Using the principles of the Professional Nurse Advocate and A-EQUIP model to improve health and wellbeing of the Health Visiting workforce.

ABSTRACT

The wellbeing of frontline health and social care staff in the United Kingdom (UK) has been topical and high on the agenda of many organisations for the past decade. This has never been more relevant since the outbreak of the Covid- 19 pandemic when the daily pressures encountered by frontline staff were well documented within the media. However, very little attention was directed towards Specialist Community Public Health Nurses (SCPHN) and specifically the Health Visitor profession during this period.

This review explores the current literature and the complex challenges faced by the Health Visiting workforce. In response to this, the A-EQUIP model and the implementation of the PNA role for Nurses has been investigated and the conclusion and recommendations applied directly to the Health Visiting role. The adoption of the principles of the PNA role within Heath Visiting will support a culture of restorative supervision whilst revisiting the seminal work of Wallbank. This will ultimately lead to psychological safety and civility for the Health Visiting profession with a resulting increase in the quality of care for families.

KEY WORDS

Professional Nurse Advocate, Health Visitor, Support, Supervision, Quality.

INTRODUCTION

The Covid-19 pandemic changed the way in which Health Visiting services are delivered in the UK. Health Visitors were forced to work more remotely. The rapid change has resulted in many Health Visiting staff working under greater levels of pressure, feeling isolated, anxious and unsettled (Baldwin et al. 2020). Survey shows 60% of Health Visiting teams affected by Covid-19 redeployment (Ford 2020). Almost half (48%) of Health Visitors in England said they intended to leave the profession in the next five years. These figures come while there

is an estimated shortfall of 5,000 Health Visitors in England (Devereux 2023). Health Visitor numbers are currently lower than they were in 2011, at the Health Visitor Implementation Plan's inception. Total workforce numbers equate to 7030 FTE Health Visitors practicing in England, which is a decrease of over a third (37%) since 2015 (Institute of Health Visiting (iHV) 2022).

The COVID-19 pandemic resulted in children being less visible to professionals with risk of harm less identifiable. The multiple impacts of a UK economic recession, escalating cost of living and rising energy bills, will ultimately lead to an increased number of children living in poverty. When families are under financial strain, challenges for parents increase, leading to more children on child in need or child protection plans (Ofsted 2022). All of these factors result in higher caseload numbers and an increase in families requiring support during a time of reductions in Health Visitor numbers.

The Professional Nurse Advocate (PNA) Programme launched in March 2021 and delivers training and restorative supervision for colleagues right across England (NHS England 2023). As joint leads for the PNA Programme at the University of Hull we both have clinical backgrounds in Adult Nursing, Midwifery and Health Visiting. Within our academic roles at the Higher Education Institution (HEI) we are experienced in teaching and supporting undergraduate and postgraduate students on all fields of Nursing, Midwifery and the SCPHN Programmes. We have also been instrumental in the delivery of the Professional Midwifery Advocate (PMA) Programme since 2017. This experience puts us both in a vital position to deliver the PNA Programme which specifically delivers on the implementation of the PNA role and A-EQUIP (Advocating and Educating for QUality ImProvement) model (NHS England 2023).

MAIN BODY

A-EQUIP model and PNA role.

The A-EQUIP model stems from the three functions of clinical supervision in Brigid

Proctor's (1987) clinical supervision that is commonly used in healthcare services:

- normative – managerial aspects concerning practice, learning and training
- formative – educational aspects such as knowledge and skills development
- restorative – supportive aspects such as improving burnout and stress

with an additional element of 'personal action and quality improvement' provided by NHS England (2017).

The PNA role is novel and unique to the UK (and Worldwide) (NHS England 2023), therefore to measure and share its impact, NHS England have commissioned independent research and an economic evaluation. However, research has already demonstrated the positive effects of the PMA and A-EQUIP model within Midwifery practice- including support for staff wellbeing and retention, improved professional resilience and patient outcomes (Whatley 2022).

Similarly, the PNA training is underpinned by the A-EQUIP model which has 4 elements of;

1. providing clinical supervision using a restorative approach
2. enabling nurses to undertake personal action for quality improvement
3. promoting the development and education of nurses
4. advocating for the patient, the nurse and for healthcare staff

all of which support the PNA role descriptors (NHS England and NHS Improvement 2021).

The Professional Nurse Advocate (PNA) Programme delivers a Masters level academic accredited course and restorative supervision for Nurses across England. The PNA Programme was launched in March 2021, towards the end of the third wave of COVID-19 and was seen as the start of a point of recovery for services, workforce and patients. Principles of restorative supervision first used in Health Visiting (Wallbank, 2007; 2011) and later adopted by Midwives (as the PMA role) are now applied to the Nursing workforce, under the PNA role. PNA's are enabled to support staff to;

- Deliver restorative supervision
- Listen to and understand the challenges and demands of colleagues
- Develop leadership skills to support staff health and wellbeing
- Deliver quality improvement initiatives for better healthcare outcomes.

The emphasis is on building personal and professional clinical leadership of nurses, to support personal development and professional revalidation. The restorative function has been shown to have a positive impact on both the physical and emotional wellbeing of staff (NHS England and NHS Improvement 2021).

Anecdotally from the contact we have experienced from practicing SCPHN's the main issues they identify are:

- Compassion fatigue/ burnout
- High levels of absenteeism and sickness
- Recruitment and retention issues.

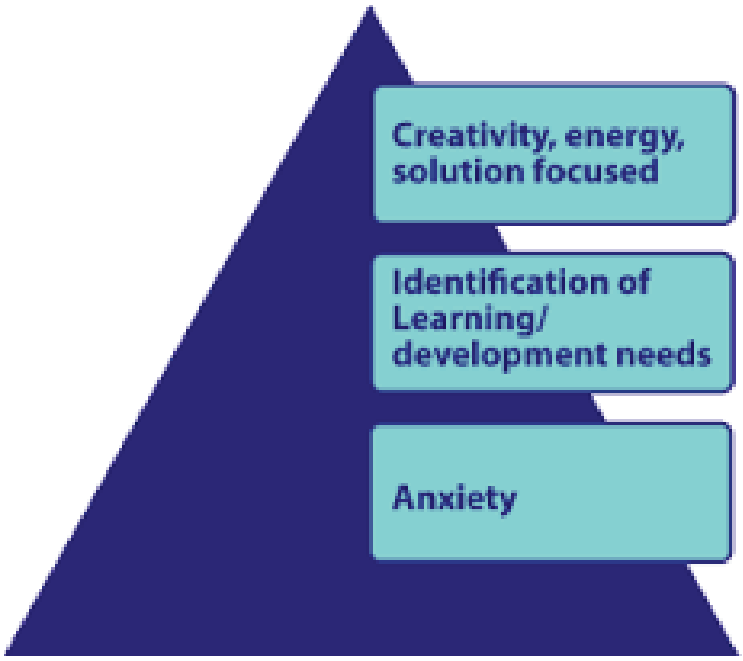
It has been well documented in recent years how nurses have had the highest levels of occupational stress and resulting distress compared with other healthcare groups (Hasan and Tumah 2019). There is less reference to SCPHN's and Health Visitor's specifically who are often working in isolation and in the most challenging of circumstances on the coal face of primary care while providing support to communities, groups, families and individuals (iHV 2021). It has been recognised that it is often viewed as a personal responsibility to look after one's own mental health and wellbeing (Billings et al. 2021). However, it has become identified more recently the responsibility to protect the workforce should rest with the employer (Gemine et al. 2021).

In reality, it could be suggested the responsibility lies with both the employer and employee to implement positive working practices.

Supervision

Health Visitors are well versed in the act of supervision, used during their complex safeguarding work with children and families. A safeguarding supervisor specifically provides child protection advice. The supervisor should have expert knowledge of child protection and supervision should "maintain a focus on the child and consider the impact of sadness and anger on the quality of work with the family" (NHS England 2014:14). Hence, this type of supervision focuses on the child.

When professionals such as Health Visitors undertake their complex clinical work, they move between states of anxiety, fear or stress. If they can process these natural feelings they are able to focus on their own learning needs and development. This enables them to enter a creative, energetic and solution focused zone where innovative thinking can be generated (Wallbank 2007). A model of restorative supervision (Wallbank 2007; 2011) focuses on staff and facilitates them to reflect, in order to spend more time in the top of their triangle than in the anxious zone at the bottom, as illustrated in Diagram 1.



Wallbank (2011) triangle Diagram 1.

Revisiting Wallbank

Wallbank's original restorative supervision model (devised in 2007) appears to have been lost in time and context. Local Authorities are currently facing greater spending demands during a time when their incomes are being drastically cut (Ogden and Phillips 2020). The initial intentions for a preventative Health Visiting service model were outlined in Cowley's (1995) original vision of the SCHPN role. Health Visiting should be a proactive process, solution focused, recognising potential for unmet need, whilst acting on long term processes (Cowley et al, 2013). However, post pandemic reactive commissioning goals (with a focus on meeting immediate or short -term health needs) appear to have discounted this essential element. As Health Visitor numbers decline, their work is being delegated and devolved to increasing levels of staff skill mixing (NHS Benchmarking Network 2020) which raise concerns about the dilution of specialist Health Visitor skills, competencies and quality of client care (Crome and Thurtle, 2010).

One way to help address the complex pressures for Health Visitors is to re-establish the importance of restorative supervision practices, using the PNA role principles and A-EQUIP model (NHS England 2023).

Historically, restorative supervision has been shown to have many positive impacts:

- staff feeling 'valued' by their employers
- significant reduction in stress and burnout
- increased enjoyment related to work
- increased job satisfaction of staff and improved retention
- reduced stress levels
- maintaining compassion
- improved working relationships and team dynamics.

These factors all contribute to staff managing their work/life balance more effectively (Wallbank and Hatton 2011; Wallbank and Woods, 2012; Pettit et al. 2015).

Unlike safeguarding supervision, for restorative supervision, the focus is entirely on the practitioner. In the ‘safe space’ of restorative supervision, staff are able to meet their own needs and find solutions, so that they can be effective and provide a service delivery of the highest standard and quality.

Safety and Quality

Psychological safety is critical for organisational learning (Lyman et al. 2020) Senek et al. (2020) identified how staffing issues and failures in leadership, left nurses feeling disempowered and demoralised. Kline (2019) suggests how staff are treated, significantly influences care provision and organisational performance. Understanding how leaders can help ensure staff are cared for, valued, supported and respected is crucially important. Inclusive organisations are more likely to be ‘psychologically safe’ workplaces. Such workplaces enable staff to feel confident in expressing their true selves, to raise concerns and admit mistakes without feeling vulnerable or judged amongst their peers. Within healthcare settings, managing staff and teams with respect and compassion significantly improves patient satisfaction, infection and mortality rates (Senek et al. 2020). Financial performance as well as lower absenteeism and sickness rates have been shown to improve when safe workplace cultures are adopted. A healthcare culture that provides psychological safety for staff by encouraging a sense of belonging and inclusivity has been evaluated to support a culture of continued development, learning and increased civility (Lyman et al. 2020). Attending to the needs of the workforce is paramount to improve quality and safety for service users.

As the implementation of the PNA role is employer-led, the organisations’ leadership team is responsible for the implementation of the PNA role and ensuring all Health Visitors have access to restorative clinical supervision. All organisations should ensure the PNA role and the delivery of Restorative Supervision is embedded in current clinical governance arrangements, including a broad oversight. NHS England (2023) recommend the local organisation and leadership team carries out the following actions:

- Chief nurse to identify a senior registered nurse who is responsible for the oversight and implementation of PNAs to liaise with NHS England and NHS Improvement.
- Appointment of a Regional PNA lead/advisor.
- Create a live register of the PNA's employed in the trust: for succession planning and maintenance of a 1:5 to 1:20 PNA-to-nurse ratio.
- Establish a PNA council/support network.
- Ensure completion of the provider workforce return (PWR) and that qualitative data from PNAs is reported monthly.

Grainger (2022) confirms, NHS organisations are accountable for improving the quality of their services and safeguarding high standards of care by creating a safe environment that is continuously evaluated. Not only is this high priority for all organisations and subsequently service user care but we are now far more interested in the health and wellbeing of the NHS workforce in their own right. There is evidence for the negative effects of mental health distress on physical health (Gray et al. 2019) which will indirectly impact on the quality of services if the workforce is continuously managing their own health concerns at the same time as the service users they support.

Evidence illustrates that workforce planning has been particularly out of focus for some time (Suter and Kowalski 2021) and that the numbers of retirees from the NHS workforce is not being matched with recruitment to Undergraduate and Postgraduate Health Programmes. We know that recruitment and retainment of staff causes an extra layer of concern and economic cost for the NHS and influential stakeholders (Spilsbury et al. 2022).

Restorative workplaces

Through enabling of the PNA role, the nursing profession has called for a ‘reset’ within the workforce so that they can recover, following the challenges of the pandemic (NHS Confederation 2023). Consideration of a renewed focus on staff wellbeing across the health and social care workforce has prompted a cultural shift. This workforce wellbeing focus must

be re applied to Health Visiting too. Braithwaite et al (2017) acknowledged that positive healthcare workplace cultures were consistently associated with improved service user outcomes: reduced mortality rates, falls, hospital acquired infections and increased patient satisfaction.

Clarity of job role and workplace design are proposed as key areas where workplace wellbeing for staff can be enhanced (Munir and McDermott 2013). Positive practices such as compassionate support for employees and expressions of gratitude are predictors of better organisational performance (Cameron et al. 2011). The West et al. report (2020) identified three core work needs for nurses that must be met to ensure staff wellbeing and to minimise stress levels;

1. Autonomy (having control over work and acting consistently with one's values)
2. Belonging (feeling valued, respected, supported)
3. Contribution (experiencing effectiveness in work) (Stone et al. 2009)

If any one of these needs is not met then motivation, performance and wellbeing of staff potentially suffers (Ryan and Deci 2000). Moreover, West et al. (2020) advised that such a transformation of the work lives and lived experiences of nurses required a coherent and effective strategic approach which would raise the quality of care provided. It is reasonable to assume that these themes could also be applied to Health Visiting practice. The three core needs could be considered by service managers, in order to support them to develop practical steps to ensure more effective and sustainable Health Visitor workforce recommendations.

Autonomy- Health Visitor's need to feel that their voice is heard across their organisation, within teams and in relation to decision-making, innovation and working conditions.
This includes having the right work conditions in relation to physical wellbeing, required resources, facilities and time. They need to sense the right to appropriate breaks and for flexible and predictable work schedules. This includes workplace characteristics of; equity,

positive diversity and inclusion. It could be argued that these conditions are not promoted because of the current isolated working practices which originated in the pandemic (home working, telephone triage, and virtual working practices).

Belonging- is nurtured by a culture of inclusive leadership styles that model compassion and demonstrate trust, instead of focusing on control and maximising productivity. The quality of teamworking, culture, inclusiveness and supportiveness of teams, are all central to a sense of belonging. This can include role clarity and stability, a shared sense of purpose and team member wellbeing (West et al. 2020; The Kings Fund 2023). To address this, there should be a focus on meeting the basic needs of the workforce, as identified in Maslow's hierarchy of needs (1943). Health Visitors should once again be autonomous and proactive practitioners, in a commissioning service that can at times feel restrictive and autocratic.

Contribution- can best be met by ensuring that Health Visitor workloads are not chronically excessive. Staff must have enabling supervisory support, with the emphasis on learning and accountability, rather than blame and directive control. They must have access to high-quality development opportunities and support to continually grow and develop knowledge. This is why it is timely to have the PNA role and the A-EQUIP model introduced now, when workforces need it the most.

There must be a clear understanding from the workforce of their own role and expectations within this working relationship with the PNA. The role of the PNA in isolation, cannot carry the magnitude of the concerns and issues raised by the workforce. Evidence from change management strategy clearly identifies that ownership of a situation which requires change, will be more successful if expectations and engagement is owned by all involved (Cleary et al. 2019).

The PNA profile needs to be clearly identified, established, and expectations made explicit. The PNA role is not one of 'servant leadership' in isolation but the role encompasses

compassionate, situational and authentic leadership (Pattison and Corser 2022). Making the ground rules very clear from the outset of the introduction of the A-EQUIP model so that expectations are realistic of what the PNA role is and how the role will support the team and the workplace culture, can only serve to improve clarity and understanding. Albeit, the PNA role is one of being a pioneer, however it has to be recognised they do not have a ‘magic wand’. The wider team have an active role in the success of the implementation of the role of the PNA and the A-EQUIP model.

CONCLUSION

This work examined some of the principles underlining the Professional Nurse Advocate role and the A-EQUIP model, in order to improve health and wellbeing of the Health Visiting workforce. This paper contributes to existing literature on the benefits of the PNA role, which can also be applied to Health Visiting specialist practice.

Health Visitors often work in isolated and challenging circumstances within primary care (iHV 2021). Their numbers have been depleted and the need for their work with families has increased, post pandemic.

If the current workforce issues highlighted are left unaddressed, the subsequent cumulative effects may prove detrimental to the quality and effectiveness of Health Visiting care.

Changes can be made at service level by Health Visitors themselves, starting with awareness of the PNA role and a return to Wallbank’s restorative supervision model. This must also include acknowledgement of how the workplace environment can positively change Health Visitor’s working practices.

Organisational and cultural change would be highly beneficial, and a focus on leadership approaches used within Health Visiting services requires further examination.

Through promotion of this kind of restorative environment, Health Visitors can be enabled to develop a sense of belonging, contribution and autonomy- in order to support their basic needs, health and wellbeing.

FUTURE RECOMMENDATIONS

- A cultural shift is needed which enable a post pandemic 'reset' for the Health Visiting and School Nursing workforce strategy.
- A return to Wallbank's (2007) original restorative supervision model is needed in respect of Health Visitor's challenging working environment.
- Consideration of the PNA role would enable equality of access of restorative working practices for Health Visitor's across the UK.
- To encourage workplace cultures that provide psychological safety and civility.
- To encourage Health Visitor's to once again be autonomous and proactive practitioners.
- To support new research, to understand what elements of the PNA could work in the complex system of Health Visiting.

KEY POINTS

1. The Covid- 19 pandemic resulted in Health Visitors working under greater pressure which led to changes to their working environment.
2. Health Visitor workforce figures have decreased by over a third since 2015, therefore workforce planning needs to be prioritised.
3. 2021 saw the launch of the national PNA Programme which introduced an emphasis on restorative practice for Nurses.
4. The PNA role and the A-EQUIP model can be applied and used within Health Visiting.
5. This is not a new concept to Health Visiting but Wallbank's model needs revisiting.
6. Changes must be made to protect the psychological safety and civility of the Health Visiting profession and a start would be to implement West et al. (2020) model.

REFLECTIVE QUESTIONS

1. How could you promote a sense of ‘belonging’ within your team?
2. How is compassionate leadership demonstrated within your team?
3. What positive changes could you make to your workplace environment to support you and your colleagues to develop a sense of inclusiveness?

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