportunities available

Table 1 Demographic characteristics of survey respondents

Survey items		RCS nurses (*n* = 73)	PNAs (*n* = 214)	PNA Leads (*n* = 15)
In which of the following regions do you work?	East of England	5 (6.8%)	32 (15.0%)	1 (6.7%)
	London	9 (12.3%)	17 (7.9%)	3 (20.0%)
	Midlands	5 (6.8%)	32 (15.0%)	3 (20.0%)
	North East & Yorkshire	23 (31.5%)	40 (18.7%)	2 (13.3%)
	North West	4 (5.5%)	25 (11.7%)	3 (20.0%)
	South East	14 (19.2%)	26 (12.1%)	2 (13.3%)
	South West	13 (17.8%)	41 (19.2%)	1 (6.7%)
	Prefer not to say	0	1 (0.5%)	0
In which field of nursing practice do you work?	Adults	58 (79.5%)	154 (72.0%)	10 (66.7%)
	Children	7 (9.6%)	27 (12.6%)	2 (13.3%)
	Learning Disabilities	1 (1.4%)	4 (1.9%)	0
	Mental Health	7 (9.6%)	26 (12.1%)	3 (20.0%)
	Prefer not to say	0	3 (1.4%)	0
What is your age?	Under 20 years	0	0	0
	20–29 years	16 (21.9%)	17 (7.9%)	0
	30–39 years	27 (37%)	57 (26.6%)	2 (13.3%)
	40–49 years	4 (5.5%)	80 (37.4%)	8 (53.3%)
	50–60 years	24 (32.9%)	54 (25.2%)	5 (33.3%)
	Over 60 years	2 (2.7%)	5 (2.3%)	0
	Prefer not to say	0	1 (0.5%)	0
What is your gender?	Male	8 (11.0%)	21 (9.8%)	1 (6.7%)
	Female	64 (87.7%)	191 (89.3%)	14 (93.3%)
	Prefer not to say	1 (1.4%)	2 (0.9%)	0
	Other	0	0	0
What ethnic group do you identify as?	Asian/Asian British	16 (21.9%)	17 (7.9%)	1 (6.7%)
	Black/African/Caribbean/Black British	7 (9.6%)	9 (4.2%)	0
	Mixed/Multiple ethnic groups	1 (1.4%)	3 (1.4%)	0
	White	48 (65.8%)	175 (81.8%)	14 (93.3%)
	Prefer not to say	1 (1.4%)	3 (1.4%)	0
	Other	0	7 (3.3%)	0
Do you consider yourself to have a seen or unseen disability?	Yes	3 (4.1%)	21 (9.8%)	2 (13.3%)
	No	65 (89.0%)	191 (89.3%)	13 (86.7%)
	Prefer not to say	5 (6.8%)	2 (0.9%)	0
If yes, how would you describe your disability or impairment? *	Developmental	0	0	0
	Learning	1	3	0
	Mental health	1	5	0
	Physical	1	5	1
	Sensory	0	1	1
	Neurodiverse	0	3	0
	Not applicable	6	25	2
	Prefer not to say	3	2	0
	Other	0	2	0
How many years ago did you complete your nurse education?	Less than 1 year	3 (4.1%)	3 (1.4%)	0
	1–5 years	15 (20.5%)	24 (11.2%)	0
	6–10 years	16 (21.9%)	29 (13.6%)	0
	11–15 years	11 (15.1%)	36 (16.8%)	1 (6.7%)
	16–20 years	9 (12.3%)	27 (12.6%)	4 (26.7%)
	21–25 years	4 (5.5%)	44 (20.6%)	3 (20.0%)
	26–30 years	4 (5.5%)	22 (10.3%)	3 (20.0%)
	More than 30 years	10 (13.7%)	28 (13.1%)	4 (26.7%)
	Prefer not to say	1 (1.4%)	1 (0.5%)	0

Table 1 (continued)

Survey items		RCS nurses (*n* = 73)	PNAs (*n* = 214)	PNA Leads (*n* = 15)
Did you receive your nurse education outside of the UK?	Yes	17 (23.3%)	32 (15.0%)	0
	No	55 (75.3%)	181 (84.6%)	15 (100.0%)
	Prefer not to say	1 (1.4%)	1 (0.5%)	0

PNA = Professional nurse advocate; rcs = nurse receiving restorative clinical supervision. *Respondents could select more than one option, so % has not been calculated

Table 2 Impact of RCS on nurse perceptions of empowerment and aspects of their nursing role - median interquartile ranges

	RCS nurses (*n* = 73)	PNAs (*n* = 214)	PNA leads (*n* = 15)
Structural empowerment			
Opportunity	5 (4,6)	4 (4,5)	5 (5,6)
Information	5 (4,6)	5 (4,6)	5 (4.5,5.5)
Support	6 (5,6)	6 (5,6)	6 (5,6)
Resources	5 (4,6)	5 (4,5)	5 (5,5)
Formal power	5 (4,6)	5 (4,5)	5 (5,5)
Informal power	5 (4,6)	5 (4,6)	5 (4.5,5)
Psychological Empowerment			
Meaning	5 (4,6)	5 (4,6)	5 (5,6)
Confidence	5 (5,6)	5 (4,6)	6 (5,6)
Autonomy	5 (4,6)	5 (4,6)	5 (5,6)
Impact	5 (5,6)	5 (4, 5.75)	5 (5,6)
Positive Work Feelings			
Job satisfaction	5 (4,6)	5 (4,6)	5 (5,5.5)
Commitment	5 (4,6)	5 (4,6)	5 (5,5.5)
Trust	5 (4,6)	5 (4,5)	5(5,6)
Low burnout	5 (4,6)	5 (4,6)	5(5,5.5)
Other			
Safety of patient care delivery	5 (4,6)	5 (4,6)	5 (5,6)
Ability to make changes to care delivery	5 (4,6)	5 (4,5)	5 (4.5,6)
Networking with others	5 (4,6)	5 (4,6)	5 (5,6)
Influence in practice	5 (4,6)	5 (4, 5.75)	5 (5,5)
Leadership of quality improvement	5 (4,6)	5 (4,5)	5 (5,5.5)
Overall rating of the effectiveness of restorative supervision			
Based on my overall experience of restorative supervision, I believe that restorative supervision is effective	6 (5,6)	6 (5,6)	6 (5,6)

Table 3 Median (Interquartile Range) rating of questions related to RCS nurses' roles and responsibilities. PNA = Professional nurse advocate; rcs = restorative clinical supervision

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

to nurses at work. Overall, however, RCS was rated very positively in enhancing structural empowerment, psychological empowerment, and positive work feelings. Responses to the additional five questions about RCS are summarised in the last section. All were rated as a median of 'moderately agree' by all three groups, illustrating strong beliefs in the effectiveness of RCS in having a positive impact on these aspects. Finally, each of the groups were asked about their overall opinion about the effectiveness of RCS. Median scores are summarised in the final row. All groups provided a median rating of 'strongly agree' to the statement *"I believe that restorative supervision is effective"*.

Perceived effectiveness in meeting roles & responsibilities

Tables 3, 4 and 5 summarise the responses of each group to questions related to their published roles and responsibilities (Critical Care Networks-National Nurse Leads, 2022). Table 3 illustrates that RCS nurses generally disagreed with the statement about completing the e-learning module on the A-EQUIP model (Q1., median 'moderately disagree'). There was median agreement with all other statements, although agreement was slightly lower for Q2. related to accessing a PNA and discussing arrangements with line managers (median 'slightly agree').

Table 4 illustrates strong agreement of PNAs with statements about their effectiveness in meeting their roles and responsibilities. The median rating was 6 (equating to

Table 4 Median (Interquartile Range) rating of questions related to pnas' roles and responsibilities

PNAs (*n* = 214)	
"I am effective in…"	
Q1. Advocating for patients	6 (5,6)
Q2. Creating care plans collaboratively with patients and/or families	5 (5,6)
Q3. Demonstrating inspirational, motivational and visible leadership in the workplace	6 (5,6)
Q4. Supporting change in clinical area(s)	6 (5,6)
Q5. Acting as a role model promoting psychological safety and situational awareness in my own practice	6 (5,6)
Q6. Discussing any professional issues, including clinical incidents, team dynamics, stress, burnout, instances of bullying, career progression, interviews and quality initiatives, as well as personal issues	6 (5,6)
Q7. Allowing (or creating) the opportunity for reflection to reduce stress and enable learning, limit compassion fatigue and improve confidence following a traumatic or stressful event	5 (5,6)
Q8. Portraying an understanding of personal and professional resilience and developing this attitude in others	6 (5,6)
Q9. Developing a nurse's ideas and actions for quality improvement and service development	5 (5,6)
Q10. Holding reflective discussions about revalidation and career development, preparation for appraisal	6 (5,6)
Q11. Coaching staff through reflection on incidents they may have experienced, with a focus on the system and processes	5.5 (5,6)
Q12. Supporting aspirant PNAs and PNAs in training, including by providing support and supervision	5 (4,6)
Q13. Collating data on the effectiveness of restorative clinical supervision (RCS) for staff, and the benefit of the PNA role.	5 (4,5)
Q14. Arranging any individual meetings at a mutually convenient time	5 (4,6)
Q15. Identifying a private and confidential meeting place	5 (4.25,6)
Q16. Mutually agreeing how long the session will last	5 (5,6)
Q17. Agreeing ground rules for the session and documenting these	5 (5,6)
Q18. Retaining and confidentially storing any notes taken at the meeting	6 (5,6)
Q19. Participating in and leading on quality improvement Programmes	5 (5,6)
Q20. Engaging in booster sessions following PNA training	5 (4,6)

'strongly agree') for 8 of the 20 statements, and none were rated below 5 (equating to 'moderately agree').

PNA leads were also asked to rate their agreement with statements regarding their effectiveness in meeting their published roles and responsibilities (see Table 5) yielding ratings of 'moderately agree' for most statements. Two questions (Q3. access of nurses to PNAs and Q4. allocation of time to PNAs and release of nurses for meetings) were rated slightly lower at a median of 4 (equating to 'slightly agree'). PNA leads were also asked to indicate 'Yes', 'No' or 'Unsure' in relation to the following statement: *"My organisation's chief nurse has identified a senior registered nurse lead for PNAs to oversee allocation, implementation and oversight of PNAs in practice"*.

Table 5 Median (Interquartile Range) rating of questions related to PNA leads' roles and responsibilities. PNA = Professional nurse advocate; rcs = restorative clinical supervision

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

86.67% (13/15) responded 'Yes' and 13.33% (2/15) responded 'Unsure'.

Open ended questions

Responses to four open ended questions were received from 158 survey participants ($n = 302$) yielding three primary themes: (1) The conditions necessary for RCS; (2) Nurse Participation, Engagement & Organisational Commitment to RCS in the A-EQUIP Model and (3) Reflection and Reinvigoration from RCS. Each theme has three connected characteristics most identified by RCS Nurses, PNAs and PNA leads (Fig. 4).

Theme 1: The conditions necessary for RCS

This theme comprised of three characteristics namely, having adequate time provision; the provision of a safe space; and adequate communications about RCS to the nurses. Three perspectives of safe space related to the provision of offices, using Microsoft Teams and engaging in group supervision.

Adequate time

Most RCS nurse respondents indicated they were given adequate time to participate in RCS, suggesting that in many settings, the process of establishing a time for RCS whilst on duty had been successfully facilitated by ward managers and PNAs. In contrast, some RCS nurses expressed frustration at '*not having time allocated*' and '*not being released*' from their clinical shift or duties, or caveated '*with adequate cover provided to allow them to leave the clinical area*'. Once in RCS sessions, on occasions the time allocated was '*not sufficient to enable issues to be explored or conducive to the topics being discussed*'.

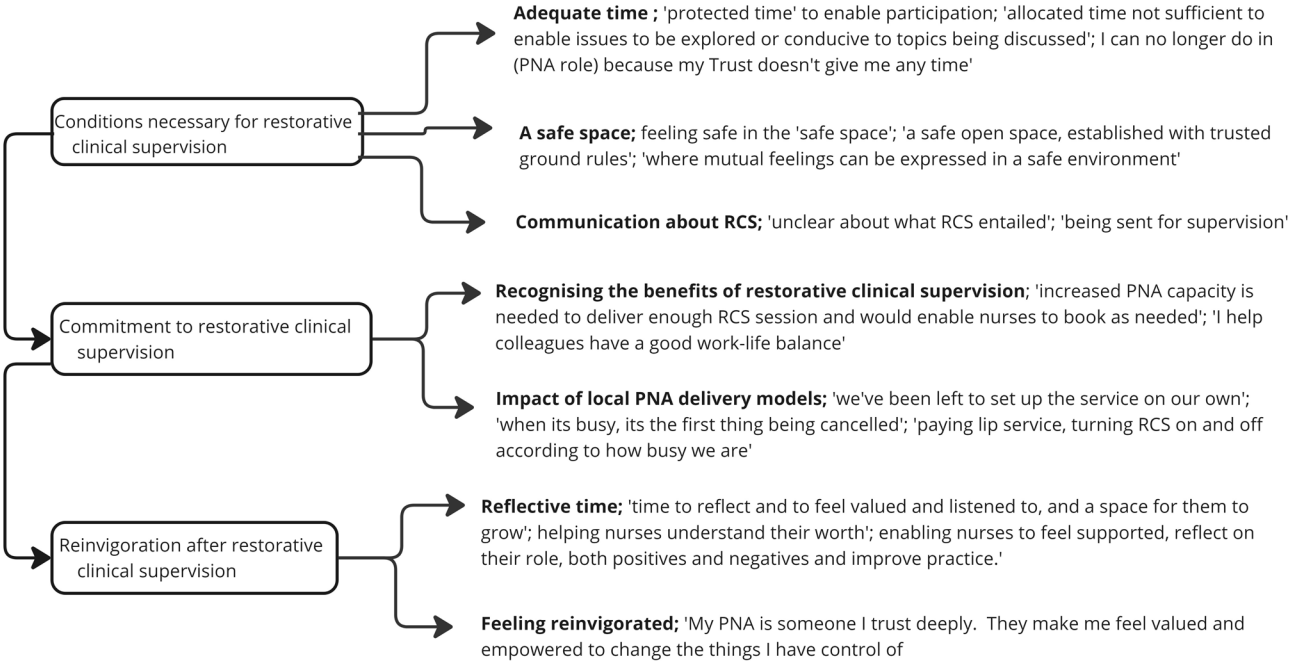

Fig. 4 Illustrating themes and connected characteristics

The varied responses revealed differences in how RCS was provided, ranging from ad hoc, to scheduled one off sessions, whilst other organisation implemented regularly scheduled RCS sessions. Satisfaction was expressed where RCS was a regular activity and *'dates were in place for future sessions'* [RCS nurse]. In contrast to RCS nurses, relatively few PNAs felt they had enough time to deliver RCS. PNAs described pressures of their day job and unmanageable, competing priorities alongside their clinical roles.

> *' ....RCS can't be done [delivered by PNAs] when overwhelmed with current workload, covering sickness or shortages [of staff] on other wards.*

Some PNAs felt that without adequate time they were losing their skills and confidence to deliver RCS. This situation was also familiar to PNA leads:

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

PNAs were very keen to deliver a service for their nursing colleagues through the A-EQUIP Model. Satisfaction was gained when supporting *'career development'* [PNA] and being able to carry out *'structured planning' to address issues raised through RCS sessions'* [PNA]. Whilst PNAs enjoyed their role, this was outweighed for some by a lack of protected and recognised time, making the role untenable, for example:

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

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

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

A safe space

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

unsuitable and left some nurses feeling *'vulnerable and reluctant to participate'* [RCS nurse]. Hence, a safe space was not always guaranteed and depended on the availability of rooms, often not know until the day. Confidentiality and trust were raised as important benefits of RCS and related to 'safe space';

Several nurses suggested RCS should always be delivered by PNAs that are '*not familiar to themselves*' [RCS nurse] to ensure their authenticity and confidentiality highlighting the need to 'feel safe' in the safe space.

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

Nevertheless, other RCS nurses described being familiar with PNAs from their ward team and this familiarity was unproblematic. Having a choice of PNA, regardless of where they are based might be the most important factor.

While using Microsoft (MS) Teams (and other digital platforms) were necessary to enable participation during the COVID-19 pandemic, this did not suit some RCS nurses. Preference for face-to-face sessions was expressed by several nurses who had experienced RCS via Microsoft Teams, stating this '*was not conducive to feel real and purposeful*' [RCS nurse]. Assumptions were made by some PNAs regarding the RCS nurse's access to personal computers or work offices, or privacy if working remotely. Consequently, inadequate access to computers and lack of privacy diminished finding a safe space and undermined delivery of some RCS sessions. Using MS Teams for RCS needs careful consideration to take account of these factors. Some RCS nurses identified a preference for group supervision, but this scenario needed to be supported by skilled facilitation and trust to create a situation '*where mutual feelings can be expressed in a safe environment'* [RCS nurse].

Group reflection was sometimes structured through clinical and management scenarios from practice where the discussion unpacked a different perspective.

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

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

> *'….safe convenient space makes it conducive for staff to explore their thoughts and form a plan.' [PNA].*

Adequate communication regarding RCS

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

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

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

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

Theme 2. Commitment to RCS in the A-EQUIP model

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

Growing appreciation of the benefits of RCS

The A-EQUIP model was starting to spread throughout healthcare organisations and become recognised by nurses as a structured emotionally supportive mechanism through RCS. Where needed, nurses were accessing PNA support to resolve practice issues they found difficult to address. RCS enabled openness [in a safe space] to generate discussion and potential self-related actions, and others, which could improve their practice. Depending on the level of confidence and experience, practice solutions could be actioned by the nurse receiving RCS or PNAs and Lead PNAs. Group supervision was favoured by some nurses, which was described by several as providing a *structured opportunity to share ideas and make suggestions*. RCS nurses enjoyed being with other nurse

colleagues in a similar position, and *'listening to others was a process of realisation'*. One nurse stated that:

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

Nurses receiving RCS stated that the process legitimised access to support, when needed bringing a positive benefit to nurses in clinical practice. A RCS nurse explained;

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

While another RCS nurse appreciated the challenge, for example;

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

Some PNAs compared the A-EQUIP Model to their longstanding supervision roles from up to 30 years ago expressing positive support and understanding for the PNA role, stating;

> *'….this new way [A-EQUIP] is different to the traditional formal learning expected from clinical supervision sessions and development of restorative clinical supervision and is needed' [PNA].*

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

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

Issues with local delivery frameworks at site level.

This theme related primarily to the way that organisations implemented and enabled PNAs to enact the role, make changes to it, secure sufficient time for the role, and whether PNAs felt valued, respected, taken seriously by management, and supported to implement the model of A-EQUIP. Whilst there was much positive feedback from RCS nurses and PNAs, there were many responses which indicated improvements were needed in local delivery approaches.

RCS nurses were not always confident that changes in practice would be implemented when needed, and many argued the importance of managerial support in responding to issues they faced, for example:

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

While the type of manager needed to effect change was not indicated, a reasonable assumption would be that this was appropriate for ward managers or matron level. PNAs were keen to see the engagement of middle, senior, and corporate level nurses to improve the strategy for delivery of A-EQUIP. Many responses indicated that although the model was working in some areas, very many PNAs felt unsupported:

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

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

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

There were many references to needing more visibility of very senior nurses and needing to feel that they understood and valued the PNA and RCS function of their role. Some PNAs did not feel valued or respected in their role by organisational leaders:

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

Where time was not allocated to the PNA's role and there was insufficient support implementing the A-EQUIP model, PNAs felt devalued or overlooked by senior nurses where they worked.

Theme 3: Reflection and reinvigoration from RCS

The process of RCS legitimised the time and nurses' need to reflect on and understand difficult aspects or experiences within their roles. Respondents explained how RCS enabled nurses to change how they felt about individual work-based issues, or personal matters. This was a rewarding activity for RCS nurses and PNAs. Many described RCS as a time to unload issues, and gain relief through self-compassion and increased insight. Two key

characteristics of this theme were the reflective process and reinvigoration.

A reflective process

RCS nurses described needing time to reflect, and to prepare for the process of RCS. Being able to 'offload' did not occur instantaneously. Nurses needed to learn what RCS entailed and how it could benefit them personally. As well as having a safe space for RCS, nurses also needed to trust the person they were speaking with.

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

RCS is a reinvigorating experience

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

> *The following extract was representative of sentiments frequently expressed:*
> *'My PNA is based in [...], they are someone I know and trust deeply. They made me feel valued and empowered to change things I have control of and to take the positives out of situations where they are not always obvious. It [RCS] has been a fabulous experience so far'. [RCS nurse]*

Discussion

The PNA Programme was developed in the context of global nursing workforce challenges including a lack of in-country nursing supply, decreasing retention and a lack of recognition and support [8]. The COVID-19 pandemic had further exacerbated these existing concerns which triggered a response in England to address nurse recognition, shortfalls in postgraduate nursing education, strengthen nursing leadership and build communities of practice and support. The response was to develop the PNA Programme, designed, implemented and continually improved by nurses [17, 22].

Since its inception, further global reports [25, 26]. have continued to highlight the critical need to support and retain nurses given the importance of their contribution to improve patient experience and patient outcomes. A scoping review of current trends in global nursing [25] identified the following four issues:

- Global shortage of nurses and a lack of strategies to retain and support nurses in practice.
- Lack of recognition and advocating on the impact of nursing and its positive effect on health outcomes.
- Need to elevate the professional status of nursing including increasing leadership opportunities and acknowledgment of nursing expertise.
- A requirement to ensure high quality nurse education to improve patient care and health systems.

The recent publication from the International Council of Nurses (ICN), Recover to Rebuild: Investing in the Nursing workforce for Health System effectiveness [26] highlighted the persistence of global nursing shortages with the addition of nurse burnout. They reported that based on the findings of 100 studies, 40–80% of nurses reported experiencing psychological distress and that more than 20% had an intention to leave the profession. They called for a systematic organisational response.

The PNA Programme [15] with its equal emphasis on education and practice has provided a credible and recognised framework for nursing advocacy and leadership, preparing nurses to support each other whilst continuously improving patient care, answers this call. Its focus on wellbeing, underpinned by the facilitation of RCS sets out a vision that to improve patient care we must also address the health and wellbeing of the nursing workforce. Given the ambition and necessity to address burnout and improve nurse wellbeing this study has focused on RCS. Further studies will be needed to review the impact of the other elements of the A-EQUIP model and PNA role.

RCS was generally viewed very positively by all three groups. It should be noted however, that more than 18% of PNAs had yet to have experience of delivering RCS, and this was reflected in some of the open text comments about 'not using skills'. Of those who had delivered RCS, there was a very wide range of experience, although the mean value of 15 RCS nurses supervised suggested good levels of experience. This mean value includes both active and completed supervision, so it is not clear from the survey results what the level of ongoing supervision might be. The positivity around RCS was evident in terms of high median ratings for statements related to the

model of empowerment (Table 2), and for the additional questions (Table 3). Respondents were particularly positive regarding their overall impression of the effectiveness of RCS, with the median rating for this statement at the highest level of 6 ('Strongly agree') in all three groups (Table 4). Only one statement across all aspects of RCS received a median rating of 4 ('Slightly agree') and this was by PNAs in relation to 'Opportunity'. In conclusion, however, the overriding impression of RCS was very positive.

In general, all three groups were also very positive about their perceived effectiveness in meeting their published roles and responsibilities. The only exception was RCS nurses' satisfaction regarding the timing to complete the e-learning module before their RCS sessions (this was given a median rating of 2, 'Moderately disagree'). RCS nurses were also slightly less positive (median rating of 4, 'Slightly agree') about their effectiveness in accessing a PNA and discussing with their line manager the timeframe for RCS sessions and implementation of the A-EQUIP model. It was notable that 5 of the 9 statements presented to RCS nurses reached a maximum level of agreement of 6 ('Strongly agree'), meaning that most respondents awarded this maximum rating for their perceived effectiveness. PNAs were also very positive about their perceived effectiveness, rating 13 of 20 statements at this highest level of agreement. None were rated lower than 5 ('Moderately agree') by PNAs. Finally, PNA leads were also positive about their perceived effectiveness. The only items that were rated slightly less positively (median rating of 4,'Slightly agree') by PNA leads related to ensuring arrangements for all nurses to have access to a PNA, that PNAs have allocated time and that nurses are released to meet their PNA. These are very important practical and workload-related issues that might require closer consideration by the PNA Programme team, Regional Leads, PNA leads within individual healthcare organisations, and others. These issues were also very evident in the open text responses to the survey. Overall, however, the three groups were very positive about their perceived effectiveness in meeting their roles and responsibilities.

Strengths and limitations

Nursing and Midwifery Council [27] membership data reported that 10.9% of registrants reported their gender as 'Male', which is very comparable to the proportions reported in the nurse group in the current survey (11.0%). It was interesting that the proportion of males fell to 9.8% of PNAs and 6.7% of PNA leads. NMC [27] also reported that 77.6% of registrants were in adult nursing, 7.5% in children's, 2.3% in learning disability and 12.6% in mental health. These proportions are again very comparable to the figures in each of the three samples recruited to our survey. The samples are therefore likely to be broadly representative of the wider nursing workforce based on these characteristics.

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

The NMC has reported that 70.8% of registrants were of 'White' ethnicity; 26.0% were of 'Asian', 'Black', 'Mixed race' or 'Other' ethnicity; and 3.2% did not declare or preferred not to say [27]. Across all hospital and community services in 2019[9], 75.4% of the nursing, midwifery and health visitor workforce reported being from a 'White' ethnicity, 20.5% 'BME' (black and minority ethnic) and 4.1% 'Unknown'. Our data is likely to have been broadly representative of these figures, although it was noticeable that ethnic diversity differed across the three groups. For example, 32.9% of RCS nurses who responded to our survey reported being from an Asian/British Asian, Black/African/Caribbean/Black British, or Mixed/Multiple ethnic groups background, but this proportion fell to 13.6% of PNAs and just 6.7% of PNA leads. This change in ethnic diversity with seniority has been identified previously. For example, the proportion of nurses, midwives and health visitors from a BME background was reported to drop from 26.0% at Agenda for Change (AfC) Band 5, to 13.4% at Band 7 and 3.8% at Band 9 [9]. It seems clear that strategies are required to enhance equality, diversity, and inclusion regarding appointment to PNA and PNA lead roles.

In 2021, 3.7% of the NHS workforce were registered as having a disability on the Electronic Staff Record. The proportion self-reporting a disability on the 2020 NHS survey was much higher, however, at 20.2%[28, 29]. The proportion of respondents reporting a disability in our survey ranged from 4.1% of RCS nurses to 13.3% of PNA leads. Given the anonymous nature of our survey, it might be expected that the reported disability rate might be closer to that of the NHS survey. This may, therefore, indicate an under-representation of respondents with disabilities in our survey, although that cannot be verified.

Conclusions

The findings from this study indicate that the PNA Programme in England shows great promise to address the underlying global nursing concerns linked to workforce wellbeing, retention, and recognition of nurse impact. One key area of positive support identified by nurses through this study was the facilitation of RCS by PNAs to improve wellbeing and reduce burnout. Despite access issues (e.g., time), RCS was viewed very positively by RCS nurses, PNAs and PNA leads. At the time of the study the PNA role was evolving, we found identifying solutions to issues were regarded as work in progress, rather than unresolvable. PNAs are well positioned to provide guidance to support nurses and navigate career conversations, which may over time, contribute to their retention in practice. When the initial practical issues be addressed it is likely that PNAs will improve wellbeing, reduce burnout, and thus improve patient care and health systems. NHS organisations reporting nursing excellence are indicating the integration of PNAs, with other mechanisms to contribute to measures of nursing care quality, which is important for its long-term sustainability. The roll out of the Programme has also stimulated an amendment to the NHS Contract [27] to include the provision of PNAs and RCS. This provides an additional layer of governance and quality assurance alongside the RCN PNA Education Standards [18] working together to support nurses to improve patient care. Given the pace and scale of implementation across all healthcare settings in England, its further spread globally is possible to begin to address the global nursing concerns as highlighted by the ICN.24.

Abbreviations

AEQUIP	Advocating and Educating for Quality Improvement
AfC	Agenda for Change
ICN	International Council of Nurses
NHS	National Health Service
NMC	Nursing and Midwifery Council
PNA	Professional Nurse Advocate
RCN	Royal College of Nursing
RCS	Restorative Clinical Supervision

Supplementary Information

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Supplementary Material 1

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Author contributions

LLD Corresponding Author. Led the research and contributed to all text. SP Designed the survey, analysed results and co-wrote this section of the paper. AA Assisted with co-design work package NB Assisted with design, qualitative data collection and analysis. AC Assisted with design, survey and qualitative collection and data analysis. EW Background, revisions and practice implications. RK Editing, Co-writing, Revisions, and Abstract. All Authors Reviewed the Manuscript.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

The study received ethical approval from Coventry University Research Ethics, approval number P139411 on 22nd August 2022. Informed consent to participate was obtained from all of the participants in the study. This study adhered to the Declaration of Helsinki principles.

Consent for publication

Consent to publish was included as a question in the consent form received from staff participants (there are no patients participating in this work).

Competing interests

The authors declare no competing interests.

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