Understanding Professional Advocacy: A protocol for a mixed method project to explore professional nurse advocacy and professional midwifery advocacy in one NHS trust.

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Abstract

Background: In the UK, specific Professional Nurse Advocates (PNA) and Professional Midwifery Advocates (PMA) centres nurses and midwives as integral to quality improvement in practice (QiP), workforce retention and transformation. However, little is known about the potential impact the PNA/PMA role might have on the daily practice of nurses and midwives, quality in practice, professional wellbeing, and retention. This project, funded by one large NHS Trust in the UK, seeks to explore, and understand the impact (if any) of the PNA/PMA role in relation to nurse/midwife involvement in QiP, professional wellbeing, and the retention of nurses/midwives in that Trust. The focus is on the key issues of the lived experience of current PNA's/PMA's; the wider nursing/midwifery workforce perspective of the use (or no use of) of the PNA/PNA role; the link (if any) on quality improvement in practice (QiP); and the workforce impact (if any) on nurse/midwife professional wellbeing and nurse/midwife retention in the organisation.

Methods: This study is mixed method and multistage design: Workstream 1 identifies the organisational context statistics of QiP, wellbeing and retention to understand difference (if any) before and after the implementation of the PNA/PMA role. Workstream 2 explores the experience of being a PNA/PMA using semi-structured interviews (n 15). Workstream 3 is twofold: Part i surveys the nurse and midwifery staff (n = 450) awareness/access/understanding of the PNA/PMA role. Part ii includes two focus groups (n=20) to detail the experiences of those who have actively consulted with a PNA/PMA, the other for those who have not yet consulted with PNA/PMA. Workstream 4 collates collected evidence to co-design, with PNAs/PMAs, nurses and midwives, recommendations for local policy, practice, and the implementation of the PNA/PMA role across the organisation.

Discussion: The integrated findings will inform the future organisational implementation of the PMA/ PNA role, strategies to develop the PNA/PMA role in relation to QiP, staff wellbeing, retention and sustainable approaches for increasing the number of PNA/PMA's. The evidence will inform local and national implementation policy across diverse NHS services and future development of the professional advocacy role for allied health professionals.

Key words

protocol, mixed method, professional advocacy, nurses, midwives, quality improvement in practice, wellbeing, retention

1 Introduction

In the UK, NHS nursing and midwife retention is a national priority. Increasingly linked to retention, are concepts of nurses and midwives' wellbeing being inherently linked to their professionalism, the quality of care they provide and the health outcomes for individuals [1]. The concept of professional advocacy, in relation to the nursing/midwifery professions, originally stems from supervision in midwifery, and was rolled out to the wider nursing profession coming as a direct response to the COVID-19 pandemic [2] Initially, the notion of professional advocacy was based on the preceding the Advocating for Education and Quality and Improvement (A-EQUIP) model. The function of A-EQUIP was expected to:

> '*Support a continuous improvement process that builds personal and professional resilience, enhances quality of care, and supports preparedness for appraisal and professional revalidation. The aim of using the A-EQUIP model is that through staff empowerment and development, action to improve quality of care becomes an intrinsic part of everyone's job, every day in all parts of the system*' [3, p11].

With the roll out to nursing, a fourth function of the model was added: personal action and quality in practice improvement [4]. From this, the PNA/PMA role was to incorporate four distinct elements, firstly to advocate for the patient, fellow midwives/nurses, and healthcare staff. Secondly, to provide clinical supervision using a restorative approach. Thirdly, enable midwives/nurses to undertake personal action for quality improvement and fourthly, to promote the education and development of midwives/nurses. The development of professional advocacy to nurses and midwives, therefore, makes this work force central to both quality improvement in practice and to retention in the NHS.

This enhanced purpose of the PMA/PNA role is now strategically linked to the NHS People Plan 2020/21 [5] and to the NHS Long Term Plan [6], additionally emphasising the position of clinical leadership, with PNA/PMAs as supporting practitioners to develop themselves and the services that they work in. Despite ambitious intentions for the professional advocacy role in nursing and midwifery, to date, an initial literature review suggests little is known about the efficacy of PNA/PMA, how the role is implemented at a local and/or national level and the potential impact (or not) on professional wellbeing and retention. This project seeks to join this wider workforce conversation by examining what is happening in one Trust from a staff-based perspective.

2 Background Review

In the UK, there are approximately 50,000 nursing and midwifery vacancies [7]. The NHS Staff Survey [8] suggests this is likely to increase, responses reporting 49% as having experienced work-related stress that had impacted their health, and 40% experienced stress and burnout [8, 9]. As such, there is a need to understand and support professional wellbeing in the work environment [14], alongside the need to retain nurses and midwives [10] and develop services [30]. One means of doing so is via the introduction of Professional Nursing and Midwifery Advocacy.

To date, however, there is little extant literature about the implementation and impact of the PNA/PMA role. This is probably because the role is new and while evidence is emerging there is a disciplinary focus and attention given to those who have engaged with professional advocacy. In addition, the evidence points to specific issues such as empowerment [11] and burnout [12] and critical care [13] rather than the overarching issues of what PNA/PMA looks like in routine practice and how it is understood by those who do and do not engage with it.

The origin of role stems from clinical supervision in midwifery. Clinical supervision has a long established and well documented association with midwifery practice [14, 15], often as a response to failing standards in patient safety and care [16, 17, 18, 19, 20]. Despite its presence in guidelines, there is little consensus as to how supervision occurs in different healthcare contexts [34], nor how this might link to retention and professional wellbeing. This is important because the operational guidance for implementing the PNA/PMA is via the A-EQUIP model which concentrates on the barriers and opportunities in care giving, combined with individual professional development and wider contributions to understanding and improving service delivery. The A-EQUIP model is based on leading change and driving improvement [4, 21, 22, 30]. However, this model and subsequent adaptations have received little empirical attention, particularly in terms of overall practice-based impact from the integration of the four A-EQUIP elements of **A**dvocating and **E**ducating for **QU**ality **I**m**P**rovement and supervision. As such, the PNA/PMA role needs to be considered alongside the A-EQUIP model to determine how the model is applied (or not) in practice. This new understanding can inform the delivery of PNA/PMA at the local and the national level.

A further problem, as evidenced in the literature, is that there is little consensus about what professional advocacy is. Advocacy for patients is a familiar concept in nursing and midwifery. In this sense, advocacy refers speaking or acting on behalf of another person/patient. The Royal College of Nursing [23, p.17] suggests that advocacy is to '*ensure that people, particularly those who are most vulnerable in society, can have their voice heard on issues that are important to them, defend and safeguard their rights, and have their views and wishes genuinely considered when decisions are being made about their lives*'. However, Scott [24] argues that advocacy for the patient has been under-examined, and indeed, advocacy remains undefined in professional regulatory guidance; the term 'advocate' is mentioned on a single occasion in the Standards of Proficiency for Registered Nurses [25] and not in the Standards Framework for Nursing and Midwifery Education [26]. Where advocacy is mentioned in the literature, it does so as an overarching term for complex issues relating to the wider moral responsibilities of the profession. For example, Choi [27] identified the attributes of an effective nurse advocate comprise of proficiency, flexibility, empathy, self-directedness, motivation, accountability, commitment, and resilience. Understandings of advocacy, so far, are geared toward the interaction between the professional and the patient [28, 29], and this change in focus toward the professional is likely to require further definition and acceptance to become fully assimilated and applied in routine practice. However, patient care remains at the heart of professional advocacy [4].

This research will join the conversation about the different notions of professional advocacy from a practice-based perspective. To ensure that this research is contextually meaningful and useful, the purpose, aims and design are securely aligned and agreed with the funding Trust requirements. Therefore, the research will include understandings into the possible impact (or not) of the PNA / PMA role in relation to the A-EQUIP model for service improvement, retention, and professional wellbeing. Importantly, it will explore how PNA/PMAs themselves understand and implement the role, and how

the PNA/PMA role is perceived and used by nurses and midwives as well as developing an understanding of what stops nurses and midwives from engaging with PNA/PMA. Overall, this research seeks to explain the how the PNA/PMA is currently described, experienced, and implemented, with the view to offering sustainable strategies to develop PNA/PMA in one large NHS Trust.

3 Evaluation Design and Methods

The purpose of this evaluation is to explore and understand the impact (if any) of the PNA/PMA role in relation to nurse/midwife quality improvement in practice, professional wellbeing, and retention of nurses/midwives in one large NHS Trust. To achieve this, the following 4 research objectives will be addressed:

- To scope the current organisational context in uptake of PNA/PMA roles, current QiP, retention and wellbeing
- To understand the experience of being a PNA/PMA
- To understand if/how whole nursing/midwifery staff understand/access/use PNAs/PMAs
- To co-develop a sustainable and organisationally orientated model of PNA/PMA efficacy in the organisation

3 Research Context

This evaluation is funded by one large NHS Trust in the UK. This Trust provides services to approx. 1 million people over a wide geographical area, including city, rural and coastal locations. The Trust employs 11,600 members of staff, of which 3329 nurses and 323 midwives.

4 Methods

4.1 Research design

This evaluation will apply a mixed methodology approach [31]. To explore individual research objectives, four workstreams (WS) are identified, each with its own method, recruitment, data collection, analysis, and reporting. The evaluation team will integrate the data sets and findings from the four workstreams to gain an understanding of what is happening using a variety of viewpoints to ascertain if, how, when and where PNA/PMA is functioning or could function more effectively in the Trust. This approach investigates the impact (or not) of PNA/PMA through the lived experiences of those who are PNA's/PMA's, those nursing and midwifery staff who use of the role, and importantly, those who do not. Each workstream (WS) is detailed as follows. An overall representation of the evaluation design is also shown in Diagram 1.

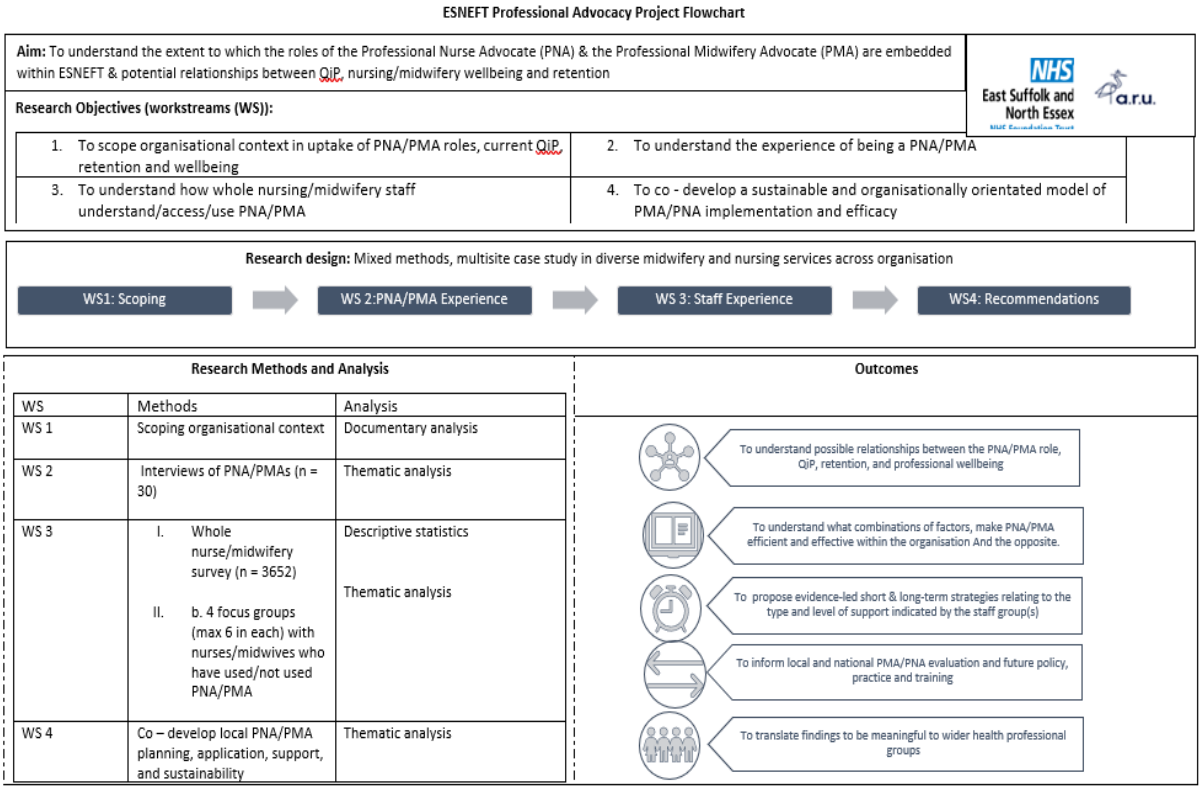

Diagram 1: Research Design

WS 1: To scope the organisational context of the Trust, internal policy and documents will be analysed and compared to nationally held data (e.g., Model Hospital), Professional Midwifery Advocacy guidance [3], Professional Nurse Advocacy guidance [30] and information from the recent national evaluation [11]. A report will be provided to the Trust. Public facing reporting of analysis will be anonymised.

WS 2: To understand the PNA/PMA experience of implementing the role in practice, semi structured interviews using open ended questions will be conducted with PNA's/PMAs across the organisational locations. Questions will be developed from the wider literature review, key national policy documents and analysis of local organisational scoping review. The core focus is their experiences of being a PNA/PMA, including what they hope to achieve by being so, examples of how being a professional advocate may/may not have resulted in QiP, retention and wellbeing, barriers to implementing the role, and their thoughts as to how the role could be best utilised in relation to QiP, retention and wellbeing. Descriptive demographic questions will also be asked to identify the band of the interviewee, current position, length of service and area of practice. To ensure consistency, one interviewer will conduct the WS 2 interviews. In preparation, two pilot interviews will pre-test the interview schedule and recording technology. The interviews are anticipated to last for 1 hour to allow for detailed conversation, instigated by the prompts. All interview data will be transcribed with biographical/identifiable details redacted at transcription. The transcripts will be thematically analysed [32] to identify themes and their concomitant categories. NVivo will be used as a data repository, providing access for the team to code and to enable blind coding to check credibility as the

coding progresses, and the enhance the capacity for cross-linking data in the four workstreams. The qualitative findings will be integrated with the quantitative data from the WS 3 online survey.

WS 3: To gain an understanding of the nursing/midwife staff awareness of PNA/PMA, this workstream is split into two parts (i and ii).

Part i will conduct a whole nursing/midwifery staff (n = 3,650) online survey to identify if the PNA/PMA role is known, how it may be known /used/types of impact resulting from engagement, and conversely, if the role is not known. The survey questions will be informed by the data analysis from WS1 & 2, and from wider available data detailed in extant literature. The intended sample size will be a return from 360 nurses/midwives for a 95% confidence interval. The distribution of the online survey will use OnLine Surveys via the Trust to relevant staff emails. The research coordinator will be available with access to a digital tablet to provide wider access for the survey completion aside from staff email. Completion of the survey will be voluntary, and return will be via OnLine portals and anonymised at this point. The research team, nor Trust personnel will know who has returned the survey to protect anonymity and confidentiality. The survey will provide the option to take part in the part ii focus groups, detailed below. Analysis of returned surveys will present descriptive and inferential statistics. This data will be integrated with the analysis of previous two workstreams and will be used to develop the focus groups prompts in part ii.

Part ii will conduct 4 focus groups. Two focus groups will be with nurses/midwives who have consulted with a PNA/PMA, and two groups with those who have not. Participants will be recruited via their agreement to take part from the staff survey, or through a general invitation sent across the Trust sites and e-communications.

WS 4: To co-develop a sustainable and organisationally orientated model of PMA/PNA implementation and efficacy. Using the integration of findings from prior the prior three workstreams, working groups comprising of Trust stakeholders, including PNA/PMAs, nurses/midwives who have used/not used the PNA/PMA service along with nursing and midwifery leaders. The working groups will be facilitated in an active process of using the research evidence to inform future practice and to improve quality in the practice of the PNA/PMA role and its use by the wider workforce. This real-world approach to translating research findings into practice offers the opportunity of ensuring that the outcomes fit with the needs and nuances of the Trust. The developed model will be presented in the final project report, with the intension that it will be implemented and evaluated with the potential to establish funding for future research streams.

4.2 Ethical Approval

Ethical approval has been gained by Anglia Ruskin University Research Ethics Committee. Permission to implement the research has been gained form the NHS Trusts Research and Development for the 3- year research life span. The gatekeeper between the Anglia Ruskin University research team and the NHS Trust research team is via the Deputy Chief Nurse. The Trust has seconded a PMA as part of the research team and to coordinate recruitment and data collection across the Trusts sites. The ARU research team have honorary contracts with the Trust. Data Sharing Agreements between the two organisations have been agreed.

4.3 Sampling

Purposeful recruitment will be used for each workstream and for each objective to ensure representation of PNA/PMAs, and nurses/midwives who have used and not used the PNA/PMA role. Sampling will occur across the various Trust location sites (city/rural/coastal). We predict sampling will snowball by word of mouth across PNA/PMAs, and for nurses/midwives who have used the PNA/PMA services and those who have not. The recruitment and data collection strategy are detailed in Table 1.

Table 1: Recruitment and data collection strategy

WS1	Objective	Sample
1	To scope the current organisational context in uptake of PNA/PMA roles, current QiP, retention and wellbeing metrics	Scope of organisational policy and metrics on retention and wellbeing
2	To understand the experience of being a PNA/PMA, and the role in relation to QiP, staff wellbeing and retention	PNAs and PMAs *n* = approx. 15
3	To understand how staff understand/access/use PNA/PMA	Part i: Whole nurse/midwife workforce online survey re awareness of PNA/PMA role *n* = 3652 Part ii: Focus groups: • x2 for those who have used PNA/PMA role *n* = 8 • x2 for those who have not *n* = 8
4	To develop a sustainable and organisationally orientated model of PMA/PNA implementation and efficacy in one NHS Trust	Consultation with core stakeholders e.g., PNA/PMAs, nurses and midwives, Trust leaders etc

Recruitment will be managed through close working with the Trust gatekeeper and the practice-based research coordinator, who will promote the opportunity for staff to participate across organisational information networks, e.g., staff e-mail, staff meetings, newsletters. The research will be advertised on flyers across Trust agreed social media outlets.

Potential participants will be provided with a Participant Information Form (PIF) and Consent Form (CF) detailing data management of confidential data, data collection and analysis and reporting. Following the return of a signed consent form, times will be established for interview/focus groups. All participants will be informed of their rights, including the option to withdraw from the study at any time without reason, the ethical implications of participation and study plans for data dissemination.

4.4 Results

The evaluation is currently in the preliminary stages of participant recruitment and data collection for WS2: The data collected in WS1 has been reported to the Trust and used to inform WS2. It is expected that WS3 will commence in late 2023 and WS4 is planned for mid-2024. Each workstream will be separately written up and then combined in the final report, which is expected in 2025.

5 Evaluation Team

The team is inter-professional and inter-organisational across the Trust and ARU. The purpose of the team is to work together across knowledge and professional contexts. The team (Table 2) will provide training and mentoring in line with guidance from the NHS confederation [33] for promoting and constructing sustaining local, place-based collaborations.

Table 2: Core Research Team

Role	Function
Principle Investigators (PI's) x 2: University	To share expertise in research design, activity, and dissemination To collaboratively plan and conduct the research. To co-ordinate research team To report on project (with research team) To ensure transparent audit trail To manage expenditure
Organisational Gatekeeper: Trust	To provide permissions and have practice-based oversight
Stakeholders: Trust	To promote the research and engage in practice-based actions to enhance impact
Research Fellow: University	To work on specific workstream activities
Evaluation Co-ordinator (Trust based)	To network and liaise with practice-based and academic colleagues. To organise research activities that suit services and practitioners.
Trust IT led	To produce and update (joint agreed) web-based and social media resources to communicate project to local and national audiences
Intern: University	To develop outward facing (dissemination) material

6 Governance

This project has 2 key governance structures:

1) A governance committee will meet 6 monthly over the 3-year project. Membership consists of representation across practice, academia, and lay perspectives. The governance group is positioned to develop and maintain transparency, trust, respect, generosity in knowledge exchange by contributing to a shared language for positive practice-orientated change.

2) To promote transparent and accessible communication, the team will use MS Teams as digital hub and meet every 2–4 weeks to review progress and focusing on the key cross-cutting themes as the stages progress. To establish inter-organisational networking and support, the research team will offer webinars and provide links to a range of PMA / PNA related resources. A project webpage, hosted by ARU, and social media will be used to include and update the wider academic and practice community.

7 Research outcomes

It is expected that the outcomes of this mixed methodology design will offer detail and understanding about the relationships between the PNA/PMA role, QiP, nurse/midwife retention, and professional wellbeing. Central to this, the practice-based evidence will provide contextually relevant insights for the Trust. The potential for the practical application of the research outcomes is a significant asset and will enable the Trust to implement strategies that consider the factors that might make PNA/PMA more effective within and across differing parts of the organisation. In addition to local outcomes, evidence to inform national PNA/PMA policy and guidelines will be provided. The is also intended to be transferable to wider health professional groups as professional advocacy is taken forward in the wider health and social care workforce.

8 Discussion

The findings and recommendations from this mixed methodology study in one large UK NHS Trust will provide new and contextually meaningful ways of viewing, developing, and implementing multi-level strategies underpinning PNA/PMA. Working in close alignment with the Trust senior leadership team, the current PNA's/ PMA's and nurses and midwives who do and do not use professional advocacy extends and maximises the reach and relevance of this research. The combination of qualitative and quantitative data in this study allows for a comprehensive exploration of the underlying issues, concerns, opportunities, and potential gains associated with engaging in professional advocacy for nurses and midwives across diverse health services and specialities and in different locations including acute and community directorates. Therefore, this design and aims deliberately speaks to the agenda set by the funding Trust. The rationale for the selected methods will firstly present an explanation of how the PNA/PMA service is currently being implemented, secondly describe the experience of using the service might/might not be, and finally, generate co-developed, sustainable strategies for PNA/PMA in a single NHS Trust.

This project is timely and necessary as the PMA and PNA role has now shifted from the rhetoric of guidance to the reality of practice. Since the inception of PMA following changes to the supervisory requirements in midwifery and the launch of PNA in 2021, the PMA/PNA role has signalled the 'start of a critical point of recovery: for patients, for services and for our workforce' [30]. However, to date, there is limited experiential evidence of PMA/PNA both in terms of the role, the delivery, and the impact. Although clinical supervision in nursing was first formally proposed in the late 1980's, the general lack of evidence for securing a systematic and fully embedded approach to professionally orientated support remains notable in the literature [34, 35]. Following the success of the PMA roll out and to address this gap, PNA training (a level 7 accredited programme) highlights restorative supervision as part of the A-EQUIP model, adapted from the original PMA training [4].

This project seeks to identify and demonstrate the ways in which PNA/PMA is understood, performed, and recognised. In doing so, the data will be used to guide each of the four distinct, yet related workstreams. There is a need to move on from the initial wave of literature and evidence which announced the arrival of professional advocacy for midwives [2, 36, 37, 38, 39] and nurses [4, 40, 41]. Publications have gone on to describe the accepted A-EUQIP model for providing advocacy, with connections to coaching, mentoring and restorative supervision [42, 43]. The lens of personal reflection is also widely used to present 'in-action' narratives [44, 47]. In addition, there are some comparisons between previous supervisory models and A-EQUIP [45, 46]. Hence, the evidence base for PNA/PMA is developing, with further examples including a professional midwifery advocate quality improvement project [48], along with projects exploring PNA and wellbeing [49,51].

However, the current available literature leans toward narrative observations rather than uncovering the processes involved in sustainably rolling out professional advocacy in the wider workforce. Consequently, the experiences and implications of PNA/PMA using the combined elements of the A-EQUIP model remains relatively uncharted. The protocol for this project is therefore situated in an agenda of discovery about what works in PNA/PMA. The point of difference is that this design incorporates both PNA's and PMA's and aims to address the gap in understanding the day-to-day, practice-based experience from a variety of perspectives. This much needed project will provide insights for implementation and strategic planning derived from how professional advocacy contextually occurs from the ground up.

The contextual orientation of this study is important. A key strength of this study is the co-operation and collaboration between the funding Trust and the research team. This inter-organisational partnership has ensured that research aims, and design are directed toward gaining practice-based insights which can inform contextually relevant routine practice to develop and maintain staff support in ways that make sense to the staff in the Trust. This approach to 'real-life' research allows staff voices to be heard and translated into favourable action, and as a result overtly shape their PNA/PMA. This is a unique opportunity to untangle individual, disciplinary, service-level, and structural components that contribute to the sustainable implementation and development of PNA/PMA in a single Trust, for which few other data sets are available or equipped to address.

Although, there are some limitations of this study to acknowledge. Firstly, the data collection, findings and recommendations are confined to one UK NHS Trust. Therefore, whilst transferable insights might be gained, there is no intention to seek or claim generalisability. Secondly, the data collection in the 4 workstreams is founded on the volunteering of information and good-will. Hence, participation and response rates cannot be guaranteed and all advertising about the research is bound by the ethical and policy procedures of the HEI and the Trust. Lastly, the Trust is a large and complex organisation, so time, planning and authorisation are needed to ensure that communications about the research reach all areas and as many staff as possible.

9 Dissemination

The dissemination strategy is designed to get the findings to those people, services, and organisations, so that they can use the outcomes in a timely way. To maximise the benefit and ensure consistent visibility, the progress, and findings for each workstream will be written up, shared, and then collated into one final report and presented across various practice and academic structures. In Workstream

4, we will ask Trust based colleagues about how to best disseminate our findings in their practice environment, this continued attention to place, people and context will help us to understand what works (or not) and construct meaningful and nuanced knowledge exchange products. Therefore, our plan is to produce targeted outputs that are in the relevant format to meet the needs of a variety of audiences. These outputs will be tailored for decision makers, policy influencers, managers, clinical staff, students, and academic colleagues, and those who are connected to initiating, delivering, and engaging with professional advocacy.

Locally, the final report will be presented to the Trust, along with a plain language summary and an informatic outlining key outcomes. We will also provide those who have participated with a summary of the overall findings which acknowledges and respects the contribution they have made. To maintain and promote our partnership approach, members of the core team will work alongside the Trust to disseminate the findings and recommendations across various groups in the organisation, for example nurses, midwives, allied health professionals and clinical leaders. We will also liaise with communication teams, IT, and other support services to ensure that we inclusively reach our intended audiences and creatively and collaboratively overcome any barriers for sharing. As such, this protocol embeds practice-based research as a series of people-centred activities, where together, we can learn and develop new ideas and ways of doing things.

Nationally, the report will be anonymised and released across various stakeholders, for example: the Nursing and Midwifery Council, The Royal college of Midwives and the combined NHSEI / HEE national body. The findings will be presented at various conferences, such as the Royal College of Nursing and the Royal College of Midwifery annual conferences. Each stage of the project will be adapted for publication across both professional and academic literatures. We will ensure that the outcomes are translated for publication across various other outlets, including the RCNi journals, the British Journal of Nursing and the British Journal of Midwifery, and the International Journal for Advancing Practice. The findings will also be streamlined for circulation around university organisations that deliver training for the professional advocacy role. To amplify the key findings, recommendations, and implications for practice, we will develop content for social media platforms/groups using appropriate hashtags to maximise promotion of the findings. In addition, we will work with stakeholders to develop the findings so that they can be made transferable across wider health professions, for example allied health professionals, comprised of fourteen professional groups, including paramedics, occupational therapy, and physiotherapy. We will also adapt the findings to make useful across the differing health care sectors.

Whilst the intention for this project is to present a model for sustainably embedding professional advocacy for nurses and midwives in one large Trust using local evidence, we are mindful of the potential for the transferable implications for the wider NHS workforce. Of particular interest is how engagement with Professional Nurse or Midwifery Advocacy may contribute to staff wellbeing and improved retention. The developed model will inform nuanced and workable strategies for how professional advocacy is understood, delivered, and received, so that practice patterns can be adjusted to support professional advocacy within specific clinical settings. The overriding advantage of this research is that it is informed by the people who are likely to use the outcomes in their day-to-day practice. Hence, it will raise awareness of professional advocacy and how research evidence can be transparently used in the practice setting.

10 Conclusion

This protocol paper has detailed in advance the projects rational, design and developing dissemination strategy. The purpose of this planned and funded study is to understand the implementation of the PNA/PMA role in one large NHS Trust, with a focus towards QiP, retention and wellbeing. This will be delivered over 4 consecutive workstreams: Workstream1 helps us to scope the current PMA / PNA scene in one Trust. Workstream 2 captures how the PMA / PNA role is currently working in practice. Workstream 3 captures how nurses/midwives may use the service, the outcome of, and if they do not, why not, and Workstream 4 models how the PMA / PNA may be integrated to develop uptake and maximise impact on professional wellbeing and retention. The decision to work with a variety of methods responds to the need to explore the depth and detail in the context of the wider picture of practice so that we can explain how the PMA and PNA role presently functions and could function in the future in different service settings. The outcomes will inform recommendations the future local and national implementation and maximisation of the PNA/PMA role and provide recommendations for translation to other health professional groups. Throughout this project, we have demonstrated the power of collaborative working to ensure that we design and implement high quality, practice-orientated research which will lead to impactful outcomes for individuals, services, and the wider organisation.

Declarations

Ethics approval and consent to participate: Ethical approval has provided by Anglia Ruskin University Research Ethics Committee. Approval to conduct the research has been approved by ESNEFT Clinical Ethics Committee.

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