DProf thesis

Service changes' impact on outpatient nurses and health care assistants

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Service changes' impact on outpatient nurses and health care assistants.

A thesis submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor in Professional Studies in Health

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Source: National Outpatient Transformation Programme: National Health Service (NHS) England and NHS Improvement (2022).

Abstract

This study investigated the impact of service changes on nurses and healthcare assistants' job motivation and wellbeing, in outpatient services within a large London acute healthcare organisation. While previous studies have focused on nurse staffing in inpatient settings, outpatient nurses are under-researched (Adynski et al., 2022). Three research questions were explored to seek answers to the research problem which included: How would the outpatient nurses and healthcare assistants be supported and motivated during and after service changes?

Based on a relativist ontological stance, a qualitative descriptive methodology grounded the choice of phenomenological approach for this study. Purposive sampling was used for the recruitment of outpatient nursing staff working within three main sites of the reseracher's organisation. Eighteen participants took part in virtual audio-transcribed semi-structured interviews, which occurred during the surge period of COVID-19 pandemic. Data were initially analysed using NVIVO12 database tool followed by Colaizzi's (1978) phenomenological method. The qualitative data was triangulated with the NHS Staff Survey (2021-2022).

Four main themes were generated from the qualitative data as follows: (1) New ways of working with increased nurse-led autonomous activities; (2) lack of staff training and development with perceived limited career progression opportunities; (3) Staff experience during redeployment COVID-19 redeployment; (4) Staff perceived lack of management and leadership support.

The findings suggest that two out of the eighteen participants had access to learning and development, which enhanced their job motivation and wellbeing. However, sixteen participants reported lack of access to training and development opportunities due to lack of Training Needs Analysis (TNA). TNA is an essential mechanism for staff to engage in their Continuous Professional Development (CPD) (Dening et al., 2019). Despite the frequent service changes and the outpatient nurses' indelible roles, there was little or no distinct career pathway leading to; lack of job motivation and professional mobility.

Kline (2014) advocated that equality and diversity need to be explicity acknowledged and integral to all NHS corporate strategies, which includes access to training and development. Perceived lack of equal opportunity for a vast majority of outpatient nurses in accessing training and development was identified as a key issue.

This study recommends implementation and standardisation of TNA and Education Facilitators across all outpatient clinical settings to align with the advocacy for equal opportunity. By addressing the identified gaps and promoting consistency in career development opportunities, this study aimed to enhance job motivation, wellbeing, and ultimately the quality of care provided by outpatient nurses and healthcare assistants.

Keywords

NHS outpatient, staff wellbeing, patient experience, change services, job motivation, registered nurses and health care assistants, Coronavirus (COVID-19) pandemic.

Statement of Authorship

This thesis is written by Martina Oparah-Evoeme and has ethical clearance from the School of Health and Education of Middlesex University. It is submitted in partial fulfilment of the requirements of the School of Health and Education of Middlesex University for the Degree of Doctor in Professional Studies in Health. The author reports no conflict of interest and alone is responsible for the content and writing of this thesis.

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"The Lord is upright and faithful to His promises: He is my Rock" (Psalm 92:15 NIV).

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Glossary of terms

Key Terms	Definitions	Source
Change management	The process of planning, implementing, and managing changes within an organization to achieve desired *goals*. It involves strategies and techniques to facilitate successful transitions.	Hiatt, J. M., &Creasey, T. J. (2012). Change management: The people's side of change. Prosci.
Compassionate Leadership	A leadership style that emphasises empathy, understanding, and care towards individuals and teams. It focuses on creating a supportive and nurturing work environment.	Lilius, J. M., et al., (2008). Compassionate leadership: A framework for compassionate, conservative leaders. Journal of Organisational Behaviour, 29(2), 193-218.
Equality Diversity Inclusion (EDI)	Promoting and delivering EDI in the workplace is an essential aspect of good people management. EDI relates to actions taken in order to shift mindsets, behaviours and practices toward more equitable and inclusive leadership for individuals, teams and organisations.	Chartered Institute of Personnel and Development. (CIPD, 2023).
Healthcare Assistant (HCA)	A healthcare support worker who provides direct patient care and support to healthcare professionals.	Royal College of Nursing. (2019). Who's who in the nursing team.

Inpatient	Referring to a patient who is admitted to a hospital or healthcare facility for overnight or longer-term care.	Agency for Healthcare Research and Quality (2018). Defining the PCMH: Inpatient care.
Job motivation	The internal drive or desire that influences individuals to exert effort and persist in achieving work-related goals. It includes factors such as intrinsic motivation (personal satisfaction) and extrinsic motivation (rewards or recognition).	Deci, E. L., &Ryan, R. M. (2000).
Multidisciplinary Team	A group of professionals from different disciplines who collaborate and work together to provide comprehensive and coordinated care to patients.	National Institute for Health and Care Excellence. (2019). Multidisciplinary team working: What is a multidisciplinary team?
National Health Service Research Ethics Committee	A committee responsible for reviewing and providing ethical approval for research projects conducted within the National Health Service (NHS) in the United Kingdom.	National Health Service. n.d. (no date) (n.d.). Research ethics committees.
National Health Services (NHS)	The publicly funded healthcare system in the United Kingdom which was founded on 5th of July 1978 (75 years), providing comprehensive medical services to residents. It includes hospitals, clinics, and other healthcare facilities.	National Health Service. (n.d.). About the NHS.

Nurse Associate	A nursing role in the United Kingdom that bridges the gap between healthcare support workers and registered nurses. Nurse associates provide direct patient care under the supervision of registered nurses.	Nursing and Midwifery Council. (2021). Becoming a nurse associate.
Nurse-led activities	Activities or interventions initiated and carried out by nurses to address patient needs and improve healthcare outcomes. These activities can include assessments, patient education, and certain procedures.	Royal College of Nursing. (2017). Nurse-led care: What does the evidence say?
Nursing and Midwifery Council	The regulatory body for nurses, midwives, and nursing associates in the United Kingdom. The Council sets standards, regulates education programs, and maintains a register of qualified professionals.	Nursing and Midwifery Council. (n.d). About us.
Outpatient	Referring to a patient who receives medical care or treatment without being admitted to a hospital. Outpatient services are provided in clinics or medical facilities.	National Health Service. (n.d). Outpatient appointments.
Outpatient Transformation	The process of improving and redesigning outpatient services to enhance efficiency, accessibility, and patient experience. It involves streamlining workflows, implementing new technologies, and optimising resource allocation.	NHS England. (2020). Outpatient transformation programme.

Registered Nurse (RGN)	A qualified nurse who has completed the necessary education and training to be registered and licensed to practice nursing. RGN is a common abbreviation used in the United Kingdom.	Nursing and Midwifery Council. (2021). Becoming a registered nurse.
Royal College of Nursing (RCN)	A professional association and trade union for nurses, nursing students, and nursing support workers in the United Kingdom. The RCN promotes excellence in nursing practice and advocates for the nursing profession.	Royal College of Nursing. (n.d.). About us.
SARS-COVID-19 pandemic (Severe Acute Respiratory Syndrome	A global health crisis caused by the novel coronavirus disease (COVID-19). It led to widespread illnesses, significant social and economic disruptions, and increased healthcare demands.	World Health Organisation (WHO) (WHO, 2020). Coronavirus disease (COVID-19) pandemic.
Service Changes	Refers to planned modifications or reconfigurations in healthcare services to meet changing needs, improve quality, and optimise resource utilisation.	National Health Service (n.d.) Service change and reconfiguration.
Staff wellbeing	The state of physical, mental, and emotional health and satisfaction of employees in the workplace. It encompasses factors such as work-life balance, stress management, and support for overall employee wellness.	World Health Organisation (2010). Healthy Workplaces: A Model for Action.

Transformation Leadership	A leadership approach focused on leading and managing organisational change processes effectively. Transformational leaders inspire and motivate individuals, facilitate innovation, and drive strategic transformations.	Bass, B. M., &Riggio, R. E. (2006). Transformational leadership.
Triangulation	A research method that involves combining multiple data sources or research methods to enhance the validity and reliability of findings for cross-validation.	Denzin, N. K. (1978). The research act: A theoretical introduction to sociological methods.
Training Needs Analysis (TNA)	TNA is an assessment tool and process of identifying the gap in employees training and related development needs.	Holloway et al., (2018). Training needs analysis - The essential first step for continuing professional development design.
Staff Development	Staff development in the nursing context is defined as the systematic process directed towards the personal and professional growth of nurses and other personnel while they are employees by a healthcare organisation	Plan and Conduct a Nursing Staff Development Programme (Ajithakumari & Hemavathy, 2016).

Chapter 1: Introduction

The National Health Service (NHS) Trusts face a various challenges which emerged from a national approach to modernisation of services, as laid out in the NHS Plan (DH, 2000) and recently the transformation of outpatient services. In year 2020 – 2021, the NHS rose to the greatest challenge in its 75 years history, responding with courage and professionalism to the threat presented by SARS-CoV-2 (coronavirus) code named, COVID–19 (NHS England, 2021). Record shows that, most of the health care services in the United Kingdom (UK) are delivered in the NHS, and most of the working nurses are employed within the NHS (NHS England, 2022). The researcher is an employee in one of the largest NHS Trusts in UK, within the Outpatient services. The researcher's organisation serves a diverse population in a major cosmopolitan city with patients from different levels of society, attend specialist medical and surgical appointments, clinical diagnostics, and one-stop services.

Nurses are an integral part of outpatient healthcare settings and they are needed to provide effective and quality patient care. The rest of the diverse multi-disciplinary teams hold their clinic sessions on a structured job-plan basis and only attend Outpatient departments when they have a list of patients booked to be seen. Hence, the full responsibility of organising the departments 'ready for patients' care' lies with the outpatient nurses for autonomous management of patient pathway and nurse-led clinics (Pearce and Breen, 2018). While the patients are at the centre of the services, historic body of evidence suggests that a milestone in the successes of an organisation (Conrad and Uslu, 2011), is to fulfil the continuous changing service needs of organisation thereby placing heavy responsibility on the staff. The issue of widening health inequalities has been brought into sharp focus by COVID-19 which requires more strategic healthcare measures (Holmes & Jefferies, 2021).

Earlier research by the Picker Institute, Blakemore (2010), shows that patients' satisfaction with their outpatient visits is most likely to be influenced by how the overall care is delivered. Nurses' attitudes towards their jobs are a determining factor (Adynski et al., 2021), which includes the way patients are treated with respect, dignity and their care needs addressed. The purpose of this study is to evaluate the impact of service changes and to use the findings and recommendations to improve Outpatient nurses and health care assistants' job motivation and wellbeing.

1.1 Background to Outpatients services and the study

Historically, outpatient services are described as the gateway into the NHS hospitals and organisations. The NHS is a publicly funded healthcare organisation that was set up in 1948 (Ham et al., 2016). The service was created with the core value that, good healthcare should be accessible to all regardless of status. Treatment is free at the point of use for people resident in the United Kingdom (Boyle and WHO, 2011). Patients attending the outpatients' services imperatively have diverse care needs, which the outpatients' nurses have a duty to provide. The basic concept of outpatient services is ambulatory, and patients are referred to the department where they are seen by doctors, nurses with the multidisciplinary team and investigations and / or treatments are instigated. The Royal College of Surgeons highlighted that reducing the number of steps in patients' journey can minimise delays in care and improve the patients' experience (Farooq et al., 2017). Also, NHS constitution created to protect the NHS, stipulates that free high-quality care should be at its core and outpatient services need to respond to the increasing care demand (Farooq et al., 2017).

The National Institute for Health and Care Excellence (NICE), and Care Quality Commission (CQC), core service framework for outpatient considered the requirements of the Equality Act 2010 and stated that, service providers must make sure services are equally accessible to, and supportive of, all people using adult NHS services (NICE, 2021). In response, outpatient care pathways are process mapped, example attached (appendices 1a &1b) with reasonable adjustments when necessary. The responsibilities of ensuring that the necessary reasonable adjustments for clinics rest with the registered nurses. Registered nurses are regulated under the Nursing and Midwifery Council (NMC) (NMC, 2018), while the health care assistants who work under the supervision of registered nurses comprise of a greater percentage of the workforce in the NHS ambulatory service. The multidisciplinary team which includes General Practitioners (GP's), patients, administrators, doctors, and nurses will always be part of the service change process and they remain unchanged, yet the frequency of modern technology implementation is constant. The opportunity to transform the outpatients' visit experience through judicious use of digital tools is huge. Therefore, the nursing staff engagement is critical to achieve effective and sustainable implementation of new electronic medical equipment (Alderwick and Dixon, 2019).

The United Kingdom government have long promoted the use of digital technology and have produced guidance aimed at improving use of digital access and documentation of nursing and healthcare (Gandrup et al., 2022). Jones and Jones, (2013) previously asserted that, even with the best strategy in place and the most appropriate organisational structure, an organisation could only be effective if the staff members are motivated to perform at high level. A key challenge to managers of an organisation is to encourage their employees to perform at high level (Jones & Jones, 2013). The outpatient nurses and the health care assistants work with the multi-disciplinary teams across the organisation to ensure that patients' care pathways are effectively delivered to achieve an excellent patient experience.

The transformation of the traditional model of outpatient services into a more flexible and responsive series of services has become one of the major challenges for the NHS (Levell, 2022). As the gateway 'shop window' of the organisation, these changes often present challenges to outpatient nurses and healthcare assistants who must ensure that robust systems and processes are always in place, to deliver safe and excellent services. Therefore, it is significant that the availability of well - motivated nurses and health care assistants is central to improving service quality. Previous NHS studies on staff job motivation were generalised and mostly quantitative staff surveys measuring extrinsic factors relating to staff job satisfaction. However, none of these researchers examined the impact of service changes on outpatients' nurses and healthcare assistants' job motivation and wellbeing.

This qualitative piece of research was explored to identify and address any gap in knowledge relating to outpatient nurses and the healthcare assistants' perception of the whole service changes, as this area of research was greatly underrepresented. With the onset of the unprecedented COVID-19 pandemic, it was of paramount importance to also investigate the pandemic's impact on the staff job motivation and wellbeing. The findings will further contribute to the body of knowledge on the level of outpatient nurses' and healthcare assistants' job motivation, in the existing NHS economic climate. The NHS services are responsible for delivering high quality care (NHS England, 2016), and ensure safety of patients, protecting them from avoidable harm and ensuring that people have positive care outcomes (Ham et al., 2016).

The constant NHS reform such as outpatient transformation and new ways of working (Adynski et al., 2021), could have some implications on how healthcare services are delivered. Considering that the NHS continuously experiences some forms of change process, whether at national or local level, the outpatient nurses and healthcare staff are key players and need some acknowledgement and recognition. This study gave the nursing staff an opportunity to narrate their experience. Although at a small scale, Creswell (2014) suggested that results from micro studies could be used to make inference about some characteristics, attitude, or behaviour of the larger population.

1.2 Limited inclusion of Outpatient nurses in the research world

Most NHS organisational values highlight that improving equality and inclusion is inextricably linked to the wider culture change at all levels (Hunt, 2007). Extensive literature review carried out by the researcher reveals huge studies carried out for Inpatient nurses reporting subjects like nurses' stress at work and burnout, to mention just a few. Amongst other studies, in April 2021 a study was launched within the researcher's organisation to investigate, 'Nurse Burnout' reference to COVID-19, and invited in-patient nurses only to participate in this study. The inclusion criteria were qualified nurses, working within the researcher's NHS Trust, adult in-patient nursing roles. Excluded from the study were nurses working in Outpatients, Paediatrics and Maternity care settings. Understandably, the Paediatric units which are not for adult care, could be excluded from the study to differentiate the adults and the children's settings. However, one would expect the adult Outpatient nurses should be included considering that this group of staff were redeployed to the in-patient wards during the surge of COVID-19, hence deserve participation in the study.

Although the Equality Act does not clearly refer to 'inclusion and exclusion criteria in research', it could be argued that all the categories of nurses who worked in the in-patient during the 'waves of COVID-19' experienced life-threatening challenges. For the purpose of Equality, Diversity, and Inclusion (EDI), the improving lives, NHS People Plan 2020 promotes a culture of belonging and trust. Lucas et al., (2020) stated that we must understand, encourage, and celebrate diversity, everyone counts where no-one is excluded, and resources are used for the benefit of all. Based on these values, no category of nursing workforce should be exempted from the burnout study.

The NHS confederation (2019) included health and wellbeing of staff as a priority, presenting an overall picture that, there were gaps that needed to be closed and supported by the workforce if the future of the NHS was to be viable and sustained. Without addressing this issue, new models of care or strategies would not be achieved (NHS confederation, 2019; NHS Workforce Race Equality Standard (WRES), 2021). The behavioural psychologist, John Stacey Adams (1965), developed a useful model for explaining why employee perceptions about fairness matters (Adams and Freedman, 1976). The Equity Theory, Adams (1965) explains the thought process which an employee uses to determine the fairness of management decision making (Cummings et al, 2021). The core of equity theory says that, individuals judge the fairness of their treatment based on how others like them are treated and nursing leadership should be underpinned by shared values (Cummings et al., 2021).

The question remains whether there was fairness in excluding outpatient nurses in the said study. In an increasingly global healthcare system, recognition and values are fundamental and important components of compassion, which should be a norm in the workplace. In terms of the research world, outpatient nurses need to be engaged and this study aims to fill this gap in research. Alam and Asim (2019) argue that salary and benefits alone do not determine an employee's motivation which explains why a promotion or raise rarely has the desired effect, which could undermine the motivation of other employees. It is therefore established that, employees place great importance on being treated fairly and equally. Excluding the outpatient and non - acute unit nurses from vital research relating to their experience working during the two waves of COVID-19 pandemic could reduce staff morale and willingness to respond to future similar redeployment.

A survey carried out by the NMC in year 2017 found that, 44% of nurses leaving the NMC register reported work conditions, stress and how they were treated differently from others as the reasons for leaving (Palmer & Rolewicz, 2021). When staff feel unappreciated, they could experience emotional flatness and become unresponsive to future management requests. In view of the lack of opportunity for outpatients nursing staff involvement in research studies, conducting this study gave this group of staff 'a voice to narrate their experiences' with service changes and the impact of the unprecedented COVID-19 pandemic.

1.3. Research Problem

Clinical effectiveness, safety and patient experience is increasingly recognised worldwide as one of the three elements of high-quality healthcare (Redwood, 1988), and the long-term plan for NHS included the idea for radical reform of the NHS. The 'Outpatient Charter' (DH, 1991; Farrell, 1999), dramatically changed how outpatient services are managed and monitored. The notion persists in policy and management discussions that hospital services such as outpatients should undergo mergers and transformations which benefit the patients and service users. All outpatients' care pathways should optimise their staff skill-mix with the Allied medical professionals and nurses should be an integral part of the service design Regional Scale Programme (RSP) and the National Innovation Collaborative (NIC). The RSP and NIC are support programmes that enable collaboration and, in turn, the rapid sharing of learning and best practice in digital transformation across the NHS while the outpatient systems and processes are constantly changed (Gandrup et al., 2022).

The issue surrounding staff shortages in the NHS and the added pressure have put staff morale at an all-time low, which could affect the care that doctors and nurses are providing to their patients, according to health experts (McNally, 2023). Hospital mergers began in the UK in the late 1990s to deal with underperformance. Despite their prevalence, there is a lack of research on how such organisational changes affect the staff morale (Lim, 2014). More so, service mergers and changes come with some challenges, Aiken et al., (2014), with increased demands for outpatient nurses and healthcare assistants to widen their roles and scope of practice, to include some responsibilities formerly undertaken by medical staff.

Ample research and reviews have been carried out on nurse staffing in inpatient settings relationship with a variety of organisational, nurse and patient outcomes, however, there is no review of outpatient nurse staffing relationship with organisational, nurse and patient outcomes (Dall'Ora et al., 2020). In view of the constant organisational changes, outpatients' care setting stakeholders and policy makers should consider improving its nursing workforce's job motivation and wellbeing, aimed at better patient outcomes, lower costs, and less nurse turnover.

1.3.1 Research aims and objectives

The terms of reference for this study were also defined with the research aims and objectives including the research questions. The overall aims and objectives of this research were to develop an understanding of the nature of service changes within the outpatients' settings. The focus and scope of this study was to explore the perceived impact of the changes on the nurses and health care assistants and gives a broad indication of what the researcher wishes to achieve in the research.

1.3.2 Research Aims

The overall aim of this study was; 'to *explore the impact of service changes on the Outpatient nurses and health care assistants' job motivation and wellbeing, from the staff perspective'.* The aims were to:

- Assess the level of outpatient nurses' workplace experience of service changes before and during the unprecedented COVID-19 pandemic.
- Identify the scale of the nurses' perceived readiness for the various service changes.
- Evaluate and analyse the effect and experience of service changes from the staff perspective.

1.3.3 Research Objectives

The following research objectives helped in developing the research.

- To identify factors that affect Outpatient nurses and health care assistants' job motivation and wellbeing, after service changes and the unprecedented COVID-19 pandemic.
- To make recommendations which will inform Human Resource and Senior Management teams, on the impact of service changes on the nurses and health care assistants' job motivation and wellbeing.
- To collaboratively establish strategies and mechanisms for supporting the staff to achieve a healthy workplace, job motivation and wellbeing.

1.3.4 Setting the Context for Research Questions

Burns and Grove (2010) defined research problems as an area of concern in which there is a gap in the knowledge base needed for nursing practice. In response to the gap identified, three research questions were formulated and to enable answer the research questions, a mono-method semi-structured interview would be explored. According to Gray et al., (2018), a research question is usually the first step in any research project and the answers to the research questions are the snapshot of reality and the real phenomenon for the participants.

As a requirement, formulating and choosing research questions are essential elements of both quantitative and qualitative research (Gray, 2021). To examine the impact of service changes on outpatients' nurses and health care assistants' job motivation and wellbeing, the researcher engaged various stakeholders to enable formulate the research questions which was scrutinised to achieve the final version for the research. For this study, the following three research questions were formulated to bridge the research gap and contribute knowledge to this discipline.

1.3.5 Research questions:

This study sought to answer the following research questions:

- How would the service changes and new ways of working impact on outpatient nurses and health care assistants' job motivation and wellbeing?
- How could the experience of outpatient nurses and health care assistants be determined in relation to the unprecedented COVID-19 pandemic and the new ways of working, due to the pandemic?
- How would the outpatient nurses and health care assistants be supported and motivated during and after the service changes?

1.4 Researchers' personal experience and reflection

Working in qualitative research, researchers are seen as the primary instrument for data collection and analysis (Tracy, 2019). It is therefore important to recognise our biases and be reflexive of the ways we might have shaped the collection and interpretations of the empirical material (Merriam, 2009). Qualitative research is interpretive by the nature of the study design and characteristics, as such, the researcher is typically involved in a sustained and intensive experience with the participants, Creswell (2014); Hatch, (2002) and Marshall et al., (2013). With this concern in mind, Locke, Spirduso and Silverman (2013), pointed out that the characteristics of qualitative research introduces a range of strategic, ethical, and personal issues into the study processes.

Creswell (2014) asserts that the ethical issues that might arise are also within the elements of the researcher's role. Therefore, the inquirers should, explicitly identify reflexively their biases, values, personal background such as, gender, history, culture and socioeconomic status (SES) that shape their interpretations formed during the study (Creswell, 2014). The qualitative research starts and ends with the biography and self of the researcher, which include their personal experience (Denzin, 1986). Similarly, for a researcher to engage in ethical research, Sultana (2007) concurs that, it is critical for the researcher to pay attention to positionality, reflexivity, the production of knowledge and the power relations that are characteristics of research processes.

With the knowledge and understanding of qualitative research dynamics, as a researcher, I acknowledge that researcher's bias is inevitable when conducting research hence I present my personal experience and own history. Mehra (2002) describes the narrative of this experience as the researcher's process of self-discovery. As a reflexive practitioner, I endeavoured to make sense of the workplace experiences in my previous hybrid role (lead nurse and service manager). In this way, the learning can be applied to the service which in turn benefits the entire stakeholders, which include the patients, staff, and the multidisciplinary team.

1.4.1 The researcher's experience with service changes

Prior to an organisational change management (restructuring) in 2010, I held a departmental nurse manager's role. Following this restructuring process, I secured a lead nurse position within the senior management establishment. It had only been six weeks in my new lead nurse role, when the general manager (GM) informed me verbally that I needed to support the administration and clerical team because, the post of the service manager was vacant, and they were trying to recruit into it. The GM who was a male with an overpowering attitude told me that; there was a problem, the service manager's position was vacant, and I needed to temporary cover for the post. The information was more of a demand as opposed to a request. Surprisingly, and unceremoniously within days, my job transformed into a 'lead nurse and service manager'. I was not aware that hybrid roles existed in nursing until then, but I was expected to get on with the new role without any form of induction.

> *Hybrid managers can be understood as individuals that hold a managerial role where they combine managerial responsibilities with a professional background (Spehar, Frich & Kjekshus, 2015). The term hybrid clinical manager, or in our case hybrid nurse manager, denotes managers with clinical backgrounds that "may or may not retain a role in clinical work" (Spehar, Frich and Kjekshus, 2015, p. 354).*

From my perspective and reflection, the hybrid lead nurse and service manager roles were hectic and very strategic, hence time demanding. I held the role for five years and the years went by so swiftly, with so many time constraints, that I was unable to reflect properly and objectively, due to the fast-moving restructurings and organisational service changes. At the time, I did not know what to describe the standalone role as, but on reflection I remember feeling that I was in a 'liminal space' especially with no similar or matching role within my organisation at the time. Griffiths (2015) argue that emerging hybrid evolving roles have created opportunities and challenges for health professionals across the world who now work within an environment of flux and uncertainty, which inevitably presents new challenges for the workforce. Arguably, the workplace for hybrid professional managers is commonly hospitals, which are complex professional bureaucracies consisting of the most central institutions in society (McGivern et al., 2015).

As such, hybrid managers within healthcare could be seen as being, at the intersection of the practice of health and the business of health (Kippist & Fitzgerald, 2009), which implies them to be a topic of societal interest and competing identities for nursing managers (Bridges et al., 2017). To define liminal space, Beech (2011) provides two ways of applying liminality such as a temporary transition while a new identity is acquired or a lengthier process of ambiguous identity during which the individual occupies the liminal space. Thomassen (2015) defines liminality as, the experience of finding oneself in an in-between position, either spatially or temporally'. Thomassen's (2015) definition of a liminal space resonates with me (the researcher) because my role was in-between nursing and operational. Liminality is not just any concept, but a concept with which to think, and it points toward a certain type of interpretive analysis of events and experiences Thomassen's (2015).

Furthermore, Attenborough (2021) in her doctoral thesis described how the identity of being a nurse by profession while undertaking another strategic role could lead to the nurse occupying a liminal space. Beech (2011) also describes the liminal process of moving towards an aspirational identity and the conflict with the authentic self and occupying the 'no man's land' or 'betwixt and between' position. Although I was determined and resilient, this description fits my situation and positionality within the hybrid role. The challenges of the hybrid and liminal role became more recognisable to me when the first outpatient Care Quality Commission (CQC) inspection took place. However, the result was rated good for both safe and caring in year 2014, although there was a scope to achieve outstanding status clinically.

The nature of my previous hybrid role involved some conflicting, competing demands and service priorities, which with a nurse background, could be viewed as a conflict of interest, particularly challenging in terms of nursing ethics and professional code of conduct. An example was safer staffing is required for the nursing skill-mix to achieve patients' care quality. On the other hand, there were very limited resources due to cost improvement plan (CIP). Nurses are commonly regarded as caring and compassionate, governed by altruistic motives, which differs from the characteristics ascribed to managers, who commonly are seen as logical, rational, and objectively oriented (Bolton, 2003). Moreover, the Nursing and Midwifery Council (NMC, 2018) code sets professional standards of practice, behaviour and Nurses and Midwives.

These standards are a set of key principles that should underpin the practice of all nurses and midwives and remind them of their professional responsibilities. Objectively, nursing professionals who occupy operational managerial roles are seen as 'hybrid managers', which implies a need to mediate between different worlds, namely the professional and the managerial world (Spehar, Frich & Kjekshus, 2015), which can be very challenging. On reflection, objectives to achieve financial savings were a priority at strategic levels when compared to safer staffing and service quality. Today, nurses constitute a large portion of the professional managers within healthcare (Currie & Croft, 2015), in which the transition from a professional nurse into a managerial position may require the nurse to learn new values and ways of being (Bolton, 2000). However, taking on a senior managerial role does not necessarily imply the nurse to embrace managerial values (Currie & Croft, 2015).

In any case, Chiavaroli and Trumble (2018) advocate that leaders should apply practical wisdom and judgement in matters such as these which would prove beneficial to the functioning of organisations. Sometimes, undertaking operational and managerial roles could be beneficial to some nurses on job learning. The appropriate support and mechanisms need to be in place to facilitate the process of on-job learning. However, in my case, the organisational structure had gaps and inadequate support for my lead nurse role which was compounded with additional administrative responsibilities, due to the combined role of 'lead nurse and service manager'.

Having just completed my master's degree in healthcare leadership at the time enhanced my leadership skills and helped me to apply theory into practice which made a difference. Exploring collaborative working with the multidisciplinary team was key and regularly compliments on the improved teamwork across the various teams which were very encouraging. Also, feedback was received from the service users on the friends and families reports which suggested that there was continuous improvement in both the nursing and the operational services. The positive feedback from colleagues was a source of motivation to continue in the hybrid role, but not for a very long period as I still felt that service quality would not be sustainable in the very long term. Therefore, I explored some models of reflection to determine my next action and personal development which included changing my role and undertaking this DProf programme.

1.4.2 Researcher's learnings from the Hybrid role

Gap analysis gives one's leadership an increased visibility into its entire operations and how well each area is working to meet objectives (Parasurman et al., 1991). Undertaking the gap analysis revealed strong areas in my work-life which needed to be addressed within the context of reconsolidating my nursing profession instead of fragmenting it with operational role and responsibilities.

My lead nurse and service manager's gap analysis (figure 1.1) highlighted my reality and enabled me to seek ways of shaping my career and professional stand.

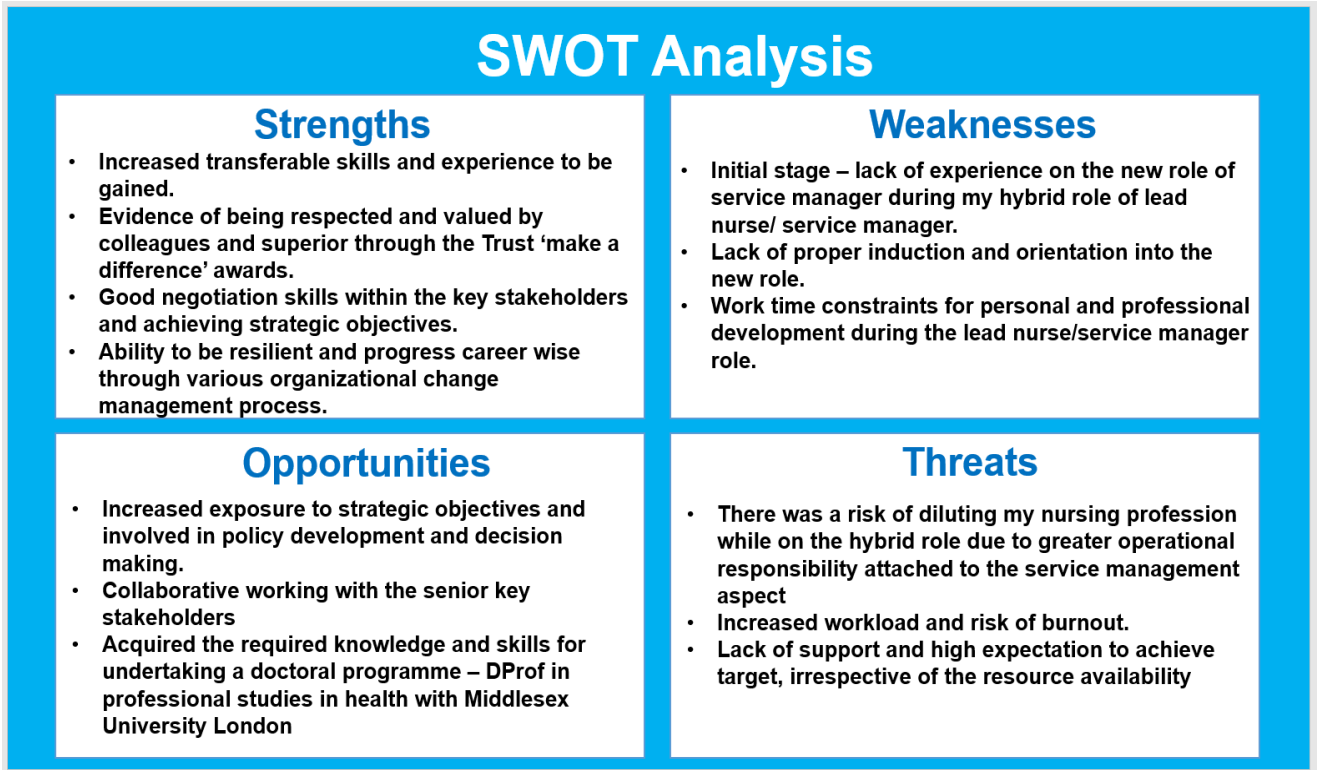


Figure 1.1 The researcher's SWOT analysis of change of roles: Framework adapted from; Humphrey (1960).

In order to learn, it is not sufficient simply to have an experience without reflecting upon it quickly or it may be forgotten, and its learning potential lost (Gibbs, 1988). From my experience, the concept of Gibbs (1988) reflective model was adopted in combination with the outcome of my gap analysis. Step 4 of Gibbs 'cycle in the analysis triggered my decision to change my role back to the senior nurse manager.

The fact that my role then was strategic, I was fully aware of an upcoming outpatient restructuring and change management, so I decided to wait for a few months for the full consultation process to be completed. Within the new establishment, I applied for and secured the position of senior nurse manager, which was my first preference. The most important change in my role which I currently hold is that the post mainly focuses on the nursing workforce, clinical management, and quality and safety assurance aimed to achieve and sustain 'outstanding' CQC rating inspection results.

Using the Gibbs cycle was useful for my reflection in my career experience. Steps 1-4 of the Gibbs cycle covered the period of my gap analysis which gave me the insight of my journey in the hybrid role. Trafford and Leshem (2008) explain that individual experiences are also one source for the researcher's theoretical perspective with a review of the literature in addition to the reflection as a nurse. The new structure had provision for other senior management positions which I was eligible to apply, but after exploring an in-depth reflection of my experience in the hybrid role. By exploring Gibb's reflective cycle (1988) (figure 1.2), my first and only preference was to maintain my nursing career, as it was imperative for me to focus on my belief of what is required to achieve care quality and safer staffing.

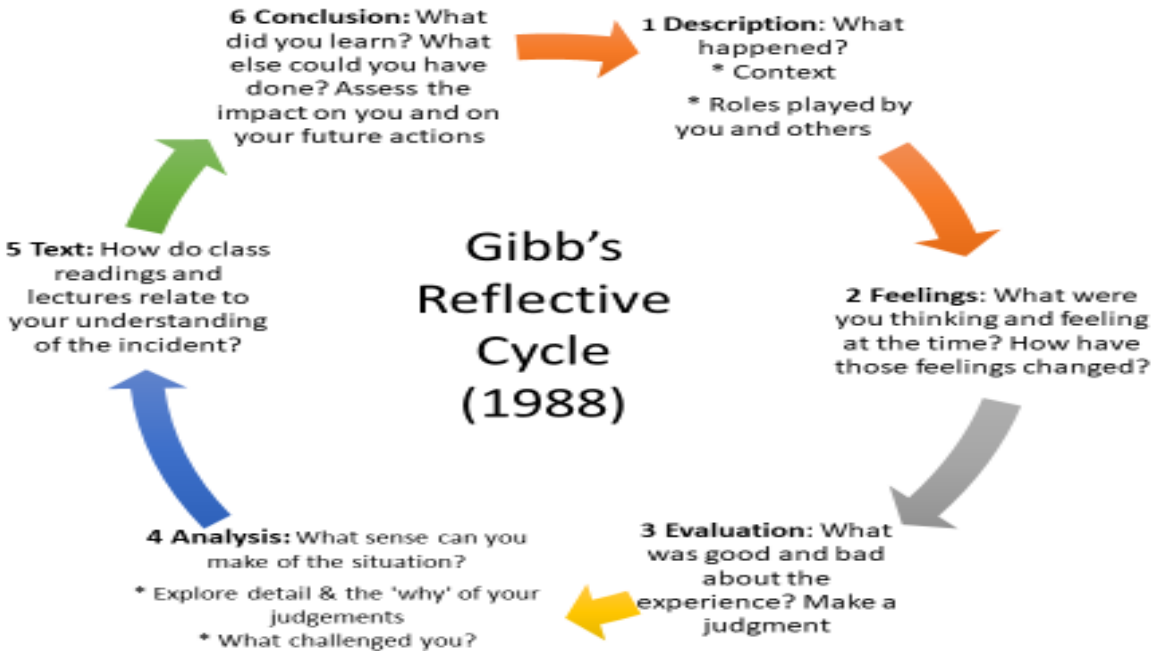


Figure 1.2– Gibb's Reflective Cycle (1988)

There are many definitions and views of identity, where Alvesson and Sveningsson (2016) refer to identity as, how one views oneself in a certain context, aiming to find answers to the questions, 'Who am I?' and "What do I stand for?" and in the extent" Who do I want to be?" Having held various roles over the years and with a better understanding of the workforce dynamics, I applied for and secured the senior nurse manager's role which I am currently holding.

The hybrid role requires the professionals to construct a desired identity in their hybrid managerial position, allowing them to answer the question of '*Who am I?'* as a hybrid professional manager (Kippist & Fitzgerald, 2009). Steps 5 and 6 of the Gibbs cycle (1998) placed me in a position of decision making, so I decided to drop the service management role and held responsibilities for my nursing role only.

In summary, using cross-sectional reflective models of both Gibbs (1988) and Rolfe's (2014), I was able to answer my own questions as follows:

- *'What? ' What was my professional interest in the hybrid role?*
- *'So what?' What was my purpose for staying longer on that position?*
- *'Now what?' What was the consequence of reverting from hybrid to nurse manager's role?*

Individuals' preferences are different but from my experience, Gibbs (1988) 'what *do I want to be?'* This question for me was answered by reverting the hybrid to full nursing management role and I wish to remain in this role while using the transferable skills acquired from service management experience, to maximise service efficiency. This form of reflexivity allowed me to explore the dynamics of my experience from my hybrid role as mentioned above. Although I gained a wealth of experience in the role, looking from hindsight, I should have challenged the lack of robustness and transparency with regards to the implementation of the combined lead nurse and service manager's roles in the structure, without any form of change management consultation process. Irrespective of the political power and privileges involved in leading a change, when carrying out a reorganisation, it is important for the change management lead and human resource to be clearer on the difference between major and minor change.

Although some managers are often unclear about changing management procedures, what seems like minor changes to the organisation can be a big deal for staff members affected. As an insider researcher, I wish to contribute to the human resource strategy by sharing my experience and increasing other outpatients' nurses' awareness on how change management and service changes could impact on them. This study explores the impact of service changes on outpatient nurses and healthcare assistants' job motivation and wellbeing, and the next sections explain the importance of the study.

1.5 Justification for the study

The World Health Organisation (WHO) urges that outpatient settings are vital parts of the healthcare continuum, as it is aimed at preventing disease and promoting wellness Lukewich et al., (2016), and key in preventive health measures to keep people healthy and out of hospitals. Similarly, Auraeen et al., (2017) highlighted the need to address quality of health services not just in inpatient care settings, but also in outpatient settings. As such, a better understanding of the relationship between nurse staffing level, motivation and care outcomes in outpatient settings may help to better understand how to improve quality in outpatient care settings (Griffiths et al., 2014). The United Kingdom government introduced the term 'ambitious NHS targets – cutting waiting times' which have been set to fuel the service users and future stakeholders' expectations (French and Bell, 1999).

As a result, fundamental policy shift has occurred in the National Health Service (NHS) with the introduction of outpatient transformation and other Key Performance Indicators (KPI) for NHS organisations. The focus on the KPIs has increased since the year 2000, culminating in a number of chapters in the NHS Plan, department of health (DH) (DH, 2008), referring specifically to outpatients and other ambulatory health services. For example, one of these targets includes the 18 weeks waiting times directives which stated that, by March 2008, no patient will wait longer than five weeks from general practitioner (GP) referral to first outpatient appointment (England, NHS and Improvement, 2020). Despite all the ambitious targets set for the Outpatient services, several published literature reviews on the topic have focused almost exclusively on inpatient care while nurse staffing in Outpatient settings has been overlooked (Park and Ko, 2020).

Prior research examining the relationships between nursing, organisations, nurse and patient outcomes in inpatient settings has demonstrated a link between nurse staffing and organisational changes and increased nurse turnover and job satisfaction (Dall'Ora al., 2020). Also, embedded in the in-patient nurse studies are the nurse patient ratios and studies on nurse burnout (Dall'Ora et al., 2020), and these studies to focus on in-patient services without any consideration for outpatient settings.

In order for an organisation to achieve its goals and objectives, the work of individual staff members must be linked into coherent patterns of activities, relationships and collaborations with the key stakeholder. Mullins (2016) pointed out that strategic goals and objectives are achieved through the 'role structure' of the organisation. While, organisational outcomes are defined as any financial or service goal of an outpatient setting's organisation where nurses work (Mullins, 2016). However, the occupational impacts are any outcomes that impact the nurses directly such as, but not limited to, nurse burnout, job dissatisfaction or other occupational issues (Jeong and Shin, 2023). Furthermore, nurses make up the largest workforce within the NHS, and it is well established that nurses are among the first people present to provide care during periods of any crisis (Buchan et al., 2017).

1.6 Outpatient nursing skills, competency and service needs

In January 2019, the Nursing and Midwifery Council (NMC) introduced a new set of standards (NMC, 2018a; NMC 2018b), which set out the skills and knowledge required to build the next generation of nurses within the Standards of Proficiency for Registered Nurses (NMC, 2018a). Another example is the introduction of Nurse Associate's role under the Nursing and Midwifery Council (NMC), a measure put in place aimed at bridging the workforce gap for registered nurses' NMC register (NMC, 2018b). Subsequent to the increasing NHS service needs, nurses' extended role of practice such as autonomous nurse-led clinical activities including the independent nurse prescribing were introduced (Summers and East, 2021). The registered nurses who are specialised and registered under NMC are allocated patients within the clinic templates to be seen by the competent outpatient nurses with the relevant knowledge, skills and extended role of practice. As a result of the introduction and implementation of extended roles of practice, new nursing structures are frequently established within the outpatient services as outpatients' transformation or new ways of working.

The outpatient registered nurses and healthcare assistants are therefore expected to be up-skilled with the relevant clinical core competencies and skills, to facilitate a more efficient and quality health service care delivery. Ensuring good patient outcomes in hospitals is increasingly challenging as national economic concerns, austerity spending and health system reforms converge to create hard choices in resource allocation (Karanikolos et al., 2013). Therefore, a better understanding of current problems within healthcare delivery enables the service providers operationally in continuous improvement and redesign of services (Usher-Smith et al., 2017).

The specific workforce population for this study were the outpatients' registered nurses and the healthcare assistants employed in the various outpatients and ambulatory services within the researcher's organisation. The outpatient services amongst others in the health sector have specific functionalities which make it 'the shop window of the hospital' that cannot be ignored. Therefore, job motivation and wellbeing for the outpatient nurses and health care assistants can play an integral role in many of the compelling challenges facing healthcare today.

> *In 2020-21, the NHS responded to the threat of the COVID-19 pandemic (DoH, 2021), which has dramatically increased the complexity of healthcare demand. The nurses and health care assistants work with multi-disciplinary teams from across the organisation to ensure that the patients' care pathways are delivered to achieve excellent* patients' experience (Fan and Smith, 2017).

Fan and Smith (2017*)* argued that previous restructuring due to the implementation of the NHS Plan (DoH, 2000; Darzi, 2018) has been termed as the 'redisorganisation' of the NHS in terms of the human resource factor. In support of the work carried out by Waddell and Burton (2006), one of the main tenets within any organisation is the human resource 'HR' therefore, there is need to improve staff job motivation by tackling issues such as increased workload, decreased morale and working practices (Whitworth and Murphy, 2018). Nursing and Midwifery Council (NMC, 2018) stated that, all nurses including nurse associates must fully understand their various roles, responsibilities and functions, and adapt their practice to meet the changing needs of people, groups, communities, and populations (NMC, 2018).

In view of the high healthcare expectations and the external driving forces, the outpatient nurses must therefore be equipped with the knowledge skills framework (KSF) and the necessary clinical specialties' competencies for safe and effective practice. Competence for registered nurses is defined as, 'the skills and abilities to practice safely and effectively without the need for direct supervision' (NMC, 2005: p.12), and for all nurses on the NMC register to follow the guidelines and to meet the NMC revalidation requirements (NMC, 2019). The onus is on the individual nurse to achieve the relevant skills and abilities for their area of practice including the training, development, and the supervision of practice (Griffiths, 2014). Competence of the nurse is not only a requirement of the nursing professional body, but it is also required by the employer (Chadwick and Gallagher, 2020).

Therefore, the need for nurses with the right skills, in the right roles, at the right time and at the right cost is paramount to achieving quality healthcare (Kennedy, 2019). However, the Royal College of Nursing (RCN) in year (2018) advocates that the employer usually accepts vicarious liability, or legal responsibility, for their employees in the event of any negligent acts or omissions in their practice (Brown, 2019). Based on these requirements, the outpatient nurses are expected to be competent and proficient in their extended role of practice.

1.6.1 Nursing workforce and high turnover

The unprecedented COVID-19 pandemic has brought into sharp focus long-running workforce issues, such as short staffing and increasing demand for services which is prompting some nurses to change roles thereby facing various challenges. It was highlighted that some steps were taken to protect nursing staff as they continue to work in challenging situations and facing issues out of their control such as reduced staffing levels and redeployment. In spite of these efforts,13,945 nurses, midwives and nursing associates left the Nursing and Midwifery Council register between 1st April and 30th September 2021, representing a four-year high which was labelled as, the nursing 'big quit' (Salmond, 2019; Munn, 2022). Safer nurse staffing level was defined by the International Council of Nurses (2018) as having an appropriate number of nurses with the appropriate educational mix, to match the correct number of patents and care needs, in order to deliver quality care (Aiken et al., 2018).

This study provides the opportunity for the outpatient nurses and health care assistants to narrate their lived experiences especially during the COVID-19 pandemic and serves as a contribution to feed into the NMC and RCN nursing professional bodies. Figure (3) below is a summary example of previous outpatient NHS staff survey result which showed underperformance on the staff job morale and health & wellbeing.

1.7 NHS staff survey and Outpatients staff performance

Figure 1.3 Staff Survey Results 2019/2020

- On all key criteria, Outpatients Directorate scored at or above the Trust-wide average
- Within these results, the themes that performed the lowest were:
  - Health and wellbeing
  - Morale
  - Staff engagement
- Those areas are worth looking at in greater depth
- Trust-wide priority issues such as; Equality, Diversity and Inclusion (EDI) are also worth considering in future research.

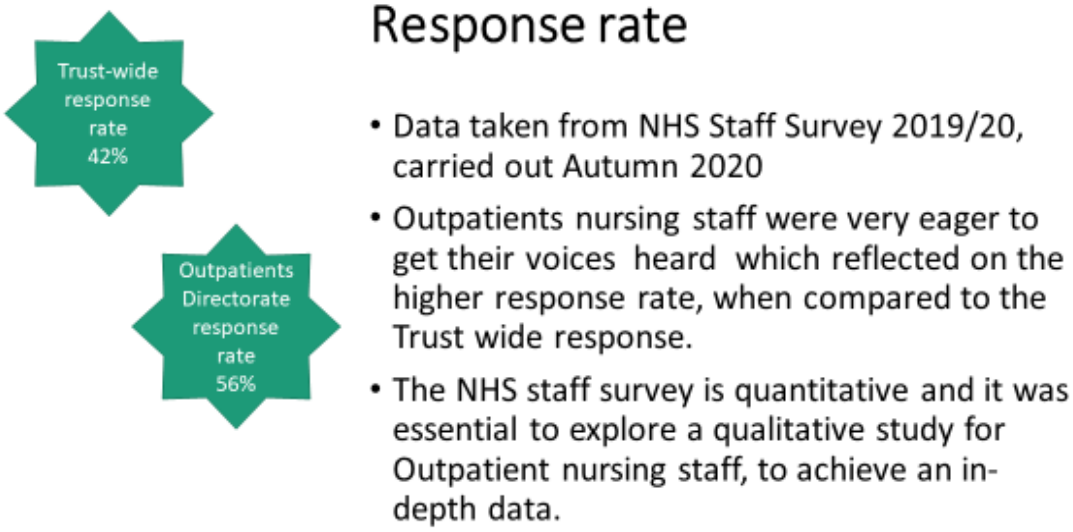


Figure 1.4 - Staff Survey Response

Following up from the NHS staff survey report (2020) and based on the fact that it was a very good response rate, it was of great concern that, low staff morale and health & wellbeing performed below expectations which was a clear indication that, further study was required in a qualitative approach to investigate these concerns.

Employees of an organisation are instrumental in these service improvements (Coleman and Thomas, 2017). Even with the best strategy in place and an appropriate organisational architecture, an organisation both small and large will be effective only when its members are motivated to perform at a high level with organisational changes (Jones and Jones 2013). Yet, there is little or no evaluation of how these changes impact on the employees who are key to the organisational success (Aiken et al., 2014). Staff are healthcare's biggest cost and greatest asset and how staff are treated impacts significantly on their health and well-being, on organisational effectiveness and on the care patients receive (Kline, 2023).

Previous quantitative research on staff motivation exists, however, none has examined from nursing staff perspective how service changes' impact on outpatient nurses and health care assistants' job motivation and wellbeing. This research project intends to address the gap in research. The findings and results from this study will further contribute to the body of knowledge on staff job motivation in the existing NHS economic climate.

1.7.1 Staff job motivation and wellbeing defined

This study aimed to determine the outpatient nursing staff job motivation and wellbeing at work, from the staff perspectives. Therefore, it was paramount to define the themes of job motivation and well being. Job Motivation is defined as the internal drive or desire that influences individuals to exert effort and persist in achieving work-related goals. It includes factors such as intrinsic motivation (personal satisfaction) and extrinsic motivation (rewards or recognition) (Deci & Ryan 2013). The intrinsic factors links closely with Pinder (2014)'s definition of motivation at work which is considered as a set of energetic forces that originate both within as well as beyond an individual's being, to initiate work-related behavior (Pinder, 2014). Hence exploring the intrinsic factor of staff motivation aligns with this study.

In terms of wellbeing, the World Health Organisation (WHO) defined wellbeing as the state of physical, mental, and emotional health and satisfaction of employees in the workplace. It encompasses factors such as work-life balance, stress management, and support for overall employee wellness (WHO, 2010). Additionally, wellbeing has been described as the combination of feeling good and functioning well; the experience of positive emotions such as happiness and contentment as well as the development of one's potential, having some control over one's life, having a sense of purpose, and experiencing positive relationships (Huppert, 2009). According to this definitions, the conceptualisation of wellbeing goes beyond the absence of ill health and includes the perception that life is going well. The WHO (2010) and Huppert (2009)'s wellbeing definitions identified the key indicators such as; emotions, stress, work-life balance, happiness and development of one's potentials as contributory factors which determine one's wellbeing. As such, the participants' wellbeing in this study was determined by the above wellbeing indicators.

1.8 Research Project outline

This introductory chapter outlines the purpose of the study, sets the background, and presents the project overview of the main study with an illustration, figure (1.5) flow chart.

1.8.1 Outline of the Thesis

This project commenced the introduction in Chapter 1, which has outlined the context of the research as:

Introduction (Chapter 1), gives an overview of the outline of this thesis. This study captures the individual experiences of the outpatients' nurses and healthcare assistants relating to service changes in the hospitals' departments' where patients receive diagnosis and / or treatment which is described as ambulatory service.

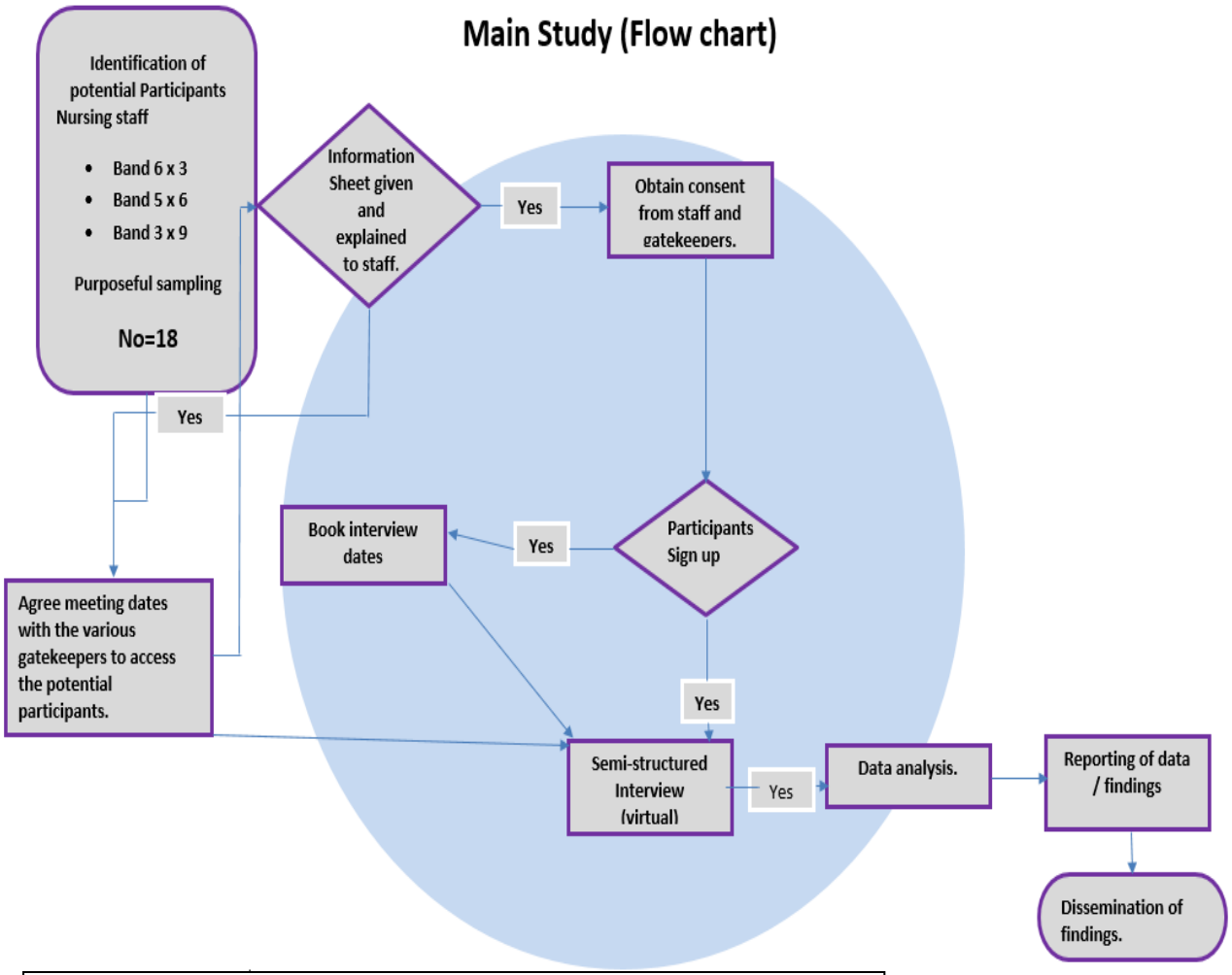


Figure 1.5: Main Study – flow chart

Literature review (Chapter 2) explains how the existing relevant literature discusses the concepts and conceptual frameworks of service changes, leadership, and followership and how this literature shaped and influenced this study.

Research design, methodology (Chapter 3), covers how the research design was created, the methodology and considered rationale for the design. It also examined the research approach adopted as well as the limitations of the method.

Project Activity; data collection and analysis (Chapter 4) describes how the researcher ensured access to data from the participants in line with research ethics procedures**.** The sample group, the period and where the study occurred. How the data was analysed using the NVIVO12, with thematic Colaizzi's (1978) analysis method. Descriptive statistics based on frequency tables and bar charts from the NHS staff survey reports provided the information in terms of data for a triangulation method with the key themes that generated from this qualitative data.

The research discussions and the overview of the results (Chapter 5), presents the findings of the research in respect to service changes' impacts on Outpatient nursing staff.

The summary chapter of the research (Chapter 6) discusses the findings of the study and the implications to practice with an overview of the researcher's reflexive account of personal and professional journey.

The conclusion, recommendations, and contributions (Chapter 7), present the conclusion, recommendations, contributions, and the dissemination of findings and any learnings from the project.

1.8.2 Conclusion

Conclusively for this chapter, outpatient nursing staff play a critical role in providing ambulatory care services, therefore, the staff wellbeing can have a direct impact on the quality-of-service delivery. By understanding the factors which impact on the nursing staff wellbeing, healthcare managers can take steps to improve the workplace environment and support the outpatient nurses' health and wellbeing. Improving staff job motivation could invariably lead to improved patient care outcomes.

Chapter 2: Terms of Reference and Review of Literature

2.1 Introduction

This chapter provides a review and critical discussion on the existing literature regarding the research topic, to provide the background and context of the research. This chapter also outlines the relevant existing knowledge to the research questions. Understanding the landscape in which the researcher is working will in effect enable them to make a valuable contribution to the field, which might be hugely underestimated (Winchester and Salji, 2016).

2.2 Aims of the study

The purpose of the literature search was to identify any existing information on the research project, gaps in research or conflicts in previous studies, if any. Conducting the literature review provided the researcher an overview of sources needed to explore while researching into the chosen study topic. This study was conducted to explore the impact of service changes on outpatient nurses and healthcare assistants' job motivation and wellbeing, from the staff perspective. Therefore, how the literatures on the outpatient services, nursing workforce, leadership and the National Health Service (NHS) overlap and interlink, will help to shape my approach in this study. Based on the search outcome, I developed a construct (figure 2.2; page 51) as a guide.

Redesigning and transformation of outpatient services to meet the growing patients' demand and to increase efficiency, has been a dominant policy focus over the past decade (Outpatient service redesign, The Health Foundation, Insight & Analysis Unit, June 2019). Research evidence shows that increased staff motivation is the key to economic recovery in the country (Bawa, 2017). According to human resources, workforce is vital to an effective healthcare system and poorly motivated health workers can have a negative impact on individual facilities and the entire healthcare process (Xiao, 2022). Additionally, the existence of any negative impact on staff will have a 'knock-on-effect' and consequently affect the patients. This literature review focused on the most updated research data and information, to demonstrate how this study fits within the larger theoretical frameworks of service changes and staff job motivation.

Research suggests that factors which may influence wellbeing are; work-life balance, stress, workload, and job satisfaction (Xiao et al., 2022). Similarly, other issues that may influence employee wellbeing include organisational change management (Yadav et al., 2014). The researcher used articles published in professional and academic journals and news articles relevant to the research topic for this project. The outcome of the literature search suggests that, at the time of writing, there was no existing study on the proposed research topic. It should also be noted that although this literature review included many recent related NHS studies, Adynski et al., (2022) affirmed that outpatients' nursing staff experience is still under-researched.

2.3 Terms of reference (TOR)

There is evidence that a well implemented or sustained change can be seen in the history of public service reforms, to create staff anxiety and stress to practice changes and performance targets, which tend to linger on for a long time therein affecting staff (Cohen, 2017). Therefore, there is need to bridge the gap in knowledge regarding nursing staff job motivation in relation to the constant service change process in acute NHS outpatient care settings. Three motivational criteria have been identified such as differences in the staff perspective of the service changes, the organisational culture and management with its leadership styles.

This chapter also discusses the motivation theories and its importance to staff wellbeing with the relevance of change management and the impact of change. Conducting a literature review helps to build knowledge and to determine if gaps in the literature exist and how research can contribute to the body of existing knowledge. Furthermore, understanding the landscape in which the researcher is working will in effect enable them to make a valuable contribution to the field, which might be hugely underestimated (Winchester and Salji, 2016).

In view of the mentioned terms of reference, the researcher explored an extensive literature search strategy reflecting the need, '*to explore the impact of service changes on outpatient nurses and health care assistants' job motivation',* as the implications still remain unknown.

2.3.1 Objectives of the Literature Review

- To identify any previous work in this discipline.
- To determine within the NHS context any qualitative study for the outpatients nursing staff.
- To explore factors that influence outpatient nursing staff job motivation and wellbeing.
- To determine how the literature review can inform this study's methodology.

2.3.2 Literature Search Strategy

Jesson et al., (2011) highlighted that extensive research in literature expands the researcher's understanding and information gathering of the research topic, as well as identify ways others have used to address similar problems. Additionally, literature reviews are the basis for research in nearly every academic field and the importance of conducting a literature review cannot be over emphasised (Fink, 2020). Furthermore, literature reviews are beneficial in identifying or refining research questions or statements which might facilitate the appropriate research process, methodology, data collection including other relevant existing data (Ridley, 2012).

2.3.3 Search Engine

In order to accomplish the literature search, some computerised databases were examined. Inclusion criteria involved the use of MEDLINE, CINAHL, MEDSCAPE, and Archive, Middlesex University Database, Journals Databases, Google Scholar, Professional Bodies like; Royal College of Nursing (RCN), Nursing and Midwifery Council (NMC), PubMed and the Cumulative Index to Nursing Health Services (NHS) literature as the main search engines. Hale et al., (2019) advocate that careful selection of search criteria is important in order to focus on the study area.

Therefore, this research focused on the connection between the outpatient nursing staff, service changes, job motivation and wellbeing. The literature search words included "nursing staff," "job motivation," "staff wellbeing," "hospital," "Outpatients," "COVID-19 pandemic," "Outpatient transformation" and "service changes".

2.3.4 Inclusion and Exclusion Criteria

Using PubMed and the Cumulative Index to Nursing Health Services (NHS) Literature, I conducted a literature search on the connection between outpatient service changes and its impact on outpatient nurses and healthcare assistants' job motivation. Excluded were research on a very tiny percentage of studies that overlap between the databases, and studies not connected to outpatient nurses delivering acute hospital care services. Only studies reported in English were used and those published requiring translation were disregarded.

2.4 Purpose of Outpatient Services

The Outpatient Department (OPD) is the shop-window / the face of the healthcare facility, for patients (Tabish, 2011), and the overarching purpose of outpatient care has always been to manage patients who do not need to be admitted in hospitals.

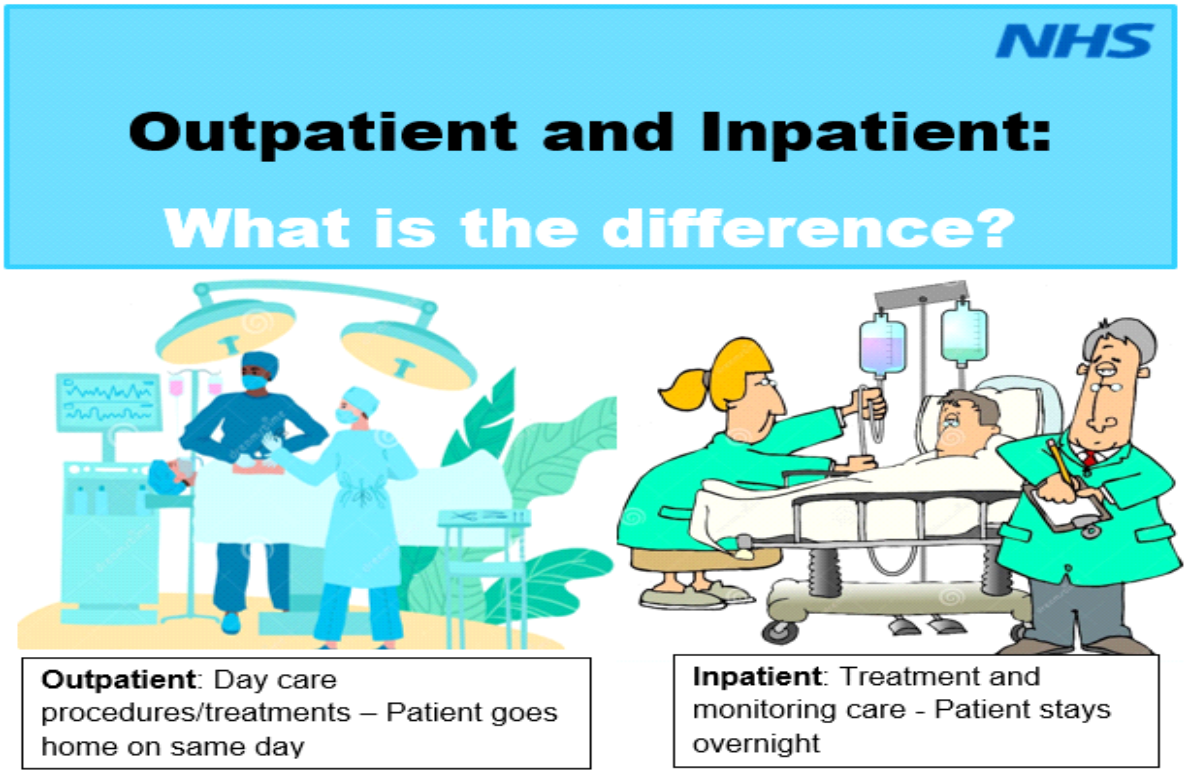


Figure 2.1 Example of Outpatient and Inpatient care interventions.

The above illustration (figure 2.1) shows the different types of clinical activities within an 'outpatient and an inpatient' healthcare settings. In acute healthcare settings, patients seek specialist opinion for their diagnosis, management of their conditions and for more complex health needs to prevent admission into inpatient beds.

Hence most patients' interactions within hospitals are through outpatient clinics (Isherwood et al., 2018). Overall, an outpatient setting is suitable for the performance of a wide range of medical, surgical, and remarkably diverse types of healthcare procedures (Griffin et al., 2020).

2.4.1 Some Key Drivers to NHS organisational change

The reshaping of the Department of Health's role within England healthcare governance since 2012 has encouraged NHS organisations to involve the public in service changes (Exworthy and Mannion, 2016). Subsequently, healthcare policies and public involvement have been identified as key facilitator of NHS service transformation, however, little is known about how these changes impact on the staff job motivation (Stewart et al., 2020). Although some management change project might incorporate staff wellbeing, the strategic aims and objectives is for organisational development.

Martin (2011) claims that expectations, change and awareness of change are the main differences in how individuals perceive change, hence, exploring the outpatient nursing staff perspective of change experience would be valuable knowledge in the research field. NHS service improvements are usually implemented through change processes, it is therefore important to examine how the service changes affect the staff job motivation, health and wellbeing, as clearly defined within one of the research questions for this project. Bolton's (2003) conceptualisation of change includes the term change shock and this is a vital part of this study. The top-down re-organisation of the NHS and periods of rapid reforms were orchestrated by NHS England Sustainability and Transformation Plans (STPs) on how best to integrate care, with the hope of making financial savings and preserving quality (Walshe, 2017; Alderwick & Dixon, 2019).

Conceptualising this in a framework shown below for this chapter (figure 2.2), places staff job motivation and wellbeing at the centre, which guides the rest of the discussions on this chapter.

Figure 2.2 The Researcher's Construct.

2.4.2 Patients - Outpatient Services Changes

The term ‘outpatient service’ is used specifically for clinical areas where individuals receive outpatient care and is also referred to as ‘ambulatory care’, (Hughes, 2022). It is well established that ambulatory care nursing differs from other nursing specialties in terms of practices due to the patients’ characteristics and populations (Karam, 2022). As a result, ambulatory care setting is highly diverse and multifaceted, requiring nurses to possess strong clinical assessment, education, and advocacy skills, with the ability to implement a broad range of interventions in a variety of highly complex settings (Mastal, 2010). Outpatient services encompass a wide variety of diagnostic examinations, treatments, and consultations that can be carried out in either a large hospital, in healthcare centres or in day care surgeries (Tokita et al., 2020). As described by the World Health Organisation (WHO, 2009), outpatient healthcare facility is for consultation and treatment and Iversen et al., (2020) acknowledged that outpatient settings are seen as a key part of the healthcare continuum, as it is aimed at preventing disease and promoting wellness.

The trend of rapid reforms and service changes within NHS resonates with the researcher, who has continuously worked within the NHS organisations for over thirty years. Studies have found that patients are sometimes admitted through outpatient services of the hospital because many medical and nursing experts offer both inpatient and outpatient services (Griffin et al., 2020). However, several published literature reviews on the nursing topic have focused exclusively on inpatient care while nurse staffing in outpatient settings has been overlooked (Adynski et al., 2022). Importantly, it is essential to acknowledge outpatient services as clinical environments which offer chances to develop skills in a specific specialty (Griffin et al., 2020).

Collaborative and multidisciplinary team approaches are well established in diverse outpatient care, and this can be linked to outpatient nurses coordinating the care as host members of the team (Cole, 2016). As part of improving the process of care pathways, it is not surprising that outpatient nurses have absorbed many extended roles including prescribing follow up medicines, or managing patients’ chemotherapy (Cole, 2016). According to Clarke (2021), outpatient care pathways in England are based around 200 National Health Service (NHS) hospital trusts serving 56 million people and establishing the health and wellbeing of the workforce is crucial.

Following the onset of COVID-19 pandemic, the NHS outpatient waiting times have increased requiring strategic action and new ways of working to deliver quality and effective patient care and treatments (Chan et al., 2022), which calls for the nurses to respond to service changes. Currently, there were approximately one million referrals from primary care, and 680,000 from other services, to English NHS outpatients in the month of February 2020. Referrals dropped during the COVID-19 pandemic, but by February 2022 primary care referrals had returned to over 90% of pre-COVID levels (NHS Improvement, 2022). An example was in February 2022, where 62.6% of those referred to outpatients had started treatment by 18 weeks (NHS England, 2022), compared with 83.2% in February 2020 (NHS England and NHS improvement, 2022).

Ibrahim et al., (2021) argued that, the fall in performance was due to COVID-19-related workforce and workspace redeployment, staff sickness and burnout. Despite the long waiting times for appointments and treatment, the NHS remains a top ranked world-class service (Schneider et al., 2017), with high patient satisfaction and good management of certain long-term conditions. However, Dayan et al., (2018) argue that the published Care Quality Commission (CQC) (2017) (www.cqc.org.uk), inspections of NHS providers show that organisations find it challenging to consistently meet all the targets associated with good care, including leadership, responsiveness, effectiveness, and safety, suggesting patient care may still fall short of required standards. In response to the waiting times and 18-week directives, earlier suggestion by Johannessen and Alexandersen (2018) indicated that NHS organisations need to move forward with the available NHS resources.

Traditionally NHS resources, including hospitals were located to serve the local needs of eighteenth - and nineteenth - century populations, and despite rebuilding and mergers, the NHS care outpatient structure is often based in historic institutions (Kay et al., 2021). Inevitably, change is required in outpatient service provision to facilitate the change process (Levell, 2022), hence workforce is central to implement the changes. Although these considerations are not new, previous attempts to merge and close inefficient units were often resisted (Wass and Lansdown, 2021). In any case, the reshaping of the Department of Health's role within England healthcare governance since 2012 has encouraged NHS organisations to involve the public in service changes (Exworthy and Mannion, 2016).

Healthcare policies and public involvement have been identified as key facilitators of NHS service transformation (Foley et al., 2017), which subsequently impact on the workforce but, how these changes affect the staff is still under-researched. Hence, it is crucial to gain a better understanding of how to manage change, enhance the workforce, and staff job motivation (Stewart et al., 2020). In support, Levell (2022) acknowledges that, successful reconfiguration cannot be based only on data-driven logic but driven by patients' needs which require consultation and explanation to accommodate and respect the wishes of key stakeholders including nurses. Moreover, the current NHS emphasis on patient healthcare outcomes and service efficiency is associated with a variety of perspectives such as, workforce management and wellbeing (Ham and Murray, 2015).

In view of the ongoing outpatient service changes, it is critical to determine how the changes or new ways of working impact the nursing workforce. Therefore, this study also aims to find out the staff perspective on service changes impact on outpatient nursing staff job motivation and wellbeing.

2.4.3 NHS waiting time and key drivers to outpatient service changes

A wealth of innovations transforming the Cardiology care were identified in the NHS on the Getting It Right First Time (GIRFT) (Ray & Clarke, 2023). GIRFT is NHS England (2020) programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence based to support change. Gathani et al., (2021) argue that, it has been most publicly evident in recent headlines showing worsening performance against the Government's own 2 weeks' wait and 18 weeks referral to treatment (RTT) process targets, especially in breast cancer cases. The long waiting time adds pressure to the service and finding clinics appointment capacity for patients to be seen within outpatient departments is really challenging. By default, outpatient nurses play a key role in collaboration with the multidisciplinary team to respond to the increasing manage service demands.

The illustration (figure 2.3) below shows the continuous increasing trend for the demand of the outpatient services where patients waited more than the 18 - week period set standard.

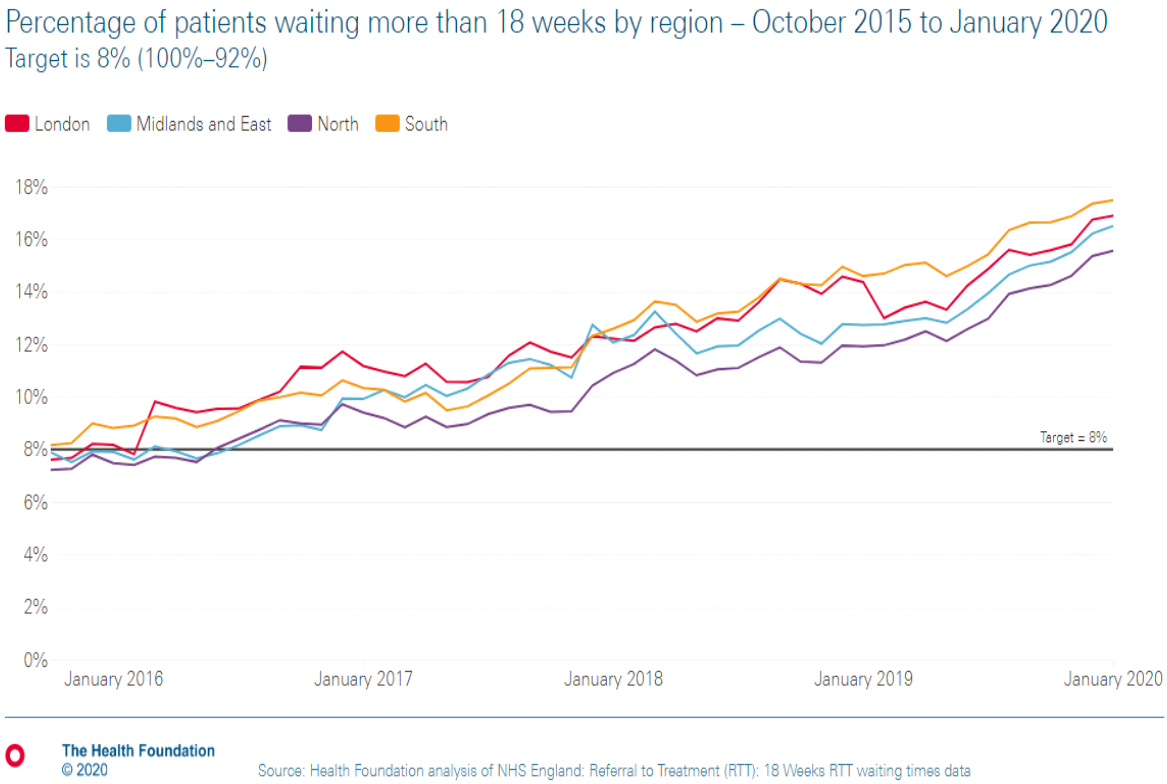


Figure (2.3) Percentage of patients waiting more than 18 weeks by region
Source: Health Foundation analysis of NHS referral to Treatment (RTT) waiting times' data. www.18weeks.nhs.uk

2.4.4 A short overview of waiting times and the 18-week standard

According to Charlesworth et al., (2020), waiting lists are as old as the NHS, but targets for waiting times are a more recent phenomenon dating back to the Patient's Charter introduced in 1992. Introducing the 18-week standard in 2004 fundamentally changed how the NHS measures and manages waiting times. Recovering 18-week standard looked particularly challenging, therefore, the NHS Long term plan (2019) was budgeted for extra funding to cut long waits for elective care and reduce waiting lists by 2023/24.

Charlesworth et al., (2020) highlighted that, a typical patient care pathway involves some stages, however, this charter did not always reflect the reality of how long people waited per stage. The three stages are;

- time from General Practitioner (GP) referral to first outpatient appointment
- time to arrive at a diagnosis and decide on treatment options, and
- time from that decision to the start of treatment.

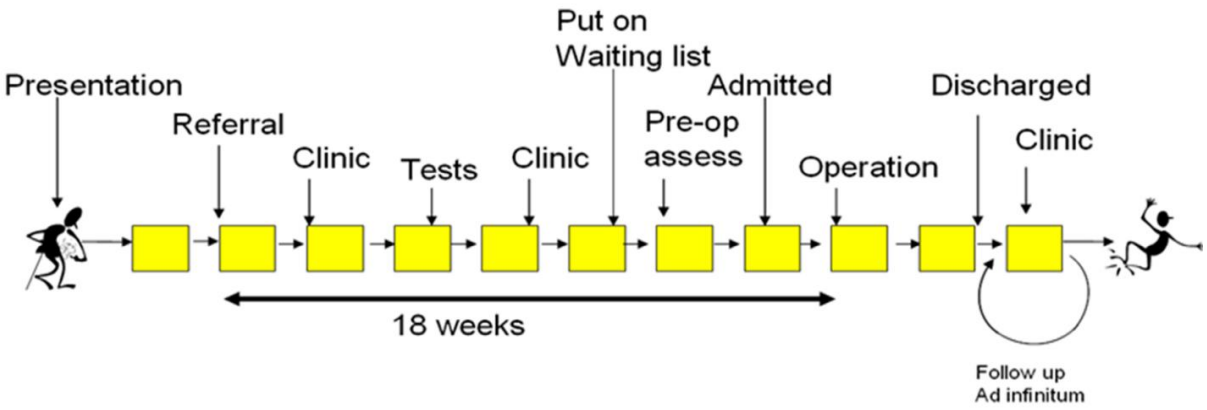


Figure (2.4) Source; www.18weeks.nhs.uk (Accessed: 16 August 2021).

Under the 18-week standard (figure 2.4), the clock starts with a GP referral to outpatient or ambulatory services and only stops when the patient starts treatment or is discharged which demands a different mindset to the previous 'stage of treatment' targets (Charlesworth et al., 2020). As a result, hospitals have to look at the whole care pathway instead, managing capacity and tracking patients through outpatients, diagnostics and inpatient services and align clinical pathways with administrative systems to achieve the standard.

Kay et al., (2021) asserted that imbalances between capacity and demand lead to considerable variation around England in the referral to treatment times (RTT). An example is the RTT in rheumatology which varied from 5-30 weeks for serious conditions, such as vasculitis and lupus erythematosus, requiring rapid diagnosis and assessment to reduce morbidity and mortality (Kay et al., 2021). Hence, the expectation was that, with the planning guidance, the waiting lists would reduce in 2020/21 and increase performance, even before the onset of the COVID-19 pandemic (Gardner, 2020), and figure (2.5; p.57) next page shows the trend of the actual waiting list and treatment.

2.4.5 Redesigning of Outpatient Services and managing change process

In order to manage and achieve the 18 weeks (about 4 months) waiting times, the NHS Improvement (2017) highlighted that there are significant gains to be made for people using outpatient services. One of the proposals was to re-design many clinical pathways across the entire system with a focus on evidence, accessibility, effectiveness, shared decision-making, and improved personal outcomes (Topol, 2019). Most importantly, the NHS Long Term Plan, (2020) outlined new initiatives and digital solutions to help the delivery safe care, in a different way ensuring services continue to meet the needs of all our patients (Plan, 2020), which includes implementing innovative approaches with the service transformation in a COVID-19 era (Cole et al., 2021).

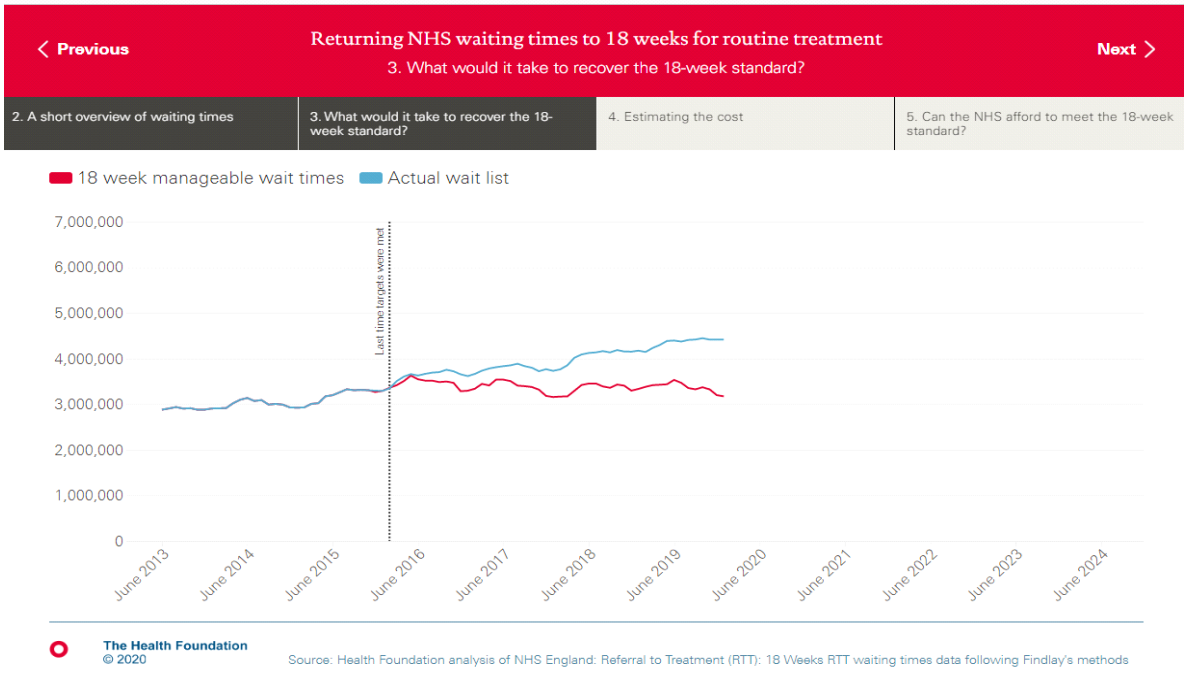


Figure (2.5). Source; The Health Foundation (2020).

Changes in outpatient services are therefore not surprising and according to Health Education England (HEE) successful implementation of change and delivery of excellent healthcare will require investment in people and technology (Cole, 2021).
In order to engage and support the healthcare workforce in a rapidly changing and highly technological workplace, NHS organisations will need to develop a learning environment in which the workforce is given encouragement to develop continuously (Gandrup, 2022), while adapting to service changes.

Some experts suggest that change is a normal and gradual process and likely to occur in any transitional experience when moving away from a comfort zone, however, this may place the employees' self-confidence and self-esteem at risk (Martin, 2016). Agreeably, the conceptualisation of change includes the term 'change shock' which needs to be identified and managed for any change to be successful and leadership styles have a significant impact on staff experiencing such changes (Cortvriend, 2004). The NHS is going through a period of unprecedented change (DH, 2012), and these changes included hospital mergers which began in UK in the late 1990s to deal with NHS service underperformance (Walshe, 2017).

As a result, the top-down re-organisation of the NHS and periods of rapid reforms were orchestrated by NHS England Sustainability and Transformation Plans (STPs) on how best to integrate and merge care, with the hope of making financial savings while preserving service quality (Walshe, 2017). However, Green et al., (2013), contends that the cost differences remain statistically significant in hospitalisation compared to cases such as, Accidents & Emergency and Outpatient departments. Hence, treating patients in good enough time and prevent delays would be more efficient in some cases. In any case, based on the current economic climate and the cost implications for healthcare, efficiency drive is inevitable which leads to service changes (Hibbard et al., 2013). In reference to NHS and Cost Improvement Plan (CIP) measures, Lim (2014) posits that, this strategy would negatively impact on staff in terms of changes and reviews within the staffing establishment.

Lim (2014) further argues that, there is a lack of research on how such organisational changes affect the staff morale. Many studies have shown that work stress and work motivation can greatly affect job satisfaction and, in turn, the quality and delivery of healthcare. The NHS can provide more effective and accessible care by the rationalisation of service delivery through merged organisations. Conversely, these mergers only illustrate the focus on organisational restructuring, as the key lever for change and not necessarily the health and wellbeing of NHS staff (Ingersoll et al., 2001).

Previous studies highlight that, limited resources and a shortage of skilled health workers create very tight bottlenecks in the provision of services. This situation leads to many healthcare workers experiencing work-related stress and low work motivation, in addition to receiving low salaries and having restricted opportunities for promotion (Zhou et al., 2013). Hence, improving outpatient nurses and health care assistants' job motivation and wellbeing, will invariably benefit the overall outpatient service quality and efficiency.

Frequent service changes is common, therefore, a strong relationship between the leaders, managers and the employees to improve staff job motivation and quality of care has been suggested (Huber, 2014). Similarly, the findings and recommendations from a study by Zaki, et al., (2018) suggest that hospitals should provide continuous emotional intelligence support to nursing staff to enhance their competencies, decision making and performance. In this way, services will be efficiently managed, and it would be a win–win situation for all parties involved, the patients, nursing staff and the senior managers (Zaki et al., 2018). The next two decades of changes in health and social care aim to address some of the predictable changes; public health, which the NHS will need to address (DH, 2021). Considering the constant changing dynamics of outpatient services, the impact of service changes on outpatient staff job motivation and wellbeing needs to be explored, to enhance support for the nurses.

In order to foster support for the workforce, the Royal College of Physicians (RCP) discouraged some reorganisations' establishment reviews and organisational change in relation to changes in roles and pay bands, where some staff are usually down banded to achieve financial savings (Mortimer et al., 2018). These changes could have direct or indirect unavoidable effects on the staff (extrinsic factor) thereby, affecting the (intrinsic factor) staff job motivation (Mortimer et al., 2018). Moreover, Martin (2016) highlighted how, even a well - intentioned national health policy creates organisational anxiety for the affected staff. Routinely, the NHS staff surveys, and predictive quantitative methods have been used to understand association between the nurse workload and staff job motivation (Oshodi et al., 2017). However, the quantitative study outcome following NHS staff survey is insufficient and lacks in-depth data for necessary remedial actions.

Evidence have shown that motivating employee is the most complex function of management, an example is the Employee - Organisation - Relationship (EOR) described as an overarching employment relationship which has continued to make remarkable progress over 30 years (Shore et al., 2018). However, there is still room for continuous improvement within the EOR and further opportunity is required to expand this important research phenomena within the concept of staff job motivation.

2.5 NHS Outpatient Nursing

Nurses are an integral part of outpatient healthcare settings, and they are needed to provide effective patient care (Adynski et al., 2022). Ample research and reviews have been carried out on nurse staffing in inpatient settings relationship with a variety of organisational, nurse and patient outcomes. However, there is no review of outpatient nurse staffing relationship with organisational, nurse and patient outcomes (Adynski et al., 2022). The Royal College of Nursing (RCN) (2019) highlighted the significant pressures on the entire health and social care system, including in existing acute-based outpatient services. The limited number of studies about outpatient nurses, especially in qualitative research, creates a gap hence this study aims to contribute to research and new knowledge about outpatient nursing staff.

Adynski et al., (2022) also reported that an extensive literature search showed that there were 28 quantitative studies out of 34 which showed outpatient nurses staffing, however, 6 (six) were qualitative studies. The same search also found that, three out of the six qualitative studies were conducted within the United Kingdom which related to patients' care outcomes. The key messages in the Modern Outpatients - A Collaborative Approach 2017-2020, align to RCN priorities for outpatient services to bridge the gap in the staff engagement strategy. RCN (2019) advocated for nursing studies as an opportunity to give voice to the nurses. However, literature review from this study suggests outpatient nurses' experience has been under researched, hence the need to explore this study to bridge the gap in research.

Kim et al., (2020) argue that, outpatient nurses are responsible for the patients' well-being throughout their medical and surgical procedures and to ensure efficient care delivery to patients. In establishing ambulatory nurses' role, the American Organisation for Nursing Leadership (AONL) and the American Academy of Ambulatory Care Nurses (AAACN) published a joint statement addressing the role of the nurse in care coordination and transitions of care across the health care continuum (Hughes, 2022). Similarly, RCN describes outpatients' clinical areas to have specifications and set priorities which include, a greater focus on the multi-disciplinary team approach to ensure that people see the right clinician in the right place, including explicit support for developing extended roles across the professions (RCN, 2019).

There is ongoing evidence of the impact of deprivation on healthcare outcomes and outpatient nurses play a key role in delivering the required care to the patients. The establishment of local Community Diagnostic Centres (CDC) within the regions, for example the North West London Healthcare (NWLH) has such Ambulatory services running at Ealing, Willesden and Wembley locations and these services are linked to the outpatient – ambulatory services in the acute hospital settings within the catchment areas. These CDC services were established to reach local communities to bring care nearer home and according Hemingway and Bosanquet (2018) nursing as a profession in a uniquely powerful position help to reduce inequality by tackling social determinants of health. Agreeably, nurses' knowledge and understanding helps in identifying and addressing health inequalities (McFarland & MacDonald, 2019).

According to Hemingway and Bosanquet (2018) RCN outlined how nurses could help in reducing mortality, in the least deprived areas for patients experiencing health conditions (Mundal et al., 2017), such as:

- A smaller reduction in deaths from coronary heart disease (31.3% reduction compared to 38.5% in the least deprived) (ISD)
- A 42.3% higher rate of mortality from cerebrovascular disease (ISD) (Mundal et al., 2017).

While outpatient activities alone cannot turn these deeply concerning statistics around, Harrison (2018) suggested that access to diagnostics, specialist treatment and effective follow up is key for those who may not have the health literacy, technological competence or connectivity.

However, Harrison (2018) expressed a particular concern where there is any presumption toward technological interaction or regionalisation / centralisation of services, without explicit commitment to providing access, support and resources to those staff who require the support for effective care delivery. Furthermore, Rush et al., (2019) promote collaborative working with other healthcare teams, such as outpatients' registered nurses to address health promotion, acute illnesses, chronic diseases and other social determinants of patients' healthcare needs.

Although a greater number of patients who require healthcare services do not need to be hospitalised overnight, they are cared for by nurses who work in outpatient services (Guest et al., 2017). With the appropriate care to these patients, most patients' hospitalisation is avoided, which enhances the patients' quality of life and saves costs to the NHS. The Nurse-led clinics improved healthcare, patient and quality care outcomes one of the responsibilities of outpatient nurses is to undertake procedures such as minor surgeries etc. (Guest et al., 2017).

In UK, it is a professional requirement for a registered nurse working in an outpatient setting to acquire a current nursing license from the Nursing and Midwifery Council (NMC, 2018) on the NMC register within the level of their qualification, competency and proficiency. Outpatient autonomous Nurse-led clinics are also introduced to support intermediate care after the acute phase of disease (Wong et al., 2013). An exploratory two phases' study conducted in Hong Kong between years 2001- 2003 addressed a particular aspect of outpatient clinic service (Wong et al., 2017).

Findings from the phases of the studies, initially from 34 clinics and secondly from 162 clinic sessions in 2001– 2003, showed that, the nurses who ran the clinics were very experienced. The same study reported that, over 80% of their work was independent or interdependent and satisfaction scores for both nurses and patients were high. The findings suggested that clinic nurse services were effective alternative models of ambulatory healthcare delivery using holistic framework**.** Conclusively, Wong et al., (2017) reported that, although physicians valued their partnership with the nurses, they were concerned about possible legal liability resulting from increased advanced roles and complex cases undertaken by these nurses.

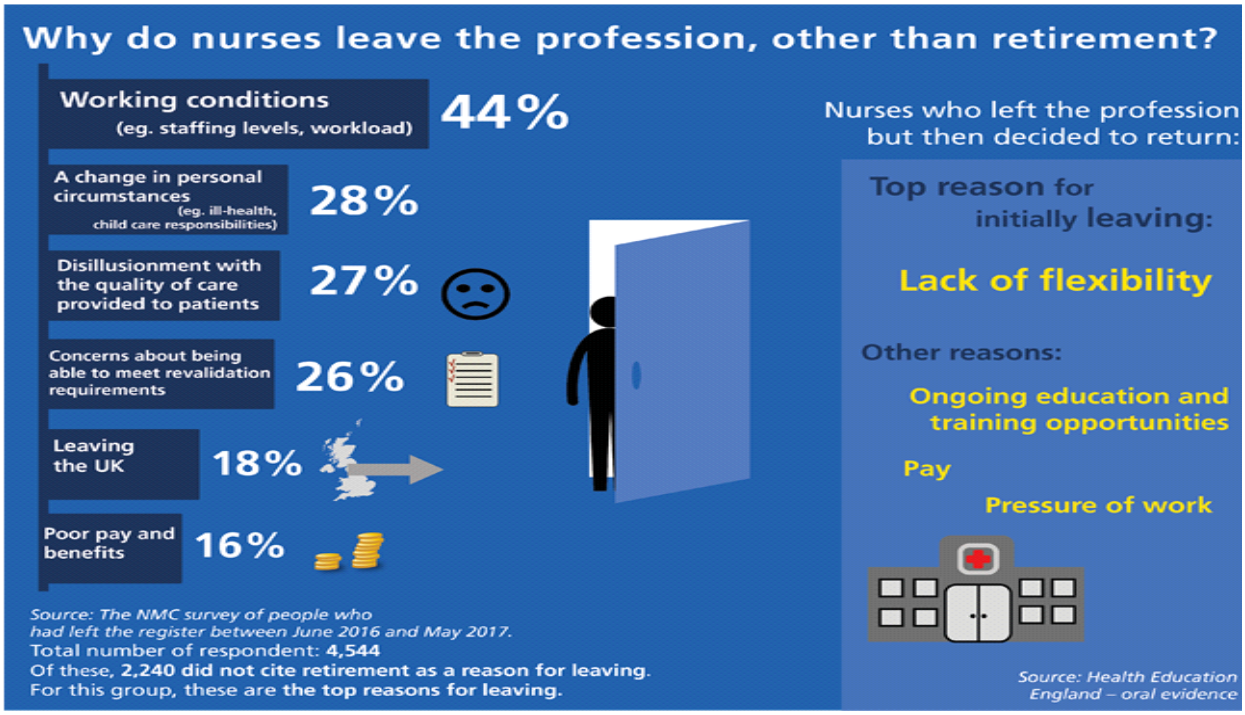
The concern regarding litigation resulting from nurse-led practices can be mitigated when policies and procedures are in place. According to NMC (2018), the role of the nurse in the 21st century demands that, they are accountable for their own actions and must be able to work autonomously, or as an equal partner with a range of other professionals, and in interdisciplinary teams. In effect, the nurse practitioners, clinical nurse specialists (CNS) and nurse consultants are deemed competent as registered nurses who play a vital role in providing, leading and coordinating care that is compassionate, evidence-based, and person-centred. Standards of proficiency for registered nurses set out by NMC (2018) states that:

> *"In order to respond to the impact and demands of professional nursing practice, they must be emotionally intelligent and resilient individuals, who are able to manage their own personal health and wellbeing and know when and how to access support (NMC, 2018, p.3)".*

Therefore, the expectation is that all the NMC registered nurses in practice must ensure they have, "the confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care" (NMC, 2018, p.3). The NMC revalidation every three years is prescribed in the Nursing and Midwifery Order 2001 and could be challenging for some nurses to maintain, which has accounted for 26% of nurses leaving the profession (NMC, 2018).

Following this survey in 2016/2017, (figure 2.6, NMC, 2017), shows various reasons why nurses leave the profession, including disillusioned with the quality of care provided to patients, work conditions, and work overload. The literature on nursing found that, employers must maintain consistent and better work conditions and sufficient staffing in order to keep nurses interested in their jobs, particularly in psychiatric outpatient settings as psychiatric care shifts from being inpatient-based to being outpatient-based (Konttila et al., 2018).

The NMC (2017) nursing survey report highlighted some reasons why nurses leave the profession and these factors could serve as key indicator measures for actions to motivate and retain staff.



Source: The nursing workforce - Health Committee - House of Commons (parliament.uk)

> The nursing workforce - Health Committee - House of Commons

Figure (2.6). Why do nurses leave the profession, other than retirement?

The findings demonstrated that nurses report a higher level of satisfaction with their jobs when there are inclusive policies and procedures in the context that support nurses in maintaining their professional identity (Nunstedt et al., 2020). Likewise, outpatient nurses would benefit from an inclusive employee engagement in terms of qualitative studies with a view to improving their job motivation, health and wellbeing at work.

2.6 Outpatient Transformation

Outpatient services are remarkably diverse in terms of clinical specialties and the various multidisciplinary teams which compounds the complexity and fast high turnover nature of the services; therefore, the leader need to make quick decisions in clinical situations.

Strategic thinking is part of all job descriptions in nursing, whether written explicitly or not, hence it is important to understand and communicate the unique team perspectives that ambulatory care nurse role brings (Bergstedt and Wei, 2020). An example is the Dermatology specialty where the British Association of Dermatologists (BAD) (Levell, 2022) outlined strategies for Outpatients Transformation Programme, to embed value-based healthcare approach with the ambition to build and implement modern outpatient services.

Collaborative and multidisciplinary team approach is required whereby nurses, pharmacists, and other paramedical staff can bring different professional skills to improve outpatient care (Levell, 2022). This strategy includes the clinicians, nurses, multidisciplinary team and patients to work collaboratively to improve care quality and the use of outcomes and experience data in enabling care services, as illustrated below on the outpatient transformation strategy (figure 2.7).

Outpatient Transformation Strategy – 2020

Figure (2.7) Source; Aneurin Bevan University Health Board – 2020.

2.6.1 Outpatient and Digital Health technology

Levell (2022) also highlighted that it takes approximately 15 years to train new doctors to become consultants. Improving capacity in the outpatient clinical team also requires training of the MDT. As a result, the term 'clinicians' which include, doctors, nurses, therapists and the multidisciplinary team are used for healthcare staff with direct patient care responsibilities. In general, challenges within healthcare and increasing complexity of patients exist regardless of whether a nurse works in a traditional hospital or ambulatory care setting (Hughes, 2022).

For example, England's National Programme for information technology (IT) was, from its outset, an ambitious effort aiming to introduce national electronic health records across NHS care providers throughout the country (Konttila, 2019). Obviously, the advent of new digital technology provides complex but unparalleled opportunities for healthcare services and staff (Kruse et al., 2021). Also, Wiegel et al., (2020) argued that users adopting a new technology require time to acquire knowledge about its characteristics, which may only be fully realised through a prolonged period of use.

There has been an increase in new ways of working over the years, most importantly, the implementation of the new shared electronic NHS Care Records Service (Brennan, 2005). However, COVID-19 pandemic has compounded to the change in practice (Levell, 2021), especially with shared electronic record service demand that, NHS organisations manage patients' records, accommodate the technology and 'paper less' into their work practices for patient safe care delivery. According to Sheikh et al., (2021), the inner London NHS hospitals were the early adopters on the patient administrative system, 'ambulatory care' shared Cerner IT system. It is a common practice to roll out new information technology systems in outpatient setting (Oates et al., 2021). Similarly, Overhage and McCallie, (2020) found out that a growing number of studies quantify the amount of time outpatient clinicians spend using the Cerner Millennium IT system which nurses must be familiar with for safe care delivery.

In terms of service changes, outpatient department are always designated as early implementers or adopters of the organisation's local service providers of the hospitals, with the role of integrating care activities. For example, for ordering of clinical tests and investigations or clinical notes, the IT adoption issues are highlighted and addressed (Black et al., 2011), within the ambulatory services, prior to roll-out to other hopsiptal services. Several limitations observed in the process with the 'early adopters' were dealt with for the first time by all stakeholders and eventually resolved through negotiation, and subsequent implementers learnt from these early experiences (Farrell and Sood, 2020). Overall, findings on cost-effectiveness of digital interventions showed a growing body of evidence and suggested a favourable effect in terms of costs and health outcomes (Gentili, 2022). In terms of patients' clinical acuity and incidents, Auraaen et al., (2017) reported that, globally, 4 in 10 patients are harmed in primary and outpatient care settings in healthcare, with 80% of that harm being preventable, thereby, highlighting the need to address quality of health services not just in inpatients care settings, but also in outpatient settings.

During service change process, outpatient nurses and the clinicians have a primary objective to ensure robust governance and resource availability to achieve the best patient outcome (Auraaen et al., 2017). With increasing innovation, survey studies found out that, the changing patient needs, workforce challenges and technological advances could help in designing different models of care for service improvements, quality of care and staff satisfaction (Tzortziou et al., 2017). However, with quality improvement-based approach, such initiatives require careful planning, close collaboration between health care professionals and allocation of appropriate resources and training for the workforce.

2.6.2 Outpatient service demands and care interventions

There has been considerable changes with outpatient service demands. Dupuis (2022), pointed out that the status of National Health Service (NHS), is facing an ever growing demand for its services, which leads to increasing waiting times and extending or modifying the roles of service providers forms part of the service changes (Dupuis et al., 2022). When reporting outpatient workload, Perin et al., (2016) highlighted that there is a new challenge in the management of outpatient workload and if this factor is not accounted for when planning staffing, understaffing will be experienced.

Across NHS England, 838,600 patients were waiting for a key diagnostic test at the end of November 2015, a 5.6% increase from November 2014 (Ogundeji et al., 2016). Evidence shows that there are no published reviews on the relationship between nurse staffing and organisational change or in relation to patient outcomes in outpatient settings (Park and Ko, 2020). Hence, this study aims to provide a synthesis and contribute to literature review on outpatient nursing staff experience. The outpatient setting was deemed suitable for the performance of a wide range of clinical procedures and care where there is a high turnover of patients. The ambulatory care forms the integral role in defining nursing practice in the outpatient services unlike inpatient care where the patients stay overnight in the hospital, or other facility where they may be constantly observed (Cavanaugh et al., 2021). Furthermore, Redwood et al., (2007) assert that service improvements and benefits to patients would have full impact when the services become more established. However, it is important to determine patients' views on the difference between nurse-led care and other services delivered to the patients and the care outcomes (Kennedy et al., 2012).

Recently, 'one stop clinics' were introduced where the investigations and procedures can be undertaken at a one-stop appointment, which helped to reduce hospital visits. On the other hand, (Oates et al., 2021) argues that this approach provides complex issues around consenting patients for procedures, therefore appropriate patient selection and safety should be considered. In view of the potential care safety concern, there is a continual focus on the nurses' education and development to respond to a wide range of situations in order to mitigate against any gap in service. Therefore, services like nurse-led pre-operative assessment clinics are set up to the effect.

Additionally, measures like seven days outpatient services and three-sessions daily, to optimise outpatient space use (Gardner, 2020), must be job planned and resourced, so that staff are not pressured to work for longer hours. In a healthcare system with finite resources, such as the NHS, clinical effectiveness on its own is insufficient to form a basis for producing guidance. With these challenges in NHS, the National Institute for Health and Clinical Excellence (NICE) was established as a Special Health Authority in April 1999 to promote clinical excellence and the effective use of resources within the NHS (Chidgey et al., 2007).

Therefore, NICE (2021) bases its recommendations on an assessment of both clinical and cost effectiveness, both in its technology appraisals and in its clinical and public health guidelines, in relation to the population's quality of life. The assessment of this incremental cost effectiveness ratio can be carried out in different ways and NICE preferred to measure the cost per individual (NICE, 2021), using a specific measurement scale for the cost. The cost is defined as; quality adjusted life year (QALY), (NICE, 2006), although alternatives are used in circumstances where appropriate data on quality of life are not available for example, life years gained or disease-specific outcomes (Rawlins, 2006). The importance of quality healthcare availability cannot be overemphasised (DoH, 2020), as NICE, (2007) previously demonstrated a plot of length of life (in years) against quality of life (or 'utility' on a 0-1 scale).

The graph compares the expected profile for a group of patients with some given treatment and others not given treatment (or given a standard treatment versus a new treatment (DoH, 2021). For example, in the longer term, both length of life and quality of life are improved for patients on treatment, Walker et al., (2007). As highlighted by Chidgey (2007), figure (2.8) below shows the decline in health events seen in the group receiving treatment which relates to the benefits of care intervention within 2 to 18 weeks wait key performance indicators (DoH, 2021).

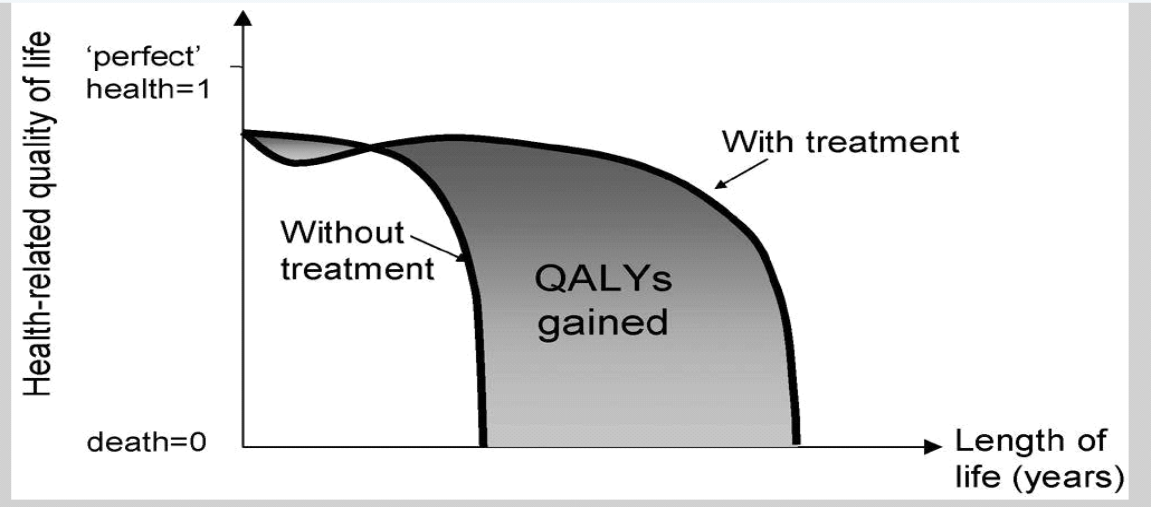


Figure: (2.8). Source; QALY concept Chidgey et al., (2007). [Accessed: 1-10-2022].

Overall, the area between the two curves is the number of QALYs gained (or lost) for a given treatment (NICE, 2007), which demonstrates that, treating patients within the set waiting time target improves the patients' health and length of life. Another earlier study in the UK identified that only 40% of patients received care in line with best practice guidelines covering four common conditions (Hanies, 2004). It was recognised that each individual guideline is likely to impact on a range of professionals and organisations, and inevitably full implementation of care interventions that need to take place over several years (NICE, 2013).

Outpatient multidisciplinary team including the nurses need to comply with these guidelines in terms of patients' treatment timelines, to prevent a breach of the 18 weeks wait. Nurse-led clinics have shown to provide more efficient outpatient care and reduce waiting times and the autonomous nurse-led activities facilitates the patients' care pathways for service quality and efficiency (Rayman and Kar, 2020) Figure (2.9) below illustrates the multidisciplinary team approach where nurses are holding autonomous multiple service capacity allocations, within the outpatients' transformation model.

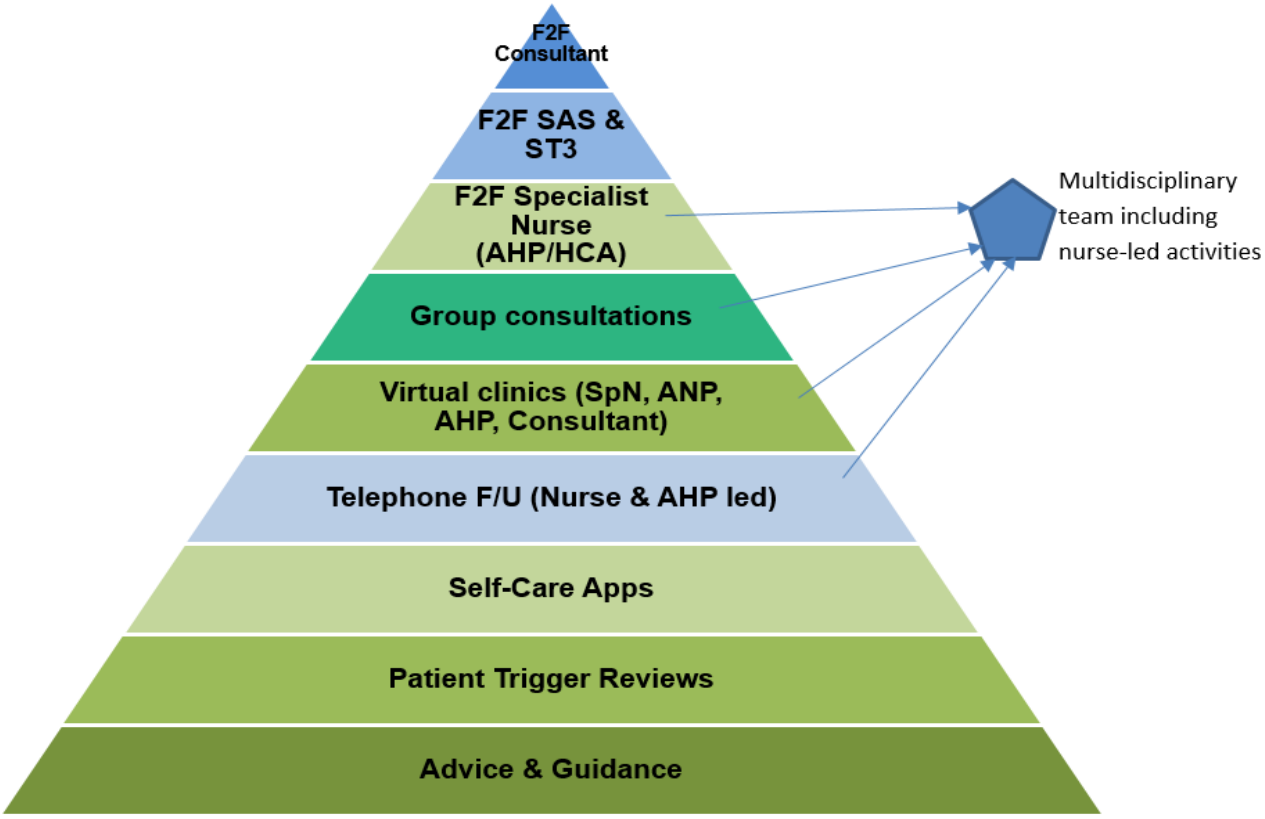


Figure (2.9) Adapted from NHS Transforming Outpatient Services – Getting It Right First Time (GIRFT) 2018.

2.7 Job design and job satisfaction

Job design is the process of creating a job that enables the organisation to achieve its goals while motivating and rewarding the employee (Hackman, 1980), and a well-designed job leads to higher productivity and quality of work, also leading to higher job satisfaction, lower absence, and lower employee turnover intentions (Daniels et al., 2017). Whilst nursing jobs are specifically structured to meet the patients' care needs and service efficiency, Gupta (2020) expressed that, it is the way a job is designed that can influence how the efficiency levels can be achieved, whether the job is motivating and satisfying to the job holder. This study explored the impact of service changes on outpatient nursing staff job motivation and job design is a core component and ingredient of service changes. Therefore, job design specifically can be utilised to create a supportive and stimulating work environment to enhance innovative work behaviour (IWB) and employee wellbeing (Parker et al., 2017), hence its relevance in designing registered nurses' job.

2.7.1. Job design motivation theory

The best-known framework as argued by (Parker et al., 2017), is the job characteristics theory by Hackman and Oldham (1980) with factors that can affect work design either directly or indirectly by influencing managers' and/or employees' knowledge, skills and abilities (KSA's) and motivation. Over the years, experts have put in efforts towards increasing managers' understanding of job design (Campion & Stevens (1991); Parker et al., 2019). With reference to the core job dimension, a review of studies conducted on magnet hospitals revealed that, both autonomy and control over nursing practice are consistently identified as magnet characteristics (Wagner, 2022) and classified as practice excellence. In terms of clinical informatics, learning from the digital health systems require not only data but feedback loops of knowledge into changed clinical practice (Scott et al., 2018). All these factors are embedded in the core job characteristics.

The five core job characteristics outlined on figure (2.10) below is a motivating framework for individuals to improve their job design which is key for the registered nursing role to enhance their autonomy in their nurse-led practices.

Hackman and Oldham's Job Characteristics Model (1980): The HR Practice (2017).

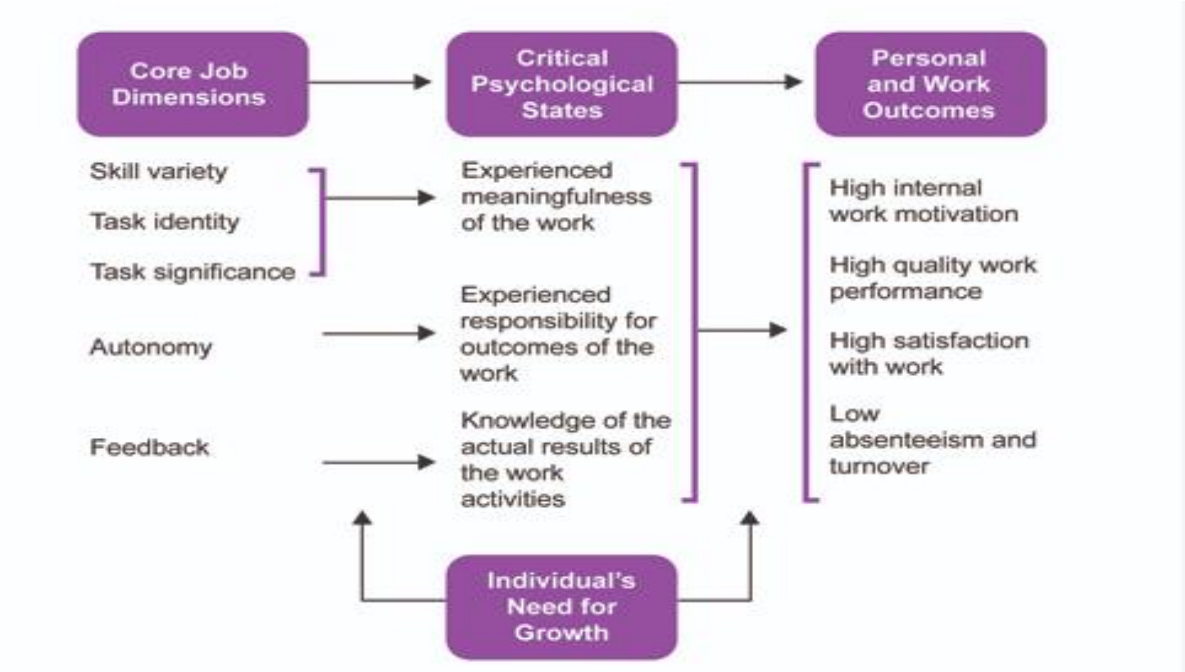


Figure (2.10) Source: A Motivation Theory: Job Characteristics Model: Management Funda; V4 Issue 3 — The HR Practice

There are several theories about how job design can contribute to work outcomes like employee motivation and job satisfaction. An example is the two-factor theory (Alshmemri et al., 2017) which states that the presence of intrinsic motivational factors of the job, such as recognition, challenge and responsibility can increase job satisfaction, while the absence of extrinsic hygiene factors, like pay and working conditions can lead to job dissatisfaction. Although this outpatient nursing study was mainly for the intrinsic motivation factors, Parker et al., (2017) concurs, that work design influences staff motivation and employee performance can be increased through the enrichment of intrinsic job characteristics such as; autonomy, task identity, significance, skill variety, and job-based feedback.

Specifically, with respect to health workers, job satisfaction is known to influence motivation, staff performance, and retention, which in turn affect the successful implementation of health system reform. However, motivation among workers requires an encouraging work environment with a conscientious effort which does not happen by chance. A recent study reported that 75.3% of health care workers were dissatisfied with their working environment, salary, promotion, and benefits, whereas the relationships with leaders and co-workers were satisfaction factors (Singh et al., 2019). Hence there is need to ensure that the staff's intrinsic hygiene factors such as job motivation and wellbeing are satisfied.

2.7.2 Staff involvement in decision making

Evidence from multiple studies indicates that change is typically turbulent and difficult for staff members (Ingersoll et al., 2001), and often affect staff work relationships. Staff involvement and decision-making during change management could be beneficial in achieving positive change outcome. Other research suggests that nurses' autonomy and control over their practice environment are positively associated with their trust in management (Laschinger et al., 2001b). As the concept of control within nursing practice evolved and it is evidence that Magnet (highly performing) hospitals have higher percentages of satisfied nurses. Hence there is lower staff turnover, fewer vacancies, and improved clinical outcomes for patients, greater nurse autonomy and enhanced patient satisfaction than non-Magnet hospitals (Jones, 2017).

The introduction of ‘Pathway to Excellence’ and the first national Shared Professional Decision-Making Council was established in year 2020 within NHS, particularly to discuss how to engage nurses during organisational change, new ways of working clinically, operationally or in terms of governance which increases staff intrinsic motivation (Gupta, 2020). Additionally, recent evidence suggests that, engaging and involving nurses in decision making following the Magnet hospital standards, has become an indicator of professional nursing excellence that signifies best practice (Lasater et al., 2017; Wagner, 2022). In line with the ‘Pathway to Excellence’ standards, one of this study’s research question seeks to explore how engaged and supported the outpatient nursing team feel at work, especially during organisational and service changes.

2.7.3 Leadership, Followership and Management

Many scholars and practitioners of leadership support the idea of interplay between leaders and followers (Kleiner, 2008) as leadership and followership are two sides of the same coin, each intimately connected with the other in a dynamic manner. Buchanan and Huczynski (2019) stated that, without great followers, leaders would become schizophrenics sitting in their offices talking to themselves. Furthermore, it is argued that good followership is more vital to a democracy than excessive leadership. Moreso, great followership is harder than leadership as it has more dangers and fewer rewards (Bennis, 2009). Despite a blurring of boundaries between management and leadership, the two activities are different (Bass, 1990). This study relates to nursing staff job motivation and wellbeing and the relationship between the followers in this instance outpatient nursing staff and the leaders being the managers. The relationship between these two groups - staff and mangers - is critical in understanding how to support and improve the nursing staff wellbeing.

Furthermore, Hollander (1992) believe that a dynamic relationship between leaders and followers reveals a possibility of interchangeable roles of leaders and followers, sometimes links to management. In other words, in some situations, “the role of followers can therefore be seen as holding within its potential for both accessing and taking on leadership functions” (Hollander, 1992, p. 71). Because of this close relationship between leaders and followers, Bjugstad et al., (2006) proposed a framework of integrating followership and leadership with the expectation to maximise organisational goals and effectiveness, with the management playing a key role as well. There is an appreciation that management and leadership skills work in synergy with the other pillars of nursing practice and the genius of leadership lies in the way leaders see, act on, and satisfy followers' values and motivations as well as their own (Burns & Grove, 2010). Therefore, leadership has traditionally been seen as a relationship, but research shows that leaders should define the relationship, which may be moderated by the followers’ characteristics (Alvesson, 2017).

2.8 Leadership Triad

Leadership is the ability to engage with people effectively and responsibly. Moreover, it is about being involved with processes and programmes to achieve the goals of the organisation, team and the individual (Davis, 2020). Figure (2.11) illustrates the relationship between leadership, management, and followership skills according to the various situations, environment, or position which they find themselves in, at any particular time.

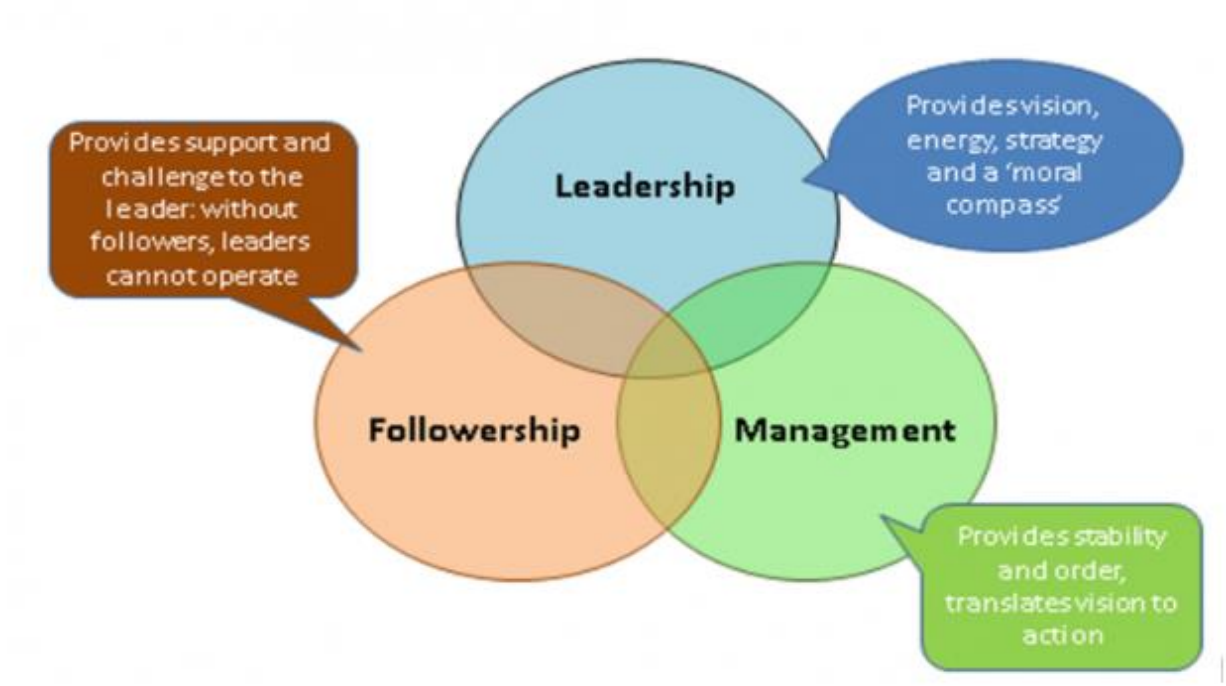


Figure (2.11).The Leadership Triad. Source; "When I say … leadership," by J. McKimm, and H. O'Sullivan (2016), *Medical Education, 50*(9), 896- 897.

Recently, there has been increasing focus on how followers shape, define, and co-create leadership and leaders' actions and identity, recognising that all individuals, both in senior and more junior positions, move around the leadership 'triad' (McKimm and O'Sullivan 2016). Sinek et al., (2017) argued that, when working in the 'leadership triad', it is not always about the 'what' to do or the 'how' to do it that is important, it is the 'why' that we need to be clear about, and once we have identified the core purpose of why, people come into agreement with the leadership and the rest will follow.

However, situational approaches to leadership (e.g., Fiedler, 1967; House, 1971) focused on aspects of the situation for example, follower or environmental characteristics that determine what leadership style is most effective, given the situational factors (Fiedler, 1964; Felfe, & Schyns, 2010: Thompson et al., 2018). Obviously, an appropriate leadership style is required for effective outpatient service changes. With the constant outpatient service changes, creating a user friendly clinical environments that foster different leadership styles could have positive impacts and harness employee performance within the organisation. In addition, Hamric et al., (2014) delineated four leadership domains of nursing practice namely; Clinical leadership, professional leadership, health system leadership and health policy leadership as summarised in figure 2.12.

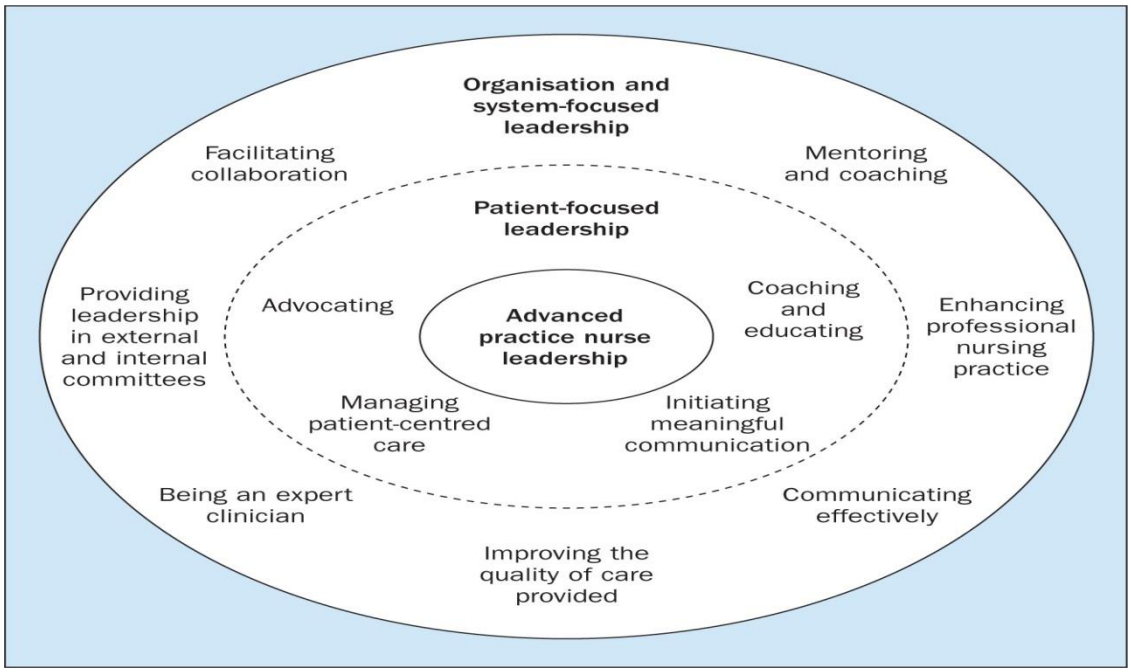


Figure (2.12). Clinical practice nurse leadership themes. Adapted from (Lamb et al., 2018).

Although these four domains are embedded in everyday nursing practice, Lamb et al., (2018) identified two overarching key themes describing leadership as: 'patient-focused leadership' and 'organisation and system-focused leadership'. Patient-focused leadership comprises of capabilities intended to have an impact on patients and outpatient nurses play a key role within this team as Clinical Nurse Specialist.

Rose (2015) argue that nurses in clinical leadership role need to respond to, inform and influence policy as well as political and practice changes. Also, nurses are expected to be aware of the complex needs of patients and new healthcare demands to improve both patients, service users and staff experience (Scott, 2018). However, nurses in clinical leadership role are already wearing several hats as illustrated by Lamb et al., (2018), needing some guidance on scope of practice.

Therefore, to clarify the remit of role responsibility, RCN (2019) asserts that:

> *In clinical practice registered nurses have been assessed as competent in practice using their expert clinical knowledge and skills. Nurse practitioners like clinical nurse specialists (CNS) have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis, and treatment of patients (RCN, 2019).*

With a move in the UK to multi-professional working, especially in England, changes towards core advanced practice skills crossing professional boundaries, registered nurses need proactive skills in cementing their leadership roles within teams (Diamond-Fox and Stone, 2021). The successful multi-professional working needs the individual professional to know the standpoint of other professionals to enable their own understanding of complex problems. With regards to the outpatient service changes, both patient focused leadership and organisational system focused leadership are applicable to outpatient nurses because, with new systems and new ways of working implemented with the objective to enhance service quality, robust leadership is crucial.

Leadership within healthcare is not just about the characteristics of those who exert control from the top, but all nurses can act as leaders as they should be leaders in patients' care (Lucas, 2019). Working out who leads and who manages is difficult, with the added anomaly that not all managers are leaders, and some people who lead work in management positions. Chreim and MacNaughton (2016) previously cited an example of a situation where the nurse clinical leader was authoritative and an expert in a clinical practice, resulting in the team becoming more passive and took direction because they trusted the leader's judgement.

However, if over time that leader starts delegating work with direct supervision to the team, the team may feel micromanaged and not trusted (Chreim & MacNaughton, 2016). On the other hand, understanding the leadership – followership dynamics helps followers think about how they work, behave and communicate in different situations and what sort of leadership they need to flourish (Rosenbach, 2018).
Leadership can be complex, and modern healthcare requires that staff work in increasingly complex teams containing both putative leaders and followers (Howell and Mendez, 2008). Everyone in healthcare works, or has worked, in the followership role, regardless of eventual seniority. Nevertheless, Thompson & Glaso (2018) contend that, how people view their roles affects both the quality of work and interpersonal interactions.

Similarly, the Situational Leadership Theory' explains the notion that, not all followers need the same task or relationship-based leadership, so the type of leadership a leader should utilise with a follower depends on the follower's readiness (Hersey et al., 2000). The illustration (figure 2.13) shows how each function overlaps and links to leadership behaviours.

Figure (2.13) Hersey and Blanchard Situational Leadership Model (1969).
Source; Hersey et al., (2000).

Following this illustration, Hersey et al., (2000) described followers as individuals who more often than not have requisite skills but still need their leader for motivation.

The Situational Leadership Model (Hersey et al., 2000) sets criteria for creating organisational environments that foster these followers' motivations. However, Henkel and Bourdeau (2018) maintain that leaders should not completely avoid supportive behaviour because if a follower feels that they are not being supported, the relationship between the leader and follower could be compromised. Therefore, deciding on the precise leadership style under specific conditions is crucial and most importantly, the leadership skills in a variety of settings should include educational aspect (Henkel and Bourdeau, 2018). In view of the ongoing outpatients transformation programme, exploring transformational leadership style in combination with other appropriate styles could be beneficial to both the nursing staff and the leaders.

2.8.1 Transformational Leadership

Transformational leadership is a relationship of mutual stimulation and elevation that raises the level of human conduct as well as the aspirations of both the leader and those led (Burns, 1978), thereby has a transforming effect on both.

> *In effect, transformational leadership occurs when leaders engage with their followers in pursuit of jointly held goals. Their purposes, which may have started out as separate but related (as in the case of transactional leadership), become fused. Such leadership is sometimes described as "elevating" or "inspiring." Those who are led feel "elevated by it and often become more active themselves, thereby creating new cadres of leaders" (Burns, 1978:20).*

Developing transformational and innovative leaders is crucial for the rapid changing care needs and increasingly healthcare demand for the NHS. Since its inception 75 years ago, the NHS has continually changed to meet the needs of a growing population and maintained the quality of its services (Darzi, 2008). However, according to the study by King's Fund (Morgan, 2022) in recent years, the NHS has come under severe financial pressures and has struggled to meet challenging performance targets. As a result, the NHS nursing workforce are required to learn new skills as extended role of practice to absorb clinical activities and responsibilities in relation to the set targets. While the approach of using incremental service improvement within single organisations has achieved many successes, this is now thought to be inadequate to deliver the scale, pace and sustainability of change required (Morgan, 2022).

Hence the quest to transform the NHS is taking place in a context where more needs to be done to build the capabilities of those leading change (Berwick, 2013; Harrison, 2018), yet, implementing these changes for service improvement is far from straightforward. It is therefore not surprising the hospitals services such as outpatients are required to undergo service changes and transformations needing leaders to drive the change processes. These changes require leadership capable of transforming not just a physical environment, but also the beliefs and practices of nurses and other health care workers providing care within the organisation. Similarly, Bohmer (2010) expounds that, in clinical practice, is the 'dance of leadership and followership' which involves being able to step up to take leadership when needed (which may be 'small "l" leadership', as leading on a task), and to recognise how and when to follow a leader (Bohmer, 2010), acknowledging that, leadership may be distributed within the team.

Although organisational transformational changes are always well-intentioned but as Judge and Robbins (2017) points out, the motivation to exert high levels of effort toward organisational goals is conditioned by the efforts and ability to satisfy individual staff needs. Therefore, it is advised that, effort towards developing a motivated workforce for the purpose of improving productivity remains the single most crucial function for heads of institutions and organisations in recent times (Gori et al., 2021). However, the reverse would be the case if staff are not motivated enough to perform their roles. With reference to nursing, higher levels of nurse autonomy and control over nursing practice have been associated with greater trust in management and leadership among nurses and greater commitment to their employing organisations (Laschinger et al., 2001b).

Most importantly, what motivates employees constantly changes and staff job motivation could lead to staff job satisfaction (Gori et al., 2021) and increased service productivity. Therefore, future research should be conducted on social well-being to examine interactions between employees and colleagues as well as organisational support following change management (Khoreva & Wechtler, 2018). The World Health Organisation (WHO) (2010) affirms that workforce resources are vital to an effective healthcare system and poorly motivated health workers can have a negative impact on individual facilities and the entire healthcare process.

Unlike transformational leadership, compassionate leadership aligns with Adair's (2002) leadership characteristics where effective leaders are described as those who possess specific characteristics. Such characteristics include the need to be passionate, inspiring and have motivational influence on people, with the ability to maintain group effectiveness and effective leadership role (Adair, 2002; Leung et al., 2018). While compassion towards patients is central to the nursing role, often 'compassion towards the compassionate' is lacking (Vogel & Flint, 2021). The need for compassion is even more important in the current healthcare environment (Day et al., 2022), due to the additional stressors experienced by nurses during the COVID-19 pandemic. Therefore, this section will briefly discuss compassionate leadership within clinical settings.

2.8.2 Compassionate Leadership

There is a growing evidence base to demonstrate that, in addition to being well led, the most effective care services are driven by compassionate leaders that understand the impact of wider inequalities on health outcomes and actively promote equality, diversity and inclusion (West, 2021). In reference to this framework, Barr and Dowding (2019) argue that these theories share a focus on the idea of leadership affecting organisational culture, however, there are some fundamental theoretical differences between the various leadership styles.

According to (Evans, 2022) compassionate leadership have values and behaviours that inspire understanding and trust, build inclusion and reduce inequalities. They are also driven by empathy and a strong commitment to listening and learning, in order to improve the health and wellbeing of all. Moreover, combination of the various leadership models makes up the compassionate leadership which places the quality of care at the heart of what they do (Barr and Dowding, 2020), while empowering people and delivering care to achieve this together.

Regardless, in theoretical terms, Shuck et al., (2019), found compassionate leadership to be unique, yet familiar as it does not have a consistent theoretical framework, instead it draws from a range of similar leadership theories as shown on table (2.1).

Leadership Theory	Supporting Literature
Transformational leadership	West, et al., (2015); de Zulueta (2015); Ali and Terry (2017); Shuck et al., (2019); Wilis and Anstey (2019)
Servant leadership	West et al., (2015); Quinn (2017); Hewison et al., (2018); Shuck et al., (2019)
Distributed leadership	Hewison et al., (2018)
Authentic leadership	West et al., (2015); de Zulueta (2015); Ali and Terry (2017); Mcclelland (2020)
Collective leadership	West et al., (2017); Hewison et al., (2018)

Table (2.1). Leadership theories; theoretical framework for compassionate leadership Source: Adapted from (Evans, 2022) and collective stated references.

Leadership is therefore no longer attributed solely to those in formal leadership positions but is seen to be the responsibility of healthcare professionals across all levels of healthcare organisations (Ali and Terry, 2017). However, many leadership theorists have criticised leader-centric research for its emphasis on individuals as leaders, how effective their activities are and how others (followers) act in response to their influence (Travis, 2015). In the caring organisation, compassionate leadership is relevant to the workforce hence seeking to find out how service changes and new ways of working support the nurses and healthcare assistants' job motivation and wellbeing. Style of leadership is key to facilitate staff wellbeing at work.

Table (2.2) presents a summary of the literature regarding compassionate leadership which has focused on what this means in practice. Ali and Terry (2017) captured this complexity by stating that Compassionate leadership is multi-faceted and requires different interventions to target different levels of the organisation.

Table 2. Examples of compassionate leadership in healthcare across different hierarchical levels

Who?	What?	Examples from the literature
System leaders and policy makers	**Bridging values between organisations**	Matching individual and organisational values (Ali and Terry, 2017) A collaborative endeavour, management of complex relationships between internal and external stakeholders (Hewison et al., 2019)
Organisation and team leaders	**Developing team and organisational culture**	Influencing organisational culture by setting expectations and norms relating to the desired behaviours. This can be done by role modelling compassionate behaviours and by implementing policies, practices and structures that enable compassion (Vogus and Mcclelland, 2020)
Individuals	**Demonstrating values and characteristics**	Demonstrating kindness, honesty and consistency, with the courage to challenge behaviours that are not compassionate towards patients. Making decisions with both 'the head and the heart' (Ali and Terry, 2017)

Table (2.2). Examples of compassionate leadership in healthcare across different hierarchical levels. Extracted from Ali & Terry (2017).

Effective leaders should be solution focused, dynamic, use problem solving processes and compassion with passionate, inspirational, and motivational influence on people (West et al., 2017). Suggestively, the application of these characteristics in clinical practice is not only important in gaining the respect of the multidisciplinary team, but it is crucial for the survival of the NHS organisations. Irrespective of the context and power, leaders need followers to exist (Alvesson at al., 2016). Hence providing effective leadership is important in achieving and sustaining continuous improvement within the organisation which is a challenge for leaders and followers is to communicate and understand the complexity of a particular situation or context (Alvesson at al., 2017).

2.8.3 Followership

As this study is about service changes and its impact on the nursing staff job motivation, how the nurses respond to the leadership is crucial to examine the staff job motivation. The debate on relations between leaders and followers also puts the focus on how leaders and followers influence each other and achieve common meanings through co-construction of a shared reality (Reilly and Jacobs, 2019). As such, leadership can only occur if there is followership, hence, without followers and following behaviours, there would be no leadership (McKimm and Vogan 2020).

According to Pearce and Conger (2003), shared leadership and followership respond to and interact with each others. Invariably, with the multidisciplinary team and collaborative nature of NHS services, health professionals are expected to function successfully in today's complex healthcare systems, therefore, developing effective followership skills is as essential as developing leadership skills (Rosenbach, 2018). As previously highlighted in chapter 2, the NHS is always undergoing constant changes hence, the need for effective leadership is critical if sustainable change is to be achieved. According to the World Health Organisation (WHO, 2010), learning how to be an authentic leader as well as a 'proactive' follower can lead to more effective inter-professional teamwork and an improvement in health outcomes.

Followership is interactive and according to Whitlock (2013), the crux of followership is appropriate skills and behaviour for optimised performance, which contributes to upholding organisational development. Indeed, good followership is underpinned by human factor science (Whitlock, 2013). In any case, Leung et al., (2018) argue that followership can be difficult to define, but generally depends upon the processes by which people follow, who they follow, and how much engagement and influence they exert. In view of all the definitions of leadership, a robust and effective leader will not be sustainable without the followers. Similarly, Crawford and Daniels (2014) contend that most research regarding teamwork in healthcare has focused on leadership whereas followers represent at least 80% of the healthcare workforce. Therefore, this study examined the experiences of outpatient nurses' experiences in healthcare environment.

From a clinical patient safety standpoint, Tee (2013) asserts that, it is vital that health professionals demonstrate self-insight, know their strengths, abilities, and limitations, ask for help when they need it. All leaders need to be experts, proficient in their roles and show by example - role modelling and train the employees to speak out or challenge actions or behaviours in potentially unsafe situations (Tee, 2013). Individuals who are committed and accountable adapt to change, take responsibility for their actions, and work well in teams for the successful organisational changes and transformation (Kelley, 2008). Furthermore, Uhl-Bien (2014) argue that a good follower should take risks and be courageous to take moral action when needed and take their own responsibility seriously.

Conversely, Howell and Mendez (2008) believe that followers' behaviours are related to leaders' behaviours, and this connection retains some level of variations in the follower styles depending on the leadership styles. Within the nursing profession, the RCN (2018b) states that, improving and maintaining professional practice is a safety issue and as a means of ensuring this strategy, the Nursing and Midwifery Council (NMC) process of three yearly nurse revalidation was introduced. According to NMC (2015), for registrant you are required to; "keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance" (NMC, 2015; paragraph 2.3, p.5). Therefore, the registered nurses need to demonstrate that they can provide safe and effective practice to remain on the register (NMC, 2018). Hence, one of the requirements to update and maintain the nurses' professional learning is by exploring reflective practice and shared experiences, as part of continuous professional development (CPD) and revalidation (NMC, 2019).

Followers also have a collective power that can give individuals a voice both in supporting a leader and in tackling difficult or intransigent issues and the 'leadership through followership' involves followers collaborating to take leadership of a situation (Kellerman, 2008). Sometimes a 'collective emotion' that is negative towards the leader can potentially unite the followers into a form of collaborative leadership in which the more power they share, the more power the team must use (Tee, 2013).

Just as one can choose different leadership approaches in various contexts, followers can learn to be more proactive and determine their own followership approaches based on their maturity, experience, competence, and confidence in various situations (Epitropaki et al., 2017). Considering the impact individuals have on their followers, an attempt by several scholars to find one set of definition for leadership is near impossible (Kellerman, 2008), hence a continued interdisciplinary field of study is required to formalise a definition for leadership.

2.8.4 Management - managing and sustaining change

Lucas et al., (2020) argued that, the concept of leadership is not tied to position on the organisation chart, but one's ability to influence people and process in an organisation to achieve goals. Providing effective management and leadership skills are important in achieving and sustaining continuous improvement within the organisation. Inspired by Floyd and Wooldridge (2011), researchers have explored the role middle managers play to facilitate strategic change. Research has revealed that middle managers are not merely recipients of strategic initiatives from senior management, but actively shape the strategic outcome through how they interpret and handle the change initiatives (Barr and Dowding, 2019).

Moreover, literature also identified how middle managers' role as change agents is characterised by duality, multiple expectations, (Balogun, Bartunek & Do, 2015) and the need to joggle and balance different interests and practices to secure the implementation of change, while at the same time overseeing day-to-day operations. Unlike senior management who decide and communicate strategic initiatives, the middle managers take on change management for these decisions made by senior management (Spehar et al., 2015). Given the uncertainties that leaders face, a key step in sustaining change with positive outcomes would be an awareness that change, and sustainability is not static, but dynamic, requiring an improvement trajectory over time (Hodges & Gill, 2014). An example is the onset of SARS-CoV-2 viral infection of COVID-19 pandemic which imposed a significant challenge to the NHS staffing and the entire healthcare system which calls for support to the workforce.

Limb (2018) acknowledge that some managers do not deal well with worries from staff and people who use services and their families, or other organisations. Therefore, measures and action plans should be in place relating to People and Culture arising from Care Quality Commission (CQC) inspections, to receive assurance from organisations to this effect (Limb, 2018). What is unclear however, is how organisations incorporate the new service changes due to the impact of the most recent COVID-19 pandemic, in the scrutiny of the People and Culture standards.

2.9 Equality, Diversity and Inclusion (EDI) in the workplace.

There is growing evidence that equality and human rights for staff and people using services play a central role in improving the quality of care (RCN, 2019). Further discussion on COVID-19 pandemic in relation to healthcare environment, Equality, Diversity, and Inclusion (EDI) and Work Race Equality Standard (WRES) and these characteristics are relevant to any workforce management. The NHS in England employs some 1.5 million people Rolewicz and Palmer (2021), which equates to around 1 in 19 of the total workforce in England. The work that NHS does would not be possible without the critical contributions of a broad diversity of people, covering different genders, ethnicities, disabilities, religions, national origins, sexual orientations, ages and other characteristics (Rolewicz and Palmer, 2021).

In the 2020 NHS Staff Survey, more than 1 in 8 staff (13%) reported poor experience at workplace. This could be from colleagues, managers or patients, and could be for the array of protected characteristics set out in the Equality Act 2010. Ratnaike, (2007) reported the inadequate representation of black and minority ethnic among senior positions in the health service with the barriers they need to overcome in their career progression. Hence, the NHS Leadership Academy was opened specifically to applicants from Black and minority ethnic backgrounds, in an attempt to address the barriers to career progression for diverse staff (Hart, 2019). The culture of an organisation is set from the top and it is crucial that the NHS operates within the context of leadership visibility and engagement to drive change and manage competing organisational priorities (Kilbane et al., 2020).

To be successful in establishing cultures within their organisations that are inclusive and which value diversity, leaders within the NHS will need to acknowledge and address their own learning needs and also take informed action alongside their system partners (Bolden et al., 2019). The NHS People Plan 2020/21 expects that: By March 2021, NHS England and NHS Improvement (2020) will have published competency frameworks for every board-level position in NHS providers and commissioners (Bolden et al., 2019). These frameworks reinforce that it is the explicit responsibility of the chief executive to lead on equality, diversity and inclusion, and of all senior leaders to hold each other to account for the progress they are making (NHS England and NHS Improvement, 2020). However, inequalities persist across different aspects of staff experience. A pleasant working environment is required to form beneficial connections and maintain open communication channels (Ho et al., 2016).

Furthermore, the service provider must be aware of the numerous patient-centred communication patterns in place and the specific roles that each team member plays (Ho et al., 2016) especially with the COVID-19 service recovery (Jackson, 2021). When organisations show concern for both the service users and the staff, they place a high value on achieving an agreement, working as a team, and involving everyone (Pleh et al., 2021). The NHS is the UK's largest employer and one of the biggest employer globally and the organisational culture influences not just the amount of power and autonomy available for care coordination but the team members' ability to get along with one another and communicate coherently (Bailey, 2020).

The NHS Staff Survey and other data show that across the range some groups are less well-represented at senior levels, and they experience more challenges in progressing in their careers (Appleby et al., 2021). Although pay is not amongst the protected characteristics under the Equality Act 2010, (figure 2.14) recent research points to continuing pay inequities, with considerable variation in pay between ethnic groups across all NHS staff (Appleby et al., 2021). It could therefore be argued that pay should be added to the listed characteristics of the Equality Act 2010.

Figure 2.14: Nine protected characteristics under the Equality Act 2010.
Source: St Kew ACE Academy - The Protected Characteristics (kernowlearning.co.uk)

Skills for Care (2021) also explained that workplace culture consists of three influences and elements which are; organisational, environmental, and social factors. These factors define workplace culture determines the workforce long term plan (Alderwick and Charlesworth (2022), with the character and personalities of the organisation which make the organisation unique. Therefore, those in charge of running a hospital must create a working environment that encourages employees to feel encouraged in their efforts to offer care to patients as part of a team (Pleh et al., 2021). In the equality, diversity and inclusion (EDI) statement (section 149 of the equality Act 2010), all protected characteristics need to be considered to make the – age; disability; gender reassignment; pregnancy and maternity; marriage and civil partnership; religion and belief; sex; and sexual orientation (Long term plan, 2019;Cambridge, 2021), however, fairness in the workplace should be embraced at all times.

By invoking the Equality and Human Rights Commission (EHRC), Act 2010; (EHRC, 2015), promoting fairness, dignity and respect should help in establishing the NHS with services fit for purpose as set out in the long-term plan (Alderwick and Dixon, 2019). The same equality concept should be applied to the research world where the outpatient nurses who are under-research should be inclusive.

The plan includes a 'people's promise' setting out the behaviours which staff can expect from the leaders and colleagues in order to improve staff experience while working in the NHS organisations (NHS Employers, 2020). The diverse talents and dedication of the approximately 1.4 million NHS staff reflect their diversity, with over 100 nationalities represented in the workforce engaged in over 350 different health-related careers (NHS Employers, 2020). The Work Race Equality Standards (WRES) requires NHS trusts and Clinical Commissioning Groups (CCG) to self-assess against nine indicators of workplace experience and opportunity (WRES, 2021).

Four out of the nine indicators relate specifically to workforce data, four were data from the national NHS staff survey questions, and one specifically considers black and minority ethnic (BME) representation on the board's level. The categories of workplace key performance indicators namely; equality, diversity and inclusion (EDI), WRES, workforce level and staff engagement report through staff surveys will be discussed in this chapter. Following the Snowy White Peak Report (Kline, 2015), the NHS introduced the Workforce Race Equality Standards (WRES) in 2015 to hold a mirror up to the NHS and spur action to close gaps in workplace inequalities between Black, Asian and Minority Ethnic (BAME) and White staff. Although regular yearly NHS staff survey reports showed the disparities in the career progression and wellbeing key performance standards, much has not changed over the years to close the gaps. This study seeks to determine how the outpatient nursing staff perceive service changes in terms of their job motivation and wellbeing.

The COVID-19 pandemic has also put in the spotlight the disadvantage experienced by staff with protected characteristics (WRES, 2021).

> *"The report presents the ethnicity aspect of this, and it is evident that there has been a worsening of the experience of BME compared to white staff in key domains, including discrimination from seniors and a sense of equal opportunity. As we plan the recovery of services following the pandemic, addressing these issues of equality and inclusion are core" (WRES, 2021, p.3).*

Undertaking a qualitative study within the NHS outpatient services which comprise of diverse nursing staffing population, geographical locations and role designation could highlight the lived experiences of service changes and the impact, if any, to the staff job motivation and wellbeing.

The NHS People Plan (Bailey, 2022) stipulates that the NHS leaders should reduce inequalities, as they affect both the workforce and patients. As there appears to be scope for the NHS to become a more inclusive, diverse and equitable workforce at every level. Within years 2016 - 2021 WRES report, employers have been asked to prioritise actions to improve diversity through recruitment and promotion practices, by developing improvement plans based on WRES findings**.** Across an array of characteristics – including ethnicity, disability, gender and religion – some groups are under-represented in certain NHS careers. For instance, men account for only 1 in 9 (12%) of the nursing and health visitors workforce whereas women account for little more than a third of medical consultants (38%) (NHS Digital, 2021b). More than 1 in 8 NHS staff (13%) reported poor experience at work in 2020, with sharp differences between some occupations.

Dobbin and Kalev (2016) highlighted that, many have stressed the importance of addressing and mitigating bias at every stage of the NHS career pathway, from job design, through to shortlisting, interviews, appointment, development opportunities and promotion. However, to date, interventions around equality, diversity and inclusion have typically focused on policies, procedures, and training in isolation, which are unlikely to make a material difference (Dobbin and Kalev, 2016). Therefore, employers need to think more broadly, for example, investing in analytics and further embedding accountability and transparency at organisational, team and individual level (Kline, 2021a).

While the health service has been described as a microcosm of wider society (Naqvi, 2020), more than a decade ago, the NHS Constitution for England stated that, the NHS must ‘make sure nobody is excluded, discriminated against or left behind’ (NHS England 2009; Department of Health and Social Care, 2021).

Notwithstanding, research also points to continuing pay inequalities, with considerable variation in pay between ethnic groups across all NHS staff Agenda for Change, within the health service (Appleby, 2021).

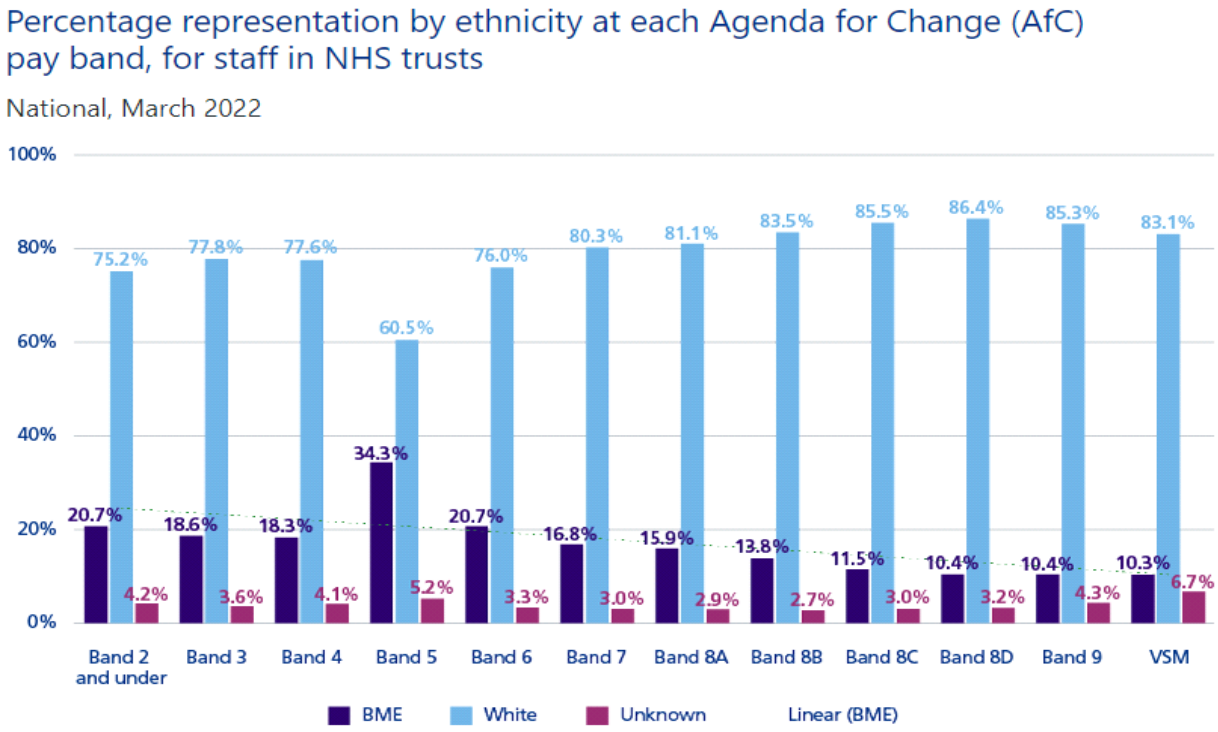


Figure (2.15). Percentage representations by ethnicity at each AfC.

Subsequent policies have reiterated a longstanding intention to improve equality, diversity and inclusion for NHS staff which dates to the Race Relations (Amendment) Act 2000 (Equality and Human Rights Group, 2006). However, the illustration on figure 2.15 does not reflect the requirement of Equality Act 2000. For example, the Agenda for Pay banding shows a great disproportion in terms of the BAME and White in senior management positions. Although demonstrating and ensuring a diverse workforce in leadership positions is a statutory requirement under the public sector equality, it is far from been achieved. Also, Trust is required to implement and comply with the national Workforce Race Equality Standard (WRES) and the national Workforce Disability Equality Standard (WDES), as stipulated in the NHS Standard Contract. They are also expected to meet the equality objectives for 2016 –2020 (NHS England and NHS Improvement, 2021).

2.10 COVID-19 Pandemic and Employees' Wellbeing

The World Health Organisation (WHO) declared the outbreak of Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2), in March 2020 which caused the disease known as Coronavirus Disease 2019 (COVID-19), a global pandemic (WHO, 2020). The onset of COVID-19 pandemic crisis highlighted that solutions to manage and sustain positive outcomes may not come from familiar local sources or authorities, and sustaining change requires a vision for new ways of working and managing (McBride et al., 2020). The dramatic impact which COVID-19 pandemic placed on the healthcare system imposed a change in basic assumptions of the whole view of healthcare delivery system (Van Hout et al., 2022) whereby, clinicians, nurses and other healthcare practitioners had to adapt and embrace new ways of working at significant pace in order to sustain maximum service delivery.

Since COVID -19 pandemic, a wealth of literatures has been produced concerning health workers wellbeing, mental health and burnout linked to the emergent nature of the crisis, unmanageable workloads, resource shortages and patient deaths (Greenberg, 2020; Lou et al., 2020; Van Hout et al., 2022). To address this disparity, many nurses from non-inpatient areas such as outpatient nurses, research and clinical nurse specialists were rapidly retrained and redeployed as elective services were halted and staff had to be reassigned to the wards due to the increased demand (Mahendran et al., 2020).

The pandemic itself imposed a sense of urgency and Cameron and Green (2019) assert that leaders responding to or stimulating change need to balance their efforts across three dimensions of any change: outcomes, interests, and emotions. In terms of 'emotions', Cameron and Green (2019) suggest that the role of the leader is to enable people and the culture to adapt to the change and leaders also need to pay attention to (what may be competing) interests, here they need to mobilize their influence, authority, and power to effect the change. Similarly, West et al., (2022), affirmed that the COVID-19 pandemic added a significant amount of additional stress to the demands that were already being placed on frontline NHS. However, in the context of the pandemic, the sphere and value of collaboration amongst the multidisciplinary team increased to cope with these stresses, although its realisation became more challenging (Sperling, 2021).

It was really heartening to learn that health organisations worldwide are working together to coordinate their efforts with limited sources (Smith, 2021), to overcome the challenges of the pandemic. Brandish et al., (2021) argue that, when confronted with a precarious circumstance, people usually decide to put their differences aside and collaborate with others to find a satisfactory solution to the problem at hand. Even if a group of outpatient nurses are working towards the same objective, maintaining long-term collaboration can be difficult when members are constantly stressed. In terms of ensuring a well-functioning NHS, it is crucial retaining existing staff, and their accumulated skills and experience (Kelly et al., 2022).

While the COVID-19 pandemic is still around, this research might shed light on how teams can maintain their resilience, collaborate effectively, and protect patients. Hence the need to engage staff and give them a voice for a better understanding on how to support them, not only during pandemic but as an on-going basis, which this study aims to raise awareness and add to the research knowledge. Following a staff survey RCN (2017), it was reported that, unhappy and unmotivated nurses are known to leave their job and healthcare practices which calls for more compassionate leadership in NHS to support the employees and possibly increase staff retention. Moreover, there is a need to find out what motivates outpatient nursing staff in their jobs. The majority of the nursing staff were redeployed to the intensive care units and the wards during the surge period of the COVID-19 pandemic. Therefore, the experience of outpatient staff during their redeployment would also help to inform strategy development in terms of staff job satisfaction, job motivation and wellbeing at work. Hence job satisfaction and motivation need to be defined in this context.

2.11 Job Satisfaction and Motivation explained

For this study's purpose, the various theories of motivation will be discussed to link them to service changes. The outpatients' nurses and health care assistants' job motivation are key to the department's workforce management. Although varied previous definitions have been given in literature for job satisfaction, nevertheless, Cranny et al., (1992) argued that there appears to be a general agreement that job satisfaction is an affective reaction to a job.

To be more precise, Mullins (2016), describes job as a particular employment role or position, such as cook, teacher or banker, whereas ‘work’ refers in a more general way to activities that one does. An illustration of the differences between job and work is seen below on figure (figure 2.16) below.

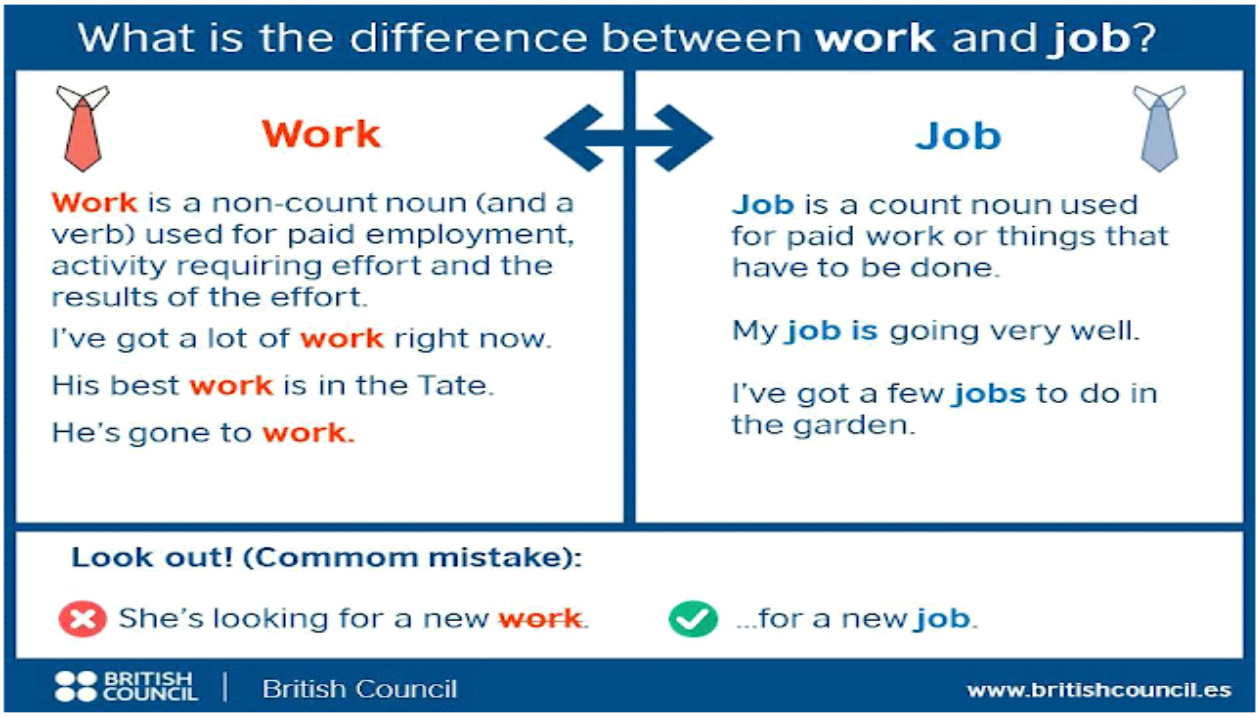


Figure (2.16). What’s the difference between work and job? Source; https://www.britishcouncil.es.

Job satisfaction can also be seen as a positive feeling an individual has towards the job, an inherent feeling (Daft, 2015), and on the other hand, motivation is defined as the process that accounts for an individual’s intensity, direction, and persistence of effort toward attaining a goal. The other two terms that need clarification are the words ‘job’ and ‘work’. Hence, job satisfaction has also been defined by Mullins (2016) as being 'more of an attitude, an internal state,’ unlike the term ‘work’ which is not used to measure employees’ internal state. Understanding the meaning and differences between work and job, and it’s relation to motivation and satisfaction is necessary as Kinnunen et al., (2000) explained that, job satisfaction as 'a complex construct and is often measured as a global attitude of an employee toward his or her work'. Cook et al., (1981) expressed that, the belief of employee's level of satisfaction can differ with specific aspects of the job.

For a better understanding, they have projected a number of elements (variables) that underlie this construct with elements classified into 5 distinct dimensions as follows:

> *Satisfaction with work attributes (the nature of the work, autonomy, 'responsibility); rewards (pay, promotion, recognition); other people (supervisors, co-workers); the organisational context (policies, promotion opportunities, procedures, working conditions); and self or individual differences (internal motivation, moral values), Locke (1976), Spector (1997), (Mullins, 2005).*

2.12 Overview - Conceptual Framework and Theories of Motivation

For this study, the theory of motivation is key and central to facilitate the findings and human resource strategy development. Greenberg and Baron (2013) earlier suggested that, these theorists have afforded opportunities to managers to design motivational schemes to influence performance. Theorists such as Maslow (1954), Herzberg, Mausner and Snyderman (1959), and Alderfer (1972), have sought to explain employee motivation by holding on to the assumption that all individuals possess the same set of needs and therefore prescribe the characteristics that ought to be present in the jobs (Yunus and Munjuri 2020).

There are other employee theories of motivation such as Vroom's expectancy theory (Vroom, 1964), Locke and Latham's goal achievement theory (Locke & Latham, 2004), Adam's equity theory (Adams, 1965) and Mc Gregory theory X & Y (1960). However, Mc-Gregor‟s (1960) Theory X and Y of Motivation describes how managers view their subordinates based on polar assumption about people and the order of their needs at work (Mullins, 2010). One of the criticisms of Mc-Gregor‟s Theory X and Y of theory of motivation is that this theory is very hard to be used with each other, thereby lacking flexibility (Yunus and Munjuri 2020). Herzberg's two-factor theory (Herzberg et al., 1959; Herberg, 2017) provides the framework for this project. These two-factor framework aim at simplifying the motivational process (Surbhi, 2022), which proved that motivation is a key factor to improve the performance level of employees.

2.12.1. Maslow's Hierarchy of Needs

Maslow's theory on the hierarchy of needs is one of the most popular theories of motivation (Aldag and Kuzuhara, 2002), and this forms one of the bases of the model for this study. Maslow (1954) identified that employees had five levels of needs and that human needs are in the form of a hierarchy ascending from the lowest to the highest. Maslow emphasised that no need can be fully gratified and that when a need is satisfied, it ceases to be a motivator, which makes a person seek a higher level of need (Drummond, 2000). The hierarchy of needs theorised that the lower-level needs have to be satisfied before the next higher-level need would motivate an employee (Armstrong, 2017). In processing nursing staff wellbeing and job motivation, the hierarchy of needs could be classified as a lower-level intrinsic need.

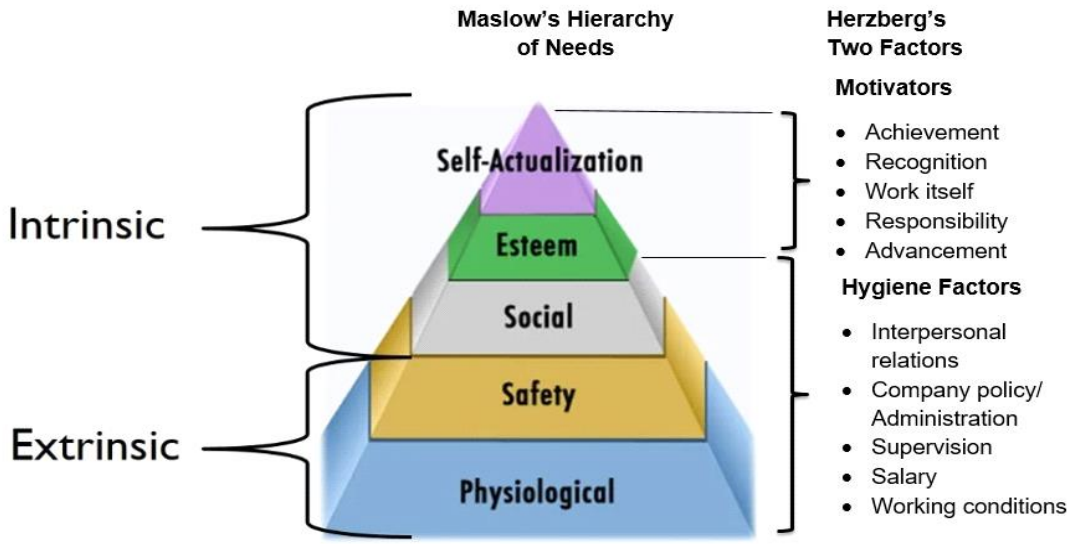


Figure (2.17). Adapted from; Surbhi, S. (2022) Difference between Maslow and Herzberg's Theories of Motivation.

According to Spector (2021), a general way to define job satisfaction is an attitudinal variable such as, seeing job satisfaction as 'is simply how people feel about their jobs and different aspects of their jobs. More so, it is the extent to which people like (satisfaction) or dislike (dissatisfaction) their jobs (Surbhi, 2022). A combined intrinsic and extrinsic needs assessment guide below (figure 2.17) is useful in illustrating the hierarchy of needs and the motivating factors, hence the impact of service changes on outpatient staff job motivation and wellbeing will be determined by exploring the hygiene factors.

Having compared the differences between Herzberg's and Maslow's theory, Surbhi, (2020) concluded that these theories are not contradictory but complementary to one another. Moreover, the theories attempt to explain employees' behaviour and provide understanding to both managers and employees of how to motivate others and become more involved in one's own motivation.

2.12.2 Intrinsic factors of motivation

With regards to employees' intrinsic and extrinsic factors in conjunction with Herzberg's Hygiene-Motivational Theory, most contemporary studies have emphasised these factors as both personal and economical factors which drive the employees' reported satisfaction and motivation at work (Zeng et al., 2022). The concept of intrinsic motivation is connected to actions that fulfil fundamental human desires for efficiency and control (Abu Yahya et al., 2019), especially where the stakes are raised, which in turn makes the action more interesting. With regards to the outpatient nurses' job motivation, the intrinsic motivation is at a basic level to enable them to accomplish their career development and wellbeing, as opposed to the higher needs perspective, where everyone acts in their own unique manner and for their own set of reasons (Sutikno, 2007).

2.12.3 Extrinsic factors of motivation

Extrinsic motivation is when an individual is driven to achieve both their own personal goals as well as the goals of their organisation by an external factor (Smith, 2015). The inspiration that comes from outside of a person is the antithesis of the motivation that comes from within that person (Muogbo, 2013) and other examples of extrinsic benefits are honours and remuneration. In any case, one of the primary forces that propels the healthcare business forward is extrinsic motivation (De Regge et al., 2022) and outpatient nurses would benefit from both intrinsic and extrinsic factors of motivation while on the job.

2.12.4 Dimensions of job satisfaction impacting on job motivation

A key factor in relation to job satisfaction is salary (Bryan and Sell, 2011). Salary is used as one type of reward along with recognition and future opportunities at the job (Deci and Ryan 2000), shows that people are extrinsically driven if the only thing that drives them is what they can gain from other people or from the outside world. Extrinsic motivation comes from outside stimuli and can be strengthened by extrinsic rewards such as compliments, awards, praise, good grades, and other advantages.

According to the findings from a study, Apex-Apeh et al., (2020), stated that hospital leaders are accountable for the effectiveness and productivity of its workforce to achieve patients' high-quality care. Providing nurses with a high level of intrinsic motivation, will enhance their performance and in-still a sense of success, responsibility, fulfilment, engagement, and ownership in individuals, which helps to improve the capacity to collaborate effectively and inevitably increase productivity (De Regge et al., 2022).

2.13 Conclusion

Based on the literature review, there are very limited studies on outpatient nursing practice and services. Additionally, no studies were found regarding the impact of service changes within the NHS outpatient nursing staff. Liiterature review from this study also suggests that when nurses are motivated in their jobs, they tend to experience greater job satisfaction, increased engagement in their various workplaces, and better wellbeing. Conclusively, this literature review found that frequent service changes within the public sectors could have a significant impact on the workforce. In view of all the related studies, experts argued that healthcare managers should carefully consider the potential impacts of service changes and take steps to mitigate their impacts on the workforce. It is hoped that the findings from this study will inform human resource strategy development.

Chapter 3: Research methodology and design

3.1 Introduction

Chapter 3 addresses the methodological approach and research design of this study, in response to a review of literature, which has demonstrated that outpatient nurses and health care assistants' job motivation and wellbeing have been under researched. According to Saunders et al., (2012) the research methodology and design outlines how the research question will be answered. In the previous chapters, I elaborated on the need to explore the research topic in terms of highlighting the gap in knowledge within this under-represented study area. To answer the research questions, the best suited research philosophy and systematic approach need to be established prior to the start of the study (Bryman, 2016). This chapter provides information about the research context including research aims and objectives, participants' selection, the pilot study, the data collection and analysis methods, and the rationale for choosing the techniques and methods.

This chapter's purpose was also to explore ways and use appropriate research tools to collect the data in a robust and reportable format to address the research problem. Parahoo (1997:143) confirmed that, "in practice the selection of a design is largely dependent on the belief and values of the researcher (they may place particular value for example on the quantitative approach), the resources available (cost, time, expertise of the researcher), how accessible the respondents are and whether the research is ethically sound" (Parahoo, 1997, p.143).

However, Bryman (2016), provides a clear distinction between the terms research design and research method which could sometimes be muddled. Hence adopting a research approach contributes to the understanding of how individual experiences differ across contexts. The research design provides the mechanism through which to examine the complexity of the real world from all angles (Rubin and Rubin, 2012). Moreover, the paradigms of inquiry can be distinguished through their ontology, epistemology, and methodology (Erciyes, 2020). As the intention of this study was to explore service changes impact on outpatient nurses and health care assistants' job motivation and wellbeing, I considered a variety of research methodological approaches appropriate for the project and to interrogate the research questions.

3.2 Philosophical considerations

Crotty (1998) defines the theoretical perspective of a research design framework as, the philosophical stance informing the methodology (Crotty, 1998), and claims there are potentially many theoretical research perspectives that result from particular epistemological and ontological stance. However, the main philosophical viewpoints to be considered in research are ontology, epistemology and axiology (Crotty, 1998). Ontology, describes the 'nature of reality', epistemology explains 'the acceptable way to obtain knowledge' while axiology involves the belief and outlook that directs how research should be carried out (Collis and Hussey, 2009). Furthermore, qualitative research seeks to gain an in-depth investigation on human phenomena, to understand the values and meanings these phenomena have for the individuals under study (Holloway and Galvin 2016). Therefore, as the researcher, I need to examine my own philosophical assumption regarding which methodological approach that has shaped my thinking to conduct this study.

3.2.1 Ontology

Ontology is understood (Crotty: 2003:10) as, "the study of being". It is concerned with "what kind of world we are investigating, with the nature of existence, with the structure of reality ..." (Crotty, 2003, p.10). Ontology relates to a central question of whether social entities need to be perceived as objective or subjective. Accordingly, objectivism (or positivism) and subjectivism can be specified as two important aspects of ontology (Blaikie, 2019). Objectivism portrays the position that social entities exist external to social actors concerned with their existence. In other words, quantitative (positivist) research assume that reality is fixed, directly measurable, and knowable and that there is just one truth, one external reality (Rubin and Rubin, 2012, p.14). On the contrary, subjectivism (also known as constructionism or interpretivism), perceives that social phenomena are created from perceptions and consequent actions of those social actors concerned with their existence (Bryman, 2012). Therefore, within the scope of a study, the researcher can decide whether the world is external to social world, or the perceptions and actions of social actors create social phenomena (Collis and Hussey, 2009).

However, while ontology refers to one's view of reality, whether it is dependent or independent of our own practices and understandings (Braun and Clarke, 2013), each type of research philosophy has its differences to be accurately considered when choosing a research procedure. Moon and Blackman (2014) highlighted that realist ontology relates to the existence of one single reality which can be studied, understood, and experienced as 'truth'; a real world exists independent of human experience.

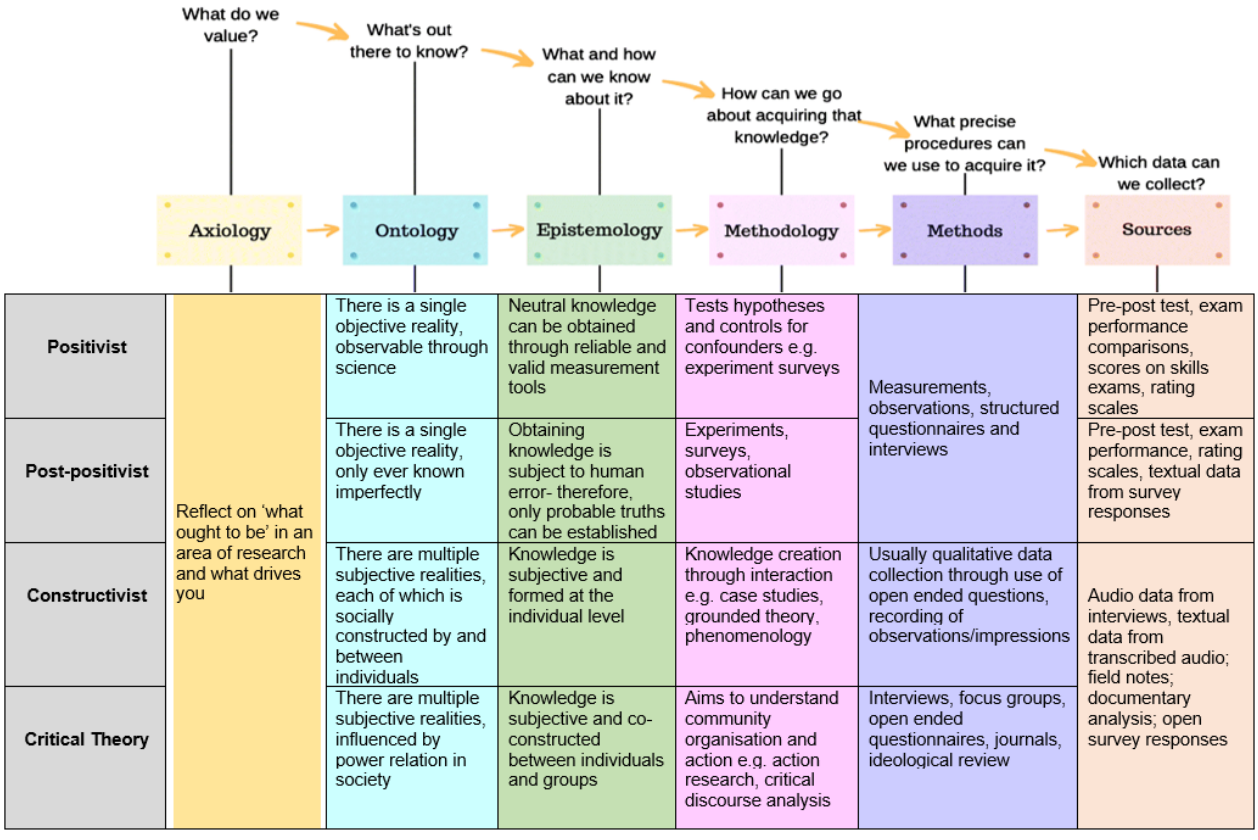
Realist ontology also supports the positivist stance of a single reality or truth (Crotty, (1998: Denzin and Lincoln, (2011). However, relativist ontology is based on the philosophy that reality is constructed within the human mind, as such no one 'truth' and no single reality exists. Therefore, reality is 'relative' to how individuals experience it, at any given time and place (Moon and Blackman, 2014).

Stemming from the understanding of the two main types of ontology, I explored a relativist stance which believes that reality can be constructed within the mind of the person experiencing the phenomenon. Moon and Blackman (2014) highlighted that there are two kinds of relativism: relativism and bounded relativism. Relativism will exist as multiple, intangible mental constructions; no reality beyond the subject. However, bounded relativism argues that one shared reality exists within a bounded group for example, in a cultural, moral, and cognitive setting (Moon and Blackman, 2014). In view of this clarity, the relativism approach of no reality beyond the subject aligns best with my staff study that explored individual nursing staff lived experience, unlike the bounded relativism which seeks for activities or beliefs for group of participants within a particular focus on a cultural context.

Relativist ideology supports constructivism (Moon and Blackman, 2014), and the value of constructionist research is in generating contextual understandings of a defined topic or problem, which conforms to this nursing staff experience study. The relativist approach contrasts with a realist positivist stance which argues that there is a single reality or truth. Therefore, adopting a relativist stance means that, "there is no objective truth to be known" (Hughly and Sayward, 1987, p. 278), the truth is subjective hence this study on exploring nursing staff experience is situated within the relativist ontological stance.

From these explanations, it is reasonable to suggest that some researchers see reality as subjective and interact with participants, while others may want an objective stance using surveys or experimental instruments to inform the study. Alternatively, a mixed methods approach is used by those who hold both an objective and subjective views (Denzin and Lincoln, 2011). In this study, where a relativist (subjective) stance was chosen, the most appropriate approach was to examine the various human experiences because individuals' perceptions differ even in similar situations. Based on the research questions of this study, individuals' nursing staff experiences were explored from their various individual's perspectives.

Brown and Dueñas (2020) outlined the research paradigm specifications process including information about the participants' data collection. Therefore, in planning of this study, the design and methodology were factored with the ontological and epistemological standpoints. An overview of the research paradigm is illustrated below figure 3.1 to find the paradigm best suited to answer this study's main research question.



Positivist	Reflect on 'what ought to be' in an area of research and what drives you	There is a single objective reality, observable through science	Neutral knowledge can be obtained through reliable and valid measurement tools	Tests hypotheses and controls for confounders e.g. experiment surveys	Measurements, observations, structured questionnaires and interviews	Pre-post test, exam performance comparisons, scores on skills exams, rating scales
Post-positivist		There is a single objective reality, only ever known imperfectly	Obtaining knowledge is subject to human error- therefore, only probable truths can be established	Experiments, surveys, observational studies		Pre-post test, exam performance, rating scales, textual data from survey responses
Constructivist		There are multiple subjective realities, each of which is socially constructed by and between individuals	Knowledge is subjective and formed at the individual level	Knowledge creation through interaction e.g. case studies, grounded theory, phenomenology	Usually qualitative data collection through use of open ended questions, recording of observations/impressions	Audio data from interviews, textual data from transcribed audio; field notes; documentary analysis; open survey responses
Critical Theory		There are multiple subjective realities, influenced by power relation in society	Knowledge is subjective and co-constructed between individuals and groups	Aims to understand community organisation and action e.g. action research, critical discourse analysis	Interviews, focus groups, open ended questionnaires, journals, ideological review	

Figure (3.1) Source: Brown and Dueñas (2020). A Medical Science Educator's Guide to Selecting a Research Paradigm.

3.2.2 Epistemology

Epistemology is a way of understanding and explaining how we know what we know, (Crotty, 2003). Epistemology can also be explained as the study of the criteria by which the researcher classifies what does and does not constitute the knowledge (Horn, 2009), In other words, epistemology is also associated with knowledge and how it is created and developed (Moon and Blackman, 2014).

> *Therefore, the theory of knowledge involves all aspects of the validity, scope and methods of acquiring knowledge, such as (a) what constitutes a knowledge claim; (b) how can knowledge be acquired or produced; and (c) how* the extent of its transferability can be assessed (Moon and Blackman, 2014).

Specifically, epistemology as a branch of philosophy deals with the sources of knowledge and it is concerned with possibilities, nature, sources, and limitations of knowledge in the field of study (Crotty, 1998). Furthermore, epistemological positions is explained as a continuum that focuses on the relationship between the subject and the object (Patton, 2015). Epistemology and the researcher's perception of reality is based on experience, which is important because, it influences how researchers frame their research in their attempts to discover knowledge (Horn, 2009), and it could be objective, constructive, or subjective.

It is therefore important for the researcher to understand the epistemological perspectives to inform the choice of research philosophy for the study. Positivist and post-positivist objectivist epistemology assume that reality exists independent, or outside, of the individual mind (Horn, 2009). For instance, "a tree in the forest is a tree, regardless of whether anyone is aware of its existence or not. When human beings recognise it as a tree, they are simply discovering a meaning that has been lying there in wait for them all along" (Crotty, 1998, p.8). In this sense, objectivists seek methods to test reality by collecting and analysing evidence to explore assertions, collaborate claims and provide correspondence with the real world (Patton, 2015). Ultimately, objectivists posit that, people can reasonably learn about the world as it actually is; the world's facts are mostly available for study (Patton, 2015).

Furthermore, Moon and Blackman (2014) argue that meaning is “created from interplay between the subject and object; subject constructs reality of object”, unlike the objectivism where the meaning “exist within the object independent of the subject” (Moon and Blackman, 2014, p.3). This nursing staff experience study involves the participants who narrate their individual lived experiences within the context of the events which differentiates it from objectivism epistemology. Subjectivist epistemology constitutes knowledge which depends on how people perceive and understand reality (Schwandt, 1994). Thus, reality is pluralistic, for example reality can be expressed in a range of symbol and language systems (Schwandt 1994; Powell, 2001) and the meaning exist within the subject to interpret their multiple reality (Moon and Blackman, 2014), and the critical theorist is underpinned ontologically by multiple and subjective realities (Brown and Dueñas, 2020).

There must be agreement with the ontology and epistemology of the researcher, Crabtree and Miller (1992) also advised that, the link between the research methodology, methods and sources of data should also be established. Within the research theoretical underpinnings, Colaizzi (1978) contends that experimental methods cannot be applied to the investigation of human experience, rather by a method that remains with human phenomena as it is experienced. In choosing an epistemological position, I considered my views as an individual and as a nurse researcher, thereby adopting the position affirmed by (Bhaskar, 1975) that, reality may have an aspect of being socially defined but how we perceive this reality is different for everyone. Outpatient nursing staff may experience some service changes at the same period, however, due to the diverse human nature the individual staff experience may differ, the subjective epistemology is relevant to this study.

Subjective epistemology is consistent with the healthcare practice environment and aligns with relativist ontology which suggests that reality is constructed within the human mind. Therefore, the relativist subjectivist stance was found adequate in seeking answers to the experience, relating to the outpatient nurses’ and health care assistants’ job motivation and wellbeing.

3.2.3 Axiology

According to Brown and Dueñas (2020), 'Axiology' is; 'what ought to be in an area of research' referring to the role of values in research. Axiology deals with the nature of value and grasps the question of the value of what is intrinsically worth. The defining characteristic of a research paradigm, axiology, calls into question, "the values of being, about which human states, should be valued simply for what they are" (Heron & Reason, 1997, p. 287).

The human engagement paradigm addresses the axiological question in terms of human flourishing. Ethics and human flourishing are valued as intrinsically valuable and participatory decision-making, and it is considered to an end, that allows people to participate in all social contexts, that affect their flourishing in some way (Heron, 1996). Within this paradigm, constructivist research seeks to gain an in-depth knowledge especially as the researcher need to investigate human phenomena to understand the values and meanings these phenomena have for the individuals under study (Holloway and Galvin 2016). The role of the researcher, therefore, is to make their values known in the study which involves the ethics, judgement and aesthetics (Bryman, 2016), and actively reports their values and biases as well as the value-laden nature of information gathered from the study. As an insider - researcher, axiology is relevant to this study because, my values as a nurse researcher should align with the research ethics and enhance this study outcome.

3.2.4 Research philosophy as worldview or paradigm

Philosophical perspectives referred to as 'paradigms' (Guba & Lincoln 1994; Morgan, 2007), perspectives (Patton, 2002), and worldviews (Creswell, 2009), are "a basic set of beliefs that guide actions" (Guba, 1990:17). Research philosophical perspectives represent a system of values and setting research priorities to which people adhere (Smith et al., 2009). Irrespective of term used, worldview or paradigm, philosophical ideas still influence the practice of research and need to be identified (Slife and William, 1995).

Therefore, the research questions for this study were addressed to establish the research methodology and one of the research questions (chapter 1, p. 29) asked was:

> *How would the service changes and new ways of working impact on outpatient nurses and health care assistants' job motivation and wellbeing?*

The research questions seek answers which would lead to new knowledge. The role of a researcher, "at the early stage when preparing a research proposal or plan is to make explicit the larger philosophical ideas they espouse" (Creswell, 2014, p.6), and the research paradigms should only be characterised by their ontology, epistemology axiology and methodology (Creswell and Poth, 2018).

3.3 Choosing a theoretical framework

The theoretical perspective is giving context for the procedure and establishing the logic and criteria of the methodology (Crotty, 2003), and provides the theoretical assumptions for the larger context of a study which is the foundation or 'lens' by which a study is developed. In defining the purpose of a theoretical framework, Grant and Osanloo (2016) asserted that, theoretical framework informs the identified problem, the purpose and significance of the research demonstrating how the research fits with what is already known (relationship to existing theory and research). Furthermore, this provides a basis for the research questions, the literature review and the methodology and data analysis to be chosen. Also, the research designs and frameworks are the specific procedures involved in the research process such as data collection, data analysis, and reporting of findings (Creswell, 2014).

In order to differentiate the philosophical research approaches, Andrew et al., (2011) illustrates the major differences between constructivism, positivism and pragmatism philosophies as shown below table (3.1).

Philosophy	Constructivism	Positivism	Pragmatism
Type of research	**Qualitative**	**Quantitative**	**Mixed**
Methods	Open-ended questions, emerging approaches, text and/or image data.	Closed-ended questions, pre-determined approaches, numeric data.	Both, open and closed-ended questions, both, emerging and predetermined approaches, and both, qualitative and quantitative data analysis.
Research practices	Positions researcher within the context Collects participant-generate meanings Focuses on a single concept or phenomenon Studies the context or setting of participants Validates the accuracy of findings. Interprets the data. Creates an agenda for change or reform Involves researcher in collaborating with participant.	Tests or verifies theories or explanations Identifies variables of interest Relates variables in questions or hypotheses Uses standards of reliability and validity Observes and then measures information numerically Uses unbiased approaches Employs statistical procedures.	Collects both, qualitative and quantitative data Develops a rationale for mixing methods Integrates the data at various stages of inquiry Presents visual pictures of the procedures in the study Employs practices of both qualitative and quantitative research.

Table (3.1). Adapted from: Andrew et al., (2011). Differences between constructivism, positivism and pragmatism philosophies

According to Andrew et al., (2011), the constructivist framework helps in the research practice to ground the research focus under study, which may be used to define concepts and explain phenomena. By contrast, the positivist and pragmatist's approaches share some levels of verifying and testing existing hypothesis and theories. There are two dominant schools of thought as far as ontological and epistemological traditions towards reality and knowledge are concerned: Objectivism/Positivism and Interpretivisim /Constructivism (Crotty, 2003). Ataro, (2020) argue that from positivist/objectivist perspective knowledge is viewed as hard, tangible, measurable, static and value free where a researcher distances self from research so as to merely observe, measure and test, etc., without any impact on the finding (Ataro, 2020).

However, from the interpretivist and constructivist perspective, knowledge is viewed as subjective, personal, unique and flexible where a researcher is engaged with the subjects. Whereas the former is highly associated with quantitative research tradition and the latter is related to qualitative research traditions (Ataro, 2020). In view of these explanations, the constructivist tradition frames the methodological approache of this study, since the chosen ontology was concerned with, 'the human experience, the impact of service changes on the nursing staff job motivation and wellbeing'.

3.3.1 Constructivism

Crotty (2003, p. 42) acknowledged constructivism to be, "the view of all knowledge and therefore all meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context". In other words, constructivism as a naturalistic paradigm adheres to the belief that, research findings are a creation of an interactive process between the researcher and the participants. Thus, it is associated with qualitative research methodology (Crotty, 2003). The naturalistic paradigm is referred to as constructivism (Giorgi, 2005; Polit & Beck, 2017). Hence by research design, the relativist and subjectivist aspect of the philosophy fall within the constructivist research (Guba and Lincoln, 1994), assumes that there is no single truth or reality therefore, individuals' experiences are subjective (Husserl, 2012).

Cashman et al., (2008) described constructivism philosophical paradigm as an approach whereby, people construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences, and it is based on the analogy or basis that individuals form or construct much of what they learn through their own experience. By contrast, positivism utilises an objective stance which assumes that reality is fixed, directly measurable, and knowable that there is one truth, one external reality (Rubin and Rubin, 2012).

Wilson (2010) argues that all knowledge is constructed from human experience and this viewpoint is based on inseparability between knowledge and knower, however, positivist objective single reality approach fails to consider personal knowledge and experience. Based on this understanding, the researcher chose to situate this study within a constructivist paradigm to get the most authentic data in exploring the lived experiences of outpatient nursing staff.

This study would be conducted under subjectivism and constructivism which according to (Crotty, 1998) determines how knowledge is known. Part of the initial planning was to design an overall view of the project and the adapted research paradigm (figure 3.2) from Saunders et al., (2012), illustrates the chosen paradigm for this study.

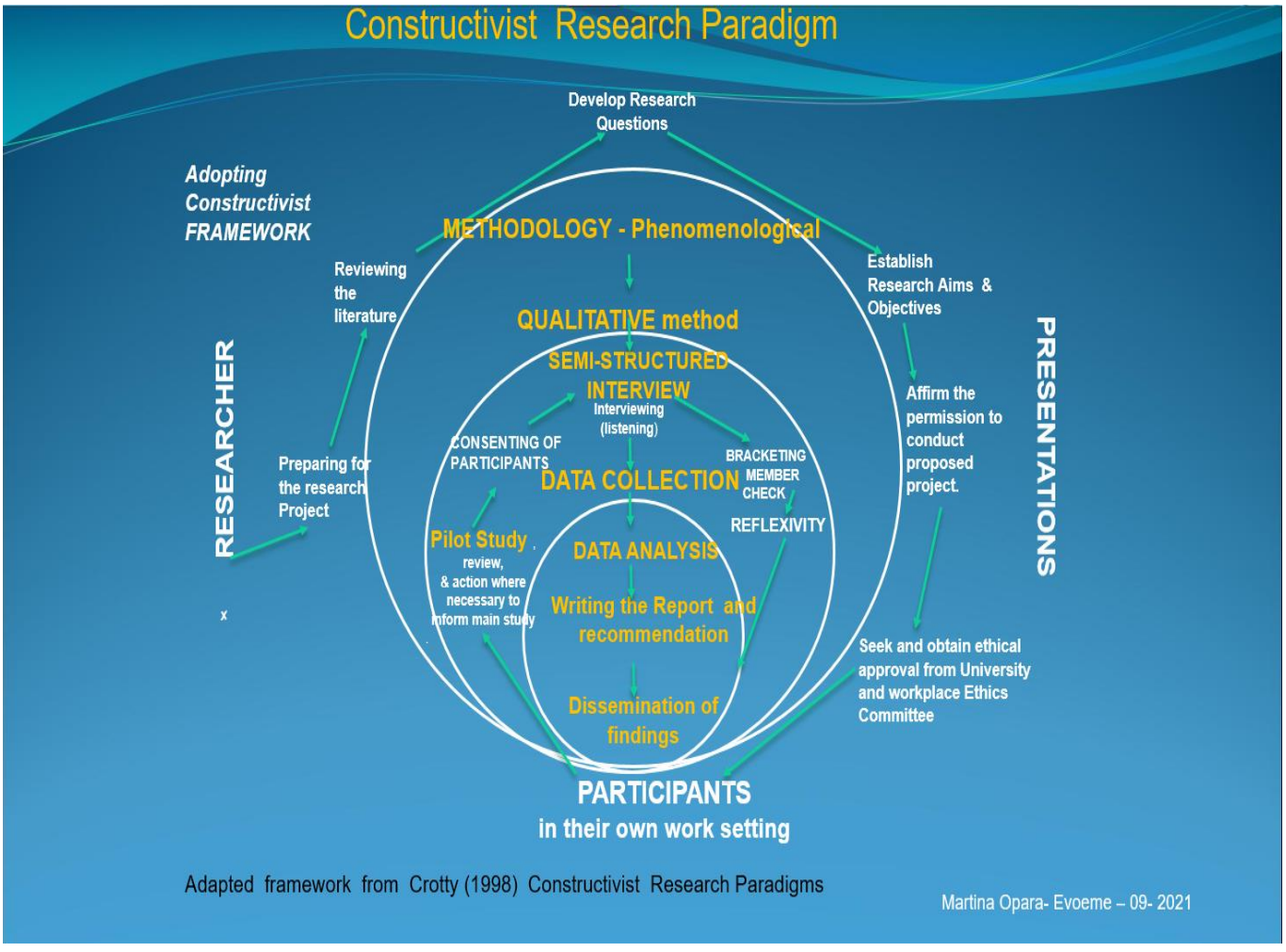


Figure 3.2: Constructivist Research Paradigm. Source; Adapted from Crotty (1998) and Saunders et al., (2012).

The belief system, values and paradigm align with the epistemological stance for this study whereby the participants would be invited to narrate and construct their own reality in the form of their lived experience. As this study involved participants who were diverse by nature, it would focus on exploring individual nursing staff experience in which reality was created by the individuals. By so doing, diversity would be recognised from their respective phenomenon, although within the same events. Hence, the philosophical stance chosen for this study was subjectivist constructivism deemed to be in congruence with the ontological and epistemological belief system.

Charmaz (2006), advocates that the research tools need to align with the research philosophy to fit with the research questions otherwise, an inappropriate approach would separate participants' experience making it fragmented and unconnected. Similarly, the research philosophy must be in agreement with the ontology and epistemology of the researcher (Saunders et al., 2012), which is fundamental and relevant to this study. The constructivist research paradigm illustrated on figure 3.2, describes the link between the study theoretical frameworks.

Earlier writers like Schwandt (1994) claimed that constructivism was more synonymous with an interpretivism approach, where the researcher conducts the study and constructs the reality from their participants' phenomena (Holloway and Torres, 2003). Constructivist approaches to research have the intention of understanding; reality is socially produced and according to (Cohen and Manion, 1994), constructivism refers to "the world of human experience" (Mertens, 2005, p.12). The interpretivist/constructivist researcher acknowledges the influence of their own history and experiences on the research and frequently relies on the participants' interpretations of the situation being researched (Creswell et al., 2006). Contrary to post-positivists, constructivists typically create or inductively establish a theory or pattern of meanings over the research process (Creswell et al., 2006).

The ontological assumption affects the epistemological inclination, which in turn influences research method and design, therefore a descriptive phenomenology, as coined by Colaizzi, (1978) was deemed suitable and was applied to this study. One of these core values is the valuing of people's lived experiences and Colaizzi (1978) stated that, to believe that my experience does not count amounts to believing that my existence does not count, and as a researcher, I really embrace this belief. Colaizzi's phenomenological approach is useful for exploring previously unknown or overlooked experiences (Polit and Beck, 2014). Therefore, to produce new knowledge within the nursing profession, the role of the nurse researcher is to impart knowledge and core nursing values to the next generation of nurses.

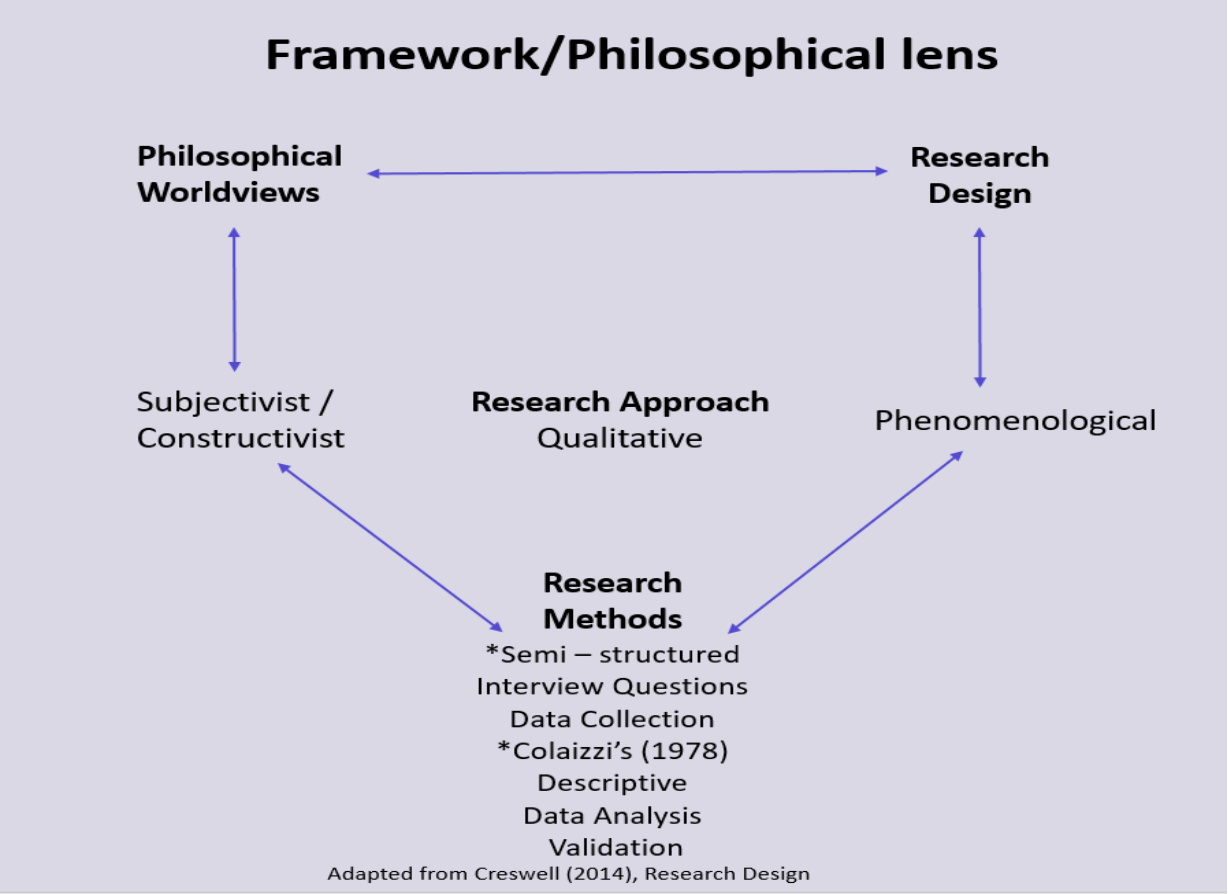


Figure 3.3. Researcher's illustration of the chosen Philosophical framework.

The adapted research framework (Creswell, 2014) research design (figure 3.3) illustrates how Colaizzi's phenomenological approach would be embedded in this study in line with the research questions. According to Appleton et al., (2001), the emic position within constructivism, the ontology and the epistemology approaches are interwoven and cannot be detached.

Further discussion on how Colaizzi's method was applied in this study will follow in the data collection and analysis sections in chapters 5 and 6. The appropriateness for choosing the constructivist research theoretical framework for this study can be linked to Cohen et al., (2017) concept that knowledge is not passively received but actively built up by the experiential world, not the discovery of ontological reality (Hein, 2007), the constructivist researcher is most likely to rely on qualitative data collection methods and analysis or a combination of both qualitative and quantitative methods (mixed methods) (Mackenzie, 2006). However, the qualitative aspect of constructivism specifically is, "a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (Creswell, 2013: 4).

A Constructivist approach was the relevant paradigm of choice to inform the research questions knowing that there was no pre-understanding of the research area being studied. The features of qualitative and quantitative research (Andrew et al., 2011), provided the rationale for choosing constructivism and based on the characteristics of the study design, an inductive strategy of qualitative research approach was chosen for this study. My role as a researcher is to be actively engaged with the research process and by taking an emic position, it allows the researcher to build data, which is generated rather than collected.

3.3.2 Inductive and deductive approaches in research

Trochim (2006) refers to two "broad methods of reasoning as the inductive and deductive approaches" in research (Trochim, 2006, p.1), and furthermore explained that the inductive approach is qualitative while the deductive is quantitative approach. Creswell and Plano Clark (2017) stated that, the deductive researcher works from the 'top down', from a theory to hypotheses to data to add to or contradict the theory. In contrast, the inductive researcher is defined as someone who works from the 'bottom-up', using the participants' views to build broader themes and generate a theory interconnecting the themes (Creswell and Plano Clark, 2017).

This study excludes the managers' perspectives, as it is concerned with staff job motivation and wellbeing an inductive bottom-top approach fits in better and aligns with this study's theoretical framework. The inductive approach would be suitable in answering the research questions of the study.

Inductive Approach	Deductive Approach
Associated with hypothesis generating approach to research	Mainly associated with scientific (or positivist) approach to research
Field work, interviews or observations occur initially and hypotheses are generated from the analysis of the data collected	A theory is examined through field work and observation and it could either be accepted, rejected or revised
Source: Adapted from: Research Methods for Students, Academics and Professionals (Second Edition) (2002) by Kirsty Williamson, Frada Burstein and Sue McKemmish	

Table (3.2): A summary of inductive and deductive approach.

By choosing a bottom-up approach, the participants would be more engaged and given the opportunity to narrate their individual phenomena from their own unique perspective. The emergence of themes can develop deductive in which the researcher brings theoretical concepts to the research or inductively where the themes emerge from the raw data (Joffe, 2012).

In some inductive approaches, Joffe (2012) affirms that, a good quality analysis will adopt bracketing position by holding one's preconceptions of the research while keeping an open mind to new ideas that might be discovered. The inductive qualitative approach aligns with this study due to the ontological and epistemological underpinnings unlike the quantitative method which is fully deductive approach by design measuring statistical data mostly from an objective perspective. Sometimes, a mixed method is required which involves a combination of both inductive and deductive approaches. Therefore, when conducting a study, researchers need to identify whether they will employ a quantitative, qualitative or mixed methods or approaches and the research questions determines the most appropriate approach (Flood, 2010).

The selection of the research approach is, “based on bringing together a worldview or assumptions about research, a specific design and research methods” (Creswell, 2014, p. 21). Other important considerations include whether the study requires inductive or deductive analysis, an illustration of induction and deduction approaches as shown below (figure 3.4). As this study is exploring inductive reasoning, a qualitative approach was deemed more suitable for this project and will be discussed later in the data collection section of this chapter.

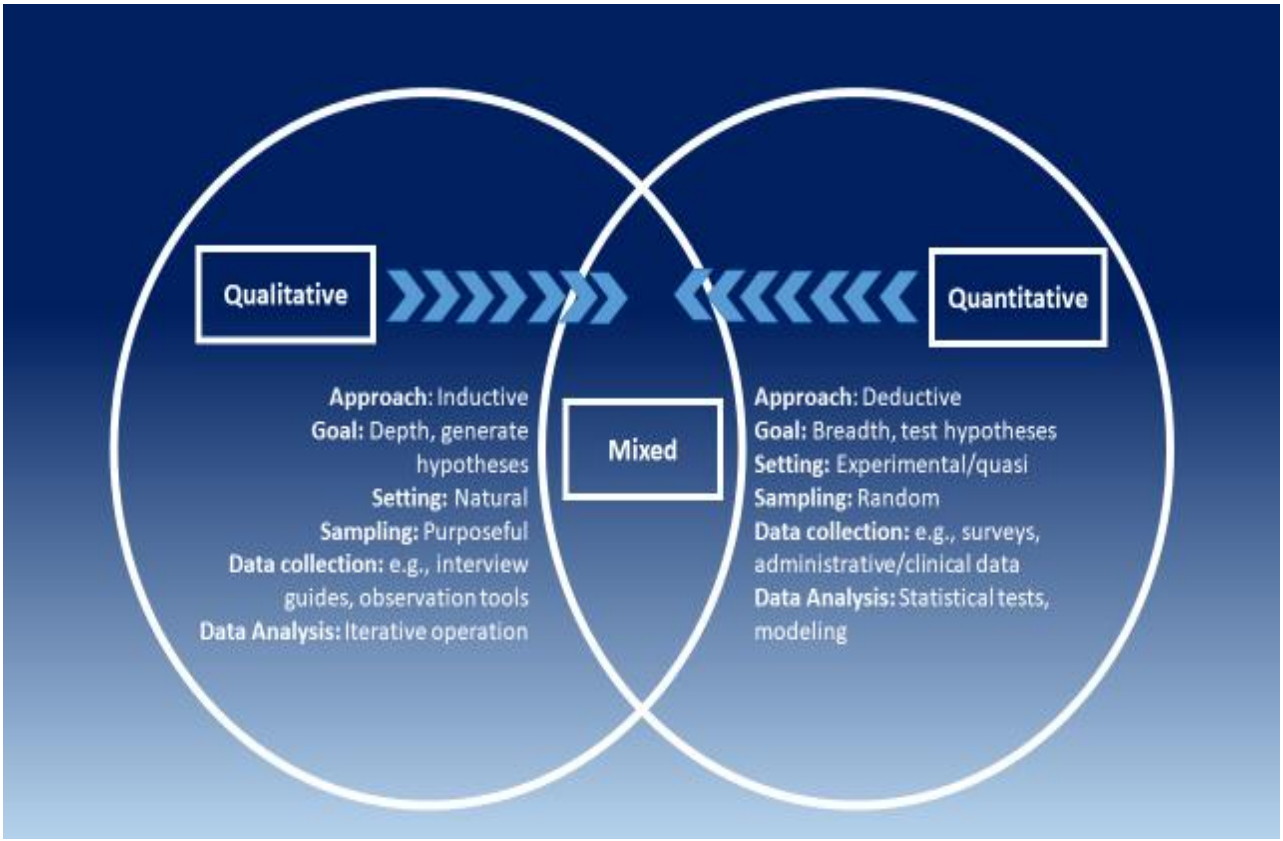


Figure (3.4) – Choice of Approach: Qualitative Approach. Adapted from; methods.sagepub.com. Yale Global Health Institute’s photo (2017. methods.sagepub.com. [Accessed; 16-05-2022].

3.4 Choosing a methodological approach

Parahoo (2014) highlighted that the methodology describes in general how, when and where data will be collected and analysed as well as giving the researcher the opportunity to choose from different approaches and methods.

Furthermore, Weller et al., (2013) explained that, Portwood's design process highlighted the importance of applying methodological stage in research. On the same note, Volante et al., (2017) describes real world research in healthcare as being complex. Therefore, while examining the nature and uses of research projects, four processes were identified all of which begin with the letter 'I'; intention, initiation, implementation and impact. Most importantly, the planning decisions, the research intention and initiation should be agreed at the research methodology stage (Volante et al., 2017).

According to Doody and Bailey (2016), there are differences between the goal of qualitative research which include; to 'uncover or discovery' as in the case of grounded theory; 'seeking to understand' as with ethnography; 'explore a process' as in a case study or to 'describe the experiences' as is expected in phenomenology. The researchers' choice of study methodology is dependent on the subject or phenomenon being investigated and Moustakas (1994) as cited by Goulding (2005), placed emphasis on the importance of capturing what the participants' lived experience mean to them (Doody and Bailey, 2016). For this project is, finding the meaning of the impact of service changes on the outpatient nurses and healthcare assistants' job motivation and wellbeing is crucial.

The main qualitative approaches have some differences which can be identified with the various research applications (Creswell and Poth, 2017). Further explanation indicate that, grounded theory requires greater population for the study and ethnography entails extended field work which were considered but not suitable for this research. Based on the outlined differences from other approaches, phenomenology is focused on the individuals in terms of data collection and analysis of the data. Moreover, in the analysis strategy, phenomenology involves identification and description from individual participants' narratives. In contrast, grounded theory and ethnography are not individual participants focused in terms of the analysis (Tie et al., 2019), which involves group participants' data collection activities. A variety of methodologies were looked at within the research approaches on how best to examine the nursing staff experience (phenomena). It was essential to recognise that each of these approaches has a different philosophical stance and links to different methodologies.

Although there are at least five research design approaches (appendix 3), however, the three main ones are: phenomenology, grounded theory and ethnography (Creswell, 2007) as illustrated on table (3.3) below.

Comparison of the Main Research Methodologies			
Characteristics	**Phenomenology**	**Grounded Theory**	**Ethnography**
Focus	Understanding the essence of the experience	Developing a theory grounded in existing data for discovery	Describing and interpreting a culture-sharing group
Type of Problem Best Suited for Design	Needing to describe the essence of a lived phenomenon	Grounding a theory in the views of participants	Describing and interpreting the shared patterns of culture of a group
Discipline Background	Drawing from philosophy, psychology, and education	Drawing from sociology	Drawing from anthroplogy and sociology
Data collection form	Using primarily interviews with individuals, although documents, observations, and art may also be considered	Using primarilty interviews with 20-60 individuals	Using primarily observations and interviews, but perhaps collecting other sources during extended firld time
Unit of Analysis	Studying several individuals that have shared the experience	Studying a process, action, or interaction involving many individuals	Studying a group that shares the same culture
Data Analysis Strategies	Analysing data for significant statements, meaning units, textural and structural description, description of the "essence"	Analysing data through open coding, axial coding, selective coding	Analysing data through description of the culture-sharing group; themes about the group
Written Report	Describing the "essence" of the experience	Generating a theory illustrated in a figure	Describing how a culture-sharing group works

Table (3.3) Choice of Methodology: Phenomenology. Adapted from: J.W. Creswell & Creswell (2017).

These three main approacheds were considered, howevere, Phenomenology aligned with the research questions for this study. An example of the research question was, 'how did the service changes and new ways of working impact on outpatient nurses and health care assistants' job motivation and wellbeing?'. This research questions would require a research methodology that allows for the exploration of the subjective experiences of the nursing staff. This is because the impact of service changes on staff job motivation and wellbeing is a subjective experience that cannot be measured using quantitative methods alone.

According to May (2011), the choice of research methodology should be dependent on the subject or phenomenon under investigation. In this case, the use of a phenomenal qualitative research setting, such as phenomenology, would be appropriate to explore the impact of service changes from the staff perspective. Denscombe (2012) recommends that, in phenomenological studies, researchers should explore constructivist phenomenal ideas to guide appropriate data collection and analysis methods. This approach would allow for the capture of the meaning of the experience of the nursing staff and provide raw and authentic data. Moreover, as an insider-researcher, the use of phenomenology would allow for bracketing to prevent the researcher's biases from affecting the analysis (Denscombe, 2017).

On the other hand, grounded theory involves discovering emerging patterns in data, which may not be the most appropriate method for exploring the subjective experiences of nursing staff impacted by service changes. Therefore, the choice of research methodology must be aligned with the research question and the nature of the phenomenon under investigation.

When conducting phenomenological studies, the value of the research should not be compromised (Ball, 2009). Rather, the values enable the researcher to explore various research methodologies to examine and gain full understanding of the subjective experience as it relates to a social or psychological phenomenon (Wilson, 2015). Having clarified the differences in the research methodologies, the researcher was well informed and chose phenomenology as the most suitable methodology.

As an insider researcher undertaking a phenomenological study, I will need to bracket myself in investigating the outpatient nursing staff lived experiences. The outlined contrasting characteristics and limitations for grounded theory and ethnography in researching individuals' lived experiences informed the researcher to choose phenomenology as the most suitable methodology for this study.

3.4.1 Naturalistic enquiry method and Empirical enquiry method

Naturalistic inquiry and empirical inquiry are two research methods used in the social sciences to investigate human behaviour and phenomena. While they share some similarities, they differ in their approaches to data collection and analysis. Naturalistic inquiry emphasises the importance of studying phenomena in their natural setting, without attempting to manipulate or control the environment in any way.

Naturalistic methods also involve observing and interpreting the behaviour of individuals or groups in their natural environment, often using qualitative research methods such as ethnography, case studies, or phenomenology. The goal of naturalistic inquiry is to understand the subjective experiences of individuals and the meaning they ascribe to their behaviour or experience (Lincoln & Guba, 1985). However, the goal of empirical inquiry is to generate reliable and generalisable knowledge that can be used to make predictions and inform decision-making (Giorgi et al., 2017). While both methods have their strengths and weaknesses, they can be complementary in research. For example, naturalistic inquiry can be used to generate hypotheses or identify important variables, while empirical inquiry can be used to test these hypotheses and quantify the relationships between variables (Creswell, 2013).

With a greater understanding of the research methods, I found that a naturalistic approach would complement the philosophy of this study's construct, based on the phenomenological characteristics which matched the research questions focusing on exploring outpatient staff experience. By choosing an inductive qualitative approach, the researcher would be able to explore and obtain the individual participants' views, experience and perspective of the impact of the service changes on work life. It is well established that the research method is the implementation stage of the research project (Myers, 2019), and it is a strategy of enquiry, which moves from the underlying assumptions to research design, and data collection. Researchers using constructivist paradigm and qualitative methods often seek experiences, understandings and perceptions of individuals for the data to uncover the individual's reality rather than relying on numbers of statistics (Merriam & Grenier, 2019). This approach would be most suitable in answering the research questions for this study, to make sense of the participants' experiences and thoughts.

3.4.2 Phenomenology

Phenomenology is a philosophy and method of enquiry that enables researchers to understand the fundamental structures of experiences (Edward and Welch 2011). This methodology uses the analysis of participants' statements to formulate themes, which is a development of what Moustakas (1994) called an essence description. Phenomenology stresses on the importance of looking closely at the lived experiences in specific settings rather than abstract theorising about human nature, appeals to academics and practitioners (King and Horrocks, 2010). Consequently, a phenomenological study explores what people experienced and focuses on their narrative of a phenomena (Robson and McCartan, 2016). Further explanation by Sunder et al., (2019) theorised that, the philosophy of phenomenology is the study of a phenomenon, for example something as it is experienced (or lived) by a human being that means, 'how things appear in our experiences' as in this research.

Understanding and producing new knowledge from the outpatient nursing staff experience is crucial and in exploring main research methodologies the characteristics which points this research to phenomenology methodology are. The notion of "to understanding the meaning of people's lived experience from the individual participant's perspective" (Sundler et al., 2019; p. 734). Van Manen (2014) further explained phenomenology from the ontological and epistemological lenses, as a study where a phenomenological researcher hopes to gain an understanding of the essential truths, which is the essences of the lived experience.

My belief as a researcher is that the study of knowledge and understanding are embedded in our everyday world. Also, the notion that knowledge cannot be quantified or reduced to numbers or statistics is applicable to this outpatient nursing study. Many organisational studies describe phenomenology as one standard methodology (Goulding, 2005; Suddaby, 2006). However, King and Horrocks (2010) argued that it is important for researchers to recognise that a range of phenomenology methodologies exist, "looking closely at the lived experiences in specific settings rather than abstract theorising about human nature" (King and Horrocks, 2010, p.181). Likewise, this study explores outpatient nursing staff lived experience in terms of the impact of service changes on their job motivation and wellbeing.

As a related point, phenomenological approaches attempt to describe experiences from the point of view of the 'experiencer' (Smith et al., 2009), with some differing assumptions or processes. As such, phenomenological research is not so straightforward and one must firstly decide which of the two main groups; descriptive phenomenology or interpretive phenomenology is applicable before conducting a research project (Dowling and Cooney, 2012). Overall, phenomenology is divided into two groups of descriptive and interpretive phenomenology which has played an important role in many practice-oriented disciplines such as education and the health professions (Smith et al., 2009), which was a key consideration for me as a researcher.

3.4.3 Descriptive phenomenology

Descriptive phenomenology is attributed to Husserl (1963; original work 1913), with the philosophical underpinnings of the lived human experience. Hence, he sought to reinstate the human world as a foundation of science that brought justice to the everyday lived experience – the going to the things themselves (Dahlberg et al., 2001). Husserlian descriptive phenomenology as a research methodology is widely used in the social sciences, one in which it aims to explore and describe lived experience (Giorgio, 2009). While Husserlian supports this**,** Heidegger (1992) refuted it, pointing, interpreting and describing human experience as he believes that bracketing was not warranted because hermeneutics presumed prior understanding (Dahlberg & Dahlberg, 2020). On the other hand, the nature of descriptive phenomenology is more appropriate and congruent when the researcher wants to describe the phenomenon under study and brackets their biases (Idczak, 2007). In support, Husserl (1963) believed consciousness was the foundation of phenomenology based on how a person experienced the phenomenon through their own thoughts, memories and perception (Reiners, 2012). Therefore, "the descriptive and explanatory nature of phenomenology embodies experiential meanings, as lived by individuals, and aligns with their understanding of their world" (Moxham and Patterson, 2017, p.7).

3.4.4 Interpretive phenomenology

According to Rapport (2006), interpretative phenomenology approach has many realities requiring interpretation, although description is a tiny fraction of the interpretative process. Subsequently, phenomenologists such as Heidegger (1962) modified and built on Husserl's theories and developed the interpretative tradition (also known as the hermeneutic tradition). Husserl's (1983) phenomenological method was descriptive based upon the intuition of the given, both in philosophy and psychology, therefore, Husserl's method was a descriptive transcendental phenomenology (Morley et al., 2017). By contrast, the hermeneutic approach was developed from the transcendental phenomenology, requiring the personal interpretation of the researcher in the absence of bracketing (Jackson et al., 2018). The qualitative research approach of phenomenology is all about the search for meaning and its roots are in the philosophical work of Husserl, Heidegger through interpretive or descriptive approach (Patton, 2019). As an insider researcher, conducting this study within my organisation, bracketing from the data is crucial hence, a descriptive approach would be more appropriate for this study.

3.5 Selected methodology: Descriptive phenomenological approach

Reiner (2012) advised that nurses interested in conducting phenomenological research should consider how their values, beliefs and experiences could influence the whole research process. Phenomenological inquiry assists the researcher in gaining a deeper understanding of the nature or meaning of experiences (Patton, 2015). The aim of phenomenological qualitative research is to deal with experiences and meanings, and "to capture as closely as possible the way in which the phenomenon is experienced within the context in which the experience takes place" (Giorgi & Giorgi, 2003, p. 27).

This study explored the individual experiences of outpatient nurses and health care assistants and how they perceived it. It is argued that a descriptive phenomenological approach is usually used when little is known about an issue and the aim of the study is to understand the most essential meaning of a phenomenon of interest from the perspective of those directly involved in it (Giorgi, 2009).

By exploring this approach, the researcher gets a sense of the participants' actual lived and narrated experience, which is in turn described into meaning units. During this process, however, "theoretical or speculative interpretation should be avoided so as to flesh out the full lived meaning inherent to the descriptions themselves" (Giorgi, 2009, p. 127). The ontological and epistemological assumptions link with the constructivist paradigm and phenomenological qualitative approach, which led to the researcher's decision to choose Colaizzi (1978)'s descriptive phenomenological analysis method specifically, to analyse the data as shown below.

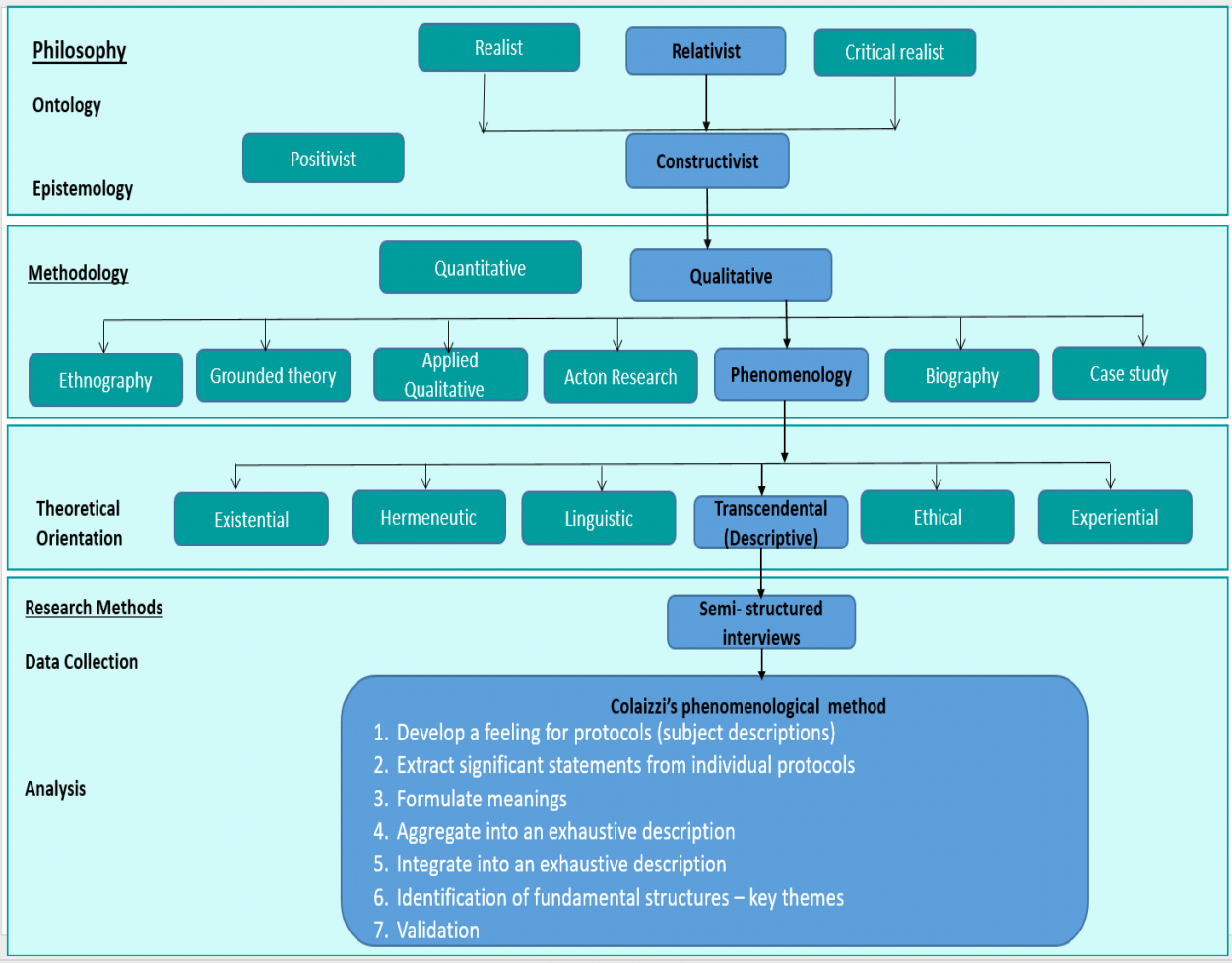


Figure (3.5). Adapted from: Gill (2020). Phenomenological approaches to research.

As an insider–researcher and a nurse conducting a study involving the nursing staff, it is critical that the choice of methodology complies with the research philosophical and value system.

Colaizzi's (1978) descriptive phenomenology advocates for researchers to explore bracketing strategies to minimize their bias, preconceived ideas, experience and knowledge relating to the research topic to prevent their own interpretation of the participants' phenomena. Conversely, Heidegger (1992) does not support bracketing hence the interpretive phenomenological approach was deemed unsuitable for this study. Therefore, this study which explores the outpatient nursing staff experience is best situated within the descriptive phenomenology as against the interpretive phenomenology which does not advocate the 'use of bracketing'. Descriptive phenomenology as a methodology requires that the researcher aligns the methods of data collection, analysis, and reporting of findings with the phenomenological assumptions (Matua, 2015).

The researcher therefore adapted Gill (2020) phenomenological approach to research framework (figure 3.5; page 122), which illustrated the link between this study's philosophical stance, methodology and research methods, all shaded in blue colour. The descriptive (transcendental) phenomenological approach was the best choice for this study, considering Patton (2015) emphasis on the importance of understanding what people experience and how they interpret the world. In view of the above discussed theoretical and philosophical understanding, the principles of this study is linked to the descriptive phenomenology rooted in philosophy.

3.5.1 Data Collection Strategy

Data collection strategy are important for the researcher to examine the research aims and objectives to link with the research questions (Teherani et al., 2015). How the information collected is used and what explanations it can generate are determined by the methodology and analytical approach applied by the researcher (Wright et al., 2016). During interviews in phenomenological studies, the questions might be broadly stated without specific references, Moustakas (1994) talked about, "asking what the participants experienced and what contexts or situations in which they experienced it" (Creswell, 2014, p.140).

Prior to identifying data collection strategies, it is important to develop the specific questions which are appropriate to the area under study (Wright et al., 2016). Most qualitative research explores purposive participants' selection which enhance understanding of the phenomenon under study (Creswell, 2009; Kuper et al., 2008). Table 3.4 shows this study's research questions and research objectives which were linked to the appropriate research method and data collection technique.

Research Questions	Research Objectives	Research Method	Data Collection Techniques
1. How would the service changes and new ways of working impact on outpatient nurses and health care assistants' job motivation and wellbeing?	To identify factors that affect Outpatient nurses and health care assistants' job motivation and wellbeing, subsequent to service changes and the unprecedented COVID-19 pandemic.	Qualitative method	Semi-structured one-on-one interview (once only)
2. How could the experience of outpatient nurses and health care assistants be determined in relation to the unprecedented COVID-19 pandemic and the new ways of working, due to the pandemic?	To make recommendations which will inform Human Resource and Senior Management teams, on the impact of service changes on the nurses and health care assistants' job motivation and wellbeing.	Qualitative method	Synthesis of findings from the research with lessons learned from the review of the literature (e.g. NHS Staff survey report)
3. How would the service changes and new ways of working support nurses and health care assistants' development, job motivation and wellbeing?	To collaboratively establish strategies and mechanism for supporting staff to achieve a healthy workplace, job motivation and wellbeing.	Qualitative method	Synthesis of findings from the research with lessons learned from the review of the literature (e.g. NHS Staff survey report)

Table 3.4 Research questions, objectives methods and proposed data collection techniques.

3.5.2 Sampling strategy

One of the most essential tasks in the study design phase is to identify the appropriate participants (Creswell, 2014). A purposive sampling is useful in conducting studies on lived experiences (Mason, 2017), it is a non-probability sampling method which occurs when participants are chosen by the judgment of the researcher (Saunders et al., 2012) and appears suited to this study.

This research study will focus on nursing staffs' experience and according to Gerrish and Lathlean (2010), maintaining a purposive sampling is how the researcher develop knowledge about the population and decisively choose the participants. Purposive sampling also involves an iterative process of selecting research subjects rather than starting with a predetermined sample (Schutt, 2006). Schutt (2006) places particular emphasis on the importance of sampling elements which are distinct and relative to the research aim (Schutt, 2006, p.155). The purposive sampling method is congruent with the philosophical stance for this study.

3.5.3 Testing of Research Questions: Pilot study

A pilot study is the first step of the entire research protocol and is often a smaller-sized study meant to assist in planning and modification of the main study (Arnold et al., 2009). Additionally, Thabane et al., (2010) argue that the pilot study can be performed either as an external pilot study independent of the main study or as an internal pilot study included in the research design of the main study. Before a pilot study begins, the researcher must fully understand not only the clear purpose and question of the study, but also the experimental methods and schedule (Arnold, 2009). This way, it would be easier for me, as an insider-researcher to become aware of the procedures involved in the main study through the pilot study, which aids in the selection of the research method most suitable for answering the research question in the main study (Thabane et al., 2010). The pilot study identifies errors in the indicative research questions, also in identifies any problems or clarifications in the questions before the final research questions is finalised.

3.5.4 Semi structured interviews

The term 'qualitative interviewing' is usually intended to refer to one of the identified three types of interviews, "in-depth or intensive, semi-structured and loosely structured or unstructured" (Mason, 2002: 62). Qualitative interviewing is probably the most common method in qualitative research (Mason, 2002). Interviews are data collection methods achieved by talking to respondents (interviewees) and recording their responses, and there are advantages and disadvantages to this method of data collection (Bowling, 2014).

In any case, qualitative research studies should never be truly unstructured (Denzin and Lincoln, 2000), and to collect specific information or data, the researcher must have a form of structure to guide the entire study process. Miles et al., (2013) differentiated between structured and semi-structured interviews, explaining that structured interviews are researcher-guided and involve specific questions with short responses, whereas semi-structured interviews take an open-ended approach and prompt participants to provide in-depth narratives. Edwards and Holland (2013) suggest that, researchers using semi-structured interviews should focus on building relationships and consider interviewing skills to ensure data quality.

While semi-structured interviews are a powerful tool for understanding individuals' thoughts, beliefs, and experiences, they can be challenging for researchers and time-consuming (Edwards and Holland, 2013). However, Blaxter et al., (2006) highlighted that, semi-structured interviews can provide insight into participants' subjectivity, which may not be accessible through methods such as questionnaires and observations. Other advantages of the interviews include flexibility to the interviewers and the ability to collect data (Farrow et al., 2020).

Advantages and Limitations of Interviews	
Advantages	**Limitations**
• It provides flexibility to the interviewers. • The interview has a better response rate than mailed questions, and the people who cannot read and write an also answer the questions. • The interviewer can judge the non-verbal behaviour of the respondent. • The interviewer can decide the place for an interview in a private and silent place, unlike the ones conducted emails and virtual which can have a completely different environment. • The interviewer has control over the order of the question, as in the questionnaire, and can judge the spontaneity of the respondent as well.	• Conducting interview studies can be very costly as well as very time-consuming. • An interview can cause biases. For example, the respondent's answers can be affected by his/ her reaction to the interviewer's race, class, age or physical appearance. • Interview studies provide less anonymity, which is a big concern for many respondents. • There is a lack of accessibility to respondents (unlike conducting mailed questionnaire study) since the respondents can be in around any corner of the world or country.

Table (3.5) Compiled from Farrow et al., (2020).

Obviously, the advantages shown on table 3.5 have made interviewing an increasingly attractive method of data collection. However, like any other research tool, interviews can be fraught with drawbacks. In any case these challenges can be mitigated as interviews can be conducted in multiple ways, for example, face to face, telephone, text/email, individual, group, brief, in-depth, each of which have advantages and disadvantages (Miles et al., 2013). Other benefits of semi-structured interviewing include its natural way of interaction which enables mutual understanding between the interviewer and interviewee, leading to more appropriate and accurate data (Dörnyei, 2007). Real time recording of interviews using tape recorders can also enhance accuracy and reduce the need for subsequent attempts to reconstruct what the interviewee said (Berg, 2007), furthermore, interviewing virtual and recording in real time can be cost effective and an economical method for data collection.

Most importantly, validity will be ensured in this study and as a researcher, I will establish clear research questions and objectives to guide the interview process following the robust protocols as recommended by the experts such as:

- Develop a structured interview guide or protocol that includes open-ended questions to facilitate in-depth exploration of the topic Rubin & Rubin (2012).
- Ensure that the sample is representative of the population of interest and that they have obtained informed consent from all participants (Creswell, 2013).
- Establish rapport with participants to create a comfortable and safe environment for them to share their experiences and perspectives (Seidman, 2013).
- Conduct the interviews in a consistent manner, following the same protocol for all participants, and should consider audio or video recording the interviews to ensure accuracy in data collection (Kvale & Brinkmann, 2009).
- Analyse the data using a systematic approach to identify patterns, themes, and variations within and across participants (Braun & Clarke, 2006).
- Consider member checking or the process of verifying findings with participants to ensure the accuracy of the interpretation of the data (Creswell, 2013).

The notion that semi-structured interview is popular and the most usual form within qualitative research is supported by Kallio et al., (2016), especially the individual, one-on-one, in-depth interviews. The interview plan for this study was to conduct a one-on-one, face to face interview with twenty participants. However, due to the onset of COVID-19 pandemic, virtual interviews were unavoidably the best option to comply with the infection prevention control directives.

3.6 Data Analysis strategy

Husserl (1983)'s development of phenomenology as a philosophy led to multiple interpretations of phenomenological research and models of data analysis. Also, Giorgi (1985) developed the descriptive phenomenological method in the early 1970s, and when using a descriptive approach, researchers attempt to describe the experiences being lived through by analysing data through an exhaustive phenomenological analysis within the perspective of phenomenological psychological reduction (Giorgi, Giorgi & Morley, 2017). This approach is because, phenomenology assumes that human beings seek meaning from their experiences and that their accounts convey this meaning. Therefore, describing this meaning entails staying close (Smith et al., 2009) to research participants' language to provide a faithful account that clearly connects the researcher's description to the participants' experiences. Moreover, the descriptive phenomenological method allows the researcher to retain the 'voice' of the participants without abstracting their viewpoint out through analysis (Giorgi, 2003).

The use of interviews in this study, within a descriptive phenomenological methodology would focus on the lived experiences of specific individuals on a one-on one interview basis. Husserl (1983) suggested that descriptive phenomenological approach is intricately linked to semantic thematic method of data analysis (Larkin & Thompson, 2012). This method includes searching and describing the themes for meanings from the informant's perspective. Therefore, this methodology is deemed to be the most suitable to explore the experiences of outpatient nurses and healthcare assistants from their perspectives.

Generating key themes using Colaizzi (1978) method is also similar to Braun and Clark (2006). However, Colaizzi's (1978) method of data analysis is rigorous and robust due to the distinctive seven step process with each step staying close to the data (Colaizzi, 1978; Shosha, 2012), and table 3.6: below illustrates the similarities and differences.

Differences and Similarities among Interpretative Phenomenological Analysis (IPA), Thematic Analysis (TA) and Colaizzi's Phenomenological Method of Analysis			
Characteristics	**Interpretative Phenomenological Analysis (IPA)**	**Braun & Clarke (2006) Thematic Analysis (TA)**	**Colaizzi's Phenomenological Method of Analysis**
Paradigm	Methodology (Smith et al., 2009).	Methods (Braun & Clarke, 2006)	Method of analysis (Gumarang, et al., 2021; Morrow et al., 2015)
Types of research questions	**Investigate about people's experiences and perspectives** (Braun & Clarke, 2006; Colaizzi., 1974; Smith et al., 2009; Morrow et al., 2015).		
Type of research	Qualitative		
Focus	Unique characteristics of individual participants and on patterning of meaning across participants (Clifton et al., 2006)	Mostly on patterning of meaning across individual participants (Braun & Clarke, 2006)	Mainly on revealing emergent themes and their interwoven relationships (Wirihana, et al., 2017).
Analytic procedure	Process consists of 'initial commenting' or 'initial noting' (Langridge, 2007)	Process consists of coding after a process of data familiarisation (Braun & Clarke, 2006)	Process consists of formulating meanings based on significant statements and grouping these into categories (Gumarang, et al., 2021; Morrow et al., 2015)
Theme development	Two levels: 'emergent' and 'superordinate' themes (Smith et al., 2009)	Emergent themes lie between codes and themes (subthemes) (Braun & Clarke, 2006)	A composition of themes were formed, with groups of theme clusters built together that reflected the issues of a particular vision (Gumarang, et al., 2021; Morrow et al., 2015)
Themes	**Generating themes** (Smith et al., 2009; Braun and Clarke, 2006; Colaizzi, 1974)		
Data	Researcher is closed to the data due to developing codes and themes on the actual data items and to focus on the unique characteristics of each individual participant (Clifton et al., 2006; Langridge, 2007; Smith et al., 2009)	Researcher identify patterns across the entire data set (Braun & Clarke, 2006)	Researcher tries to understand people's experiences in their own perspective (Wirihana, et al., 2017)
Data collection	**Interviews are used to gather data, and requires a small number of participants** (Smith et al., 2009; Braun and Clarke, 2006; Colaizzi, 1974)		
	No step in executing bracketing (Giorgi, 2011)	Step required for bracketing (Braun & Clarke, 2006)	Step required for bracketing (Colaizzi, 1974; Gumarang et al., 2021)
Data analysis	Interprets phenomenological experiences (Smith et al., 2009)	Researcher is not looking beyond the surface meaning of the participants' narrative (Braun & Clarke, 2006)	Allows researcher to reveal emergent themes and their interwoven relationships (Wrirhana, et al., 2017)
Member check/Validation	Credibility check required during the interpretative and analytical stage (Love et al, 2020)	Credibility and Member check required in the method (Braun & Clarke, 2006)	Credibility and Member check required in the method (Colaizzi, 1974; Gumarang et al., 2021)

Table (3.6): Differences and similarities between the various data analytical methods.

A comparison between different thematic analysis of Interpretative Phenomenological Analysis, Braun and Clarke Thematic Analysis and Colaizzi's Phenomenological as illustrated on the table 3.6 shows that this study is best situated under Colaizzi's phenomenological method. The most specific step is the additional rigor stage of participants' validation at the seventh step which increases data credibility. Thus, the plan in this study is to follow the final step in Colaizzi's method, the end result generated in the form of the key themes would be sent to the participants. Although the seventh step has been criticised by Giorgi (2006) who stated that, the participant may have different perspectives of the description of the phenomenon. However, Wirihana et al., (2018) asserts that, using the individual participant's validation of the narratives on the phenomena enhances the standards of the study rigour and needs to be considered at all stages of the project.

3.7 Colaizzi's Descriptive Phenomenological Analysis Method

Colaizzi (1978) analysis method offers a clear and systematic approach, and its thematic nature is more familiar and accessible than the distilling style offered by Giorgi (1985) (Morrow et al., 2015). Figure 3.6 below illustrates the seven steps sometimes iterative.

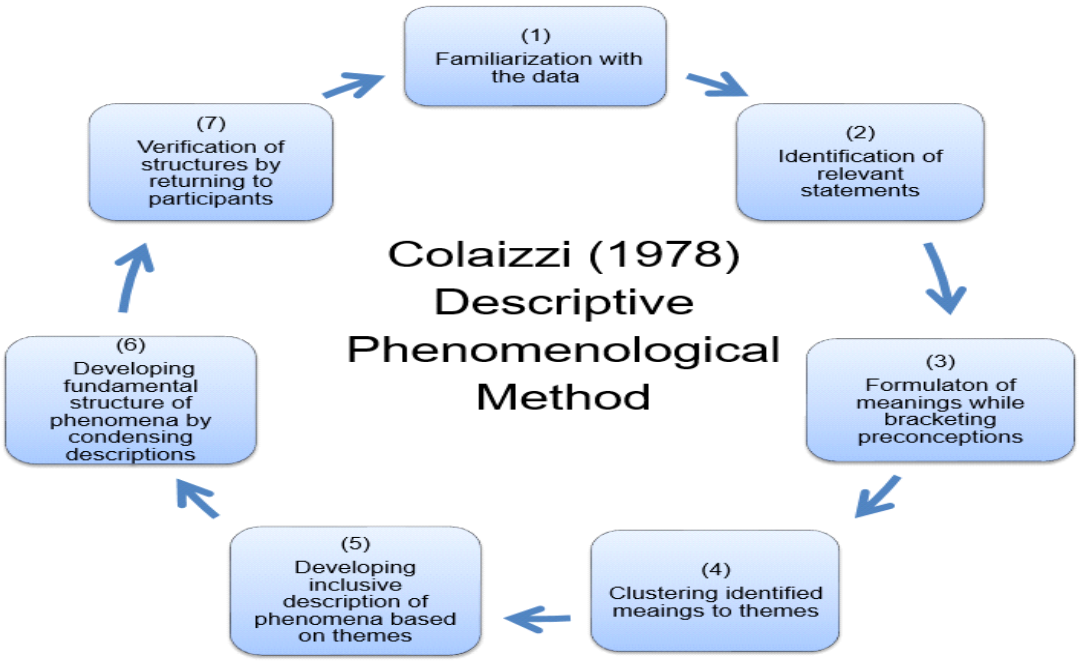
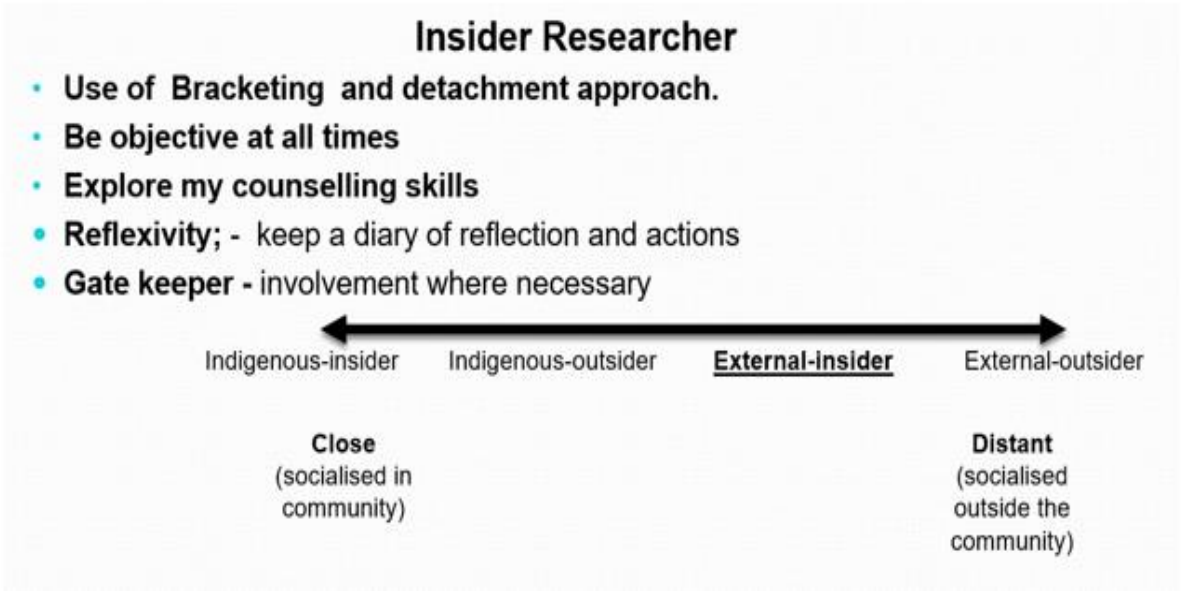


Figure (3.6) Colaizzi's seven steps descriptive phenomenological analysis adapted from: Ataro, 2020

Therefore, the data analysis plan for this study was Colaizzi's (1978) descriptive phenomenological method. Descriptive phenomenology is especially valuable in areas where there is little existing research (Giorgi and Morley, 2017), as is the case with the outpatient nurses' situation. While Giorgi's descriptive phenomenological method has been widely known for its use in the social and human science fields, Colaizzi (1978) has also contributed to the development of a descriptive method which has been mostly recognised in the health science areas as illustrated above.

The Colaizzi's seven steps descriptive phenomenological analysis (figure 3.6) above, illustrates the cycle of phases for data analysis. The seventh step has been criticised by Giorgi (2006), who stated that the researcher and the participant will have different perspectives of the structure. This major step is expected to add value to the rigour of the study. The researcher also planned to carry out member check soon after data collection and validation of the generated key themes in order to increase the data rigour, as recommended by Colaizzi (1978), (appendix 4). By exploring thematic analysis of members checks which depends upon first-person accounts and the seventh step of validation, a comprehensive level of study rigour should be achieved. In addition to increase study rigour, Cohen and Daniels (2001) insist that researchers set aside their own biases, experiences, and pre-conceived ideas. It is essential so the researcher can gain understanding as to how the phenomenon appears to the participants rather than how it is perceived by the researcher, otherwise known as bracketing (Cohen and Daniels, 2001).



Insider researcher approach: Adapted from Banks, (1988).

Preconceived notions could exist for the insider - researcher in which case, it is necessary to use a reflective diary to mitigate possible biases that could occur (Banks, 1988). As an insider researcher, I fully understand the importance of bracketing strategy how to facilitate bracketing during this study. Lopez and Willis (2004) advocate that where the researchers bracketed their biases, the primary data should be sent to the participants to confirm the accuracy of data. In this study, it was planned to carry out member check using the verbatim interview transcript as soon as the data was captured, which would be more appropriate for the individual participants to clarify any omission or inaccuracy.

The exploration of a human phenomenon also requires the suspension of all preconceived judgments to allow the phenomenon to emerge (Husserl, 1983). As espoused by (Morse 2015), the researcher engaged in ongoing bracketing of preconceived knowledge, assumptions, and expected findings to allow the phenomenon to emerge from the analytical process. Specific to this study, the researcher will need to bracket out knowledge and assumptions about previous instructional experiences for every step of the research study and applying this method to the current study would enhance the credibility and rigour of the study.

3.8 Triangulation with NHS Staff Survey

Smith (2017) acknowledges that qualitative approaches are becoming more widely used as analysis methods to improve and search for better ways of gathering data about a problem in addition to the use of triangulation logic in the social sciences. Triangulation is a methodological approach in qualitative research that involves the use of multiple data sources, methods, or researchers to increase the validity and reliability of findings (Creswell & Poth, 2016). Hence, this study will also explore the synthesis of findings from the previous NHS staff survey and literature review to check if there are any commonalities in the themes that will emerge. I intend to compare the outpatient nursing staff NHS national survey report with this study outcome, to enhance the validity of the study data. By using multiple methods or researchers, triangulation can increase the study's reliability by ensuring that the findings are consistent and replicable (Flick, 2018).

3.9 Maximising study rigour

Rigour is simply defined as the quality or state of being very exact, careful, or with strict precision or the quality of being thorough and accurate (Biggs and Buchler, 2007). In terms of research, Morse et al., (2002) set forth some key strategies for ensuring that validity include investigator's responsiveness and verification through methodological coherence, theoretical sampling and sampling adequacy, an active analytic stance, and saturation. Furthermore, when used appropriately, "these strategies, force the researcher to correct both the direction of the analysis and the development of the study as necessary, thus ensuring reliability and validity of the completed project" (Morse et al., 2002, p.17). Morse (2015) further presented strategies for ensuring validity in a qualitative study as; "prolonged engagement, persistent observation, thick and rich description, negative case analysis, peer review or debriefing, clarifying researcher's bias, member checking, external audits, and triangulation" (Morse, 2015, p. 1214). These criteria were refined to credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985).

3.9.1 Trustworthiness

Trustworthiness is one-way researchers can persuade themselves and readers that their research findings are worthy of attention (Lincoln & Guba, 1985). Lincoln and Guba (1985) refined the concept of trustworthiness as the criteria of credibility, transferability, dependability, and confirmability to parallel the conventional quantitative assessment criteria of validity and reliability (Connelly, 2016).

3.9.2 Credibility

Credibility relates to the 'truth' of the findings, therefore using direct quotes from participants to illustrate or develop themes can enhance credibility (Schwandt, 2001). However, Lincoln and Guba (1985) state that 'member checks' are the strongest measure of credibility. The process of member checks is where the researcher sends the interview transcripts or final analysis to the participants for them to check and find out if the data is accurate and reflects what was discussed during the interview. The development of the study's inclusion criteria was another way of ensuring data credibility and the research findings' usefulness.

In order to ensure a backup system is available and means for data comparison, a Microsoft Teams virtual one to one semi-structured interview was set up in a quiet room to maintain privacy of the meeting. This means that both the encrypted tape recorder and Microsoft teams are recording the participants at the same time and after the interview, the encrypted tape recorder is securely locked in the designated metal cupboard.

Maximising rigour trustworthiness check list table.		
Quality Assurance Measures		
Quantitative Research	**Qualitative Research**	**Application to this project**
Internal Validity	Credibility	Member checks was carried out by sending the raw transcripts to the individual participants for validation. Raw data of the 18 participants' interview audio-tape and transcripts were shared with the researcher's two academic supervisors.
Generalisability	Transferability	Detailed description of study activity, sampling, data analysis processes. Dissemination of work in peer reviewed, meetings and conference presentations.
Reliability	Dependability	Full interview transcripts and audio recorded transcripts were kept in the qualitative part of the study shared with the eligible academics supervisors on secured technology system.
Objectivity	Confirmability	Independent review of qualitative data analysis using Colaizzi's validation step.

Table 3.7 Maximising study rigour. Adapted from Lincoln and Guba (1985).

Therefore, the researcher will use a checklist (table 3.7) adapted from Lincoln and Guba (1985) as a guide to maintain rigour throughout the study process. Patton (1990) suggested that another aspect of credibility is referred to as the 'researcher credibility', which is the faith that can be put on the researcher. Although being an insider researcher is not without its potential problems such as role conflict, (Asselin, 2003), pointed out that there are some benefits of being a member of the group. The benefit of belonging to the group one is studying is acceptance and automatically provides a level of trust and openness in the participants that would likely not have been present otherwise (Dwyer and Buckle, 2009).

The ethos of subsequent COVID-19 pandemic highlighted both nurses' and midwives' roles in healthcare delivery and served to exacerbate the existing NHS workforce challenge (Couper et al., 2022), requiring support. As a safety representative under Royal College of Nursing (RCN), my positionality and key role is to ensure staff safety and wellbeing at work, which might inspire the staff confidence and trust for this study. My nursing background and counselling skills have enhanced my self-reflection and positively influenced my confidence as an insider-researcher. These attributes would facilitate the process in this study to investigate the impact of service changes on outpatient nurses and health care assistants' job motivation and wellbeing, especially with the challenges encountered by the NHS workforce due to COVID-19 pandemic.

3.9.3 Transferability

Transferability refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings (Guba and Lincoln, 1985). From a qualitative perspective transferability is primarily the responsibility of the one doing the study, Guba, and Lincoln (1989), express the view that, the qualitative researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that were central to the research. For this study, a purposive sampling is planned due to the inductive approach and technique considered for data collection.

Purposive sampling enhances the transferability of the results (Sandelowski, 1986), also interpretivist and constructivist research follows an inductive approach that is flexible and increases the transferability of the research findings. This study adopted the interpretivist/constructivist and inductive approach which provided an index of transferability. In this study, I used reflexivity and asked myself question such as, 'can the finding from this study be transferred to other outpatient settings within the NHS healthcare organisation?' Bearing this check in mind, I applied some strategies such as detailed description of project activity flow chart for my study plan (page 146). Purposive sampling was used to form a nominated sample group for data collection, followed by the participants validating their own data as an assurance, in line with Colaizzi's (1978) method.

3.9.4 Dependability

Dependability refers to the consistency and reliability of the research findings and the degree to which research procedures are documented, which allows someone outside the research to follow, audit, and critique the research process (Polit and Beck, 2017; Speziale et al., 2011). Keeping a reflective diary and the use of interactive review process as a researcher would facilitate every step of this research project. Moreover, every document that was used for this research would be archived and all recorded responses would be kept for years until it is no more necessary. Similarly, Robson and McCartan (2016) point out that pure intentions in conducting research do not guarantee trustworthiness and for research to have merit it must be believable and truthful. Dependability will be enhanced by the use of an electronic diary to record the details of the semi-structured interviews to enable virtual Microsoft Teams access.

All participants will consent to both audio and video recording and automatic verbatim transcription of the interviews. Steps will be taken to keep a track record of the data collection process (Lincoln and Guba, 1985). As a researcher, communication with the potential participants will be sustained and supporting information technology and material will be readily available at my workplace in compliance with General Data Protection Regulations (GDPR) (GDPR, 2018), to secure data collection transcribing and analysis. All the steps for research data protection will be maintained as outlined in the study participant information sheet (PIS). The use of OneDrive for the researcher and the Middlesex Academic Supervisors will be enforced for data security.

3.9.5 Confirmability

Confirmability is concerned with establishing that the researcher's study findings are clearly derived from the data, requiring the researcher to demonstrate how conclusions and interpretations have been reached (Tobin & Begley, 2004). According to Guba and Lincoln (1994), confirmability is established when credibility, transferability, and dependability are all achieved with the confidence that the results would be confirmed or corroborated by other researchers. In this study, the participants will be informed of the use of digital video recording during the interview and this information will be captured in the participant information sheet (PIS). Hardcopy signed consent form from all the participants will create a paper trail that increases the study confirmability.

3.10 Reflective Journal

The researcher commenced a reflective journal at the beginning of the project and created a task and finish timescale diary to monitor progress of my DProf project (figure 3.7), shown below. There is evidence that keeping reflection journals can help practitioners in their critical thinking skills and encourage them to think about their actions (Homik and Melis, 2007). Most importantly, the use of reflective journal and reflexivity facilitate the process of achieving qualitative research outcome (Dowling, 2006). In order to comply with subjective research approaches to data analysis, keeping a reflective diary and a reflective journal enabled me to deliberately attune to my reactions throughout the study process.

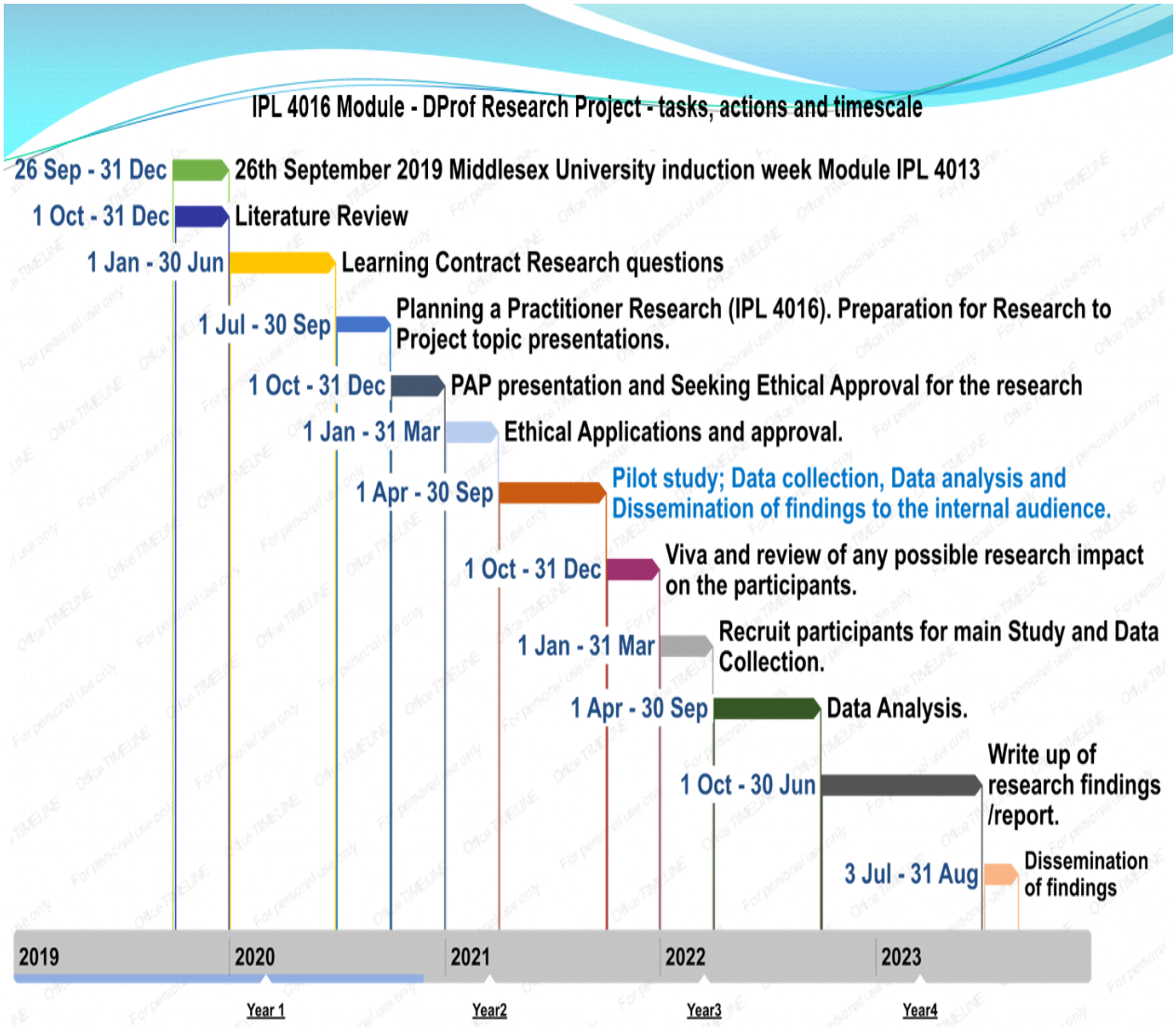


Figure (3.7). DProf Research Project – tasks, actions and timescale.

3.11 Ethical considerations

Ethical considerations can be specified as one of the most important parts of the research (Bryan and Bell, 2007). Therefore, when it comes to dealing with human participants, research projects should rigorously follow ethical considerations (Pilbeam et al., 2022). As a researcher, I am fully aware of the need to follow the ethical considerations stated in table 3.8, and rest assured the following strategies are followed in this study.

Nature of ethical Issue	Action taken to address
Potential disclosure of unethical conduct of outpatient nursing staff.	Researcher discontinues process or the option of the specific participant to withdraw from the study if necessary.
Staff may inadvertently disclose an area of 'concern' which has not been reported. Staff who discuss a concern which they have knowingly not reported.	Researcher will escalate concern to the appropriate department/personnel without implicating the participants by following duty of candour disclosure policy that protects the individual.
Potential distress due to disclosure of concerning event. Relaying experience may be a way of gaining therapeutic benefit.	Time given to recover and option for withdrawal from study if necessary. Refer staff for support from the Trust's counsellors or occupational health as appropriate.
Conflict of interest: Staff may consider involvement as a way of seeking favour from the researcher who is a member of the management.	Gate keeper requirement was fulfilled. Bracketing strategy at all stages and recruitment of participants from other clinical areas that are not managed by the researcher.
The potential for emotional impact may compromise the researcher's position during data collection, detracting from the study and delaying completion.	Researcher has access to the organisation's CONTACT services for support.

Table (3.8). Sources: Adapted from: Bradbury-Jones & Alcock, 2010; Pilbeam, et al., (2022).

The nature of ethical issue and action taken to address the issue, moreover Cohen et al., (2017), stated that, interviews are considered as intrusion into respondents' private lives, therefore, a high standard of ethical considerations should be maintained.

The researcher is aware that ethical issues should be considered at all stages of the interview. In other words, participants should be well informed and provide their informed consent before participating in the interview, which are key steps researchers should adhere to throughout the whole research project. However, an ethical challenge to researchers would be the openness and intimacy of the interview situation which may lead respondents to disclose information that they may later regret. There is also a risk that the interaction may become a therapeutic relationship for some researchers who have not been trained in the discipline (Birt, 2016).

All participants' data are confidential and will be processed in accordance with the Data Protection Act (2018). The researcher believes that the use of reflexivity in the form of reflexive journals and regular academic supervisors' meetings, feedback and follow-up actions further firmed up the study process. Therefore, to protect the participants' rights and to avoid causing them any harm, researchers should ensure that the collected data will be strictly confidential and anonymous. More importantly, participants should be informed that their participation in the interview is entirely voluntary, and that they can withdraw at any time, details shown in the participant's information sheet.

According to Bryan and Bell (2007), the following points among other need to be considered and expanded for effective research;

- Research participants should not be subjected to harm in any ways whatsoever
- Full consent should be obtained from the participants prior to the study.
- The protection of the privacy of research participants has to be ensured.
- Anonymity of individuals and organisations participating in the research has to be ensured.
- Research ethical consideration and approval process will be discussed in chapter 4, page 147.

3.12 Consent

Following some indication of interest and response from the research advertisement (appendices 3a & 3b), the researcher will contact all the potential participants by invitation emails and telephone calls. Participants will also be issued with information sheet (appendix 4) which outlines all of the details that they needed before the interview is carried out and they will also be issued with a consent form (appendix 5) to be signed before proceeding with the study. The ethical principles applied in conducting this study include:

- Before commencing data collection, the researcher obtains ethical approval from the Research Ethics Committee of Middlesex University's School of Health and Education, Health and Social Care Ethics Sub-committee (appendix 6).
- All relevant information in line with the Data Protection Act (2018) and the General Data Protection Regulation (GDPR) (2018) throughout the research process, will be made available.
- Participants would be assured of anonymity and confidentiality by the researcher and where there is a possibility that a participant could be easily identified, the data would not be used.

Research has many ethical implications and the participants' rights, such as the right to refuse to participate in the study, right to refuse to answer certain questions, the right for confidentiality and the right to informed consent, should at all times take precedence over research objectives (Parahoo, 2006). Therefore, as part of their rights, participants in the study will be given the choice to opt for the study or stop the interview when deemed necessary.

3.12.1 Harm

In accordance with membership of the Nursing and Midwifery Council (NMC) disclosure should be made to the relevant authority, if there is a potential for any harm or risk to anyone relating to the research (NMC, 2018). It was therefore essential that participants could decide whether they wished to take part in the study by giving their informed consent. The researcher would ensure that the ethical principles were maintained throughout, and the participants were safe and guarded against harm. The researcher is fully aware that a participant has the right to choose not to participate and similarly, the right to withdraw at any stage in the study process.

3.13 Summary

Chapter 3 described the research design, choice of the methodological approach and philosophical perspective as well as discussed, the rational for applying a qualitative descriptive phenomenological stance in this study. The next chapter presents the project activities, research data analysis and presentation of the results.

Chapter 4: Project Activity

4.1 Introduction

One of the most important stages in achieving the project aims and objectives is by determining and planning the project activities using a project plan (Yildiz, 2016). Chapter 4 discusses the content of the project activity flow chart as shown below (figure 4.1). This chapter also provides an account on the method used in conducting this study on outpatient nursing staff experience.

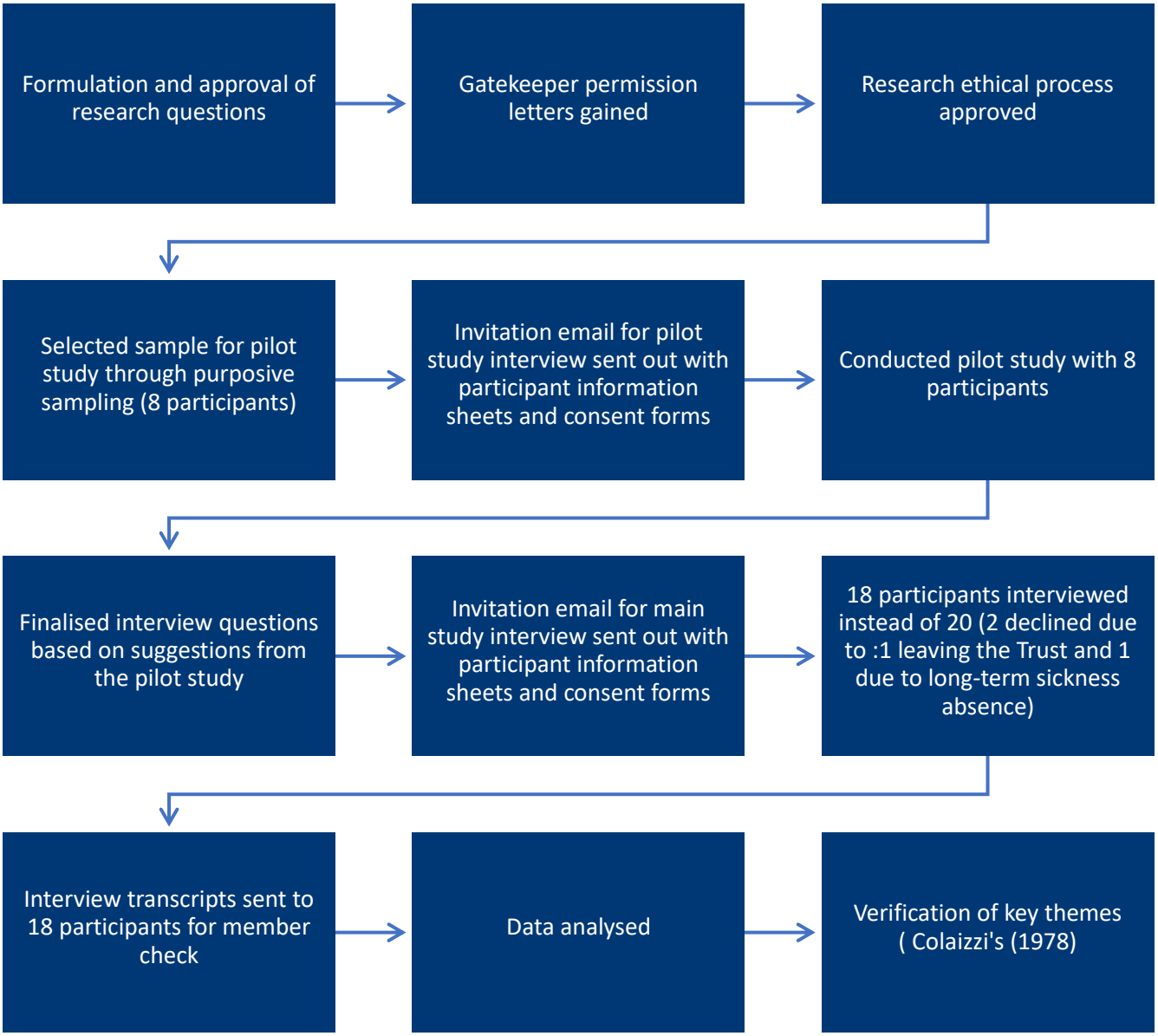


Figure (4.1). Project activity flow chart

A project flow chart (figure 4.1) was designed as a structured plan for this study. A well-thought-out research proposal forms the backbone for the study. The flow chart is considered as most important step in the process of conducting a research (McGranaghan, 2016), especially as research work in the present era is a challenging task due to the constantly evolving trends in the qualitative research design (Malakar, 2022). Each step of the project activity flow chart will be discussed accordingly. It includes the process of obtaining ethical approval, and the selection criteria for this study's participants. Also, the rationale for using virtual semi-structured interviews will be explained, followed by discussions on the data analysis process and the steps including the relevant tools used in generating the themes for the data.

4.2 How the research questions were designed

The focus of this study was 'to examine the impact of service changes on outpatient nurses and healthcare assistants' job motivation and wellbeing'. Initially, three draft research questions were generated through engaging with some peers from the Royal College of Nursing (RCN) safety representative, for their contribution in developing the indicative interview questions. This brainstorming and information sharing helped me to formulate more focused and subjective research questions linked to this study's objectives. Jasper (2005) suggested that preliminary research on the general topic to find out if the research already exists in order to fill in the research gap. Therefore, an extensive literature review was undertaken (chapter 2 of this project) to find out what is already known about the research topic.

4.3 Indicative semi-structured interview questions were developed

Research questions can address different formats depending on the aspect to be evaluated (White, 2009). By engaging the researcher's colleagues in drawing up the research questions some key domains were derived, based on the established research questions. It was important that the key words from the research questions were considered and factored while designing the indicative interview questions. Formulating the research questions was an iterative process which entailed constant reviews and amendments to ensure the key aspects were covered.

The '**Q'** stands for 'Question' with numbers indicating how the research interview questions were formulated, as illustrated below:

- Service changes **(Q1 & sub Q)**
- Staff wellbeing at work **(Q 2, a & b)**
- Work–life imbalance (WBL) **(Q 2, a & b)**
- During Peak of COVID -19 Resource allocation; for example; Staffing level, Material conditions **(Q 3)**
- Training, development and achievements **(Q 3a)**
- Environment, (PPE's) during the surge of COVID-19 pandemic **(Q 3b)**
- Management and work challenges; example: Support system and mechanism; recognition, appreciation, awards **(Q 3b)**
- Job design and job motivation **(Q 4)**
- Level of staff engagement, value, respect, acceptance (**Q 4 sub Q)**

Before the interview questions were finalised, a brainstorm exercise was carried out with work colleagues for ideas and feedback. The draft version was thereafter reviewed by the researcher's university academic supervisors to achieve the interview questions which could yield rich answers to the topic under study. The notion is that, semi-structured interview is popular and the most common form within qualitative research, especially the individual one-on-one, in-depth interviews (Kallio et al., 2016). Twenty participants were planned for the one-on-one interview by-virtual Microsoft Teams. A face-to-face interview was considered but ruled out due to the ongoing COVID-19 pandemic. Although, face-to-face interviews are often perceived as the "gold standard" of qualitative research (Novick, 2008, p.397), recent safety measures were put in place during the COVID-19 pandemic meaning, researchers have to conduct interviews using remote modes (Dodds & Hess, 2020).

4.4 Seeking and Obtaining Gatekeepers' consent

Farrimond (2013) proposes the notion of gatekeepers providing a chain of command ethically, with whom the researcher needs to gain access to the participants. Within this context, a major influence upon gatekeepers' decisions are the lenses and knowledge through which each gatekeeper will examine requests made to them for research access (Collyer et al., 2017).

Prior to obtaining this study's ethical approval from the Middlesex University, I identified the demographical area of the potential participants, and sent emails to the departments' nurse managers requesting for their permission as gatekeepers, to access the staff for participation in this study. Based on the explained process, the indicative interview questions were compiled and passed to the Programme Approval Panel (PAP) for this study, approval letter attached (appendix 6). Gatekeepers' permissions were obtained from the selected outpatient departments within the researcher's organisation, sample attached (appendix 7).

Indicative Research Interview Questions

No	Questions	Responses / Comments	Data captured on tape recorder.
1	What changes did you experience in your work place in the last 4 years before COVID -19?		
	Can you say something about what caused the changes?		
2	How prepared were you before the specific changes were rolled out?		
	a. How prepared were you during the first surge of COVID-19 pandemic?		
	b. What challenges did you go through at work, with the onset of COVID-19 pandemic?		
3	How did COVID-19 pandemic affect you personally and at your workplace?		
	a. How would you describe the training and development opportunities available to support you in your role		
	b. How supported and appreciated do you feel at your workplace?		
4	How would you describe your overall work experience in general?		
	What would you like to discuss that I have not covered?		

** Note; *Service changes are new ways of working or any changes in the patients' care pathway.*

Ref; MOP – Indicative Research Interview Questions – 2021 – Outpatients

Table 4.1

4.5 Application of research interview schedule

Semi-structured interviews are best conducted with the use of semi-structured interview schedule (appendix 8); updated version (appendix 9), which is considered as some steps to increase the interview's credibility and validity. The first step considered was logistics; confirming the date, venue, and materials necessary to conduct the interview. DeJonckheere and Vaughn (2019) asserted that, one key characteristic of semi structured interviews is to have it scheduled in advance.

Also, careful planning particularly around the technical aspects of interviews can be the difference between a ‘great interview’ and a ‘not so great’ interview. Therefore, it was ensured that the participants’ interview slots were structured following the order in which the participants responded to the interview invitation. Within the second step, I expressed gratitude to the individual participant for taking part in the study. The length of the pilot interview was explained to last 45 to 60 minutes long. However, following the outcome of the pilot study where the average length of the interview was 20 to 45 minutes, the main interview time scale was therefore amended to the effect (appendix 10). The interview schedule served as a prompt for me as the researcher to establish rapport with the participants, which made them feel comfortable.

DeJonckheere and Vaughn (2019) stated that, a number of interviewers start with chatting as an icebreaker and try to establish rapport and trust to create a user-friendly space and easier for the participants to freely narrate their lived experiences. The third step included verbally asking the participants for their verbal consent to go ahead with the interview, although the participants’ written consent was already obtained before the interview sessions. Fourthly, I used the six questions checklist which was included in the participants’ consent form to establish the participants’ understanding of the study’s purpose. During the fifth and sixth stages, I conveyed a sense of being in the interview together with each participant. DeJonckheere and Vaughn (2019), suggested that interviewees can help ease any discomfort in such interactions. This stage involves the exploration of thoughts and to encourage a dialogue with the participants, and according to Adams, (2015), the agenda for a semi-structured interview is never carved in stone, in other words, the participants’ narration could lead to various topics. I explored the above-listed strategies which stimulated responses and lastly, extended gratitude to each participant with information regarding how the findings of the study would be disseminated.

4.5.1 Research ethical consideration and approval process

The objective of preparing research proposal would be to summarise the research and the issue that needs to be addressed, and approvals from the various committees including ethics committee (McGranaghan, 2016).

Some researchers discuss the significance of ethical issues to prepare for the unpredictable nature of qualitative research (Walker et al., 2005). Hence, the ethics approval and gatekeeper permission for this study were obtained before approaching the respective potential participants for study recruitment and interviews. The project plan for this study was developed and presented at Middlesex University (MU) for approval. Some of the documents required for the Programme Approval Panel (PAP) included: (1) participant information sheet (PIS) (appendix 4), (2) consent form (appendix 5), (3) gatekeepers' permission letters (appendix 7), (4) structured interview schedule (appendix 9) and (5) main study interview questions (appendix 10), and (6) research fieldwork risk assessment with the form attached (appendix 11).

Following the PAP approval letter, (appendix 6), I accessed the Health Research Authority (HRA, 2019) online decision tool as recommended by Hendrickson et al., (2019) and checked if this study required NHS Research Ethical Committee (REC). The decision tool report (appendix 12) indicated that NHS REC application was not required for this study. I was aware that approval was required from my organisation's research ethics committee, therefore I sought approval through my workplace local REC. I also completed Integrated Research Application System (IRAS) (2020), form for application and submitted for health and social care research, just for the research record. The local ethics committee did not hold regular meetings due to the surge period of the COVID-19 and it took a while before they could set up a virtual meeting to process local research applications. Once the local REC approval was gained (appendix 13), I contacted the gatekeepers and distributed the study recruitment advertisement and PIS to the various outpatient departments (appendices 3a, 3b & 4).

4.5.2 Reflection on the ethical approval process

As a researcher, I was mindful that gaining gatekeepers' permission and approval prior to approaching any potential participants for the study was crucial (Kay, 2019). Hence, receiving the gatekeepers' approval was key in the process. The concept of ethics consideration is crucial to understanding the risks and consequences of research, as well as, for undertaking a safe, ethical and effective research (Lee, 1993).

The question I asked myself was, ‘who would want to be interviewed regarding work related issues, when a global issue like COVID-19 was being dealt with?’ Guillemin and Gilliam (2004) argue that reflexivity contributes to safe and ethical research practice through building awareness of practical and ethical dilemmas that may arise in the research process and being ready to respond.

Bearing this in mind and despite all the constraints at work such as, staff unavailability and other issues, I summoned the courage, approached the identified outpatients’ gatekeepers, and thanked them for their consent, approval to access their staff to participate in the study. It is also worth noting that, one of the unit managers declined discussions relating to any studies and understandably stated that, they were overwhelmed with excessive workload, therefore unable to sign up for the nursing team to participate in any study, at the time, as it was not feasible to free up time. Anyway, I thought it was a missing opportunity for this nursing team to get their voices heard on this subject. In any case, the outcome and recommendations from this study will be shared Trust-wide, available to all staff within the organisation.

4.6 Recruitment for Pilot study

Once the local REC approval to proceed with the project was received (appendix 13), the recruitment for the pilot study commenced. Purposive sampling is governed by the focus of the phenomenon and the research questions for studies seeking to explore lived experiences. Therefore, the purposive sampling method was deemed most suitable which was agreed as part of this project proposal approval. On invitation, I joined the various outpatient departments’ teams meetings, where I discussed the study and displayed the study advertisement poster (appendix 3a) on the staff boards, with the permission of the respective gatekeepers. In research approach, “pilot study interviews are used primarily to build researcher's expertise in using/troubleshooting the interview platform” (Pratt & Yezierski, 2018, p.15).

The recruitment of participants for the pilot study is from two different sites, due to the small purposive sample size of eight, and to utilise time more effectively. According to Patel et al., (2003), this step is essential as recruitment is the interaction that occurs between a researcher and prospective participants, well before consent is initiated and to gather a sample that accurately depicts the intended audience.

Also, the goal of the purposive recruitment was to select equally distributed participants of nurses, who fit into the inclusion criteria. Initially, the pilot study was planned to be carried out on a face-to-face basis, however, due to COVID-19 pandemic, the government implemented a social distancing rule. Therefore, potential participants were contacted through emails or phone calls and the pilot study was conducted through Microsoft Team.

4.6.1 Demographic characteristics and variables template for Pilot Study

In line with the inclusion criteria, all the outpatient nurses and health care assistants who were approached for participation were permanent staff of the organisation, over the age of 18. According to LoBiondo-Wood and Haber (2006), purposive sampling is appropriate for collecting data from a particular group or population and this type of sampling is required when researchers are challenged with choosing the appropriate samples (Denscombe, 2012). The demographic characteristics used in the potential participants' recruitment process are shown below on table (4.2).

	Variables	Working Definitions(Attributes)	Code
1	**Respondent - Type**	NHS Registered Nurses & Healthcare Assistants	RTN
2	**Gender**	Male/Female/Others; please indicate	GDR
3	**Age**	Age of Respondents	AGE
4	**Ethnicity**	Origin	ETH
5	**Work location**	Sites and Clinical Specialities	LOC
6	**Designation**	RGN band 5 & band 6	RGN
		HCA band 3	HCA
7	**Years of Experience**	Length of Service in Outpatients Department	EXP

Table (4.2) Template for demographic variables and Attributes.

4.6.2 Characteristics of Participants

The selection of participants varied from band 3 to band 6 levels. In this study, band 4 nurse associates were excluded from this study because the role is new and form a small fraction of the current NHS nursing workforce which is easily identifiable.

Following the recruitment plan, I ensured that the number of registered nurses (RGN) and non-registered (HCA) nurses were equal during the pilot study recruitment. The categories recruited for the pilot study were; four HCAs at band 3, two RGNs at band 5 and two RGNs at band 6, with a total of eight participants. The eight potential participants were selected within the four-week period of 26th November 2021 to 20th December 2021, which was deemed a good sample for a pilot study.

During the recruitment process, I informed the potential participants of the aim and purpose of the study and explained the content of the PIS. For participants who were deemed eligible and consented to the study, a Microsoft Teams interview invite was scheduled based on the participants' availability. The eight participants selected met the research inclusion criteria as described in the demographics below which included years of experience in their various role and job titles as shown on table 4.3 below.

Pilot Demographics

	Variables	Working Definitions (Attributes)	Band 3 (HCA)	Band 5 (RGN)	Band 6	TOTAL
1	Respondent – Type	NHS Registered Nurses & Healthcare Assistants	4	2	2	8
2	Gender	Male	2		1	3
		Female	2	2	1	5
		Others; please indicate				
3	Age	Age of respondents				
		20-30	1	1		2
		31-40	2		1	3
		41-50	1		1	2
		51+		1		1
4	Ethnicity	Origin				
		African/Caribbean	1	1	1	3
		Asian	1	1	1	3
		White/Caucasian	2			2
5	Work location	Sites and Clinical Specialities				
		Site A	2		1	3
		Site B *This site was not visited due to sample size *				
		Site C	2	1	1	4
		Sites ABC (staff working across sites)		1		1
6	Designation	RGN bands 5 & band 6		2	2	4
		HCA band 3	4			4
7	Years of Experience	Length of Service in Outpatients Department				
		2-5 years	1			1
		6-10 years	2	1	2	5
		11-15 years	1			1
		16-20 years		1		1
		20++ years				

Table (4.3) Overview of Pilot Demographics Variables and Attributes of Participants

4.6.3 Conducting Pilot Study Interview

Pilot studies refer to a trial study administered to a small group chosen from the respondents using the same procedure, techniques and instruments as the actual study (Green et al., 2016).

Although a face-to-face interview was initially considered as the plan for this study, this approach was ruled out due to the surge of COVID-19 pandemic at the time which required compliance with social distancing guidance at workplace. Therefore, the interview was conducted virtually on a one to one through Microsoft Teams. Face-to-face interviews are often perceived as the "gold standard" (Novick, 2008, p.397) of qualitative research, however, recent safety measures were put in place during the COVID-19 pandemic meaning, researchers must conduct interviews using remote modes (Dodds & Hess, 2020).

Prior to commencing the pilot study, I liaised with the gatekeepers and booked quiet room to ensure privacy and confidentiality on each hospital site, equipped with computers and Microsoft Teams functionalities. In line with the participants' recruitment process, the hard copy of the study participants information sheet (PIS), consent form and interview schedule were sent to the potential participants. The interview schedule forms part of the ethical rigour and will be discussed later in this chapter. The manually signed consent forms by the participants were securely locked in the researcher's office cabinet, accessible by the researcher only. The second step was crucial in explaining the information already provided to the proposed participants, at the early stage of recruitment.

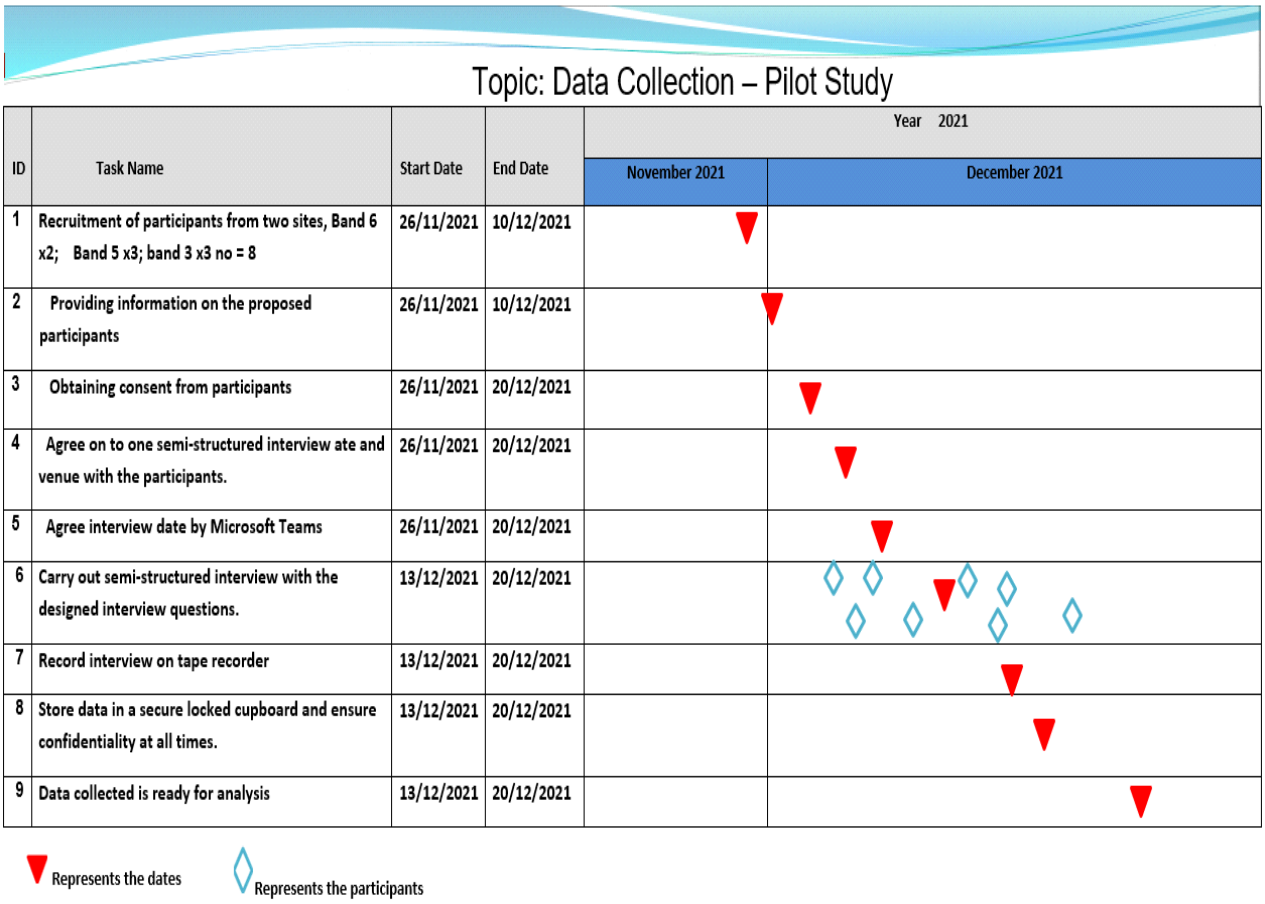
According to Rodriguez et al., (2003), for consent to be valid the process of sole information is not enough because the element of understanding is the foundation of validation, when obtaining consent. The potential pilot study participants have expectations from the researcher as they are expected to assert themselves and stand up for their rights, which will improve the calibre of the study (Rodriguez et al., 2003). Moreover, the prospective participants should have access to comprehensive information about the study they are consenting to, including the potential benefits and harm of the study to the participants (Kraft et al., 2018). Therefore, I provided a clear and cohesive explanation and information about the study to ensure the participants' informed choice and protection.

After obtaining informed consent from participants, the next steps were mostly about planning coordination of the interview. Steps 4 and 5 were about planning the venue and date of interview with participants. However, since the semi-structured interviews were carried out at the surge of the COVID-19 pandemic, all the interviews were conducted online through Microsoft Teams hence no note taker was required. Once the coordination was carefully planned, in step 6, the semi-structured interview was carried out with the indicative interview questions as a pilot study. At this stage, the objective was to create space for participants to narrate their experiences, with the open-ended interview questions specifically tailored to answer the research questions.

The semi-structured interview method's advantage is that it fosters reciprocity between the interviewer and participant (Galetta, 2013), allowing the interviewer to produce impromptu follow-up inquiries in response to the participants' responses (Polit & Beck 2017) and providing space for participants' unique verbal expressions. Therefore, in every interview, I asked for the participants' thoughts on the questions that were just asked and established that the questions were understood. For instance, in question number 4, the participants were asked if there were other questions that they would want to add to make the study richer. Majority of the participants embraced this opportunity and contributed their views, suggestions and narratives which further aligned with the study research questions.

In step 7, the use of Microsoft Teams video recording helped in retaining essential data by participants in real time. Also, the interviews were captured in an encrypted tape recorder as a backup and securely locked in a metal cabinet to always ensure confidentiality. Dahike and Stahlke (2020) explains that the ethical challenge confidentiality is primarily upheld as a means to protect research participants from harm. Consequently, both the computer and tape recorder used in storing the interview records were kept securely locked. The last step (9) involved analysing of the pilot interview data to determine the appropriateness of the interview questions and the interview schedule plan.

For the pilot study, the interview stage, transcribed data collection and analysis were conducted simultaneously. The outlined steps below illustrate the process followed in completing the pilot study.



ID	Task Name	Start Date	End Date
1	Recruitment of participants from two sites, Band 6 x2; Band 5 x3; band 3 x3 no = 8	26/11/2021	10/12/2021
2	Providing information on the proposed participants	26/11/2021	10/12/2021
3	Obtaining consent from participants	26/11/2021	20/12/2021
4	Agree on to one semi-structured interview ate and venue with the participants.	26/11/2021	20/12/2021
5	Agree interview date by Microsoft Teams	26/11/2021	20/12/2021
6	Carry out semi-structured interview with the designed interview questions.	13/12/2021	20/12/2021
7	Record interview on tape recorder	13/12/2021	20/12/2021
8	Store data in a secure locked cupboard and ensure confidentiality at all times.	13/12/2021	20/12/2021
9	Data collected is ready for analysis	13/12/2021	20/12/2021

Figure (4.2).Flow chart of the pilot study activities.

4.6.4 Outcome of pilot study

The pilot study response was analysed based on the thematic analysis with the main aim of testing test study interview questions and establish whether they were fit for the purpose. The suggestions made by participants were captured and considered. Following the pilot interview and feedback, the final main study interview questions were established ensuring that the final version was still grouped into probe questions.

The overall feedback from the participants were positive in terms of the interview timing, the virtual setting, privacy, and the full process. However, some clarifications were required on the indicative interview questions number 4 (Q4). Pilot studies are often referred to as feasibility studies (Williams-McBean, 2019), which allows an understanding of how to engage with the participants and formulate appropriate questions. Notwithstanding, there is a noted vast literature on the uses and outcomes of pilot studies especially in qualitative studies. Moreover, some of the scripted semi-structured questions within the interview questionnaire could be modified following the pilot study (In, J. 2017). It is important that the interview guide aligns with the methodological approach and a structured interview guide usually includes predetermined questions posed in the same way to all interviewees with the purpose of eliciting responses to the exact same phrasing. In this pilot study, six out of the eight participants expressed that there was nothing they would add to the questions and all aspects were covered.

However, two participants commented on question number 4, "***How would you describe your overall work experience in general?***" The two participants made some suggestions regarding question number 4 as follows: One of the participants (A) stated that, Q4 was a bit 'too much' and should be narrowed down to discuss staff job motivation only. The other participant (B) suggested that a sub-question should be included within the number 4 section, which would link with staff job motivation during the COVID-19 pandemic. The question suggested by participant (B) was, **"*How can I describe my job motivation before the onset of COVID -19 pandemic and at the present?"*** Majority of the participants stated that the sub-question number 4 **"*What would you like to discuss that I have not covered?"*** allows the participants the room to expand on their experience. Therefore, this question remained unchanged but was labelled as question number 4b. Based on this feedback, question number 4 (Q4) was tweaked slightly (tables 4.4), which shows the slight amendment to the indicative interview questions (table 4.1; page, 146). This final interview question was therefore rephrased with the same meaning as, '***How would you describe your job motivation before the onset of COVID -19 pandemic and at the present?'*** and was added to the pre-set questions as number 4a.

The feedbacks from the pilot study helped in modifying the research interview question, therefore realigning, breaking down and clarifying question number 4, which was then split into two sections (4a) and (4b). According to Hill et al., (2005) grouping interview questions into probe questions facilitates the participants' full engagement and interaction which enhances the data quality. As such, applying the appropriate study qualitative interview questions is an opportunity to give voice to the participants who may not be heard elsewhere.

Based on the pilot study, the interview questions were slightly altered as some of the participants commented on aspects that should be changed or added. The comments from the participants gave a glimpse on what it would be like during the main interview. Considering the participants' contributions, the pilot study conducted was useful due to a number of reasons and according to Doody and Doody (2015), a pilot study is beneficial to the planning and conducting of the main study which also enhances the study's credibility. Shown below is the final version of the interview question after factoring participants' feedbacks from the pilot study.

Main Research Interview Questions

No	Questions	Responses / Comments	Data captured on tape recorder.
1	What changes did you experience in your work place in the last 4 years before COVID -19?		
	Can you say something about what caused the changes?		
2	How prepared were you before the specific changes were rolled out?		
	a. How prepared were you during the first surge of COVID-19 pandemic?		
	b. What challenges did you go through at work, with the onset of COVID-19 pandemic?		
3	How did COVID-19 pandemic affect you personally and at your workplace?		
	a. How would you describe the training and development opportunities available to support you in your role?		
	b. How supported and appreciated do you feel at your workplace?		
4	How would you describe your overall work experience in general?		
	a. How would you describe your job motivation before the onset of COVID-19 pandemic and at the present?		
	b. What would you like to discuss that I have not covered?		

** Note; *Service changes are new ways of working or any changes in the patients' care pathway.*

Table 4.4

The pilot study was analysed based on the path of the study model of Braun and Clarke (2006) step by step thematic analysis. The main aim of the pilot study was to test the study interview questions and establish whether they were fit for the purpose. The suggestions made by participants were captured and considered.

In summary, I conducted the qualitative pilot study to assess the practicality and the validity of the qualitative methods of data collection and processes of data analysis, mostly, to find out the extent the qualitative phase could provide answers to the study research questions. Following the pilot interview and feedback, the final main study interview questions were established ensuring that the final version was still grouped into probe questions (table 4.4).

4.7 Participants' recruitment and its challenges

This project proposal was approved on the basis that the potential participants would be recruited through telephone and emails. Thereafter, I emailed the participant information sheet (PIS) with the consent form to the eight selected participants for the pilot study. The initial plan was to recruit eight pilot participants and to complete the pilot interview, prior to recruiting the twenty participants for the main study. However, some challenges were encountered reaching the potential participants for the main study. Several follow up phone calls were made to the various departments, with very minimal responses because, the clinics were very busy. The effect of the COVID-19 pandemic added to the clinical workload; therefore, it was not surprising that some challenges were encountered in recruiting suitable nursing staff who were interesting to participate in this study.

Gradually, one or two responses came through at the first attempt, followed by a total of five responses from different departments within the first 2 weeks of the launch of the study. In view of this challenge, with little progress made at the initial stage of recruitment, I also used the available opportunity to continue on increased staff awareness for the main study. Staff time constraints was an issue. Munn, (2019) reported that, three quarters of the almost 2,250 nurses who responded to Nursing Standard nurses' wellbeing survey stated that, it was common for staff not to have a single break during a shift, findings also showed that, 80% have gone a whole shift without a drink of water. Some chasing through phone calls was necessary to increase the response rate, and the eight participants intended for the pilot study were recruited.

In view of the recruitment challenge and to keep the momentum going, I made further phone calls to the gatekeepers and requested to attend their team meeting again with the intention to recirculate the study's PIS and consent to the target group in order to facilitate the response rate. Three out of the four gatekeepers responded and invited me (researcher) to their team meetings, which was really helpful. The team meetings were held at 8.00 hours before start of clinics session and I was given 10 minutes time slot to discuss the study and to provide answers to staff questions. During these meetings all staff maintained social distancing and wore masks in line with the COVID-19 guidance. Again, I informed the teams of the study's purpose and process, as contained in the PIS, and printed information were made available to the staff.

Hard copies of the PIS were also distributed during the meeting and some of the nursing staff who were unavailable during the first meeting due to shift pattern and annual leaves, were present and fully engaged in the discussion. With my visibility within the departments, staff awareness of the study was increased, and I was able to approach and recruit some participants, who were deemed eligible and met the purposive selection criteria for the study. Based on Polkinghorne (1989), a study's sample size of 15 to 25 was suitable for a phenomenological approach, and the sample size ranging from five to twenty participants is used in nursing research using phenomenology (De Chesnay, 2014). Built on these suggestions on sample size for phenomenological studies, through purposive sampling, I recruited a sample size of 20 participants who met the inclusion criteria for the study.

4.7.1 Participants' invitation to main interview

Becker et al., (2012) advocates careful selection of participants in purposive sampling, where the individuals or group have experienced a particular phenomenon. Therefore, a purposive sampling was explored to align with the research topic which provided consistency of the participants' inclusion criteria. The recruitment process was not very smooth.

At the mid-point review of the recruitment process four staff were needed to complete the initial sample size which comprised of; three registered nurses (two band 5 and one band 6 nurses), and one healthcare assistant. To recruit the remaining potential four participants for the main study, a third attempt was made by direct telephone contact to the target group.

I identified a chance to complete the required sample size and made follow-up calls which proved useful. Thereafter, three registered nurses and one healthcare assistant responded and consented to participate in the main study. As previously discussed, twenty participants were initially planned for the main study and a total of twenty participants were recruited through the purposive sampling. However, two participants withdrew their consents, one participant was unable to participate due to ill-health and the other was due to resignation from the role. Therefore, a total of eighteen participants consented and proceeded with this study and the participants' demographics are shown on the table below.

Table 4.5 shows the demographics of the participants for the main study.

Main Study Demographics

	Variables	Working Definitions (Attributes)	Band 3 (HCA)	Band 5 (RGN)	Band 6	TOTAL
1	Respondent – Type	NHS Registered Nurses & Healthcare Assistants	9	5	4	18
2	Gender	Male	2		2	4
		Female	7	5	2	14
		Others; please indicate				0
3	Age - recheck	Age of respondents				
		Under 25				0
		25-34	3		1	4
		35-44	2	3	1	6
		45-54	4	2	2	8
		55-64				0
		64+				0
4	Ethnicity	Origin				
		African/Caribbean	4	2		6
		Asian	3	1	2	6
		White/Caucasian	2	2	1	5
		Undisclosed			1	1
5	Work location	Sites and Clinical Specialities				
		Site A	4	2	1	7
		Site B	2		1	3
		Site C	3	1		4
		Sites ABC (staff working across sites)		2	2	4
6	Designation	RGN bands 5 & band 6		5	4	9
		HCA band 3	9			9
7	Years of Experience	Length of Service in Outpatients Department				
		2-5 years	3	2	1	6
		6-10 years	1		2	3
		11-15 years	1	1	1	3
		16-20 years	2	1		3
		20++ years	2	1		3

Table (4.5). Overview of Main Study Demographics Variables and Attributes

4.8 Data saturation for this study explained

According to Kyngas (2020), the researcher should ensure that the gathered data could be organised into categories, concepts, and themes, hence verifying a complete analysis. The suggested sample size for medium sized thematic analysis research projects, including a professional doctorate thesis, is between 6-15 participants (Braun and Clarke, 2021). However, it is also argued that the sample size depends on the population size and other factors which are considered when determining the sample size for this study. As pointed out by Guest et al., (2006) the concept of saturation in qualitative research is often invoked but rarely defined and over the years. Similarly, Marshall et al., (2013) argued that the concept of saturation has become a vague term that needs to be precisely defined. Hence, the definition of the concept of qualitative data saturation according to Marshall et al., (2013) can be viewed in different ways;

- the point in time when the collection of new qualitative data no longer changes or changes little in the coding manual
- the point at which each recent qualitative interview produces only previously discovered data which was repetitive
- the point at which the performance of the research declines, i.e., each new interview makes a similar contribution than the previous one.

The sample size for this study was considered at the initial planning stage. The upper limit suggested by Braun and Clarke (2021) was 15, but I was optimistic and aimed to interview 20 participants, to ensure sufficient and rich data to aid the development of the themes. However, 2 participants who were recruited for the study withdrew because one of them was on sickness absence and the other staff member resigned from the job and was working out the notice period to leave the organisation. This study's data saturation is further explained in the data collection sections on pages 161 & 162.

4.9 Data Collection - Main study semi-structured interviews

Phenomenon such as experiences, attitudes, and behaviours can be difficult to accurately capture quantitatively (Korstjens and Moser, 2018), whereas a qualitative approach allows participants themselves to explain how, why, or what they were thinking, feeling, and experiencing at a certain time or during an event of interest.
In congruence with adopting the constructivist approach, it was deemed appropriate to engage the participants in the form of semi-structured interview for data collection. There is a strong emphasis on lived experiences in phenomenological research (Dowling & Cooney, 2012), and collecting data presents the opportunity for both the researcher and participants to connect and gather information that will form the findings of the study. I began each interview by reminding the participants about the nature of the study and their participation, and thereafter, validate their written consent to participate.

The participants were interviewed virtually using a semi- structured interview method after obtaining their consent, individually. All interviews were audio recorded and transcribed verbatim via Microsoft Teams. By exploring Colaizzi's (1978) method, a structured phenomenological data analysis method was used to guide the data analysis for this study. Smith et al., (2009) recommend that interview schedules should not be lengthy and suggested an average of 45 minutes. Although the pilot interview was scheduled for 45 to 60 minutes, because it lasted between 20-45 minutes, the main interview schedule (appendix 10) was updated to the effect.

Most importantly, the qualitative method of phenomenology provides a theoretical tool for educational research as it allows researchers to engage in flexible activities that can describe and help to understand complex phenomena, such as various aspects of human social experience (Flood, 2010). Consequently, understanding the meaning of lived experiences for the outpatient nurses needs the appropriate setting for interaction between the researcher and participants to narrate the phenomena. Having interviewed 18 participants, I found out that in-depth information has already been collected with several repeated key themes, which informed the study data saturation point.

The initial plan was to interview 20 participants, but 18 participants' data were collected and the NVIVO 12 data software was used in organising the data into a statistically visible format (appendices 16a & 16b). Although I was prepared to continue recruiting for the remaining 2 to achieve the initial number of 20 participants, however, the initial review of the data collected showed that sample saturation could be reached. Also, it was observed that, the 18 participants' data produced repeated nodes and themes when the data was imported into NVIVO12 data software. At this stage with repeated nodes and no new themes generated from this data, the concept of saturation was looked at for guidance. This decision was based on Marshall et al., (2013)'s concept of saturation on qualitative interview which states that saturation is reached when data produces repetitive and similar information. Research data saturation is crucial for variation and enough data needs to be available, in order to answer the research question (Kyngas, 2020). Hence no further participants' recruitment and interview was conducted, since rich information was generated from the 18 participants' narratives during the semi- structured interviews.

4.10 Data Analysis

Kiger and Varpio (2020) highlighted that thematic analysis is a powerful and flexible method of qualitative analysis and empowers researchers at all levels of experience to conduct thematic analysis in rigorous and thoughtful way. Initially, descriptive thematic or Braun and Clarke's (2006) analysis were considered for this study to analyse the semi-structured interview data as some similar themes were evident. Therefore, the first step of Braun and Clarke's (2006) was explored in the pilot studies by returning the interview transcripts for validation and feedback.

4.10.1 Initial member check of data - Main Study

With Braun and Clarke's (2006) approach, member checking occurs at the beginning of the data processing to ensure that the analysis and interpretation of the data adheres to trustworthiness principles (Merriam, 2009).

This step covers a range of activities including returning the verbatim interview transcript to participants which occurred in this study's pilot and main semi-structured interviews, using Braun and Clarke's member check approach. Birt et al., (2016) argue that, within an objectivist epistemology, asking a participant to check the transcript of their interview potentially enhances accuracy of the data. More so, within constructionist epistemology, it can be used as a way of enabling participants to reconstruct their narratives through deleting extracts they feel no longer represents them in a negative way (Maclure, 2013; Morse, 2015). Member checking covers a range of activities including returning the interview transcript to participants. Returning the interview transcript to participants within an objectivist epistemology, asking participants to check their interview transcript potentially enhances data accuracy.

4.11 Researcher's process for identifying suitable data analysis for the study

The process of identifying appropriate data analysis method for this study was mapped out using the flowchart, figure (4. 3) as illustrated below.

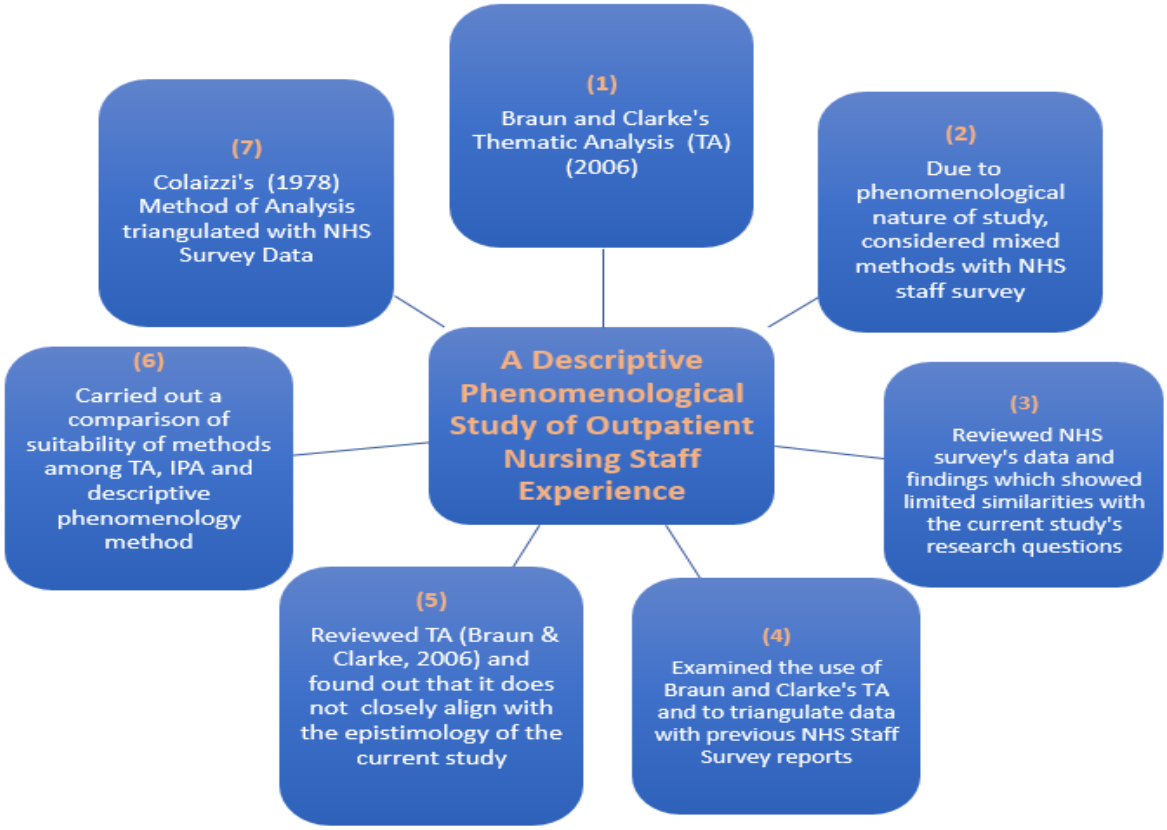


Figure (4.3) Researcher's process to identify appropriate data analysis for the study.

Having reviewed the epistemological stance and the research question for this study, I needed further scrutiny of the data, especially being an insider researcher. Therefore, an additional phase of thematic analysis was explored to meet the descriptive epistemological framework for this study. By so doing, a more suitable thematic analysis by Colaizzi (1978) was considered which requires an additional phase (seventh step) to further increase this study rigour, details of the researcher's iterative process of this study data analysis' cycle follows (figure, 4.3; p.163). Thematic analysis was used to gain approval for the research proposal; therefore, I explored the additional step of the thematic analytical Colaizzi's (1978) method to further enhance the data analysis outcome. With the use of Microsoft Teams recording, most of the semi-structured interviews were transcribed from start to finish. The participants' interview data were obtained with the use of real time auto transcription of the interview data through Microsoft Teams. As a thematic analysis was to be carried out, each of the interview transcripts was listened to on a repetitive basis in order to familiarise and group similar nodes.

Sixteen out of the eighteen participants' interviews were auto transcribed through Microsoft Team audio and video, whereas two participants declined the Microsoft Team video call interview and preferred the interview recording without the video call. These two participants' interview discussion were therefore captured with an encrypted tape recorder and the recorded data were transcribed manually. The participant information sheet had option to use tape recorder as well. Following the completion of data collection, the individual participant's transcript was sent by email to the respective participants in the form of initial member check, to confirm whether the content reflected the interview discussion. Member checking is the process of sharing interview data or preliminary findings with research participants to verify the trustworthiness of the data (Doyle, 2007).

Lincoln and Guba (1985) described member checking as a crucial process to establish credibility in qualitative research, given its focus on verifying the accuracy of descriptions of participants' accounts and narratives. Seventeen out of the eighteen participants (94%) confirmed that their transcripts reflected the meeting discussions. one of the participants updated a section of the transcript during the member check process to reflect the exact meaning of their experience, which was really useful and added value to the data quality (anonymised email appendix 18a).

When all the participants' responses were received, the participants' verbatim transcriptions and audio tapes were sent to the researcher's two University Supervisors for consistency check, prior to commencing the data analysis. Colaizzi's strategy for phenomenological analysis (appendices 14a & 14b) aligned with the epistemological approach for this study.

Step one: Familiarisation with the data

Each participant's verbatim transcript was repeatedly read to get an overview of the content and I conducted the initial analysis of the data, ensuring that the steps of proper bracketing was explored. In order to capture and uncover the actual phenomenon as lived experience by the participants, the data was completely verbatim. In this way, any preconceived notions, thoughts, feelings and ideas of an insider researcher would be mitigated against. Following the data familiarisation, with the use of excel spreadsheet, I explored a data analytical tool (NVIVO12) to facilitate the data analysis process.

Step two: Identification of the themes

According to McNiff, (2016), NVIVO is a computer-assisted qualitative data analysis software package designed to help researchers to organise and analyse qualitative data interviews. I undertook and completed training on how to use the NVIVO12 database software for data analysis, certificate attached (appendix 15). After the raw transcripts has been checked and confirmed by participants through member check, the transcribed checked data was uploaded to NVIVO12. The data was uploaded into this software which enabled the generating of thematic clusters which was thereafter manually processed. The use of NVIVO software allows patterns to be presented in the form of codebook, to improve the quality of the data analysis (Roddesnes et al., 2019). The initial thematic clusters were developed through NVIVO12 whereby every answer from the participants for each interview question were inputted on excel document separately. The excel spreadsheet layout enabled the counting of the number of times a specific theme appeared on each participant's narrative experience. A PESTLE (Political, Economic, Social, Technological, Legal, and Environmental) Analysis (appendix 20) shows examples from significant narratives which were extracted from the participants' data.

Throughout the process, I maintained bracketing to retain the authenticity of the data at the initial analysis of organising the raw transcript of the interview data. The categorising of data is the process of subdividing raw information and allocating it in categories as themes (Dey, 2003; Wong, 2008). Figure 4.4 below illustrates Colaizzi's seven steps data analysis process and method used in this study.

Figure 4.4: A summary of Colaizzi's strategy for phenomenological analysis
Source: Adapted from Shosha (2018).

Initially, eleven clusters referred to as parent nodes were developed using the NVIVO12 software and these parent nodes were, thereafter, manually condensed into the final main themes with sub-themes. I carefully read and re-read the raw data and ensured the credibility of the generated themes.

Colaizzi's steps 3-7 are shown on appendices 14a & 14b. The decision to carry out verification of the data (seventh step) is often based on epistemological and ethical considerations, as well as methodological constraints and possibilities (Birt et al., 2016). With this study, Colaizzi's data analytical method required verification of data, hence the research findings were sent to the participants to ask for validation. Further member checking resonates with phenomenological approaches which acknowledges that, participants hold valuable knowledge that can be integral to the analysis of research findings (Caretta and Pérez, 2019).

4.12 Verification of key themes by returning to participants

I sent the overall key themes generated from the interview data to the participants for them to have an overview of the results of the study as attached (appendix 18b), and requested for their feedback. Returning the data to the participants enabled them to compare the study findings to their various personal experiences. At the time of the validation activity three study participants could not be reached by their work emails and the researcher found out that the three participants had already left the Trust within 9 months of the interview period. The remaining two were on long-term sick absence at the time of the request for data validation and were unable to respond to their emails. Hence, 13 participants were contacted for data validation.

Feedback from 13 out of 13 participants (100%) suggested that the key themes reflected their lived experiences. The verification step was an assurance to the participants as they were made aware during the recruitment process that, they would receive the data prior to the dissemination of findings. Following this validation, the audio recorded data and transcripts were shared with the researcher's Middlesex University Academic Supervisors for a recheck, through a secured shared OneDrive. In line with the approved PIS, care was taken to protect the participants' identity and that of their designated departments by anonymising all the identifiable information.

4.13 Ethical considerations and rigour

Scientific rigour was developed through evidence and correlating concepts of trustworthiness, which includes the four components of credibility, dependability, confirmability, and transferability (Lincoln & Guba, 2005).

Credibility, dependability, and confirmability were established through reflexive journaling to provide insight, assist with ongoing bracketing, and assist in methodological decisions. The figure below illustrates how the quality assurance measures were applied in this study.

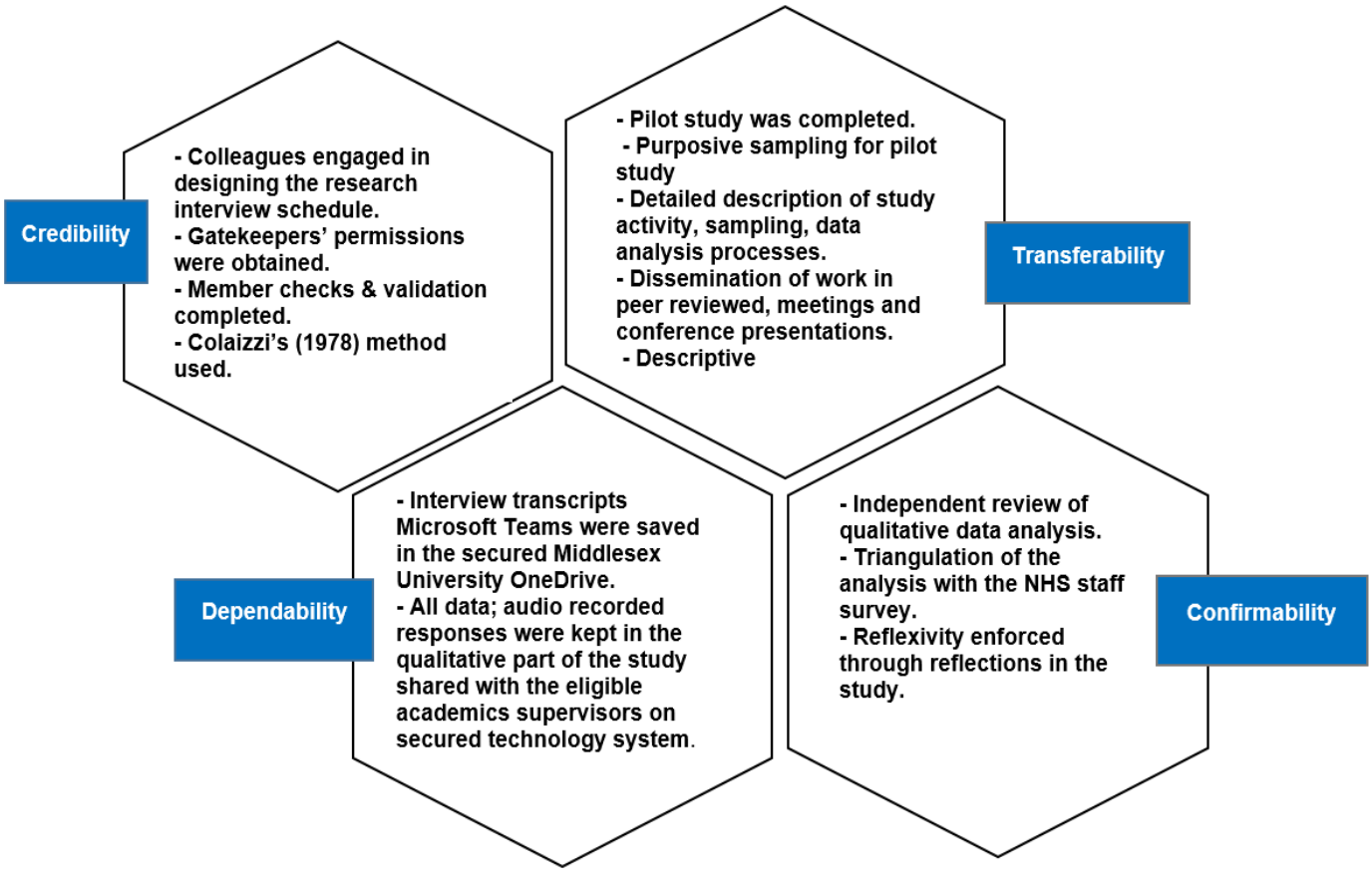


Figure 4.5: Researcher's Quality Assurance Measures: Adapted from Cameron (2011) and Guba and Lincoln (1985)'s Framework

The entire research process provided a clear audit trail and evidence. For example, purposive sampling also promoted rigour (Creswell, 2014), and in this phenomenological study, all participants experienced the phenomenon and were able to provide information relevant to the phenomenon itself. As a researcher, my experience as a nurse manager in a variety of healthcare outpatient care settings increased my motivation to investigate this phenomenon. To maintain the validity of the study, reflective journaling was used to engage in ongoing bracketing of any preconceived knowledge, expectations, or assumptions. Additionally, participants' feedback through member check on the interviews' raw data were completed, followed by revalidation using Colaizzi's seventh step.

4.13.1 Informed Consent

Pick et al., (2013) suggested that informed consent is when participants have adequate information regarding the research, and can comprehend the information, enabling them to consent or decline participation in the research voluntarily. The consent forms for this study detailed the aim of the research and it further outlined details of the research and emphasised that it would be strictly confidential. Therefore, it was incumbent upon me to ensure that I inform the participants that their participation was completely voluntary, they had the right to withdraw from the research at any time.

4.13.2 Data Protection and Confidentiality

Consent forms were kept in a locked file cabinet in my office, accessible to only myself. Consent forms were separated from the recorded interview data files to maintain anonymity and confidentiality. Each recorded interview data file and demographic data collection form was assigned a number. I kept one file with a master list of information that matches participants' initials with their assigned number, in a password protected encrypted data, kept in a locked file cabinet in my office. All recorded interview data were transferred from the recording device in a secured computer for my access only. The files with the master list and recorded interview data were secured with codes and protected passwords. After all interviews were completed and transferred to the external hard drive, the recording device would be wiped clean in line with the Middlesex Data protection policy.

Participants were informed that no identifying data will be in study reports, also participants were given the option of receiving study results once it is completed in the form of the data validation and published report. All electronic files with the master list, recorded audio data files, and interview transcripts will be permanently deleted, the external hard drive will be wiped clean within the Middlesex University (MU) Code of Practice (CoP) for research, after the completion of the study. All hard copies of study documents, including the consent forms, will be shredded within the CoP time scale after the study's completion. The ethical issue of confidentiality meant that, as a researcher, I informed the participants that their names would not be used (anonymity) and that the transcribed data will be destroyed on completion of the research project following the MU Code of Practice for research policy.

4.13.3 Work base Insider Researcher and Reflexivity

According to Holloway and Galvin (2016), reflexivity is a conscious process and attempt by researchers to acknowledge their own involvement in the study. It is seen as a form of self-monitoring in relation to research that is being carried out, whereby researchers engage in explicit self-aware analysis of their own role (Holloway & Galvin, 2016). Hence, as an insider researcher, I ensured that reflexivity and bracketing strategies were explored from the commencement of the project to the completion stage.

As a requirement in the study process, I had to bracket my thoughts and avoided influencing the participant's narrative, as they were recounting their experience. Therefore, in choosing the philosophical framework for this study, my positionality as both a manager and work base researcher were considered and actions put in place to mitigate any conflict of interest. Reflexivity could also be a critical reflection on what has taken place or been thought from the insider-researcher perspective or reflection. The use of gatekeepers was helpful for the researcher to access and to engage staff with the study process. However, one manager who was approached to act as gatekeeper declined the requests stating that, the unit was very busy and they lacked time to release staff for the interviews. As a result, this team of outpatient nursing staff could not participate in this study.

Floyd and Arthur (2012) inferred that insider position may be given privileged access and information, but the researcher's role in an organisation may also act as a constraint to the researcher. On the same note, Mercer (2007) argued that insider researchers have freer access, stronger rapport and a deeper, more readily accessible frame of shared reference to interpret the data they collect. Semi-structured interviews often require the participant to reveal sensitive and personal information directly to the interviewer, it is important to consider the power imbalance between the researcher and the participant. Bracketing of any previous knowledge and assumption was explored as much as possible at every step of this study and with this strategy, the credibility and rigour of the study was enhanced. Thereby, creating an atmosphere of trust which added to the principle of veracity and in so doing, my professional accountability within the entire research process was established.

4.14 Summary and conclusion

This chapter provided information regarding the activities of the project with a mapped-out flowchart (figure 4.1; page 143). This chapter discussed the processes followed in the formulation of the research questions, how the gatekeepers' access and ethical approval were obtained, and the challenges encountered during the study participants' recruitment process. A brief overview of phenomenology as a philosophical framework used for this study was discussed, with emphasis on the concepts of Husserl's (1963) and Colaizz's (1978) descriptive phenomenology which aligned with this study's research questions.

Aspects of the methodological plan included; purposive sampling and recruitment strategy of participants, specific hospital sites and outpatient settings. Scientific rigour and protection of human subjects was also presented as part of the methodological approach and the importance of reflexive approach as an insider researcher was also discussed. By exploring a reiterative cycle in choosing the appropriate data collection and analytical approach, I gained valuable insight on how best to engage the study participants. The presentation of the research findings and data analysis will follow in the next chapter.

Chapter 5: Presenting the research findings

5.1 Introduction

This chapter outlines the findings generated after transcribing the semi-structured interview data with 18 outpatient nursing staff participants. The participants' description of their experiences is considered as significant statements that reflect the participants' phenomena (Colaizzi, 1978; Shosha, 2012). In line with Colaizzi (1978) approach, I read the transcription several times and re-checked each interview transcript multiple times and became familiar with the interview data.

5.1.1 Results from semi-structured interviews

I looked at 160 unique statements generated from the outpatient participants' narratives and grouped them into more general statements and similar patterns. These statements were therefore reviewed and grouped together into categories based on similarities and differences. This process resulted in 4 main themes with 4 to 5 sub-themes, which described the experiences of the outpatient nursing staff (appendix 17).

Highlights of the participants' demographics (table 5.1; p.173) showed the following:

- 14 females and 4 males out of 18 (22%) participated in this study.
- More engagement was seen from nursing staff with 2 to 5 years of experience within outpatient services.
- The population of the Black, Asian and Minority Ethnic (BAME) nursing staff formed a greater percentage (66%) of the participants.

The Nursing and Midwifery Council data showed that, the United Kingdom has 89.3% female to 10.7% male nurse registrant ratio (RCN, 2019). Similarly, the NHS Digital's workforce statistical team reported in year 2018 that, 89% of nurses and health visitors were women making the nursing staffing group a female dominated profession, while the male population was 11% (RCN, 2019). However, NHS mental health trusts have a much higher percentage of male nurses about 20% compared with 11% in all trusts (NMC, 2020). Based on this information, 22% was a particularly good representation of male nursing staff engagement in this study.

Furthermore, the National Audit Office (NAO) reported an increasing NHS workforce aged 45 and above, with the average age being 43 forming a higher proportion of healthcare and community nurses, an average of 35% (NMC, 2020). Hence the ageing NHS workforce is an issue that organisations need to address with the nursing skill-mix and strategic workforce planning, as a technical process to predict demands for care (Sutton et al., 2023). The demographic data shown below describes the range of the various participants' characteristics and locations.

Main Study Demographics

	Variables	Working Definitions (Attributes)	Band 3 (HCA)	Band 5 (RGN)	Band 6	TOTAL
1	Respondent – Type	NHS Registered Nurses & Healthcare Assistants	9	5	4	18
2	Gender	Male	2		2	4
		Female	7	5	2	14
		Others; please indicate				0
3	Age - recheck	Age of respondents				
		Under 25				0
		25-34	3		1	4
		35-44	2	3	1	6
		45-54	4	2	2	8
		55-64				0
		64+				0
4	Ethnicity	Origin				
		African/Caribbean	4	2		6
		Asian	3	1	2	6
		White/Caucasian	2	2	1	5
		Undisclosed			1	1
5	Work location	Sites and Clinical Specialities				
		Site A	4	2	1	7
		Site B	2		1	3
		Site C	3	1		4
		Sites ABC (staff working across sites)		2	2	4
6	Designation	RGN bands 5 & band 6		5	4	9
		HCA band 3	9			9
7	Years of Experience	Length of Service in Outpatients Department				
		2-5 years	3	2	1	6
		6-10 years	1		2	3
		11-15 years	1	1	1	3
		16-20 years	2	1		3
		20++ years	2	1		3

Table 5.1. Demographics of Main Study Participants.

In terms of the various sites, 'Site A' has a greater population of staff due to the larger size of the hospital when compared to the other two sites. Hence more participants were proportionately recruited from Site A, which has all the clinical specialties – Medical, Surgical, Maternity and Paediatrics. All the outpatient clinical specialties were represented, the Medical and Surgical teams had more participants due to the higher population of staff and clinical activities in these departments. Looking at this study's participants' age, the 45 to 54 age bracket were four band 3 HCAs; band 5 registered nurses were two, also two band 6 registered nurses fell within this age. Overall, eight participants were aged between 45 - 54 years (44.5%), which was slightly higher by 1% when compared to the NHS national average.

The participants aged 35-44 formed 33.3%, while the younger age range of 25-34 formed 22.2%. This study show a significant gap and reflect the increasing ageing NHS workforce. Also, Advanced Nursing study (Halcomb, et al., 2018), found that, there is a high turnover among younger nurses under the age of 30. The most recent available data from the researcher's organisation, shows that nursing staff within the age range of 25 and below has the lowest percentage of the working population (figure 5.1), an indication of less interest for the younger generation in joining the NHS.

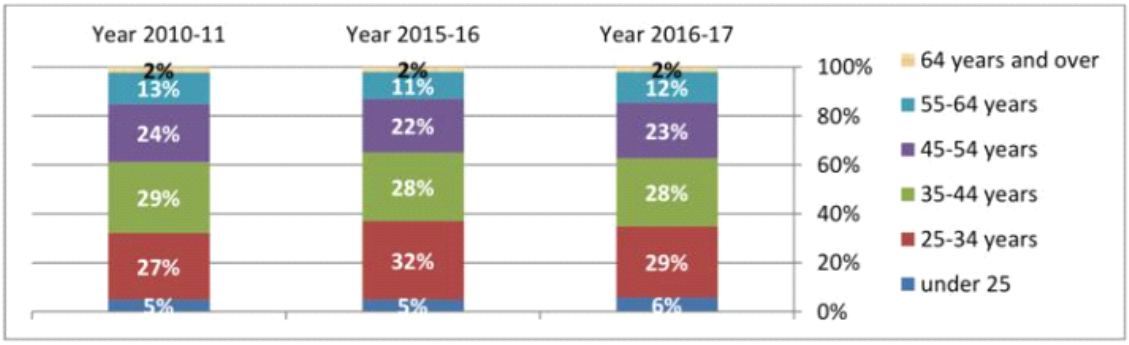


Figure 5.1: Age breakdown of the researcher's organisation workforce age range.

Increasing higher age of 45 and above in the staff population (figure 5.1), is seen in years within nursing workforce as shown on the demographics of the NHS staff age breakdown published in 2019. The report also showed that 43 is the average age of healthcare worker, which mirrors the age population of the participants in this study that took place in one of the largest NHS Trust in London.

Figure 5.2: Age breakdown of Agenda for Change staff

Source: https://www.nhsemployers.org/articles/age-nhs-infographics

In terms of the ethnicity backgrounds of the participants, a higher BAME percentage was found in this study, which was like a recent demographics by NHS in 2021 (figure 5.3) illustrated below, where only London areas had a higher percentage of BAME than any other ethnicity.

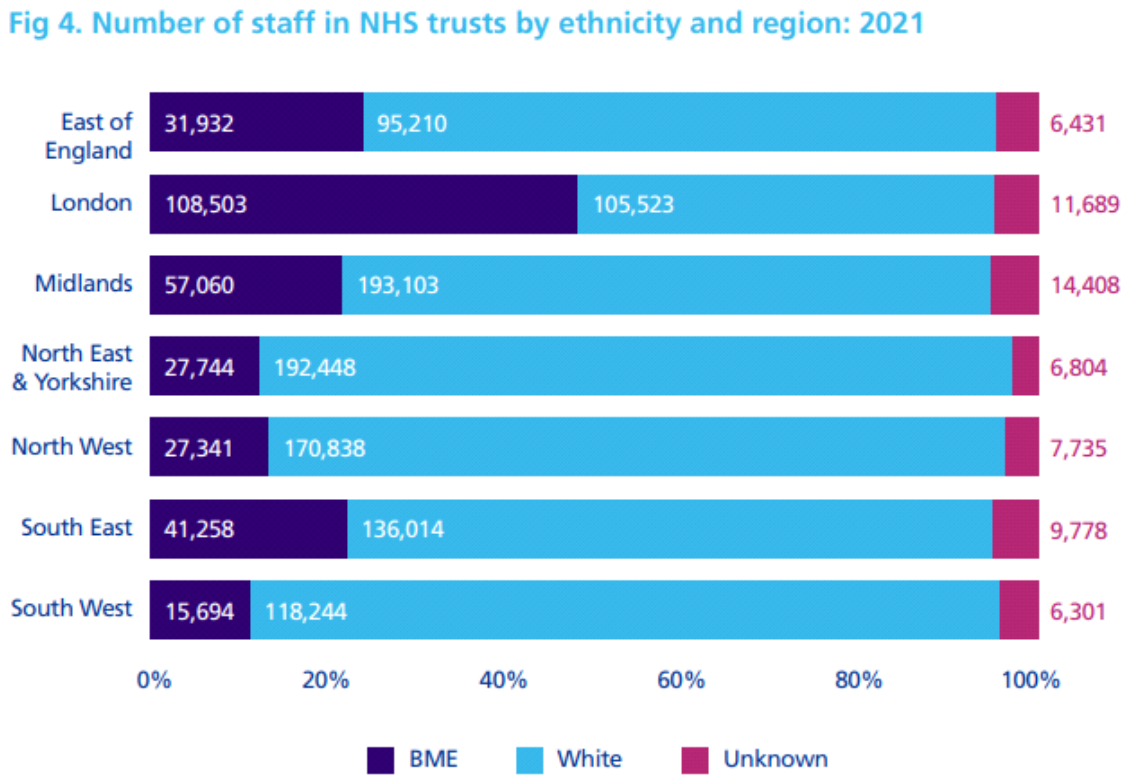


Figure 5.3 Number of staff in NHS trusts by ethnicity and region: 2021
Source: [Workforce-Race-Equality-Standard-report-2021-.pdf (england.nhs.uk)]

5.2 Generating the key themes

Following Colaizzi's (1978) framework, I ensured that I familiarised myself with the data by iteratively reading and the initial codes were produced and grouped into themes. Subsequently, the initial codes and themes were reviewed and further modified. Initially, the data was organised into 7 themes which were: (1) Career progression, (2) Issues during the COVID-19 pandemic, (3) General Support, (4) Incidents or Datix, (5) Work-life balance and wellbeing, (6) Management and Leadership, and (7) Understaffing. These themes were generated from the participants' narratives with the relevance to the study's research questions.

Some overlap between the themes were seen, however, they were distinct themes in themselves, so existing codes were modified, and new codes generated. The data was thereafter organised into sub-themes to capture significant findings after reviewing the initial themes. For example, the initial theme 'understaffing' and 'work-life balance and wellbeing' overlapped with the theme 'overwork' as supported by the data. Table 5.2 below shows the initial themes.

Theme: Career Progression	Theme: Issues during COVID-19 pandemic	Theme: General Support	Theme: Incidents or Datix	Theme: Work-life balance and wellbeing	Theme: Management and Leadership	Theme: Understaffing
Lack of training and guidance	Lack of information	Colleagues/ Peer support	Delayed clinics	Anxiety	Frequent management change	High staff sickness level
No induction in the new roles	Lack of preparation	Management support	Estates issues	Fear	Poor management	High turnover of staff
Self-directed learning online for use of equipment	Redeployment	Training and development	No feedback or outcome for reported incident (Datix)	Challenges at work in general	Power-bully harassment	***Work overload*** – work beyond remit
Self-reliance	Remote working		Transport patients	***Issues with PPEs***		***Stress at work***
	Self-isolation			Increased job demand		
	Issues with PPE			Longing or families/friends		
				Stress at work		
				Work overload		

Table 5.2: Initial themes

The themes were grouped into key themes with sub-themes during the modification process. Several codes, which fit more than one theme, were underlined in table 5.2 above. According to Creswell (2014), similar codes should be combined into categories to create new themes and sub-themes. The final themes and sub-themes that emerged after this procedure was repeated are described below. After analysing and condensing the themes, table 5.3 illustrates the final key themes and sub-themes that were extracted from the participant's responses.

Within each of the four major themes, each theme was renamed and divided into a range of four to seven minor themes. The four main themes finally developed from the data in relation to how the service changes could impact the outpatient nursing staff job motivation and wellbeing were: (1) *New ways of working*, (2) *Training and Development Opportunities Issues,* (3) *COVID-19 Pandemic Redeployment Issues* (4) *Management and Leadership Factors*.

Theme 1: New ways of working	Theme 2: Training and Development Opportunities	Theme 3: COVID-19 Pandemic Redeployment Issues	Theme 4: Management and Leadership Factors
1.1 Skill-mix reviews (changes in roles) **1.2** Nurse-led activities **1.3** Working out of scope of their role / Cross sites working **1.4** Excessive workload **1.5** Long day shifts, working through break times and weekend clinics	**2.1** Limited training and career progression opportunities **2.2** Gap in role competencies for some staff in a particular unit. **2.3** Lack of proper induction in new role **2.4** Datix Issues (no feedback/outcome reported)	**3.1** Inadequate PPEs **3.2** Lack of preparation **3.3** Family and social life were affected due to self- isolation from family members after work. **3.4** Issues relating to staff shifts including remote working	**4.1** Frequent management changes at senior level **4.2** Lack of support/appreciation **4.3** Power dynamics a) bullying; top-down b) Undermined c) Felt unsettled – frequently moved to various clinic areas **4.4** High vacancy leads staffing shortage, which leads to high staff sickness level **4.5** Stress at work a) Reduced staff morale b) Uncertain whether to stay in the nursing profession in the future

Table 5.3: Final key themes

Each key theme and sub-themes were discussed through the participants' explanations of how they experienced the event with specific quotes from the participants' interviews' transcripts, which related to the key themes. The discussions on the study's thematic findings followed with emphasis on how each participant narrated their specific phenomenon based on their lived experience.

5.2.2 Theme 1: Nurse-led activities and new ways of working

The first theme, new ways of working, discussed various novel ideas or methods of operation that were implemented in outpatient NHS healthcare settings, as well as any consequences or problems that may result from them. This theme is crucial because it draws attention to some of the achievements and challenges the outpatient nursing team encountered at work (table 5.4). According to the statistics for this theme, as shown in table 5.4, 18 participants voiced their perspectives on several novel ways of working. Appendix 19 contains the precise viewpoints which each participant discussed regarding their experience with redeployment during the surge of COVID-19 pandemic. Some participants also discussed new working methods, nurse-led activities and excessive workload, while other participants voiced their concerns regarding duties conducted by nurses outside their work remit or scope of practice, including lack of break time for the staff.

Theme 1: Nurse-led activities and new ways of working

Key themes	New ways of working *(56%)*	Nurse-led activities *(22%)*	Work out of their scope / role / remit *(17%)*	*Workload (39%)*	*Lack of breaks (22%)*
P 1 – RN5	X		X	X	
P 2 – HCA	X			X	X
P 3 – RN6	X	X	X	X	X
P 4 – HCA	X				
P 5 – RN6	X	X			
P 6 – HCA	X			X	X
P 7 – RN5	X	X			
P 8 – HCA	X				
P 9 – RN6				X	
P 10 – HCA					
P 11 – RN5	X				
P 12 – HCA			X	X	
P 13 – RN5	X	X			
P 14 – HCA					
P 15 – HCA					
P 16 – RN5					X
P 17 – RN6				X	
P 18 – HCA					
Total	10	4	3	7	4

*** Participant (P), RN (Registered Nurse), HCA (Healthcare Assistant)**

Table 5.4: Key theme: Nurse led activities and new ways of working.

Theme 1: New ways of working

When asked about service changes which the participants experienced, some participants (22%) discussed some new ways of working introduced in the service. The participants highlighted many different innovations such as digitalisation, working across different hospital sites, staff rotation, improving support for self-management, virtual clinics and skill-mix reviews. In terms of the redesigned workplace environment and care pathways including centralisation, Participant 6 stated:

> *"So the department went like in overhaul. So, for example, we used to have 2 reception desks and now we have one central reception desk. And the way that clinic was ran and also the phlebotomy and then while the work was being done, it impacted the way we work. For example, our waiting area changed and how we call patients changed. Umm also we used to call through notes, we used to have a cupboard behind the desk so therefore we used to pull notes from there and but then it changed. And that individual clinics actually had their own notes, and they work on the reception staff"* **(Participant 6, HCA).**

P6 described how their department changed physically, and also how it positively improved the service as the changes helped in making their job more efficient. Another participant stated:

> *"And in blood room, the supervising role. And also, like paperwork, paperless and using Cerner which enables us to access patients' records easily. Ummm also, the band 5 roles umm increased in the outpatients here at my workplace"* **(Participant 5, RN).**

In this case, P5 stated about the introduction of Cerner led to a paperless system in their workplace which was beneficial to promoting a greener environment government agenda. This system provided a shared access to patients' health records which enabled the registered nurses in carrying out patients' risk assessments and triaging the patients before they are seen by the doctors, thereby fast tracking the patients' care pathways which in turn reduces clinic waiting times.

Working across other hospital sites

Another branch of new ways of working included where a participant discussed working across various hospital sites which had some negative impacts on the team. Some participants expressed that they experienced lack of autonomy in the role. For instance, participant 1 stated:

> *"So this is something that would've impacted on us, because we are short of staff here. And they have to go all the way to another hospital, and they did not need to go. But if the doctor says that there's a patient that needs to be seen, there's nothing we can do. Some patients have to be discharged, they have to be seen urgently".* **(Participant 1, RN)**

In this instance, there was an indication that the priority was to see patients on admission to facilitate patients' discharges and free up the inpatient bed in order to increase the bed capacity for incoming admission cases, despite the situation in the outpatient department.

Staff rotation

This aspect of new ways of working involved staff rotation, for the nurses to work in the various clinical specialties. The participant's initial reaction of being rotated to different places was one of unpreparedness, uncertainty about their daily work assignments. They felt unsettled by this development. Specifically, P8 stated:

> *"Rotation for me when I started as a part-time, they started taking me in different places. When they started rotating me, I was not ready. I do not know where to work in the morning, you know like whenever I come. But slowly and gradually, I accepted in a way"* **(Participant 8, HCA).**

It is worth noting that while participants accepted the rotation though they felt it was challenging but they had no choice than to adjust to the changes. Communication and support from management during the rotation process could have helped in alleviating any uncertainty or anxiety experienced by employees, allowing them to make the most of the experience. Participants did not discuss whether the staff completed the induction process in the different clinical areas of their rotation.

Improving support for self-management

Briefly discussed is another new way of working such as enhancing patient education and health improvement through nursing activities to support and empower patients in their care and self-management. One participant stated that patients are the work priority:

> *"As a registered nurse, the patients are my priority and I enjoy patient care, teaching them"* **(Participant 7, RN)**

The participant's response highlights their passion for patients' care as a registered nurse, indicating that the nurses are enthusiastic about teaching patients, which can enhance patients' better understanding of their health conditions and treatment options. Participant 7 used the term 'patients are my priority', which suggested some elements of dedication and passion about providing excellent patient care and educating patients.

Virtual clinics

Also, virtual clinics were discussed as part of new ways of working, which was a major transition for outpatient nursing staff. Participant 4 discussed some challenges that they encountered and stated:

> *"Ummm the challenges like I said, we just didn't know what we were doing. No information. Every day we didn't know what clinics were telephone what were face-to-face. Patients were turning up that should've been telephone. Every day was a different challenge. There was no specific thing, we just something different every day".* **(Participant 4, HCA)**

The participants' response indicates that they had to deal with daily challenges such as uncertainty about clinic operations and patient management, which could cause frustration and stress for healthcare workers. It also suggests that the participant adapted to the new situations and created strategies to manage the challenges.

Another participant revealed some challenges such as working long shift hours caused by new ways of working and stated:

> *"Because we're here at 8:30 morning and we finish at 7:00 and we are expected to get back here again. We're pretty much doing a long day. Also, in terms of clinical patients who are waiting tend to be very frustrated especially virtual. So having telephone consultation. Now we find that it's getting bigger. There are more patients who are coming face-to-face. Also, doctors are expected to call the patients phone and reach the number of the patients as well. And in that case, then the doctors are delayed to do so"* **(Participant 5, RN).**

P5 also suggests that virtual and telephone consultations have added to the challenges faced by healthcare workers, as patients may experience frustration and delay in their care. The participant's response indicates that healthcare workers are expected to adapt to changing patient care practices, such as the increasing demand for virtual consultations, and this can cause additional stress and workload.

With the outpatient transformation and new ways of working in line with the clinical programme groups, only patients with high clinical acuity and care needs were seen on a face-to-face basis in outpatient clinical settings. However, some patients' health conditions might deteriorate and require them to attend a face-to-face appointment instead of the pre-booked virtual clinic. The additional unexpected attendance results in increased workload. Healthcare workers are often required to work extended hours, which can be physically and mentally challenging, also could negatively impact on patient care and the well-being of multi-disciplinary teams, of which nurses form a greater population.

Skill-mix reviews (changes in roles)

Nursing establishment reviews in form of skill-mix reviews or changes in roles were reported by 28% of the participants. They discussed some changes and how additional roles were created. For instance, the additional Band 4 nurse associate (NA) role was included in the nursing establishment and participant 4 stated:

> *"Umm what I experienced is, they've created new jobs: Band 4 which we didn't have. It was admin support and phlebotomy is part of that"* **(Participant 4 HCA).**

Participant 4 stated that the nursing associate and phlebotomy supervisor's roles were recently introduced within the department, which will be explained further in the next section (Chapter 6). Another participant discussed the switching of roles between the band 3 and band 2 and stated:

> *"Uhmm also, uhmm some of the HCA, went to band 2 to 3, some of band 3 went to band 2, as an admin. Uhmm yeah that sort of change that I've had in my workplace in the last 4 years before COVID-19"* **(Participant 2, HCA).**

The participants revealed that due to restructuring and skill-mix review, some staff were down banded while others were promoted. According to the participants, the rationale for the service changes were not discussed, although skill-mix review and changes in establishment structure is a workforce change management that required a staff consultation process, for an effective implementation and service outcome.

Sub-theme 1: Increased nurse-led activities

Findings showed that 22% of the participants discussed an increase in nurse-led activities. Some of the participants gave some examples such as:

> *""Every day we have this update with our courses like conferences and everything, we just need to make sure that we have updates in new medication treatments, with the skilled conditions and everything that. So far we are encouraged more to learn and be exposed because. I forgot to mention, previously as well we go the wards also to see patients. So it's something new for me, so it's a good thing. So many things to learn. Because I have my two colleagues now as well, so I have the opportunity to manage to share my knowledge also to them. So I'm hoping because they're gonna be sign post also so they can do it independently also so it would be nice to share your knowledge also"* **(Participant 3, RN)**

Although this participant seemed excited that they had in-house training to increase their skills and responsibility in managing patients' care and treatment. However, the staff implied that these clinical competencies would not enable them to gain academic qualifications to pursue for further career development.

Participant 3 expressed how satisfying it was to share knowledge with colleagues and this narrative shows how increasing the nurses' clinical knowledge, skills and responsibilities could increase team spirit. Another participant stated:

> *"Okay, umm personally I got both positive and negative which the positive is umm I was one of the... actually team of specialist nurses and consultants and me, not a specialists (laughs) in a team to setup we got a new service here in out… in our department we got plastic surgery minor operations team and plastic surgery minor injury. Which I participate to establish that service last year which I was very proud of it and until now we got the services so it's still existing I trained all staff from band 6 to unqualified nurses so yeah (smiles) that's the greatest achievements I have. And of course positive is I discover that I can work under pressure. As a person, I became resilient, I challenged my capacity as person" (***Participant 13, RN)**.

The narrative from participant 13 shows how staff contributed their knowledge and expertise in successfully setting up and establishing new services with nurse-led activities which became the main feature of outpatients nursing.

Sub-theme 2: Working out of scope of role.

Some participants (11%) pointed out that sometimes they were expected to carry out tasks that were not within their work remit, such as to see patients on the wards. An example was expressed by a participant who stated:

> *"Okay, before we see about 80 patients in a day. And now we're seeing, we go to the wards to see patients that are referred to us. Sometimes it's not.. we go to the patient, it's not in our job remit but we have to do. Sometimes we go there and we have go there 3 hours and we have to train the nurses in the wards on what to do. So that's…. a daily routine to do"* **(Participant 1, RN).**

Participant 1's description reflects how in-patient activities were given priority especially if the patient was due for discharge to speed up bed capacity release.

The trend of patients' care pathway is changing to enhance their patient experience whereby, the discharge plan includes specific care needs to be completed before the patients go home on discharge, outpatient nurses see patients on the wards collaboratively.

With the streamlining of services, the patients' care pathway requires a diverse and multidisciplinary approach to save the patient an additional visit to the hospital. Hence the outpatient nurses sometimes attend to the patient on the wards before they go home after discharge. It is really important that the patients in the wards are not delayed when discharged so that the beds are freed up in order to release capacity for new admissions. Another participant reported how they were inappropriately delegated duties and so stated:

> *"If I mean sometimes they say go and see this patient because they have seizures so and so... under the COVID and see the patients, it's just... It's not something that we can do or something that we're trained to do. So that we have to say that "this is not in our remit. Can you find somebody who's more uhmm specialised in doing this?"* **(Participant 12, HCA).**

In this situation, P12 requested that, for safety reasons, they should find a registered nurse who was qualified and more competent to attend to the particular patient. Although the health care assistants (HCA) are trained and competent in taking patients' observations, the HCAs might find it very challenging to attend to patients with very high clinical acuity and co-morbid care needs.

Sub-theme 3: Excessive workload

Some participants (39%) discussed excessive workload. This sub-theme is a ripple effect of the first sub-theme under understaffing. The participants' statements showed seven narratives where excessive workload experienced was expressed due to staffing shortage. Participant 3 gave examples and stated:

> *"Someone got workloads and so many things to do, like documentation, we need to give some time to each other. And just make sure we have our break or anything"* **(Participant 3, RN)**.

Participant 3's narrative showed how the staff supported each other to enable them have their break and further stated:

> *"And clinics are getting busier and busier and bigger. And for the most part we feel much stretched. However, it's a job that fulfil and give us bills to pay".* **(Participant 3, RN).**

Participant 3 also highlighted that sometimes staff had no choice but to adapt to the busier clinics as their job was needed for 'paying their bills'. However, it was noticeable that this participant also expressed having a passion for the job despite feeling stretched due to workload.

Sub-theme 4 (a): Working through break times and unable to take annual leaves

Twenty-two (22%) of the participants stated that there were times when they were unable to take their annual leaves and breaks due to staff shortages. Although all staff are entitled to a break time and annual leave for their well-being. However, some participants expressed that it was challenging sometimes for them to find time for breaks due to work overload, so they had to skip their breaks. For instance, P2 stated:

> *"The staff need more support. Outpatients staff needs more support in terms of leaves. We need more support. Especially in hospitals appointments. It's not only me, not only talking for myself, talking for my colleagues as well. We don't get the time. Sometimes we do, sometimes we don't"* **(Participant 2, HCA).**

Participant 2 highlighted a common issue which affected most of the staff working on a regular Monday to Friday schedule. The office working times make it difficult for the staff to get a face-to-face appointment with their General Practitioner (GP). Thus the participant advocated for colleagues stating that they were speaking not only for themselves but expressing the concern of their colleagues too. In terms of lack of regular break times, another participant highlighted the problem stating that:

> *"Because sometimes we forget that we are human beings as well. With all the workload, we have so many things to do. Sometimes, even if it's our break time or lunch break, we are still reading our emails and everything. I think we need to give some time to ourselves"* **(Participant 3, RN)**.

Sub-theme 4 (b): Lack of staff consultation before service changes occurred.

When asked about how they viewed their jobs and if they were consulted about service changes before implementation, some participants expressed that they experienced inadequate consultation before services changes took place. Participant 1 said: *"Our manager just... she calls the meeting and then she comes and tells us what has been said."* **(Participant 1 RN).** In other words**,** staff were not consulted, they were just informed about the changes that were about to be implemented.

Similar feedback was received from Participant 12:

> *"I find before the COVID, uhh the changes they implanted uhh nobody ask you before the changes. They just receive it at briefing or quick email depend where you work. So including with the COVID is how you move is how you get emails".* **(Participant 12, HCA).**

P12 stated that nobody asked them before the changes were implemented. On the same note, Participant 11 also gave similar feedback and stated:

> *"Cause things happen without our knowledge, we're not involved in any decision making"* **(Participant 11, RN).**

This narrative shows that participant 11 felt disregarded for not being involved in the decision making. On the other hand, participant 2 said that they were informed about the changes, although they still ended up feeling stressed and not prepared, stating:

> *"How prepared I was.. We've been informed about changes, we've been informed. But we are not, I wasn't prepared because we did not... at that time we didn't have no PPE and there were miscommunication regarding wearing the mask and if PPE was enough. It was a bit stressful. It was a bit stressful. There were not very much preparation for that"* **(Participant 2, HCA).**

Triangulation with NHS Staff Survey Results for 2022

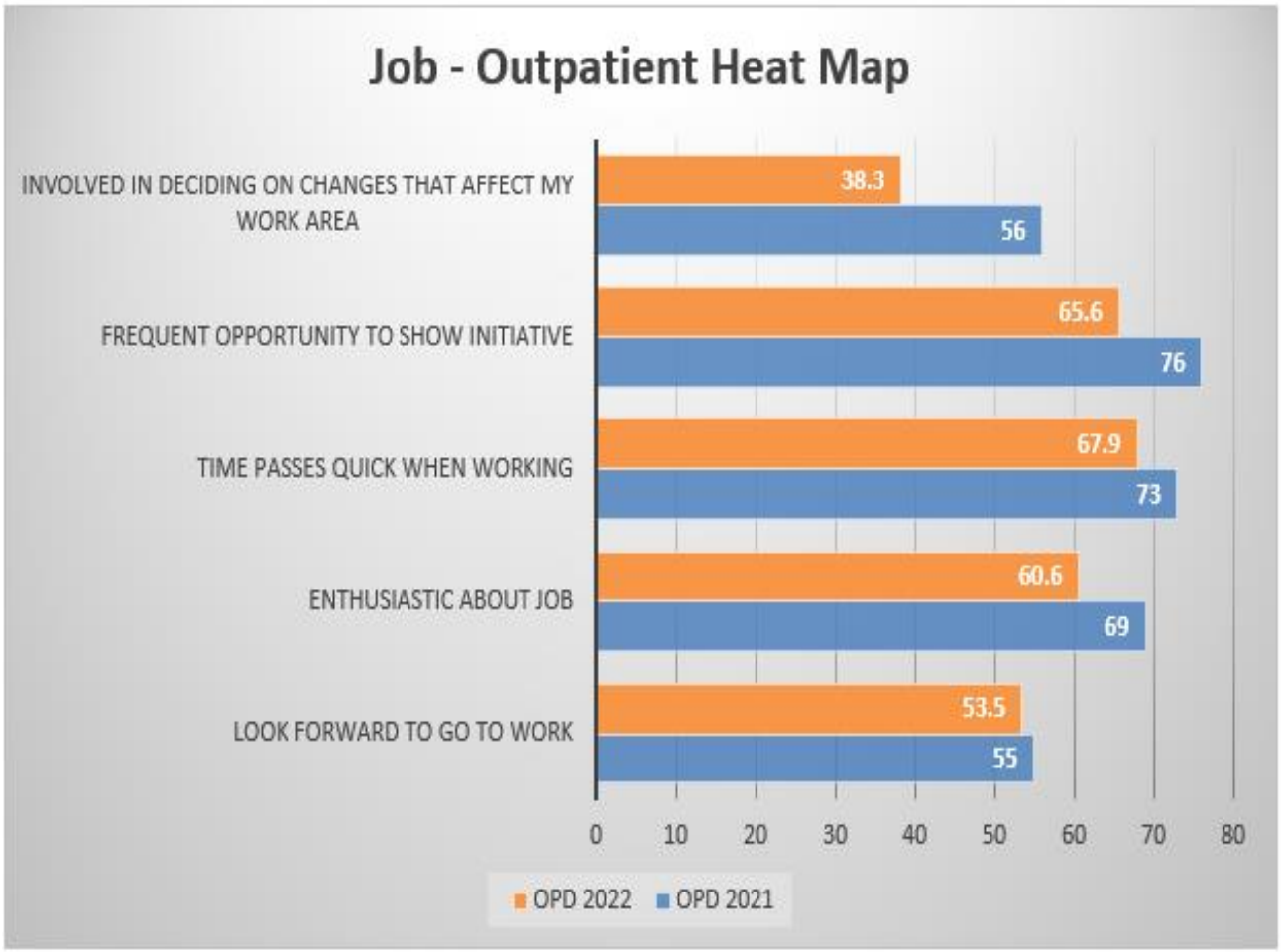


Figure 5.4 NHS Staff Survey result (2021 and 2022) Outpatient Department

The NHS staff survey result figure (5.4) within outpatient workforce in the researcher's organisation showed a decrease in the performance for all the categories especially the first one, which investigated whether staff were "involved in deciding on changes that affect my work area". The satisfaction rate from staff involvement during service changes massively dropped from 56% to 38.3% which correlates with some feedbacks from this study as one participant stated:

"*We are made just to be just uh… objects. No consultation in any decision made. Everything just happens"* **(Participant 11, RN).**

Summary

The first key theme highlighted the participants' experience of new ways of working, increased nurse-led activities, working out of their scope or remit followed by work overload. Subsequently, they expressed a lack of breaks which was a knock-on –effect of work overload. Figure 5.5 illustrates the extent of the specific sub-key-themes.

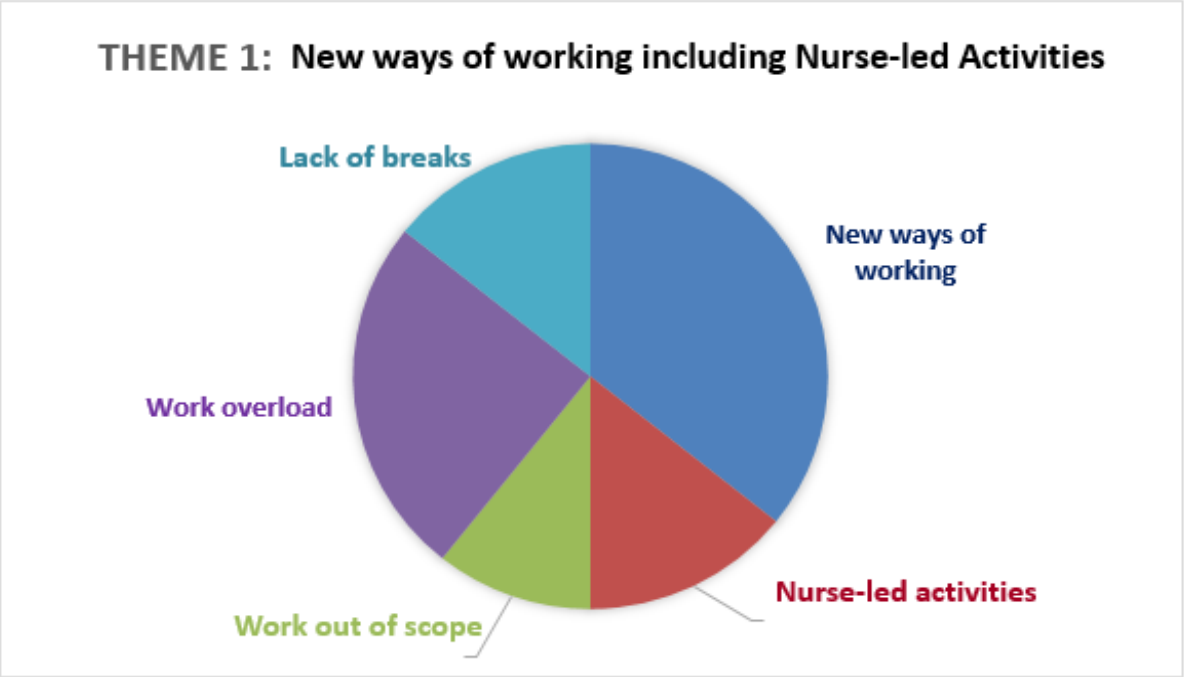


Figure 5.5: Categories of participants' discussions about new ways of working

Overall, the theme of new ways of working highlighted the potential benefits and challenges encountered with the innovations and service changes in outpatient clinical settings within the NHS healthcare. More discussions to follow in chapters 6 and 7 of this project.

5.2.3 Theme 2: Training and Development

Within the second theme, the importance of *Training and Development* was highlighted as a great concern due to the lack of Training Needs Analysis (TNA). More so, some participants expressed lack of training access to carry out their continuous professional development. Datix, sometimes called incident logging issues were raised in this theme which showed that outpatient nursing staff valued feedback from the outcomes of incidents. Lessons from reported issues could be practical guide for training and development (Griffin, 2022).

Inconsistency or inadequate staff induction was also reported. In terms of training and development policy. Trust induction is mandatory training, and the expectation is to achieve 100% for all newly employed staff. However, a few participants reported lack of proper induction in their new roles.

Theme 2: Training and Development

Key themes	*Limited training and career progression (83%)*	*Gap in role competencies (11%)*	*Lack of proper induction in new role (11%)*	Datix issues *(17%)*
P 1 – RN5	X		X	
P 2 – HCA	X			X
P 3 – RN6				
P 4 – HCA	X			X
P 5 – RN6	X			
P 6 – HCA				X
P 7 – RN5	X			
P 8 – HCA	X			
P 9 – RN6	X			
P 10 – HCA		X		
P 11 – RN5	X			
P 12 – HCA	X		X	
P 13 – RN5	X	X		
P 14 – HCA	X			
P 15 – HCA	X			
P 16 – RN5	X			
P 17 – RN6	X			
P 18 – HCA	X			
Total	15	2	2	3

*** Participant (P), RN (Registered Nurse), HCA (Healthcare Assistant)**

Table 5.5. Sub themes – Training and development

The narratives indicated their desire for consistent development which also highlights the significance of career development among the outpatient nursing staff (Table 5.5). In this key theme, most of the participants cited some concerns relating to the lack of effective communication. While a considerable number of participants reported their concern with 'limited training and career progression', additional participants (11%) highlighted that there was a 'gap in role competencies' and some reported 'working out of scope of practice'.

Sub-theme 1: Limited training and career progression

A huge number of participants (83%) of both nurses and healthcare assistants discussed the lack of training and career progression in their jobs; For example, participant 2 stated:

> *"To be honest, apart from mandatory training, there's not much been offered. And because of COVID, some of these trainings are stopped. Before COVID, there's not much training apart from mandatory training especially for HCAs"* **(Participant 2, HCA).**

Participant 2 acknowledged that they had access to mandatory training only, however, apart from those statutory mandatory training courses, there was no other training available especially for the role of the HCAs.

Another participant said:

> *"I've been in a workplace before, which is apparently stuck on the same kind of leadership, the same kind of work routines, the same kind of patients. Two or three years it's fine, but after three years you felt a bit stagnant on that work mechanism and you don't feel like growing. I do not think that we are given the opportunity to develop"* **(Participant 9, RN).**

This participant 'felt stuck' in their roles as there was the same kind of people managing them and they also have the same type of work or routines with no career progression. This gave the participants the feeling of stagnation as there was nothing new that was happening, even if the type of patients was similar. It was clear that the participant wanted to grow, but the opportunity was unavailable. Another participant who had similar experience stated:

> *"Personally, I don't have development. I try to keep up with my personal online training but the skills that I possessed now, are almost the same skills that I had 4 years ago"* **(Participant 11, RN).**

One participant discussed how supportive their manager was and stated:

> *"Even my manager, my first manager she even trying to convince me to do this course: nurse prescribing. But when I am about to study, the two of us are gonna to start. So our manager said okay not this time because we don't have staffing. So I stopped that time so I ended up going for tissue viability course. So I managed to finish my tissue viability course just recently. So so far with the support of the team, we are doing okay"* **(Participant 3, RN).**

This participant explained how they were supported by their manager, and they were encouraged to take courses for their professional development. Despite a delay in taking the course, the staff were satisfied with the support they received. This is supported by another registered nurse, participant 9:

"Well, as I was saying umm, we get good support from our, uh for training. Uh, and learning development in terms of the work that I'm doing and it's not like a something I need to beg for. It's always handed to us like this is something offered you like it. Can you do it? And that's how it works. So I feel like. I'm lucky having that kind of opportunity and it's just the timing wasn't great to get all the kind of learning that I needed during the pandemic. But uhh in general our way of training of staff. Ummm monitoring about their learning development is really good in our department. And I think it is something that needs to be supported all the time as well, and we just, you know, staff should recognise that kind of opportunity all the time". **(Participant 9, RN)**

In this instance, participant 9 was supported and even expressed that staff should recognise every opportunity presented to them at all times. This participant stated that they did not have to ask for training, "It's always handed to us". Regarding participant 3 and participant 9, it was clear that these two participants' experiences were enhanced because they were supported in their training, development and career progression.

Sub-theme 2: Gap in role competencies for some staff in a particular unit.

A few participants (11%) expressed their frustrations about the gap in role competencies in their workplace. An example is participant 13 who stated that:

> *"I've been here longer um... I see that... not all staff are competent enough… enough to respond to the need of the services in… in our department because ermm I observe our department serve the different services are also evolving like they need more… more skills and knowledge from the staff so that they will be able to be effective as part of the team, so.. because I see that as a challenge in our team because not all staff, I will say about being a nurse not all nurses are able to function as the other band five nurses and even band six I believe I can say that not everyone band five and band six can do… can deliver the services they are not competent to deliver or their knowledge and skills are not enough to deliver the services here in our department"* **(Participant 13, RN).**

In this case, Participant 13 expressed the desire for members of the team to be competent enough to deliver services to the patients *(Reflective Journal)*. Participant 13 observed that services were evolving and so core competencies of nurses should be reviewed and updated with higher skill sets to meet the changing trend of the clinical activities.

On the other hand, another participant also expressed frustration at feeling looked down upon despite their competent skills. In this case participant 10 stated:

"I feel because I think people think if we are in the Gray uniform, we are unqualified as they put. And that's a word, it's really you know it really touches me sometimes. When people are call me… calling me unqualified […] I have a lot of things under my belt so what I'm doing I'm trying to I'm trying to achieve and explore and help in situations where I could but my wish is that HCA could get a lot more support in doing a lot of things motivates us in doing things that we can achieve in doing our goals" **(Participant 10, HCA).**

According to participant 10, the HCAs who were skilled and experienced were not recognised and valued because they wore the grey uniform designated for the HCA role and this situation affected the participant's self-confidence. However, this participant desires to achieve more to grow further in the care setting and calls for the registered nurses to support and motivate the HCAs.

Sub-theme 4: Datix (no feedback/outcome reported)

Some staff (17%) expressed their disappointment regarding lack of feedback when concerns are logged through the incident reporting system (Datix). For instance, participant 4 stated:

> *"Ermm when we do complain, when we do Datix or complain, nothing seems to improve in our department. Going back it is still same as it was. Nothing's got actually better. Some things got worse. But other than that, there was no Datix, reporting this reporting that is still the same…… So I think there should be some actions to follow up these incidents. Other than that, that's it"* **(Participant 4, HCA).**

Another participant stated:

> *And another thing also, in terms of Datix results. We do a lot of Datix on different transport delays, clinic delays, umm estate issues. But nothing much get back to us. We do not get much response or what is the improvement on that. We're just part of the statistics. I believe that's it really* **(Participant 5, RN).**

Participant 5 was concerned about possible missed learning or improvement that could have occurred if Datix were managed and feedback provided. This feedback is useful in highlighting the importance of feedback and outcomes to promote continuous learning and improvement. These two participants emphasised the value of reporting incidents and near misses, and the potential for these reports to inform training and development initiatives for both staff and management alike.

In comparison with the Outpatient NHS staff survey 2021 & 2022 report regarding personal development, figure 5.6, below shows underperformance in every category, except for 'feeling supported to develop their own potentials', which scored the same at 54% for both years. However, the biggest drop in performance was the first category which says 'In the last 12 months, have you had an appraisal, annual review or knowledge and skills', which dropped from 91% - 80.5%. In this outpatient study, most of the participants reported that their career development was put on hold.

Similarly, the category on the Heat Map report, 'I am able to access the right learning and development opportunities when I need to' dropped from 63% in year 2021 to 62.6% in 2022. The findings from these two studies reflected a downward trend in the staff personal development review performances

Triangulation with NHS Staff Survey Results for year 2022

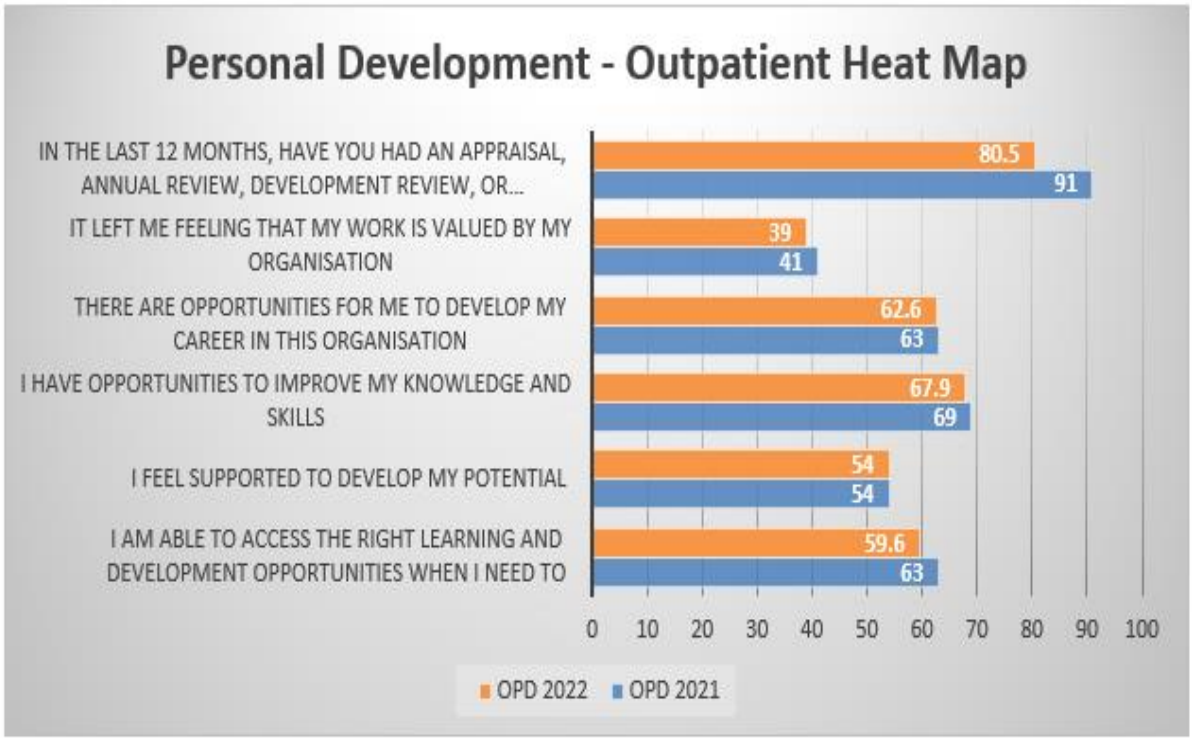


Figure (5.6): Personal Development – Outpatient NHS Staff Survey Results for years 2021 and 2022 Heat Map within the researcher's organisation.

The NHS staff survey report on career development opportunity is very significant. The lack of staff training needs was a setback to the career development and progression for a significant majority of the participants (83%), table 5.5; p.190.

Summary

Overall, most participants discussed lack of training, development and career progression which was a constraint for them in achieving career growth. Summary of the highlights are illustrated below (figure 5.7) as briefly discussed by the within this key theme.

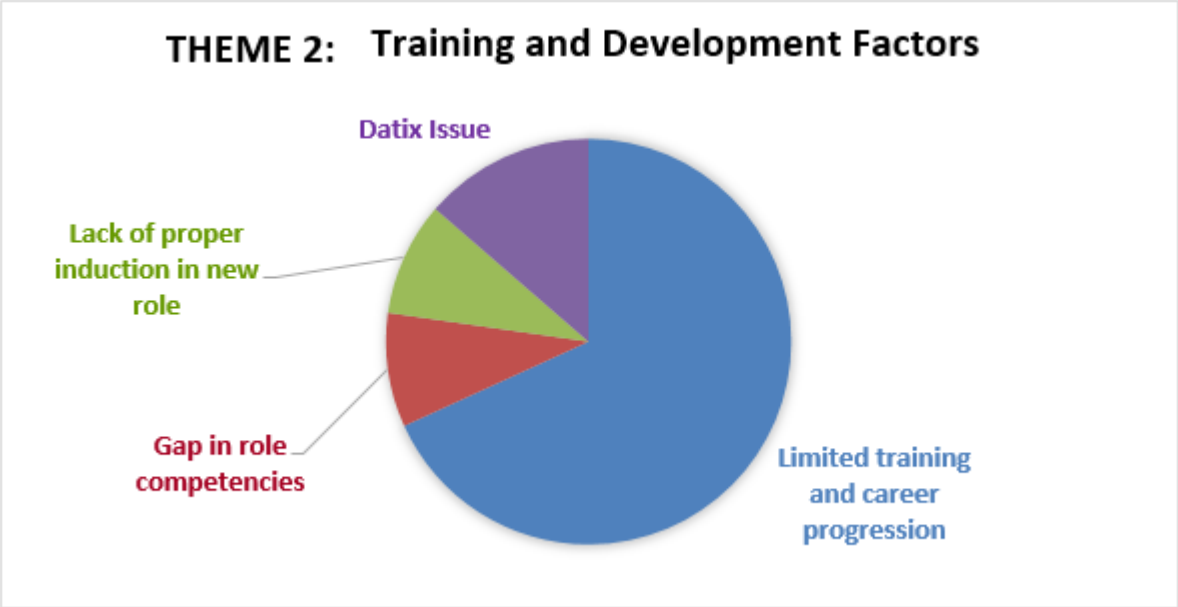


Figure 5.7: Categories of participants' discussions on Training and Development.

The main sub-theme that emerged in this key theme was limited training and career progression. Many participants expressed frustration due to lack of professional development opportunities within their organisation, citing lack of support and access as the contributing factors. However, a couple of participants benefited from their managers' proactive support and achieved their career progression as a result.

Managing staff expectation could be particularly challenging, unfortunately the lack of support to staff could lead to feelings of stagnation and disengagement among staff, which could impact on the service delivery, patients and multi-disciplinary team as a whole. In terms of access to university studies and this finding reveals a lack of process or system in place to support the outpatient nurses in their career development. This situation could be seen as, lack of Equality, Diversity, and Inclusion (EDI) under the domain of education and career development opportunities.

5.2.3 Theme 3: Redeployment during surge of COVID-19

The third key theme comprising the experiences of outpatient nursing staff during their Redeployment at the surge of COVID-19, captured the other associated factors and how the whole situation impacted the staff well-being. The participants described both positive and negative experiences and what each phenomenon meant to the individual staff from their own perspective. Table (5.6) below illustrates the sub-themes with the percentage of the participants' responses on this key theme.

Theme 3: Effect of Redeployment during the surge of COVID-19

Key themes	*Inadequate PPE (44%)*	*Lack of preparation (94%)*	*COVID-19 impact on health and social life (33%)*	*Issues relating to staff shifts (28%)*
P 1 – RN5	X	X		
P 2 – HCA	X	X		
P 3 – RN6		X		
P 4 – HCA	X	X		
P 5 – RN6	X	X	X	X
P 6 – HCA	X	X	X	
P 7 – RN5		X		X
P 8 – HCA		X	X	
P 9 – RN6	X	X	X	
P 10 – HCA			X	
P 11 – RN5		X		
P 12 – HCA	X	X	X	X
P 13 – RN5		X		
P 14 – HCA		X		
P 15 – HCA		X		
P 16 – RN5	X	X		X
P 17 – RN6		X		X
P 18 – HCA		X		
Total	8	17	6	5

*** Participant (P), RN (Registered Nurse), HCA (Healthcare Assistant)**

Table 5.6

Sub-theme 1 & 2: Lack of preparation and Inadequate Personal Protective Equipment (PPE): Lack of information and miscommunication

These two sub-themes are inter-linked, and the finding showed that 94% of participants highlighted the issues they encountered due to 'lack of preparation' during the surge of COVID-19 pandemic, especially the inadequate supply of PPEs. This issue specifically affected the participants for example, one of the participants stated:

> *"Although some departments don't do that, we have to do it. Because they can cough in whatever. So that was something that we had to get used to. We didn't have adequate PPEs at that time. So, we had aprons we were using before. But we didn't have the mask. So, before we started seeing patients, we asked for the masks"* **(Participant 1, RN).**

In line with the infection prevention control policy, participant 1 expected the correct PPEs to be readily available for the safe delivery of service, most importantly, to protect both the patients and staff members from contracting and spreading the virus. In this instance, the participant articulated that lack of PPEs was of great concern. Similar narratives were given by other participants (appendix 19), covering other issues within this key theme. There were overlapping knock-on–effects within the COVID-19 related key theme such as; high staff sickness level, understaffing, and excessive workload and reduced staff morale and these intertwined issues could impact on the staff job motivation and wellbeing.

Lack of risk assessment and Anxiety/Fear of contracting the COVID-19 virus

In relation to the previous sub-themes, the lack of risk assessment before redeployment was highlighted as a major issue by 28%, (table 5.6; page 197), of the participants. The participants expressed that they experienced anxiety and fear of the unknown as they were not sure whether any exposure to the COVID-19 ward environment would put them at risk of contracting the virus. For instance, participant 11 said:

> *"It affected me personally in that my seniors didn't know about the challenges I have personally. And then.. I was expected to do what I was unable to do without proper assessment"* **(Participant 11, RN).**

Participant 11 also expressed that the senior team members were not aware of the challenges that the staff on the floor were experiencing at the time and how it affected them personally. Aside from this they were also expected to do something but not to be accurately assessed if she is physically well enough to do the work in a riskier work setting. The same concern was expressed by participant 3:

> *"So it is something that is daunting for me. And no preparation and no risk assessment or we were just told to go to the wards, then you start on this day. So straight away. Yeahh"* **(Participant 3, RN).**

In this case participant 3 stated that, despite no preparation or proper risk assessment they were just assigned to work on the wards and start working like it was business as usual on normal workdays.

For these participants, it was really ‘daunting’ but they just had to follow instructions from management. Another participant stated:

> *And also, in terms of staff who are at risk, when the risk assessment came around, anything about the who this the staff who are at risk there was confusion in checking who are at risk or less risk – so we were all fighting at that time* **(Participant 5, RN).**

The staff anxiety and fear were compounded by the lack of risk assessment, which caused chaos and confusion as the staff were not sure who was at risk and suitable for redeployment. It was inevitable for the participants to talk about anxiety or fear of contracting the virus and 50% of the participants discussed how it affected them, participant 17 said:

> *“What challenges... uh... First, I think it's the working environment. It's not only because of the COVID that has been happening to the country, but because of like personal fear that I might get it to my... from you know… coming to work. You don't know if you'll get it to from your work or from you know... traveling, going to work. It is just uh... I feel like it's just scary to work during those surge”* **(Participant 17, RN).**

This participant stated that the challenges were more within the work environment as they might accidentally contract the virus at the workplace or even the mere traveling to work could also be risky. Another participant highlighted how just being close to colleagues or patients was a risk stating: “*Thinking if I get too close where I catch anything”.* The fear was really overwhelming as explained by participant 14:

> *“Also, was there were fear there. Thinking if I get too close where I catch anything. Have you got a virus and I don't know. You know so the changes was awful. I'm sure if everyone really everyone not being comforted about around everyone. And fear fear fear most of the most of it really is being fearful”* **(Participant 14, HCA).**

As pointed out by participant 14, being close to anyone outside the family bubble was scary and staff could contract the virus from the people in the workplace. The increased fear and anxiety made it more challenging for some nursing staff to attend duty during the surge of the COVID-19 pandemic.

Sub-themes 3 & 4: Impact of COVID-19 pandemic on Social life and physical health and staff shifts

Some participants expressed that their physical health and social life were affected by their redeployment. For instance, participant 9 stated:

> *"Personally, I mean my relationship with my wife has changed uhh dramatically during that time cause instead of me having a regular day off a week, like two days a week, it was like me working seven days a week. So, when you get home, you're so tired. My mgrs. would have to say like, OK, just get some rest so. There was a bit of a umm factors affecting the relationship uh personally and also my uhmm. If we hear so much news, we hear updates of how many people die from COVID, it just affects my mental state as well"* **(Participant 9, RN).**

These participants felt disappointed that they worked all through without a proper day off like rest day which is required for the staff's wellbeing. Similar experience was reported by another participant who said:

> *I had quite COVID you know so I suffered quite with the COVID and I'm still experiencing many health issues umm because of COVID such as breathlessness, and I still get tired very quickly but still at workplace, I still try to give my 100% and they know already that… what I'm suffering from. You know so yeah, I'm trying to manage. So yeah I can say that"* **(Participant 8, HCA).**

In this statement, participant 8 described the adverse health effects they experienced after contracting the COVID-19 virus as they developed long COVID with its associated health issues. However, participant 8 pointed out that they did at work despite all the conflicting priorities and challenges. Another issue that arose during COVID-19 which was discussed by some staff (22%) was issues related to staff shifts. Since everything was changing, the pandemic also had an impact on their staff shift. One example is when P12 said:

> *"Even when I had reservation, even when I have last month COVID, they refused to pay for 2 of my shifts because they said the government said you need to come back 7 days to work. So we're not paying you for 8 days. Even if you're not feeling well, you'll be left with nothing. So I feel that this is continue, that I feel like COVID somehow become a deeper excuse for the people to push more things off the carpet. So this is how I feel"* **(Participant 12, HCA).**

Participant 12 stated that they had issues with underpayment for the lengthy hours of shifts worked. Also, participant 8 narrated that, when concerns were expressed, the issues were ignored or swept under the carpet which was very frustrating.

In another scenario, Participant 7 highlighted the lack of clinic appointments to see patients and this lack of appointment capacity led to clinics over-bookings, stating:

> *"And at present, when I see waiting list build up, we cancel patient on the list. We change our shifts now. We come in a bit early than we used to. So yeah, that's where we are at the moment"* **(Participant 7).**

Remote working or "working from home" as best described by participant 16, had its challenges as narrated below:

> *"We didn't have information about ourselves, about what to do, you know how to do it. Another one was work from home, I was asked to work from home. And when I was asked to work from home, I was not given any access to umm to work from home. I didn't even have log in to work. I was calling IT. IT was just asking me questions and I will explain myself so I couldn't log in and that's happened for days"* **(Participant 16, RN).**

Participant 16 expressed great frustration, was upset and still felt emotional during the interview. This study found that participants who were redeployed during the surge of COVID-19 pandemic experienced various issues while on the redeployment.

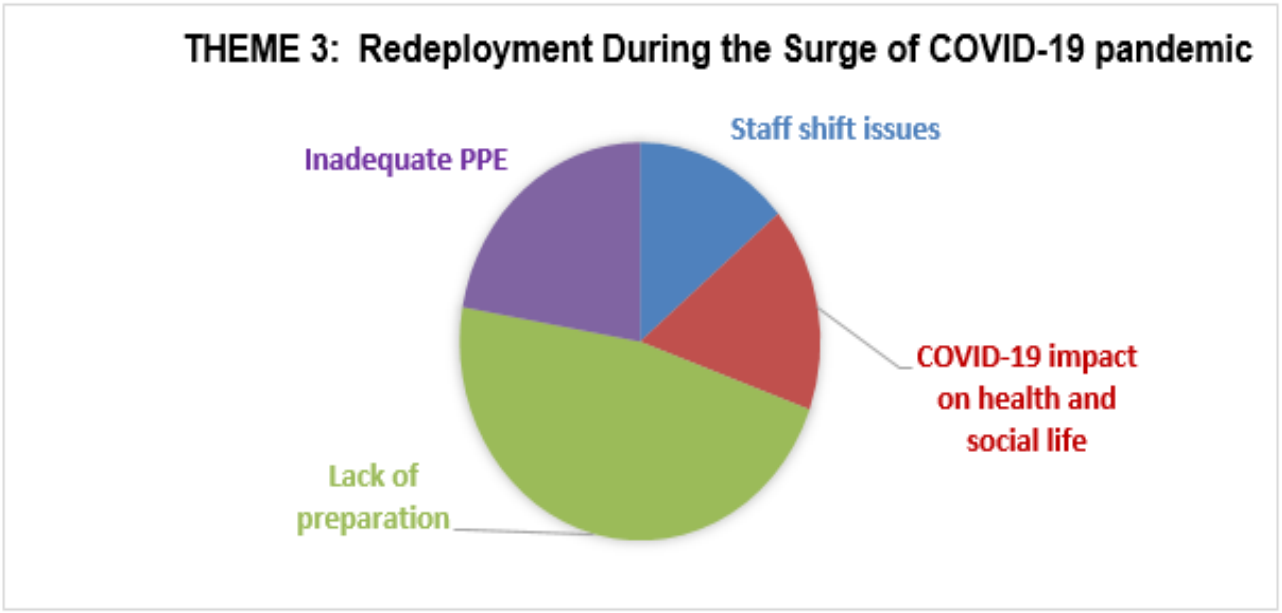


Figure (5.8). Categories of reported issues during the surge COVID-19 redeployment.

In summary, figure 5.8 above illustrated the participants' phenomena which includes: lack of information and miscommunication, lack of risk assessment prior to staff redeployment, insufficient PPEs which increased staff anxiety or fear of contracting the COVID-19 virus. The participants described both positive and negative experiences during their redeployment, which had a notable effect on their mental and emotional health.

Overall, this study suggests that the impact of redeployment on nurses' well-being was complex and multifaceted, with both positive and negative effects. However, lack of preparation and support during redeployment emerged as a significant issue which had a negative impact on many nurses' health and wellbeing.

5.2.5 Theme 4: Management and Leadership Factors

The fourth theme: *Management and Leadership Factors,* illustrates the effect of the Leadership or the management styles on the nursing staff wellbeing. The factors generated within this key theme are illustrated in table 5.7 below.

Theme 4: Management and Leadership Factors

Key themes	Frequent management turn over *(17%)*	Lack of support *(33%)*	Power dynamics *(50%)*	*Understaff (61%)*	*Stress at work (83%)*
P 1 – RN5	X		X	X	X
P 2 – HCA				X	X
P 3 – RN6					
P 4 – HCA		X		X	X
P 5 – RN6		X		X	X
P 6 – HCA			X		X
P 7 – RN5				X	X
P 8 – HCA			X	X	
P 9 – RN6	X				X
P 10 – HCA			X	X	X
P 11 – RN5			X	X	X
P 12 – HCA			X	X	X
P 13 – RN5	X	X		X	X
P 14 – HCA			X		X
P 15 – HCA		X		X	
P 16 – RN5		X	X		X
P 17 – RN6				X	X
P 18 – HCA		X	X		X
Total	3	6	9	11	15

*** Participant (P), RN (Registered Nurse), HCA (Healthcare Assistant)**

Table 5.7. Distribution on which participants discussed about Theme 4's subtopics.

Sub-theme 1: Frequent management changes at senior level

Seventeen percent of the participants revealed that they noticed a frequent change in management. Among the changes participant 1 stated:

> *"In the last 4 years, I think we've had a third manager. We've had frequent changes in management. And things have changed because at first we couldn't get any courses to do. And now we have courses to do it. It's taking a long time cause there's always no money, so things just come to a standstill" (***Participant 1, RN).**

Participant 1 discussed the frequent changes and highlighted the challenges they encountered in accessing courses. Another participant discussed similar experience and stated:

> *"When I came here and joined the team, there was a manager but left. Then there was a new manager in the role. Also, not enough Band 6 Nurse and they are hiring. The proportion of number of clinics/patients to number of nurses was low"* **(Participant 13, RN).**

As a new member of the team, participant 13 specifically described how the high staff vacancies and disproportionate availability of nurses to patients' ratio affected the nursing team.

Sub-theme 2: Lack of Support and Appreciation

Six participants (33%) discussed issues with not receiving support from senior managers. Although the interview questions were not related to the senior management team, the participants still expressed their phenomena regarding management, with a mixed feeling of both positive and negative experiences. For instance, participant 5 stated:

> *Yeah umm I feel supported with my colleagues and some managers and admin team as well. But getting a recognition for the hard work that we do on a daily basis, there is nothing much done like that. However, you do see, other senior manager, you know glorified with their work yet we are not. So we really feel under appreciated and even forgotten within outpatient"* **(Participant 5, RN).**

Participant 5 acknowledged support from both their colleagues and some managers. However, this participant felt that they were not given recognition for their hard work and further stated that, they were, “even forgotten within outpatient”. Similar feeling of frustration was also reported about by participant 13, stating:

> *“As uhh.. When I joined, I myself uhmm... actually I felt lack of support for my transition in this department. I think it’s more on the routine of the department like guidelines and protocols that they follow here in the department. I think that’s the areas where I was not supported by uhmmmm... by the senior” (***Participant 13, RN).**

Increased teamwork, peer support – Collaborative working, Support from the Organisation’s Charity.

Although some participants said they had insufficient support from the management, most said they were supported by their colleagues. For instance, participant 7 stated:

> *“So the challenges that I went through was that I didn’t get support because it was done in a different building and bringing patients’ treatment. I couldn’t get help, I couldn’t get support. Anyway, I have colleagues who are supportive, bringing items over. Otherwise if I have no one, I bring a big suitcase with the department manager, who knew this was happening. And eventually, I got sick. Like muscle pain, I just went up to the higher manager, the nursing manager who tried to get support for the department. Then COVID came. This went along till COVID came. Now it’s sorted. So it was a stressful period. Those were the challenges that were in the department”* **(Participant 7, RN).**

Although teamwork among colleagues was highlighted at the first part of this statement, however, participant 7 expressed that they escalated problems to their line manager for necessary actions. Another participant discussed good teamwork and stated:

> *“To be honest, we supported each other. But other than that, some managers were good, but not all of them were good. Some of them didn’t sleep days on end and just left the nurse in charge and one sister”* **(Participant 4, HCA)**

Participant 4 seemed contented with the support from colleagues and participant 16 added that they also received huge support from the Charity organisation, stating:

> *"Some colleagues were supportive because they think they are going through the same thing, so it's like I know what you're going to need to I'm going through it because sometimes we talk and you see that your colleague is passing through the same thing, feeling like, uh you know, rubbish you know, feeling like quitting. So like they will just say, oh, we know what you're going to meet you. I'm going through. So I felt supported by my colleagues. I felt supported from a Trust charity who sometimes they will bring some things to appreciate us the way we are, you know, working. So I felt supported that time, that side. But like I said from my I wouldn't"* **(Participant 16, RN).**

Sub-theme 5: Power dynamics

Half of the participants (50%) figure 5.7; page 202, discussed their experiences regarding power dynamics at their workplace. This sub-theme was separated into three smaller themes: (a) bullying; top-down, (b) undermined and (c) felt unsettled – frequently moved to various clinic areas. These are discussed below:

a) Bullying; top-down

Some participants expressed that they were bullied by their managers, one participant stated:

> "I *was working in a ward, ward X. There was a ward manager, she was known by everyone to be not the nicest to people, difficult, very rude and unsupportive. And she made it a point, that whenever she saw me. She would say something, look at me a certain way and make me feel not welcome and not part of the team. And she even locks the PPEs so we could just use one PPE. There was a point that I've had enough after that several interactions with this nurse. I then just went to my own unit manager and had to escalate because I felt like I was not able to work in that position. Because with the pandemic and the position, it was already hard enough without people trying to make the working environment even worse"* **(Participant 6, HCA)**.

It was good that participant 6 escalated the issues and negative experience to their department's manager who took appropriate action to mitigate the situation. Another participant also discussed about feeling bullied by their own department manager, P18 said:

> *"I've had an experience that the management told me when I did apply for my holiday, – which I will never forget and when I'm saying it I still feel very depressed, stressed I cried when I remember it and I was not given the holiday when I wanted and I was made to come back a day before my holiday – which is not meant to be, when I had time left. Something like that shouldn't be happening in this day and age, in ah uh a Trust like this. But people still will I say uhh I don't know the right word to use to be honest so that I don't (laugh) you know mistreat people unjustly like that"* **(Participant 18, HCA).**

During this study interview, most of the participants showed some emotions while narrating the encounter they had with their managers. The frustration came out on the description at participant 18 further stated:

> "*Something like that shouldn't be happening in this day and age, in ah uh a Trust like this"* **(Participant 18, HCA).**

Undermined

Some participants also expressed concerns on feeling undermined as they were not getting the support they needed from their management. One participant stated:

> *"Staff always get the blame. It's not only about patient. Staff should be looked at as well. I wish every manager, supervisor and leader that it's not only patients. Some patients have no manners, they treat you like nothing. I look around in Europe, and I see patients don't treat staff anyhow" (***Participant 10, HCA).**

Participant 10 expressed that the staff wellbeing was overlooked, and the patients were the main focus. This comment was also supported by another participant who stated:

> *"In my opinion, I don't think that most of the staff are being treated right in anyway because sometimes, line managers are biased and unfair. So when you tell them something you want to be done for everyone's beneficial.*

They will say they will do something but nothing's done. Only when something goes wrong then, they take things more seriously" **(Participant 18, HCA).**

In this case, participant 18 pointed out that sometimes, "line managers are biased and unfair". Unfortunately, with the statement given, this participant experienced a sense of mistrust of the managers.

Felt unsettled – frequently moved to various clinic areas

Some participants discussed being frequently moved to various clinical areas which could be either a positive or negative experience depending on the individual staff's goal and expectations in their role. For instance, participant 8 narrated:

"Rotation for me when I started as a part-time, they started taking me in different places. When they started rotating me, I was not ready. I do not know where to work in the morning you know like whenever I come. But slowly and gradually, I accepted in a way. Nowadays I'm okay in any department. Wherever they put me in the morning they say okay you're going to ENT and after one hour, two hours they will say. Oh we need you in the blood room. Then after half an hour oh we need you in oral. Nowadays It's okay but when it started it does affect me cause I was not mentally ready going in different places yes" **(Participant 8, HCA).**

Participant 8 expressed that they were frequently moved and rotated to other clinical areas, which created a feeling of not settled in the role, although eventually the situation was accepted but noted that it was very challenging and unsettling.

Another participant described in detail their experience rotation as follows, stating:

"I appreciate that but the only thing now that I find the other day I was going like a yoyo, and it was really getting me and I was like no this thing needs to stop when come in in the morning you have a sheet that tell you where you gonna be then once you start you have to clean the next thing you know you have to move from there you have to go here you have like fifteen minutes, then fifteen minutes you have move again and I'm like right now I nearly walk out one day because I'm like this is too much now is like I'm a ping pong and I don't want to be a ping pong…

I'm not here to be a ping pong I am here to help people to do the right thing make sure people leave the department wanting to come back more because of the treatment they receive not that because management moving you like a ping pong and sometimes it can get you frustrated" **(Participant 10, HCA).**

Being moved around many times in a day seemed frustrating to participant 10 who in reference to the rotation stated: *"I nearly walk out one day because I'm like this is too much"* **(Participant 10, HCA)**. This was a note of warning that frequent staff rotation might increase staff absence at work.

Sub-theme 4: Understaffing due to high staff vacancy level

Both registered nurses and HCAs discussed the difficulties they encountered due to understaffing, high staff vacancy levels, and insufficient staffing during their duty. Analysis of the participants' narratives identified a link between the problems which were intertwined such as additional workload led to lack of break times, which added to staff work-related stress and invariably increased staff sickness levels. For instance, participant 1 stated:

"That is a bit much because we have to do their clinic, including ours. We do not have enough staff, but we have to do it. Regardless of what is, we have to continue in doing it" **(Participant 1, RN).**

There was an indication that participant 1 felt they had no autonomy over their workload and had to continue despite the staff shortage. Another participant stated:

"So the staff has more for you to do. Before, they have 2-3 people to do the job. You can feel and know that it is due to shortness of staff. 'Lots of challenges, from not enough staff. So of course, you need to go around and they will say to you, you need to do this now because we don't have enough. We are short of staff. There's no leadership. It was chaotic, everyone was hysterical. And people are getting sick, so it was stressful to see this" **(Participant 12, HCA).**

It was apparent that Participant 12's experience had a significant negative impact on the well-being and the expression showed some level of frustration when the leadership aspect was narrated.

Another participant stated:

> *"Sometimes it's very busy. We need more staff to be honest. Ermm.. It would be easier if we have more staff to support each other. It could be very very stressful down there, in the blood room"* **(Participant 2, HCA).**

The feedback from participant 2 illustrated frustrating moments experienced in a particular outpatient department unit, the 'blood room', which got extremely busy and required more staff.

High staff sickness level, contributed to shortage of staff

The effect of understaffing and overworking had a knock-on-effect which could lead to high sickness levels and vice versa. Overall, 39% of participants discussed the challenges they experienced due to the staffing shortage. For instance, participant 7 stated:

> *"Challenges were staff shortage due to sickness, others were looking after family members. During pandemic, my colleague was away. There was just 2 nurses covering the department for xxxx patients"* **(Participant 7, RN).**

Participant 7 explained that staff shortage remained a key issue, hence the massive impact on the staff. Although staff could manage to carry out their roles, the quality-of-service delivery could be affected. Participant 17 also cited understaffing stating:

"There's a lot of staff was affected, went off sick, it means that we're understaffed. And with all this understaffing days and shifts, we end up like working more than we should be working" **(Participant 17, RN).**

In terms of the staff wellbeing factor, a triangulation with the NHS staff survey result was explored to find out the wider experience of outpatient workforce experience. The triangulation approach also saved as comparison, as this qualitative study had a limited size of participants unlike the quantitative staff survey.

Triangulation with NHS Outpatient Staff Survey Results for Years 2021 & 2022

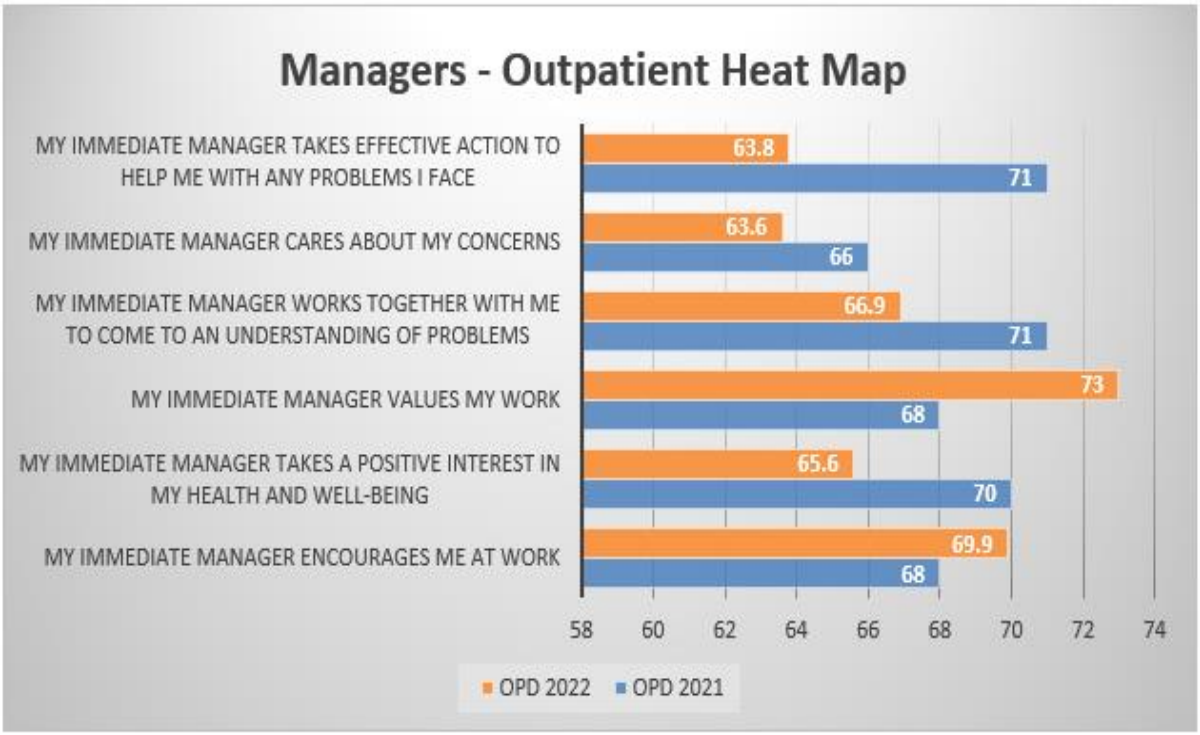


Figure 5.9: Comparison of the NHS Outpatient Staff Survey result for 2021 and 2022.

Figure 5.9 illustrates the NHS staff survey results within the researcher's organisation which showed a decrease on almost all the categories except for these two: 'My immediate manager values my work' from 68% to 73% and 'My immediate manager encourages me at work' from 68% to 69.9%. These two categories were specifically work-action-related, focused to maximise the staff work performance. Overall, the rest of the categories which are directly linked to management support and staff wellbeing had lower and diminishing performance than the previous year-2021. In comparison to this outpatient nursing study, most of the participants expressed the lack of support from their managers, similar to the findings from the outpatient nurses' qualitative study. However, 33% of the participants in this qualitative study reported that they felt supported by managers.

Another domain in terms of staff wellbeing at work was used in triangulating for this qualitative outpatient nursing data in form of staff survey report - 2021 and 2022 (figure 5.10) below. The two aspects that received positive reports were, 'I receive the respect I deserve from colleagues,' and 'team members' understand each other's roles.

This survey findings correlate with the outpatients nurses' qualitative study, were participants reported that their colleagues were very supportive.

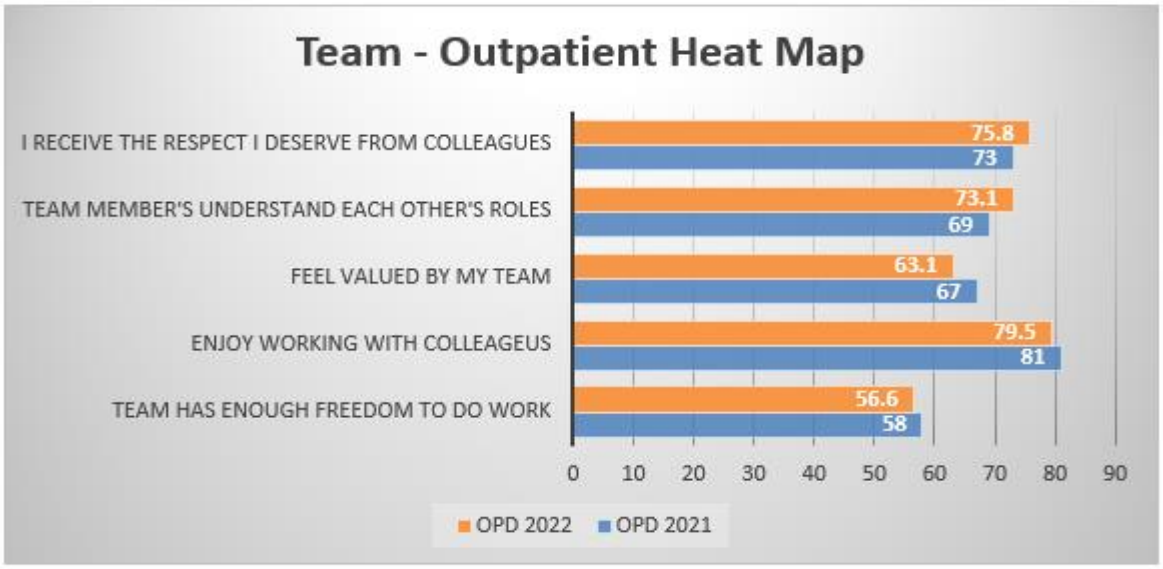


Figure 5.10: Comparison of NHS Outpatient Staff Survey result for 2021 and 2022.

Participant 7's narrative was an example of significant support, team and collaborative working within colleagues which was similar to the outpatient NHS Staff survey result. Participant 7 stated:

> *"With my colleagues, we did supported each other, we shared ideas when we have meetings. We can have one to one meeting but because there was no meeting going on as usual, the team will support each other whilst we work"* ***(Participant 7).***

The positive teamwork experience resonates with some participants who said they received support from their colleagues and could positively impact the staff job motivation and well-being at work.

Sub-theme 5: Stress at work

Work related stress was discussed by most of the participants and one stated:

> *"So much more paper work, so much more computer work so much more was added, so the patient focus was lost, and you'll find you're like a headless chicken running up and down trying to sort some things out, and it's not enough time. So you go home stressed because nothing's left and done. And you come tomorrow and there's more issues and problems"* **(Participant 12, HCA).**

This statement described how work overload and rotation to new teams caused stress for the staff. For instance, participant 6 stated:

> *"So, it was it was kind of we just didn't know what was happening. So that was one of the challenges that we had. Umm But then also, meeting new team members. So for example everyone was stressed and no one really knew the guidelines was at that point"* **(Participant 6, HCA).**

Participant 6 explained how the confusion brought stress to the staff which showed that excessive workload and confusion could lead to increased staff stress level.

Reduced staff morale

The findings from this study showed a significant percentage of participants (67%) who reported having experienced reduced staff morale and these participants expressed that management support was lacking, which reduced their staff morale. For example, participant 11 stated:

> *"The majority of us would say, we lack support – especially when we need it. When we try to bring attention for something, we don't know who to turn to. Even with our senior manager, it's hard to air out our views"* **(Participant 11, RN).**

This participant expressed a feeling of helplessness and similar experience was reported by participant 14 who said:

"It's not very supportive. Not very supportive at all, the same thing over and over the certain individual and nothing happens. No one is listening or hearing. So I don't feel very supportive to be quite honest" **(Participant 14, HCA).**

In this instance, participant 14 expressed the same sentiments stating:

> *"Yeah, it's. Yeah, I've already mentioned so many of them positively. Like I said, I got support from colleagues. Some colleagues were supportive because they think they are going through the same thing, so it's like I know what you're going to need to I'm going through it because sometimes we talk and you see that your colleague is passing through the same thing, feeling like, uh you know, rubbish you know, feeling like quitting.*

So, like they will just say, oh, we know what you're going to meet you" **(Participant 16, RN).**

Despite the workplace challenges, participant 16, as a registered nurse showed some resilience and felt positive in the role which included the increased nurse-led activities. In view of the narratives, the close working relationship with colleagues seemed to be a source of strength to the nursing team.

Summary

The fourth theme discussed leadership and management factors which highlighted the various aspects of the participants' experiences which included frequent management changes and power dynamics as illustrated below, figure 5.11.

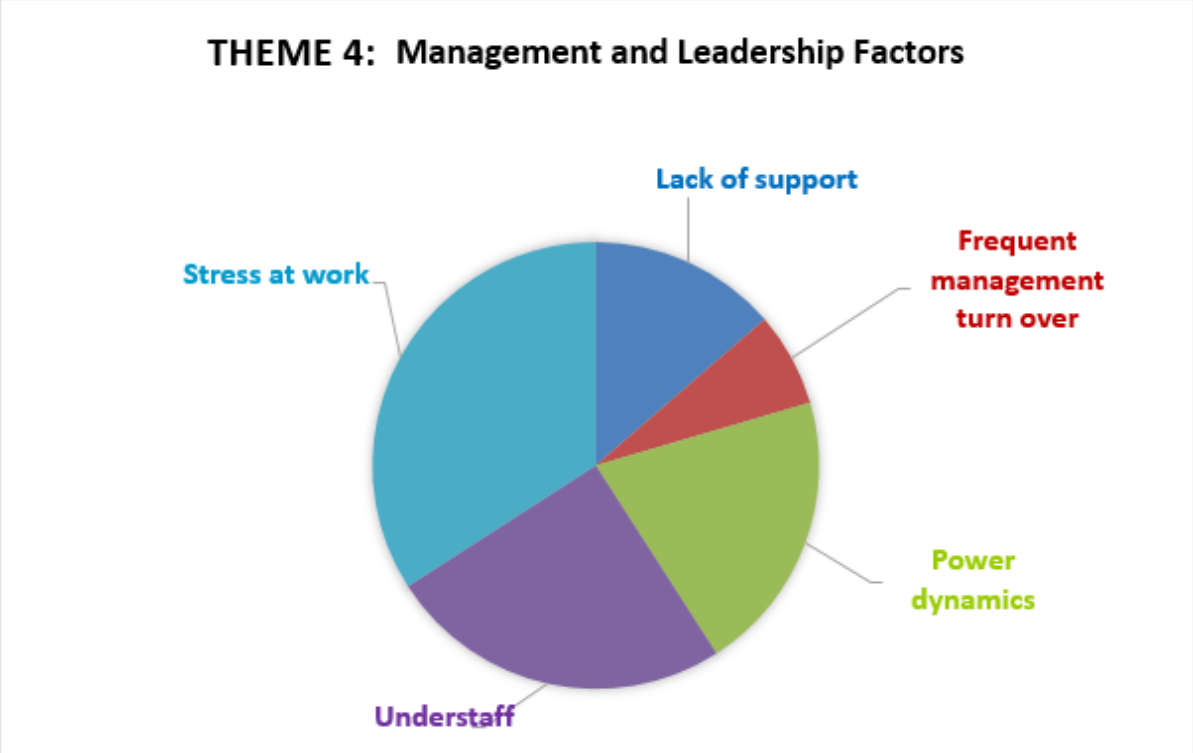


Figure (5.11). Categories of participants' discussions about the sub themes of Management and Leadership Factors.

This outpatient study suggests that management and leadership factors have a significant impact on the staff well-being. Overall, the participants discussed several factors related to management and leadership that affected their well-being.

Although some positive leadership practices such as management support and recognition were reported to have a positive impact on a negligible number of nurses' well-being. In contrast, power dynamics were identified as a significant factor affecting nurses' well-being.

5.3 Summary and conclusion of chapter 5

This project explored the impact of service changes on outpatient nursing staff job motivation and wellbeing. Based on the findings and in line with the study's research questions, some key themes were generated. These key theme include; innovation and new ways of working within outpatient services, lack of training, development and career development for the vast majority of participants.

The participants' narratives indicated that there was no mechanism or process in place to facilitate staff training and development. Management and leadership factors were highlighted which included power dynamics, some elements of lack of inclusiveness. Although some good experiences and benchmarks were seen in this study, however, majority of the participants highlighted the lack of training and development which impacted on the outpatient nursing staff's job motivation and wellbeing, requiring strategic actions.

Chapter 6: Discussion of findings

6.1 Introduction

This chapter modelled the theories of job motivation in relation to the findings from this study. As previously discussed, this project explored the 'impact of service changes on outpatient nurses and health care assistants' job motivation and wellbeing', using the following research questions.

1. How would the service changes and new ways of working impact on outpatient nurses and health care assistants' job motivation and wellbeing?
2. How could the experience of outpatient nurses and health care assistants be determined in relation to the unprecedented COVID-19 pandemic and the new ways of working, due to the pandemic?
3. How would the outpatient nurses and health care assistants be supported and motivated during and after the service changes?

Also linked to this chapter is the data analysis method by Colaizzi's (1978), used in processing the key themes. The findings from the data were grouped into key themes, as well as for identifying and highlighting any gap in knowledge with its relevance to this study. The implications for practice were also outlined followed by consideration of the limitations to the study and possible direction for further research.

6.2 Discussion: Theme 1- Nurse-led activities and new ways of working

This study aimed to shed light into how outpatient nursing staff experienced service changes and its impact on their job motivation and wellbeing. Most of the participants discussed new ways of working which included collaboration with the acute and primary care settings. In recent years, the National Health Service (NHS) United Kingdom has implemented new ways of working for nursing staff to improve patient outcomes. With the outpatient transformation, one of initiative is the introduction of new ways of working and a more integrated, personalised model and coordinated care within local communities (NHS England, 2022).

Due to the NHS initiative on coordinated and collaborative care network, community services have been established called Community Diagnostic Centres (CDC). Procedures like skin prick tests, patch tests, mole mapping and other nurse-led activities which outpatient nurses are specifically trained to perform take place in the CDCs. Hence, the outpatient nurses work between the acute hospital and the community services to carry out these procedures are extended nurse led activities. This new model of care delivery involves multidisciplinary teams working approach to address the health care needs of the local population, with the nursing team playing a key role in providing proactive and preventive care.

Another new way of working is the adoption of 'digital nursing' practices, which involves the use of technology to support nursing care. For example, the use of electronic health records and Telehealth can help to improve communication between healthcare professionals and provide more efficient care for patients (Konttila et al., 2019). The COVID-19 pandemic has accelerated the adoption of more 'digital nursing' practices. When implementing and using digital solutions, the NHS needs to take account of the workforce, especially the clinical teams (Farrell & Sood, 2020). The findings from this outpatient nursing study highlighted some new clinical processes and functionalities such as electronic patients' documentation.

New shared information technologies were implemented to reduce errors by eliminating the need for hand-written notes thereby reducing the risk of transcription errors (Institute of Medicine, 2012). The participants in this study discussed the implementation of Cerner in their workplace. The Cerner system is designed to support clinical workflows, improve patient safety, and enhance communication and collaboration among healthcare professionals (Lechleitner et al., 2003). Changes to the outpatient conventional work environment such as the traditional way of working has been replaced by a modernised environment in which work can be undertaken in a variety of venues due to developments in Information and Communication Technology (ICT) (Cole et al., 2021). Staff in this study revealed that there were many meticulous processes previously used when paper documentation existed.

In terms of nursing training, a report by the NHS Digital Academy stated that, training nurses in the use of technology is critical to enabling them to deliver high-quality patient care in a digital age (NHS Digital, 2022). The report recommended that nursing education programmes incorporate digital literacy and training into their curricula to prepare nurses for the changing landscape of healthcare technology. The NHS has also established the Digital Ready Workforce Program, which aims at providing digital skills training to NHS staff, including nurses, to support the delivery of digitally enabled care (NHS England, 2022). Findings from this study suggest that outpatient nurses embraced the new digital ways of working.

Working across other hospital sites / Community Care / Staff Rotation

Some participants in this study expressed that they worked across hospital sites which has become a common situation as NHS nurses work across other hospital sites and outside the acute hospital settings, such as community health centres. According to Brennan (2017), high role expectations and difficult working conditions place some nurses in challenging trend of healthcare requiring resilience to progress professionally in the face of adversity. The NHS Long Term Plan (2019) states that nurses will be able to work in a greater variety of settings, including care homes, schools and prisons, as well as working in multidisciplinary teams that bring together health and social care professionals (NHS, England, 2019).

Working in various places can have both positive and negative impacts on NHS nurses. However, it can broaden nurses' experience and knowledge, enabling them to develop new skills and competencies which provide staff with opportunities for career development, where the support mechanism is in place, although, the unsettling situation could affect staff wellbeing and job satisfaction. According to a survey conducted by the Royal College of Nursing (RCN) in 2018, 56% of NHS nurses reported feeling under significant pressure due to staff shortages and increased workload, which can impact their ability to provide safe and effective care (RCN, 2019).

Staff rotation can provide opportunities for professional development and skill acquisition, as well as promote team building and collaboration among nurses. According to a study by Duffield et al., (2009), rotation of nurses can provide opportunities for learning new skills, enhancing clinical practice and reducing professional isolation (Duffield et al., 2009). However, Murrells et al. (2008) asserted that frequent rotation can lead to increased stress and burnout among nurses, decreased job satisfaction and lacked continuity of care delivery. Additionally, working in different settings can lead to fragmentation and poor communication. Some studies found that, "frequent changes in working environment, role and shift pattern can cause stress and contribute to nurses' intentions to leave their job" Murrells et al., (2008 p. 54). While staff rotation can offer benefits to nursing staff and patients, it is important to carefully balance these benefits against potential negative impacts to consider the individual needs and preferences of nurses when implementing rotation policies in NHS organisations.

Improving support for patients' self-management

Outpatient registered nurses carry out health improvement activities and promoting the patient's health is embedded in clinical protocols which formed the skills-set and clinical core competencies for this workforce. Therefore, educating and empowering patients in the support for self-management within the outpatient setting is an ongoing patient care pathway. An example is the NHS England's Long Term Plan (2019) which states that health and care professionals will support people with long-term conditions to manage their health more effectively, including through self-care and self-management, with greater use of technology and more personalised care plans (NHS England, 2019). Furthermore, the NHS also emphasised the importance of nurses in promoting self-management, stating that nurses are well placed to support self-management for patients with long-term conditions, through education, coaching, and goal setting (England NHS Improvement, 2020).

This outpatient study found that some staff rotated from acute to community care settings on ad-hoc basis, to deliver health improvement activities and promotion of patients' self-management. The drive for nurses to work in the community settings was to reduce patients' journey to hospitals. However, the staff rotation was multifaceted with benefits and challenges which could be very unsettling for the nurses.

Increasing Virtual Clinics

Virtual consultations have been found to significantly improve access to healthcare services, reduce patients' wait times, and increase patient satisfaction which can improve work-life balance and reduce travel time and costs (Kruse, 2021; Farre et al., 2023). Although some patients could be seen remotely, the nature of some nursing care to patients could not be carried out virtually, hence, face to face sessions are required for physical healthcare interventions. Despite the benefits, virtual consultations can pose challenges for nursing staff, including issues with technology and difficulty in establishing rapport with patients, and concerns about care quality provided remotely (Greenhalgh et al., 2010). Most importantly, better-quality care could be achieved with collaborative community-based face to face services than virtual consultations, although increased workload and responsibilities may apply (Doolin, 2016).

6.2.1 Skill-mix reviews (changes in roles)

Outpatient services like most healthcare departments evaluate the employees' skills and competencies to align with the service needs aimed to optimise the service efficiency. In this study, 5 out of 8 participants reported some changes in their roles following establishment or skill-mix reviews. The NHS pay system, Agenda for Change (AFC) (figure 6.2, p. 226) differentiates bands that determine the roles and pay of the staff and within the AFC. The participants in this study comprised of health care assistants, and nurses within bands 3, 5 and 6. and there was no band 4 role from the implementation of the nursing pay bands. Therefore, NHS introduced a new role, Ball et al., (2019), within the nursing profession as nursing associate, to fill in the gap between band 3 and the band 5 roles.

Griffiths and Robinson (2010) asserted that national regulation of such bridging roles would improve patient safety by ensuring mandatory, standardised training, controlling access to employment, and clarifying the scope of practice. However, new roles in healthcare are associated with widespread ambiguity and challenges (Wakefield et al., 2009). One of the participants discussed the new band 4 Nurse Associate (NA) role within the outpatient establishment, as a change in their workplace, without elaborating on how this new role fitted into the nursing skill-mix.

In this role, the NA is expected to work with the lower banded staff (HCAs) and registered nurses, and the role is considered as a stepping stone for HCAs to become registered nurses Peate, 2023). The nurse associate role was introduced in the National Health Service (NHS) in England in 2017 as a new member of the nursing team (Glasper, 2020). Despite the expansion of roles such as NA across the breadth of health and social care services (Kessler et al., 2021), maintained that, providers are struggling desperately to recruit and retain staff with the right skills and the right numbers to meet the increasing service needs. Another benefit of the nurse associate role is that it provides a career pathway for healthcare assistants to become registered nurses (Glasper, 2021), which could address and alleviate the shortage of registered nurses in the NHS and provide opportunities for career development and progression.

However, there are also several challenges associated with the nurse associate role (Kessler and Nath, 2019) and one of the challenges is the potential role conflict and overlap with existing nursing roles. Therefore, RCN highlighted the importance of clarifying the scope of practice and responsibilities of nurse associates to ensure they work effectively within the wider nursing team (RCN, 2019). Another challenge is the need for adequate training and support for nurse associates. It is important to ensure that they have the necessary knowledge and skills to provide safe and effective care to patients. Moreover, the Health Education England (HEE) and NHS Long Term Plan emphasised the importance of developing a robust education and training program for nurse associates (Long Term Plan, 2019).

6.2.2 Increase in nurse-led activities

The National Health Service (NHS) in the UK has been exploring ways to increase the involvement of nurses in leading outpatient activities (England NHS Improvement, 2021). This initiative was driven by the need to enhance the quality of care provided to patients and improve efficiency in outpatient services. Some participants discussed their various roles which included nurse-led activities. One way in which nurses are being empowered to lead outpatient activities is through the introduction of nurse-led clinics (England NHS Improvement, 2021).

These clinics are designed to provide a more efficient and effective service for complex clinical cases, with nursing teams taking on a greater role in a range of services such as chronic disease management, medication review, and health promotion. A study by Goncalves et al., (2022). Patients with multi-morbidity in hospital, due their complexity, benefit from a nurse-led care management model. However, there is no evidence that nurse-led activities is a pathway for the nurse career progression.

New ways of working	
Outpatient Nurse-led activities	**Examples**
Dermatology nurse–led minor skin procedures.	Warts removal, Cryotherapy, Phototherapy, and patch tests.
Nurse-led mastoid ENT clinics	Skin prick tests
Nurse-led Macular Eye clinics	Administration of intravitreal injections, Visual Fields and Biometry measurements.
Managing caseload for cancer treatments	Hormone injection clinics
Vascular Dressing clinics	Use of Dopplers in diagnosing Deep Venous Thrombosis (DVT), varicose veins compression bandaging, complex ulcer wound dressings.
Day case Rheumatology clinics	Infusion administration in conjunction with the MDT. Administration of steroid injections.
Haematology nurse-led clinic	Management of blood transfusion, venesections and administration of injections. Thrombophilia screening tests.
Nurse – led patients' pre-operative investigations	Health Promotion and Improvement activities - Education and Preventive healthcare
Cardiology Outpatient risk assessments	Triaging patients such as requesting for pts' diagnostics Echocardiogram, ECG etc. prior to consultation.
Gynaecology nurse-led clinics include	Early pregnancy screening, smear test clinics, HRT implant, pregnancy advisory sessions and general gynaecological screening

Table 6.1 **New ways of working**

Although, increasing nurse-led activities (table 6.1) in outpatients can provide numerous benefits for patients and the healthcare system, it is crucial to design a structured academic continuous professional development pathway or model such as Training Needs Analysis (TNA) to enhance the outpatient nurses' evidence-based practice and career progression.

6.2.3. Working out of scope of the role.

Some participants in this study discussed how they undertook tasks which they deemed out of scope of their role, and they felt pressured and challenged in learning the new skills. Whereas some staff perceived that learning new tasks enhanced their clinical skills. Great emphasis is placed on professional development which is defined as the development of an employee within an organisation according to the needs of the organisation and the results, capabilities, and preferences of the employees (Armstrong and Taylor, 2020). With changes in practice, registered nurses with increased years of experience reported higher levels of resilience which enabled them to manage their stress, accommodate, and recover from the change to their working practices (Hart et al., 2014).

Recently, research findings suggest that developing a life-long learning mindset in employees enhances both objective and subjective career success (Sullivan and Page, 2020). More so, employee professional development increases job satisfaction and reduces turnover (Glazer et al., 2019). This observation was corroborated by further evidence suggesting that older nurses experienced less stress levels (RCN, 2019), whereas younger, less experienced nurses experience increased stress level (Robert, 2021). Despite less positive elements of redeployment, some staff used redeployment as an opportunity for positive professional fulfilment (Achour and Ballantyne, 2022).

6.2.4 Excessive workload

Barpanda and Saraswathy (2023) highlight that chronic excessive workload could be detrimental not only to staff health and wellbeing but also to the staff ability to provide safe care to patients. In this study, seven participants (39%) discussed workload as being excessive and challenging. The knock-on-effect of staffing shortage could have resulted in excessive workload for the available nursing staff on duty, which was highly expressed by these participants in this outpatient study.

For instance, **participant 1 (RN)** said, "*We do not have enough staff, but we have to do it. Regardless of what is, we have to continue in doing it.*"

Moreover, **participant 17 (RN)** stated, "*When the COVID started, a lot of staff were affected, went off sick, it means that we're understaffed. With understaffing, we ended up like working more than we should be working.*"

Understaffing could have an undesired effect on the quality-of-care delivery by the nursing team and needs to be addressed. Wilkinson-Brice (2022) advocates for the government to work hand-in-hand with various NHS organisations to mitigate against the excessive workload issue which nursing staff are experiencing. Hence, it is essential to mitigate or completely address this problem and improve staff wellbeing.

In terms of the health and safety aspect of the NHS staff survey results, there were similar downward trends an illustrated-on figure (6.1) below, which showed the performance to be lower than the pre-pandemic years, followed by a much larger decline between 2020 and 2021.

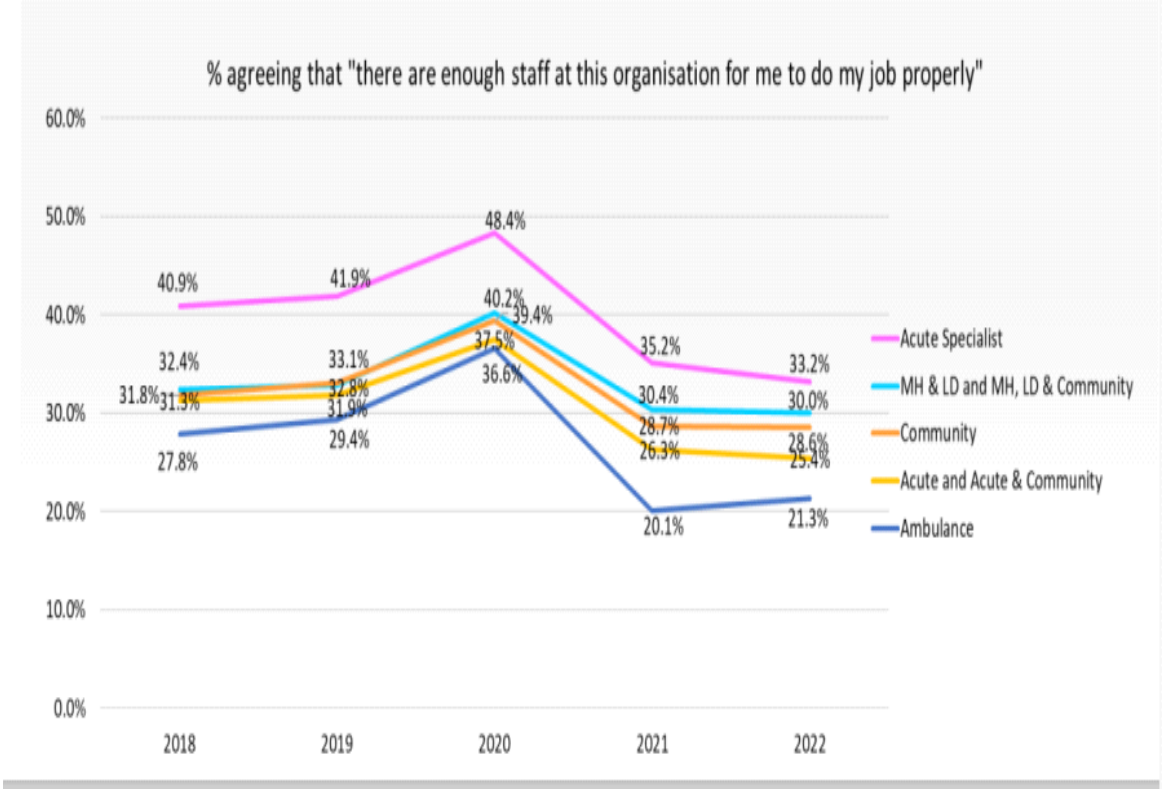


Figure (6.1) Source: [NHS-Staff-Survey-2022-National-briefing.pdf]

Overall, this qualitative outpatient nursing study showed a greater percentage of the participants who reported understaffing as a significant issue.

6.2.5 Lack of staff break times and issues with getting annual leaves

Table 5.4; page 178 showed that 22% of the participants discussed the difficulties they encountered getting their entitled breaks, and sometimes missing their break times entirely. The NMC (2017-2020) Peoples Strategy document states that leaders and managers should create a culture in which employees feel valued and appreciated that fosters agile ways of working that meet the needs of staff and the organisation alike. As a caring organisation, valuing people's wellbeing through collaborative working and effective compassionate leadership would be beneficial to both service users and providers.

6.3 Discussion: Theme 2: Lack of Career Development and Progression

One of the key themes identified from the interview was lack of training, development and the limited scope for career development. According to Mayo (2000), employee development includes the continuing generation and exchange of knowledge and experience, is the key driver of value growth in any kind of organisation. Therefore, training should have specific goals within these three categories: (1) increasing the personal effectiveness of employees (such as competence improvement); (2) increasing the added value being achieved currently (such as the use of new systems and better methodologies); and (3) generating future value such as, developing the expertise and potential of people (Mayo, 2000). Most importantly, Training and development practices enable employee skill development facilitating effective change implementation (Maheshwari & Vohra, 2018).

Overall, findings from this study highlight the lack of Training Needs Analysis (TNA) and CPD for the greater percentage of the participants which impacted on their career development opportunities. Based on the context of service changes, the pace of change, uncertainty, unpredictability and ambiguity of events with the intensified development of modern technology, the work environment is dynamically shaped (Williams, 2020). With these influencing factors, it is critical to examine the human factor and include a culture of lifelong individual nurturing and development. Bersin, (2018) asserts that human capital development is no longer just a set of organised, time-based activities, rather it is aimed at changing human behaviour and development which encourages teaching and learning work environment.

6.3.1 Limited training and career progression opportunities

A vast majority of the participants (83%) in this outpatient nursing study revealed that they had little or no access to non-mandatory training which hindered them from achieving career progression. Most of the participants expressed that they '*felt stuck in the same position*' and most of their training was mainly the organisation's mandatory training which had lesser benefits in terms of acquiring qualifications. However, 17% of the participants reported that they had access to career progression opportunities which allowed them to grow further and garnered them career advancement.

This qualitative study also shows that the outpatient nursing staff are disadvantaged in their training and development when compared with the NHS national staff survey 2021. Evidence from this outpatient nursing study highlight lack of the presence of Training Needs Analysis (TNA) for the outpatient nurse and further enquiry confirmed that the outpatients' nursing establishments lack Education Facilitator's role. Secondly, there is a disproportion of representation in the staff designations, as shown on demographics table (6.2). Although the majority of the junior positions of band 3 HCAs and band 5 registered nurses were occupied by the African/Caribbean group of participants, yet, there was no representation at band 6 level.

	Variables of participants	Working Definitions (Attributes)	Band 3 HCA	Band 5 RN5	Band 6 RN6	Total
1	Respondent – Type	Registered Nurses (RN) & Health Care Assitants (HCA)	9	5	4	18
2	Gender	Males	2		2	4
		Females	7	5	2	14
		Others; please indicate				0
3	Ethinicity	Origin				
		African / Caribbean	4	2		6
		Asian	3	1	2	6
		White / Caucasian	2	2	1	5
		Undisclosed			1	1

Table 6.2 Demographics variables of participants.

Literatures reviews suggest that there is still a huge gap in equality, diversity and inclusion within the NHS workforce, for the BAME attaining a position of Very Senior Manager (VSM), figure 6.2 below. Where nursing staff at the lower levels are deprived of the training and development opportunities for career development, as the findings show in this outpatient nurses' study, will there be a fair chance for this group of NHS workforce attaining the VSM position?

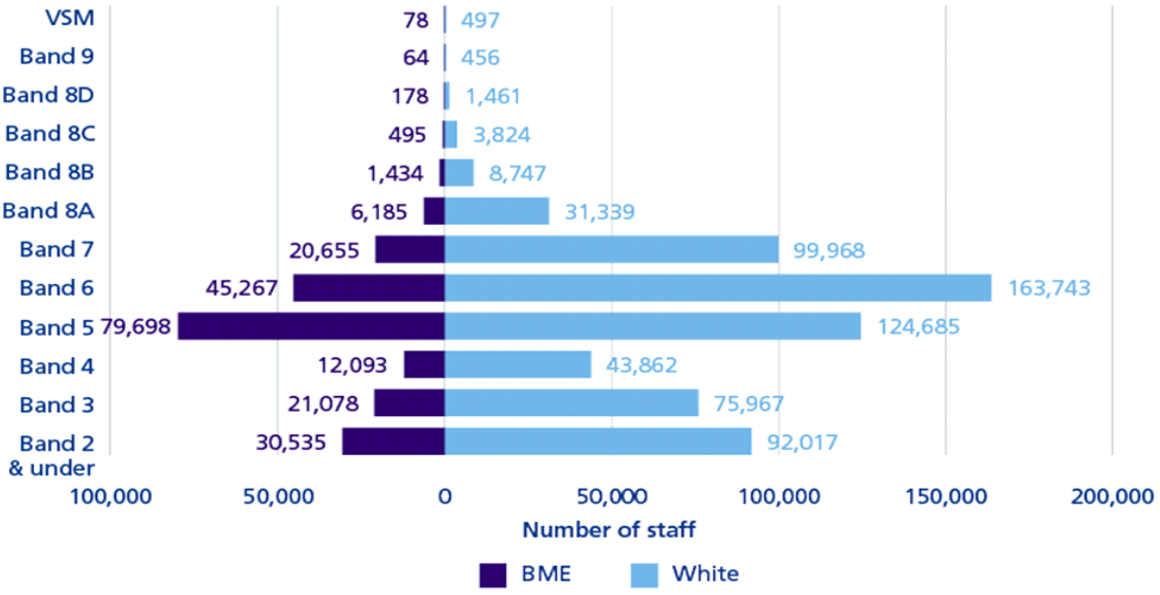


Figure 6.2: Agenda for Change (AfC) bands: Clinical (headcount)

Source: NHS England » NHS Workforce Race Equality Standard (WRES)2022 data analysis report for NHS trusts.

According to the NHS Constitution for England (Department of Health and Social Care, 2021), 'high-quality care requires high-quality workplaces' and makes a pledge to provide 'a positive working environment' for staff in addition to the legal right that 'you are treated fairly, equally and free from discrimination of all types (England NHS and NHS Improvement, 2021). Previous national policies such as the NHS People Plan (2000) and recently in year (2020) have reinforced commitments to improve diversity and inclusion. However, compliance is not the only rationale to act, there is also an undeniable moral obligation and everyone has a role to play in an organisation's race equality and inclusion effort – through leadership to address inequalities (Ross, 2020).

Historically, the perception of outpatient clinical activities was deemed as non-critical, nevertheless, with the changing trend in healthcare, complex cases and procedures are undertaken within the ambulatory outpatient care settings. The lack of outpatient nursing staff's access to formal training and development could reduce the chance of the staff attaining their full career potential. Hence the outpatient nurses need to access TNA for their career progression.

The Care Quality Commission (Limb, 2018) has recognised evidence on the link between workforce equality and inclusion, and the quality of care for patients. The correlation between diversity and quality of care is also suggested in the 2019 Workforce Race Equality Standard, with better-performing trusts reporting a greater percentage of staff recommending care at their trust as part of the Staff Friends and Family Test. Similarly, analysis of the NHS Staff Survey (Waters, 2022) suggests that, in organisations where staff undesired experience from colleagues, or perceive unequal opportunities for career progression or promotion, patients are less likely to be satisfied. There is also strong evidence that a more diverse workforce results in improved staff outcomes, retention, and engagement (Kline, 2019). Moreover, where staff receive fair and equitable treatment, and encouraged to contribute to the effectiveness of that group, care provision and organisational performance are increased (Kline, 2019).

Achour et al., (2022) asserts that, the nursing workforce considered redeployment as a professional and moral requirement and even an opportunity for development, however, the lack of organisational commitments and support is what makes the staff less motivated, anxious and incapable to be redeployed. Due to the changing trend of the NHS, services previously managed as in-patients care are now delivered as day care procedures which the outpatient multidisciplinary team operation manages. Similarly, some participants in this study reported that they were expected to perform additional tasks which were out of scope of their role, with minimal support. Organisations have a responsibility to provide their employees with opportunities for professional development, which could lead to increased job satisfaction, employee retention, and overall organisational success.

As noted by Achour and Ballantyne (2022), employees who receive adequate support and resources engage in the workplace and have clear communication and expectations about the goals and thereby benefits from professional development. From Armstrong and Taylor's (2020) perspective, professional development is usually defined as the development of an employee within an organisation according to the organisational needs and capabilities as well as the preferences of the employees.
In relation to this study's participant's feedback, nurses who experienced increased scope of practice at workplace such as autonomous nurse-led activities felt the need for further structured formal professional development to facilitate their career progression. In line with the NMC (2018) mandates, nurses must participate in appropriate learning underpinned by evidence-based practice to gain the specialist skills needed to maintain patient safety. Therefore, the nursing workforce strategy should embed all nurses' personal and professional development accordingly to achieve the best quality care (RCN, 2019).

However, the findings from this outpatient nurses' and HCA's study show that, only 17% of the participants were satisfied with their training and development, while 83% reported that they experienced lack of access to the relevant courses when they requester. The experience of two registered nurses with the same job title and band narrate their respective accounts as follows:

> *"Even my manager, my first manager, even trying to convince me to do this course: nurse prescribing. But when I am about to study, the two of us are gonna to start. So our manager said okay not this time because we don't have staffing"* **(Participant 3, RN).**

Unfortunately, this staff has missed an opportunity which impacted on career development as well as job motivation and wellbeing. Another staff even initiated their own training and said:

> *So I expected more training which was not happening. I remember I initiated self-initiated training myself when I discovered that nothing was coming forth and I got an email and I got an ah opportunity and I was denied opportunity because they didn't have mentor. I was denied opportunity because they didn't support. So that was very discouraging* **(Participant 16, RN).**

From Participant 16's narrative, the learning and development needs were unmet which indicates the necessity for a designated mentor or Education Facilitator to be assigned to the outpatient nursing teams. Under the Nursing and Midwifery registered members' continuous professional development (CPD), access for funding is available through the respective NHS Nursing Education departments. The other registered nurse 'felt lucky' that their department had a proactive and good support system for staff training and development and reported as follows:

> *"Well, as I was saying umm, we get good support from our, uh for training. Uh, and learning development in terms of the work that I'm doing and it's not like a something I need to beg for. It's always handed to us like this is something offered you like it. Can you do it? And that's how it works. So I feel like I'm lucky"* **(Participant 9, RN).**

Training and development for nursing staff should not be by luck or chance. TNA and CPD are relevant to NHS nursing staff in various ways as both help in identifying areas where staff training is needed, enabling the development of targeted training programs that meet the staff learning needs and service improvement plans. TNA is a crucial aspect of developing nurses' skills and knowledge, moreover, research evidence suggests that to support their professional development (Holloway et al., 2018).

The benefits of TNA in improving nurses' competencies and job satisfaction for nurses cannot be over-emphasised and this strategy has resulted in significant improvements in nurses' knowledge and skills, as well as their job motivation levels (Dening et al., 2019). Nurses are expected to be dynamic in response to changing health care needs. This expectation requires the purposeful and effective development of nursing workforce capability through continuing professional development (CPD). Hence, an evidence-based approach to training needs analysis (TNA) is a highly recommended, yet an often missing first step in designing a CPD strategy for service improvement (Holloway et al., 2018). The findings from this study highlight a significant lack of TNA process within the outpatient nursing teams which greatly impacted on their training and career development opportunities. To bridge the gap and foster a more inclusive and supportive environment within the nursing profession, urgent action is required to promote career progression.

6.3.2 Team and collaborative working

In this study, elements of positive team and collaborative working were reported by the participants, within the various teams which helped reduce staff stress levels despite inadequate management and leadership support. Collaborative working with the organisation's Education Facilitators to complete the TNA for nurses would enhance the process. Holston-Okae and Mushi-Brunt (2018) espouse collaborative team-working along with effective management and leadership style to achieve high staff retention. Moving forward, a multidisciplinary team approach, collaborative working with key stakeholders and effective compassionate leadership would be beneficial to patients and the outpatient nursing team.

A friendly-user workplace is created when staff endeavour to work with each other thereby supporting and strengthening the team which results in synergy. Moreover, in terms of service productivity, it is well established that within an effective team, every one achieves more especial with the appropriate combination of leadership styles. Literature review suggest that staff tend to stay in the jobs where they appreciated and supported. Other studies suggest that multiple factors trigger intentions to leave and actual turnovers, such as job dissatisfaction, organisation misfit, job mobility, negative working environment, unfavourable organisational culture, and lack of value-goal congruence (Al Mamun and Hasan, 2017).

This study's findings suggests that majority of the nursing staff were self–motivated, resilient, engaged in teamwork, and were able to adapt to the ward environment, despite all the challenges they experienced especially during the surge of the COVID-19 pandemic. Studies reported by Holston-Okae and Mushi-Brunt (2018) advocate that organisations should focus on increasing employees' job motivation, reduce staff turnover and increase productivity.

In terms of outpatient nursing staff, their career needs should also be met. The NHS leaders are expected to take on different roles in a complex and changing world while accepting the uncertainty facilitates the problem-solving process with proactive support that can help build the practitioners' resilience (Baldwin et al., 2022). In any case, the participants in this study expressed the need for support in terms of leadership visibility, relevant training and development with clinical supervision which could have positively enhanced their experience in the workplace.

6.3.3 Datix - Reported incidents without feedbacks/outcomes

Some participants discussed their frustration over logging incidents on a Datix (incident reporting system), whereby the formal complaint should be escalated to the relevant managers responsible to investigate and respond with actions on the concerns. Incident reporting is an important aspect of clinical care which highlights safety issues that need addressing and supports learning to keep our patients safe from avoidable harm (Rodger, 2021). However, some of the participants reported that they did not get feedback from the incidents to enable the learning process to take place for possible service improvement. For instance, one of the most common incidents that staff discuss is delayed transport system for patients which stated:

> *We do a lot of Datix on different transport delays, clinic delays, umm estate issues. But nothing much get back to us. We do not get much response or what is the improvement on that. We're just part of the statistics. I believe that's it really* **(Participant 5, RN).**

The main concern expressed by participants about logged incidents was that there were times when patients waited over 2 or 3 hours to be picked up in the department which could deprive the patients of the comfort of their homes. Macrae (2016) highlighted the significance of learning from critical incidents. Therefore, feedback or outcome report would be necessary to give a sense of satisfaction or provide a sense of clarity to the one reporting regarding the status of their complaint. Hazan (2016), highlighted that, one of the reasons why nurses dislike reporting incidents is due to the lack of feedbacks and actions after reporting incidents.

6.4 Theme 3: Redeployment during surge of COVID-19 pandemic

During COVID-19, every aspect of patient care was reassessed and reorganised which brought about a significant impact on the nursing staff jobs (Jackson, 2021). Moreover, the challenge of the bigger demand in excess of capacity for acute surgical services has been made more challenging by high staff sickness and self-isolation of nursing staff (McBride, 2020). Therefore, to address the discrepancy during COVID-19, most nursing staff were promptly retrained and redeployed as elective services were halted and staff had to be reassigned to meet the increasing demand (Bridges & Maben, 2020; Sun et al., 2020). The surge of the pandemic coincided with the data collection period of this study. Some participants expressed that they had no option but to be redeployed. Within this key theme, there were positive and negative effects of redeployment discussed by the participants.

6.4.1 Inadequate Personal Protective Equipment (PPE)

Most of the participants in this study reported that they had issues with lack of PPEs during their redeployment. One of the participants during the interview stated that, "*There was not much proper equipment, PPE. And everyone was just walking around, not really knowing what to do*" **(Participant 4, HCA).** However, the main negative effect of redeployment discussed by the participants was the difficulty in getting used to wearing PPEs and getting the appropriate PPEs especially for those who had sensitive skin and lung problems.

The nursing staff were not sure about the correct protocol as various managers were telling them different rules about the proper wearing of PPE and correct procedure when dealing with patients. Similarly, Achour and Ballantyne (2022) found in their study, 55 registered nurses were interviewed, and 62% of them felt that their redeployment were not clearly communicated. Some participants reported that they were even surprised that they had to be redeployed right after their annual leave without any previous discussions. A participant stated as follows:

> *"Uhhmm personally, after working in a couple of time hmm in January, in February, somewhere in the middle of February, I had an email telling me that I have a shift for 6 weeks"* **(Participant 1, RN).**

"And I was thinking I bought all this time, when they were asking us to go to the redeployment. And I told them I can't because I have these 2 conditions. It took them all of those months, until the middle of February, to tell me I have to shoot. Which I was thinking, they could have told me earlier when I was given all this information. And nobody said anything. I think that affected me the most because I was thinking, have I put myself at risk or…because I was being careful, I was washing my hands, gelling, using the face masks, everything" **(Participant 1, RN).**

This example showed how information was delayed which was also similar to what one of the participants in the study by Achour and Ballantyne (2022) reported, stating that the staff were notified the night before they were redeployed. In terms of their mental, physical and psychological health, better preparation would have improved the nurses' preparedness and wellbeing and invariably enhanced patients' care. Some participants discussed that they were neither consulted when the decision to redeploy was made nor properly consented prior to redeployment. An example is where a participant stated:

"no preparation and no risk assessment. we were just told to go to the wards, and then you start on this day. So straight away." (**Participant 3, RN).**

It sounds like the staff felt obligated, and they had no autonomy over what to do in terms of their occupational situation. The same experience was found by Achour and Ballantyne study (2022), where some participants felt resentful and stated that they had no say at all, and another revealed that senior management-imposed redeployment on the junior staff. These narratives highlighted the desire of nursing staff to be involved in the decision-making process, which was essential for them, to feel a sense of belonging which could raise their job morale. Effective communication is key in the nurses' role, and NMC (2019) stipulates that communication is an essential requirement and standards for safety of patients' care. The theory of motivation also includes the concept of Maslow's hierarchy of needs where employees need belongingness and well-being to be satisfied, as this overcomes the feeling of alienation (Maslow, 1954; McLeod, 2018).

The need for self-esteem could also be satisfied within this context, if consulted before being redeployed as a form of respect from others. The lack of risk assessment created unsafe clinical environment and according to research conducted by British Medical Journal (BMJ) some NHS trusts in England were delayed in completing COVID-19 risk assessments for their staff from ethnic minority groups more than two months after the NHS first told them to do so, an investigation by BMJ (O'Dwyer-Cunliffe, 2021) In this qualitative study, five participants (28%) stated that lack of risk assessment and improper consenting were of great concern during their redeployment. In view of these findings, O'Dwyer-Cunliffe (2021) from the NHS England and NHS Improvement reported that, progress was increasingly being made to improve the process of redeployment although, there was obvious urgency to mitigate against the redeployment risks.

Therefore, NHS managers were urged to ensure that staff risk assessments were completed in real time and to publish their progress. Similarly, the Royal College of Surgeons (RCS) supported the England's precautionary approach of risk-assessing staff at potentially greater risk, to make arrangements accordingly, especially where the risk was high, to protect staff adequately (O'Dwyer-Cunliffe, 2021).

6.4.2 Lack of preparation and anxiety/fear of contracting the COVID-19 virus

Most of the participants who were redeployed discussed being anxious or scared due to the virus, and even more so, because of redeployment. The consistent responses further reiterated the narratives of the participants on how their family and social life were affected due to self-isolation from family members after work. A couple of participants in this outpatient study narrated their situation and stated:

> *"Well, it's affect me by in one way, that you know you can't go see friends and loved ones..."* ***(Participant 10, HCA)***.

> Another said: *"Personally, I mean my relationship with my wife has changed uhh dramatically during that time cause instead of me having a regular day off a week, like two days a week, it was like me working seven days a week. So when you get home, you're so tired."* ***(Participant 9, RN).***

Both instances showed how losing social life negatively impacted their wellbeing. Most of the participants experienced great anxiety of possibly bringing the virus to their family, friends or loved ones. Other concerns included participants who reported that they worked out of their contracted hours of duty, and they were allocated shift duties including night duties and long days. Unfortunately, these participants' family members had to make some adjustments to accommodate these nursing staff new work patterns. The work pattern changes could have some physical and psychological impact on the affected nurses. Maslow (1974) hierarchy of needs advocates for psychological needs such as love, affection and belongingness essential for an employee to reach their highest potential (Jerome, 2013).

In any case, Maslow's theory of safety needs pyramid (figure 2.17; page, 97), shows how essential the feeling of safety is, (Maslow, 1974; Jerome, 2013), and this factor should not be ignored irrespective of the unprecedented nature of COVID-19 pandemic. Understandably, redeployment occurred without prior planning and lack of knowledge on how the new virus could impact on people. However, some staff used redeployment as an opportunity for career development and professional fulfilment despite the less positive elements of redeployment (Ballantyne and Achour, 2022).

6.4.3 Challenges of Remote Working

During the participants' interviews, issues relating to remote working were reported, which were described as significant changes in the staff work life. One instance was when a participant reported that they were made to pay back hours because they had difficulties logging in to the system, despite getting no support and no training on how to use the system. Another instance was in relation to the sudden service changes, where a participant was not redeployed due to her medical conditions, however, the participant stated that they were tasked to do some administrative works and required to work from home, although their role was patient facing roles. Remote working is defined as a working agreement that allows individuals to carry out their work obligations from another location by utilising internet access and technology to communicate with the organisation (Madlock, 2018).

Remote work has been of interest to managers and the peak period of COVID-19 pandemic have changed attitudes toward remote work, as it became a necessity for many organisations (Pokojski et al., 2022). Although remote working has grown dramatically in recent years, and it is a primary driver of change, and it has also influenced the pace and nature of work and has placed pressure on organisations to react to competitors while keeping up to date with technological changes (Wilkinson et al., 2017), however, remote working might not be suitable for all types of jobs.

6.5 Theme 4 - Management and Leadership Factors

Management and leadership commitment to healthcare professionals is vital in firming up quality and integration of care (Lamb et al., 2018). Consequently, this theme discusses the impact of management and leadership factors and how these factors impacted the outpatient nursing staff's job motivation and wellbeing. When leading change, management is fundamental for organisations (Kotter, 1996) and the role of managers cannot be ignored. The distinction between leadership and management has received much attention Kotter, (1990; Alvesson, Blom and Sveningsson, (2017), hence its relevance to this chapter. In this study, the participants specifically highlighted their experiences which contribute to new knowledge within this discipline.

6.5.1 The impacts of management and leadership styles on the nursing staff

One of the factors expressed by some participants was management styles which lacked recognition and appreciation for the individual staff and team efforts. In terms of staff morale, 33% of participants in this study expressed that they did not receive support from their line managers and senior leadership team, especially during the pandemic and they felt like leaving the job. Robbins (2019) explained that the words recognition and appreciation are used interchangeably, but there's a big difference between them. The former is about giving positive feedback based on results or performance. The latter, on the other hand, is about acknowledging a person's inherent value. This distinction matters because recognition and appreciation are given for different reasons and these are effective ways to maintain staff engagement and motivation (Robianto and Masdupi, 2020). The challenges in retaining the existing staff need to be addressed, stating that a long term plan for increasing staff to improving recruitment and retention is the way forward (Lacobucci, 2022).

The Royal College of Physicians (RCP, 2021) asserted that staff absenteeism and turnover impacts on the overall team dynamics hence, the clearest and most urgent need is to implement strategic action to retain staff, as numbers count of the workforce. Some healthcare workers are more 'resilient' than others, and likely to cope better with challenging times, and therefore remain in the workplace (Edmonstone and Scowcroft, 2013). However, the Department of Health and Social Care (DHSC), have had over 46, 800 nursing vacancies in June 2022, which seems like a workforce crisis impacting on individual nurses, their families and patients (Palmer and Rolewicz, 2022). Although some participants in this outpatient study expressed some level of resilience during their day-to-day jobs, they still need to be supported. Research suggests that resilience building strategies such as seeking mentoring relationships, achieving work-life balance and positive emotions, personal growth and reflection were found to have protective factors that can help individuals achieve positive personal outcomes (Jackson et al., 2007; Hart et al., 2014).

6.5.2 Lack of appreciation and leadership visibility

Lamb et al., (2018) advised that management and leadership visibility inspires confidence to the junior members of staff and can be considered in the healthcare environment as a form of support in relation to the role of the manager or leader. Supportively, when discussing frontline nursing practice, Bergstedt and Wei (2020) advocates that, managers should formulate a vision and engage others to share it, in accordance with organisational strategies such as regular management visibility which could help to create and maintain a culture of trust and support among employees.
In this study, some participants expressed that the management sometimes emailed them in appreciation for the work performed, they preferred management and leadership visibility and support than just a general email. For instance, a participant stated:

> *"But if I think, if I get an appreciation or verbal appreciation at least with the manager I work with or from the department I work, it might be a different experience. I would also like a verbal appreciation on a one to one at least from the manager than just a general email thank you"* **(Participant 9, RN).**

Clearly, the participant would appreciate a more personalised 'thank you'.

Other participants reported that there was less visibility of managers and leaders on the floor during the surge of the pandemic which made them feel helpless and abandoned by the people in higher positions. The feeling of helplessness was supported by another study which suggested that there was a sense of mistrust or a gap in leaders/managers who are not in the frontline or not dealing with redeployed staff (Achour & Ballantyne, 2022). Lack of recognition was also highlighted as a concern by the participants in this study. Personnel recognition seem to be an important factor for physical wellbeing at different career levels and and peer reviews when embedded establishes the quality of the core values (Tennant & Ross- Hellauer, 2020). This feedback suggests that the participants echoed the need for support in their various roles in order to enable them function effectively and increase service efficiency.

Employees play a crucial role and are considered as priceless resources in an organisation, therefore, services are unlikely to achieve their success without their employees' backing and commitment (Maitland and Thomson, 2014). Despite some workplace culture lacks employees' recognition and appreciation, this factor plays a more effective and significant role in business performance than previously understood (Nelson, 2016). As such, employees who feel ignored by their managers may dislike their jobs regardless of the level of pay they have obtained and how satisfied they may be with their jobs. Wagner (2022) acknowledged that job recognition overrides many motivational factors, however, sufficient training, physical working environments, and career advancement enhances the staff wellbeing.

6.5.3 Frequent management changes at senior level

When the participants were asked about the changes that occurred in their workplace before the pandemic, a number of the responses indicated that they experienced frequent management changes at senior level which caused some feeling of uncertainty and anxiety amongst the staff while some staff seemed unaffected Similar result was found in a study by Ngotgngamwong (2014), wherein the perception of employees on impact of frequent changes in management was studied, and they found both positive and negative perceptions.

Sometimes rapid transitioning is considered necessary as the focus of care for many problems have shifted to the outpatient setting (Bernabeo et al., 2011). Therefore, managers at strategic positions should take all the necessary steps to retain middle managers for a long time, as abrupt frequent changes have negative impact on employees and it could affect the quality of services (Bolton, 2003). One of the changes discussed by participants in this study was the new ways of working, especially going paperless, without hand held patients health records and all the multidisciplinary teams' documentation was on the electronic Cerner system.

Evidence show that projects to maximise the usage of digital services improved efficiency and effectiveness to patients and clinicians (Wachter, 2016). Online software is designed to support clinical and operational efficiencies to maximise care (Tajirian et al., 2022). Agnew (2022), highlighted that, Nurses are at the forefront of digital advancements in healthcare, as hospitals and other care facilities are integrating new technologies into their health systems.

Some participants highlighted career opportunities within the nurse-led activities. For instance, a participant said:

> *"I feel like I have achieved something new and I'm so proud that I managed to challenge myself with this new ahhh area in nursing. So far there are still so many things to learn. I am so happy with the department but I'm grateful with my previous manager, the one who sent me for the course which gave me a you know a way, that's why I'm in this role. That's why it gives me a chance to explore more areas and to become like a specialist nurse. So I am grateful for the opportunity. It is a big help and opportunity".* ***(Participant* 3, RN).**

The increasing nurse-led activities for most of the registered nurses were highlighted as greatly motivating, which could be seen as a professional process to increase one's skill set. Motivation amongst healthcare professionals and educational opportunities were found to be positively correlated (Glazer et al., 2019). Additionally, exposure to appropriate educational opportunities while being supervised by a skilled nurse manager may encourage the growth of nurses' motivation.

Career development had the greatest power to inspire nurses to work hard at their jobs and one key factor which may influence nurses' job motivation and staff turnover is the nurse managers' leadership (Suliman et al., 2023). However, some of the participants in this study felt unsettled, bullied and frustrated which could hinder their career progression.

6.5.4 Power dynamics

In terms of power dynamics, the concept of power is related to leadership because it is part of the influence process (Northouse, 2021). Some participants expressed frequent changes in management and the feeling of unsettledness as they were frequently moved from one clinical area to the other, even though their employment contract was site specific working. On the other hand, some staff felt proud and accomplished by being frequently moved as they could learn various things from different departments. The narrative below shows the need for staff to be accorded some respect and valued in their duties. Managers need peoples' skills to effectively manage change, to enable the employees to achieve their basic needs based on Maslow's (1974) hierarchy of needs (Jerome, 2013).

Some participants said they felt bullied by their unit managers in their own department and on the units where they were redeployed. One stated:

> *"I was working on a ward, ward X. There was ah a nurse, it was nurse Y she was known by everyone... to be not the nicest to people. And she made it a point, that whenever she saw me. That she would like say something, look at me a certain way and or just not making me feel not welcome and or not part of the team. And there were even PPEs in her office and she would lock it in her office, so she can get one piece and that would be your one piece for the day. Even though at that point we didn't know what was going on. Umm but so she just went out of her way to make us feel unwelcome"* **(Participant 6, HCA).**

Although most of the participants stated that they felt supported by their managers, most of them reported that, they felt supported by their colleagues. Power dynamics and concerns about overwhelming top-down approach by some managers were reported by some participants who described the situation as being undermined and undervalued.

Branch et al., (2021) reported that some research literature published upwards bullying which were deeply anchored in a pre-pandemic work environment and appeared to be pervasive in many locations and health care services and such situations should be discouraged. Also, Karatuna et al., (2020) highlighted that within the nursing research environment and international nursing conferences upwards violence was evident. An environment that tolerated bullying of its leaders would also create an environment or fertile ground for lateral or peer bullying (and this culture must be discouraged by the managers and leaders (Gaudine et al., 2019).

Therefore, managers, especially in healthcare settings, should learn how to care for their employees, eliminate bullying and enforce zero tolerance (Branch et al., 2021), in order to reduce staff anxiety, increase staff morale and invariably achieve high quality care service delivery to patients. Obeng et al., (2020) advocate that engaging employees and being supportive in enhancing their well-being in an organisational is very paramount. Past studies show that these practices and policies are beneficial to the commitment level of the employer and the employee in the attainment of employee performance (Obeng et al., (2020).

6.5.5 Understaffing due to high staff vacancy level

The NHS's biggest asset is its workforce, who are essential in providing high quality care (King's Fund, 2018). However, in 2021, reports showed that 21% of the NHS staff experienced job dissatisfaction due to declining staff morale brought on by the poor working environment, and almost a third considering leaving the NHS (Wilkinson-Brice, 2022). This study which investigated the impact of service changes on outpatient nursing job motivation and wellbeing, found that most of the participants experienced understaffing and discussed how it negatively affected their work situation, job motivation and wellbeing. Similar account was supported by an analysis from the King's Fund (2018) which reported that, despite the United Kingdom Government's target to recruit 50,000 nurses by 2024, the long standing workforce shortage issues (Morgan, 2022), is not yet resolved.

It was therefore not surprising that staffing shortage has dented staff morale and wellbeing, which is reflected in the results of the latest NHS staff survey for the year 2021 (Waters, 2022). The British Medical Journal (BMJ) reported that, barely one in four (27%) people working in the NHS feel that there are enough staff in their organisation to allow them to do their jobs properly (BMJ, 2021).

While there are increasing concerns with the staffing shortage, the proportion of staff suffering from work related stress also increased and these nurses contemplated quitting the NHS (Palmer and Murray, 2022). Prior to COVID-19 pandemic in year 2019, staff shortages already existed in the NHS (Lin et al., 2021), and this account supports the government investment in more nurse training centres and added maintenance grant for nursing students with incentivised international recruitment (Holmes, 2022). Despite the rise in the number of nurses following the government's incentives, the number of staff vacancies did not decrease (Holmes, 2022). Also, this outpatient study's participants reported that they experienced understaffing, especially during their redeployment period and the figure below shows the trend of nursing vacancies before the onset of COVID-19 pandemic and recently.

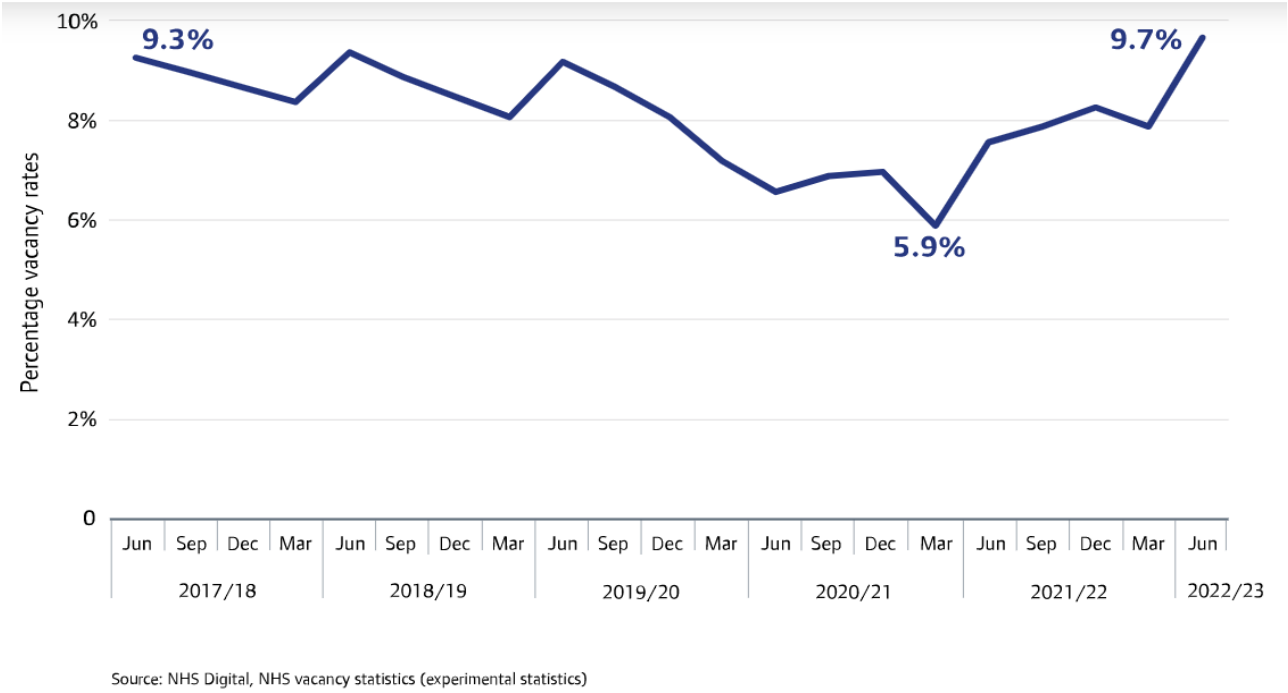


Figure (6.3). Total NHS workforce vacancy rates, England, June 2017 to June 2022.

This NHS Digital data supports several reports which showed that the number of nursing staff vacancies is still increasing as illustrated in figure 6.3 above. These reports were reinforced by the King's Fund report which shows the increase in nurse leavers in England. The NHS vacancy statistics published by NHS Digital (2022) explain that, while reported vacancy rates fell during the pandemic, they have risen over the past 12 months, with the overall vacancy rate for England now above pre-pandemic levels. Inevitably, at the end of June 2022, there were more than 132,000 vacant posts, which was a vacancy rate of 9.7% – two percentage points higher than 12 months before and the highest for 5 years. Based on the King's Fund's data (Figure 6.4), the number of full-time nursing posts increased during the COVID-19 pandemic recovery period. However, about 61% of nurses were also looking for new jobs as they felt undervalued, pressured, and underpaid in their existing roles (Holmes, 2022).

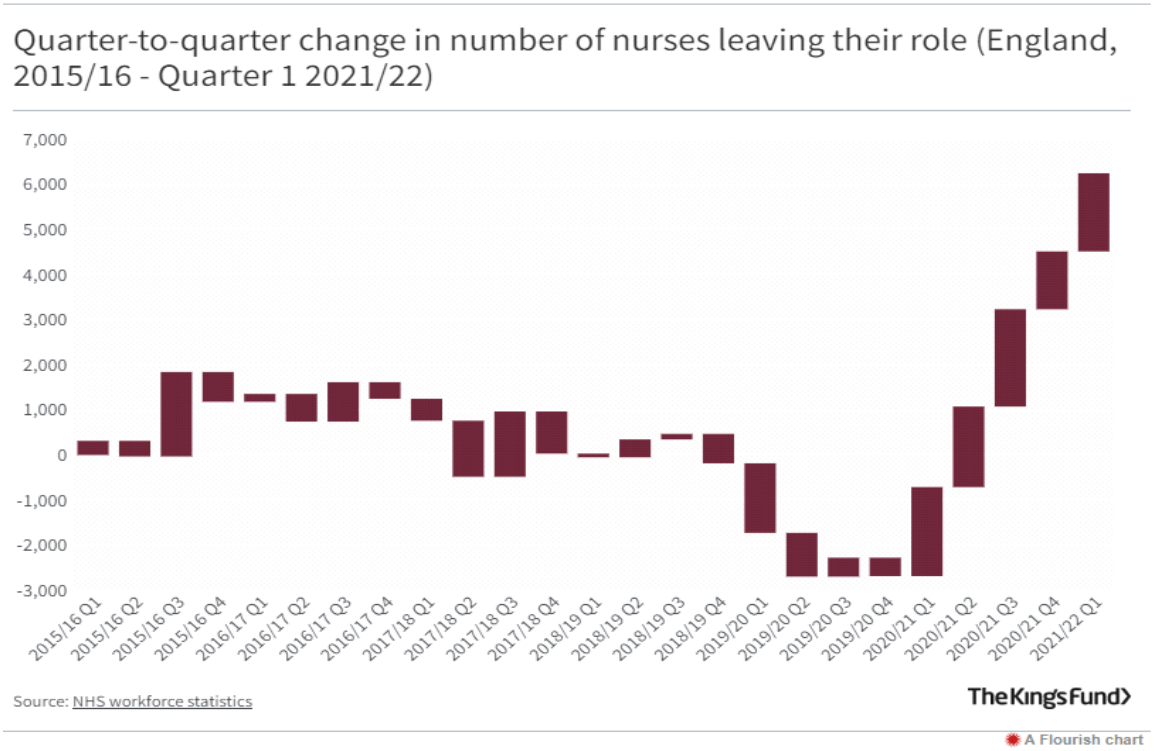


Figure (6.4). Source: NHS Workforce Statistics - The King's Fund (2022)

Another study was conducted by RCN in year 2021 and 9,577 registered nurses and health care support workers responded. This RCN study showed that 64.7% participants reported that they were also thinking of leaving their post due to low staffing level , affecting their health and wellbeing. Similarly, this outpatient study's findings highlighted that some participants experienced dissatisfaction and were unhappy with their jobs, which correlates with the outpatient NHS staff survey (2022).

6.5.6 Staff stress level and sickness absence

The findings form this study showed that a greater percentage (83%) of the participants experienced stress at work. Soomro et al., (2019) suggested that stress is a motivational force that encourages employees to work hard and improve work efficiency. On the other hand, work stress negatively impacts on employee performance and employees need to spend time and energy to cope with stress hence work stress cannot motivate employees and negative emotions negatively impact on the employees (Purnomo et al., 2021). From a psychological and emotional perspectives, Lai et al., (2022) argue that, work stress influences employees' psychological states, which invariably affects their motivation and effort levels at work.

Positive psychology proposes that work stress includes two main categories: challenge stress and hindrance stress (LePine et al., 2004). Based on their views, challenge stress represents stress that positively affects employees' work attitudes and behaviors, which improves employee performance by increasing work responsibility. However, Deng et al., (2019) argue that hindrance stress negatively affects employees' work attitudes and behaviors, which reduces employee performance. The multidimensional construct of work stress could be seen as beneficial in the work environments where the challenge stress triggers positive outcomes. For example, the new ways of working was one of the distinctive findings from this study which led to increased nurses-led activities such as; nurse-led hormone injections, minor skin biopsies and cryotherapy. Some particpants in this study reported that they had opportunity to learn *which* increased the staff job motivation in spite of the increased work demand. An example was where one participant stated, "I *feel like I have achieved something new and I'm so proud that I managed to challenge myself with this new ahhh area in nursing*" **(Participant 3, RN).**

In order to get a healthy work-stress balance, effective and efficient leadership is paramount to strategically manage service changes. Nurses who experience high levels of work stress are more strongly related to poor general health owing to the nature of their work (Khamisa et al., 2016). High staff sickness level was a common key theme generated by the participants in this outpatient study.

Around 40% of all staff sickness absence in the NHS is due to work stress costing the NHS up to £400 million per year (Jones, 2020; Glasper, 2020). The effect of staff shortage due to high staff sickness level was highlighted by seven participants (39%), during this outpatient nursing study. The NHS Sickness absence data shows 128,161 full time equivalent days were lost in February 2022 due to nursing staff absence (Holmes, 2022).

According to the King's Fund study, the sickness absences were not entirely physical, most of the sick days were due to anxiety/stress/depression/other psychiatric illnesses. These staff sickness episodes affect the overall nursing workforce with increasing points of 46.8% of staff sickness due to work related stress (Boddy, 2022). The high sickness absence has been a concern and the mental health of NHS staff is gradually under more pressure due to high workforce shortages. As the sickness absence shows no sign of abating, more staff are overstretched while providing patients' care, due to colleagues' absenteeism for various reasons (figure 6.5). Consequently, the remaining staff on duty experience work-overload, burnout and sickness as a knock-on effect which looks like a revolving door (Holmes, 2022).

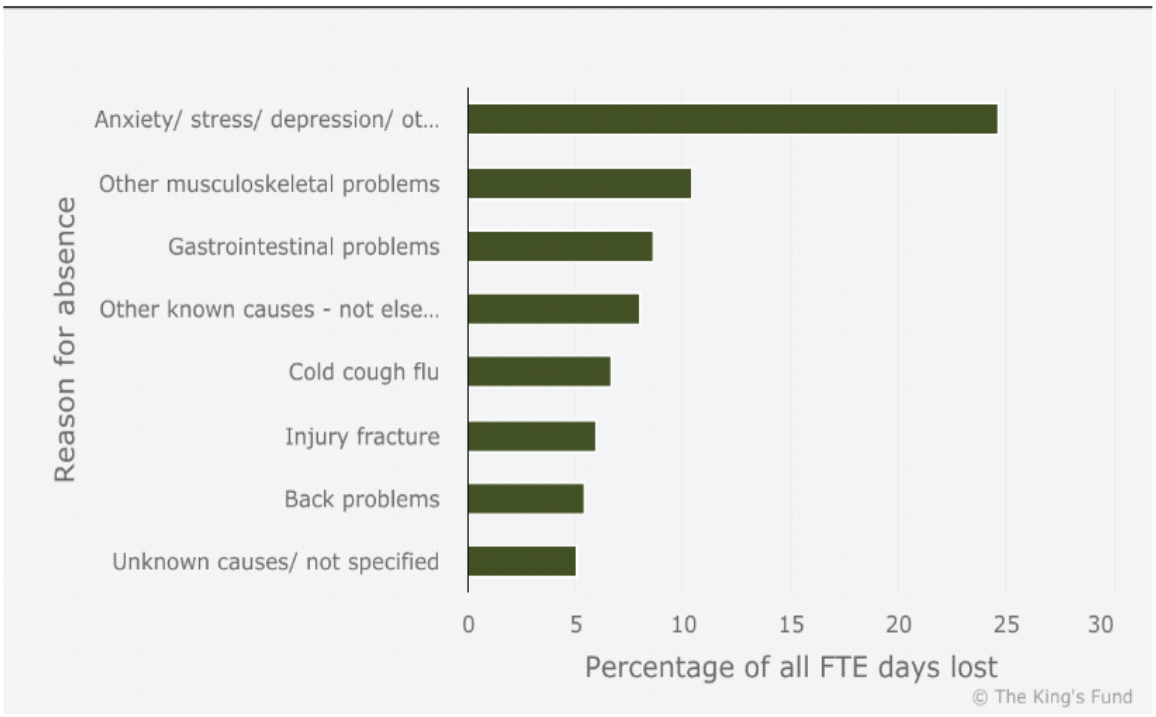


Figure (6.5). Most common reasons of absence among NHS staff as percentage of all FTE days Source: The King's Fund, 2022.

Although the participants in this outpatient nursing study were not asked specific questions around sickness absence, some participants volunteered information relating to general staff sickness absence. Khoreva and Wechtler (2018) advocate for managers and leaders should be more aware that service changes' impact can lead to increased staff anxiety and wellbeing, although some change management benefit to the organisations. Other NHS staff survey studies showed that a greater percentage (54.5%) of the participants reported that they went to work although they were not doing well enough to perform their duties, figure (6.6).

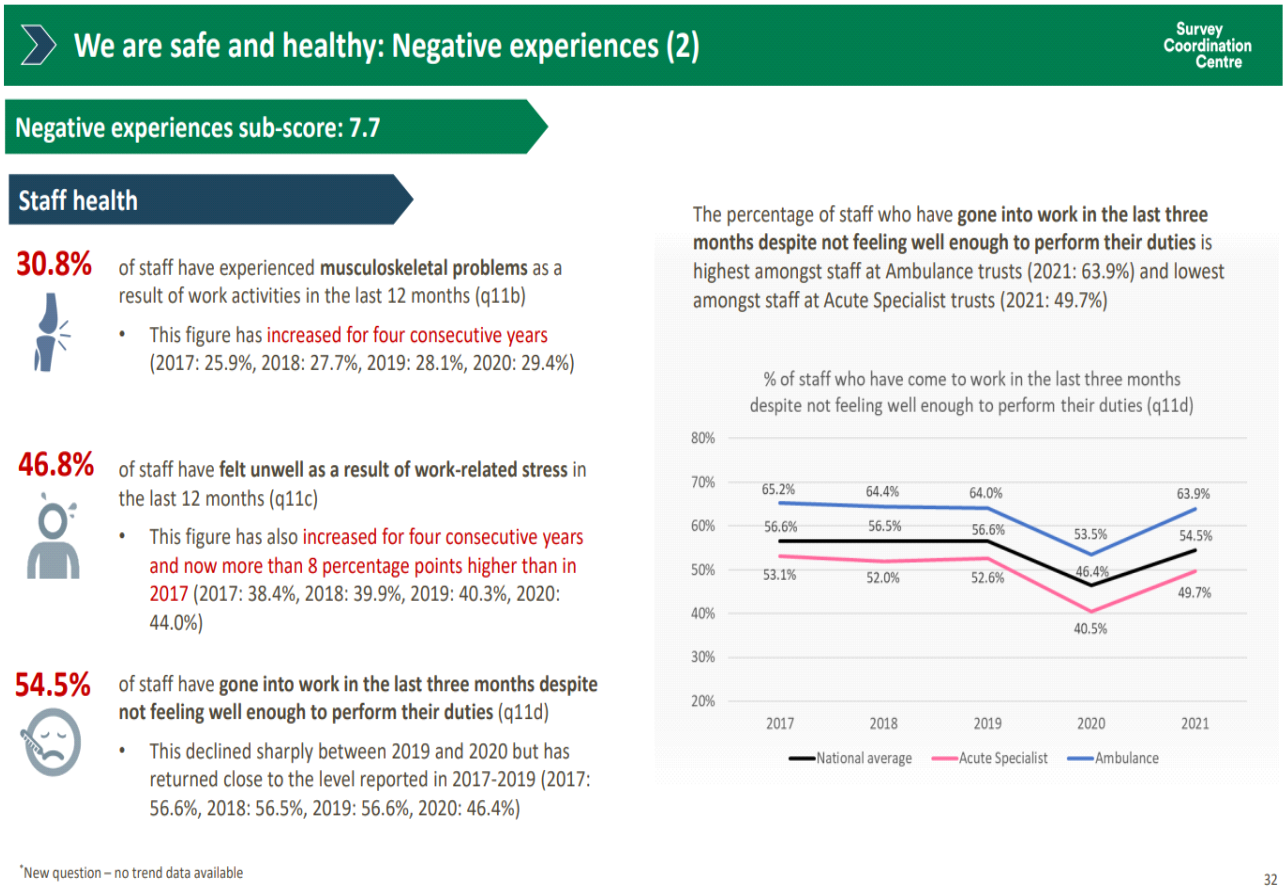


Figure (6.6). Source: NHS Staff Survey National Results Briefing 2021

These finding supports the current outpatient study's results which found that many staff attended duty despite feeling overstretched and unwell, because they felt there were insufficient staff to cover the shifts. Example was where participant (7) reported:

> *"Feeling sick but we still have to go to work because you have patients on the list that needed treatment. So was very stressful for me and affected me* ***(Participant 7, RN)".***

Participant 7's narrative collaborates with the NHS staff survey data where a significant percentage (54.5%) of the respondents, reported that, 'they had gone to work despite not feeling well to perform their duties'. Furthermore, the same report shows that 46.8% of participants felt unwell due to work-related stress, which also reflects the findings from the outpatient qualitative study. Although there were no specific criteria in this study to determine whether the nurses' sickness absence was work-related, some participants expressed that they experienced work related stress. According to NHS Digital statistics, sickness absence for NHS staff in England rose to its highest level of 6.7% in January 2022, which is 1% point higher than January 2021. The past 4 years have seen a steady increase in NHS sickness absence rates (NHS Digital, 2022), (figure 6.7).

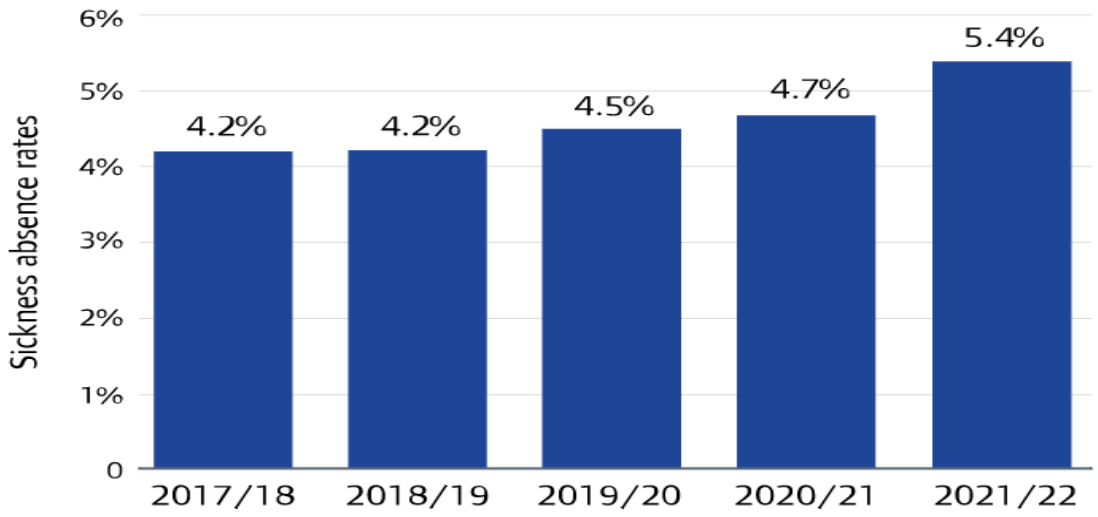


Figure (6.7). NHS sickness absence rates for England, 2017/18 to 2021/22.
Source: NHS Digital statistics (2022), sickness absence for NHS staff in England

In comparison to this outpatient nursing study, 50% (9 out of 18) of the participants reported that they experienced work related stress, a higher score than average NHS staff survey report of 43.1% (a difference of 6.9%), which is significant and could impact on the nurses' wellbeing. Also, findings from studies conducted during the Restorative Clinical Supervision (RCS) review suggests that the use of clinical supervision and support reduces staff stress by 62% and staff burnout by 43% (NHS England, 2022) and, reduces staff sickness absence level. Evidently, stress has a substantial effect on the staff's health and wellbeing, and which is linked to high turnover and could lead to poor service delivery.

6.5.7 Staff morale and nurses leaving / intention to leave the job

Research by RCN found that, 43.1% respondents (figure 6.8) said that their stress levels were reasons for (RCN, 2021). Also, the NHS Staff survey (2021) found that, lack of support was a huge issue for staff and 27% reported that they experienced bullying and harassment within their organisations and nearly 12% of the incidents were reported as, 'managers on junior staff' events.

When compared to this outpatient nursing staff study, 23% of outpatient participants stated that they felt supported and motivated in their job, which was good for their morale. However, 77% of the participants expressed reduced staff morale and also felt undervalued, which scored slightly higher than the overall NHS staff survey where 75.4% of the respondents were reported to have felt undervalued. Similarly, in the NHS England survey year 2021, the report showed that, almost a third of nursing staff often thought about leaving the organisation. Looking at figure 6.9 below, 'staffing levels indicated low level with a score of 64.7% which was slightly higher than the outpatient study participants' level of 61% (table 5.7, page 202). However, both studies highlighted understaffing as a significant factor which invariably impacted on the other workforce issues, as listed in this report.

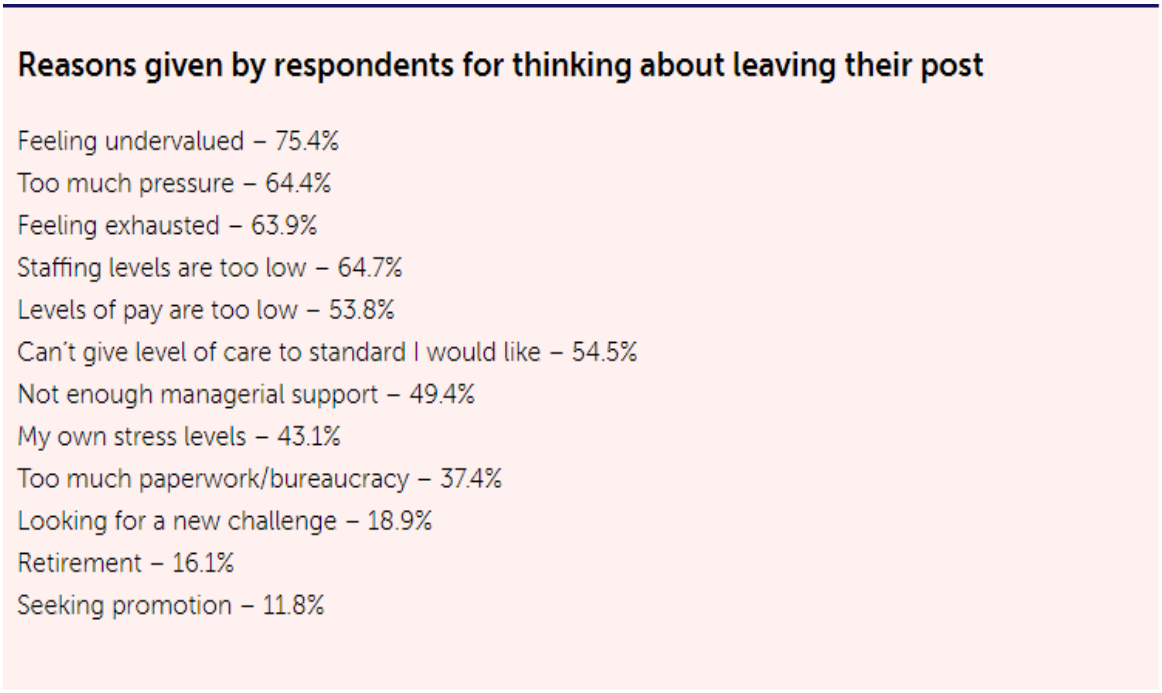


Figure (6.8). Reasons for Nursing Staff Leaving their post.
Source: RCN, Employment Survey 2021.

A combination of staffing shortage, excessive workload, work-related stress is interlinked (Livne et al., 2018), which inevitably affect the staff morale and invariably staff job motivation and wellbeing. As illustrated on figure (6.9) below, the over-aching knock-on-effect of the identified work-related factors could have significant impact on the outpatient staff job staff morale and lead to their intention to leave the nursing profession.

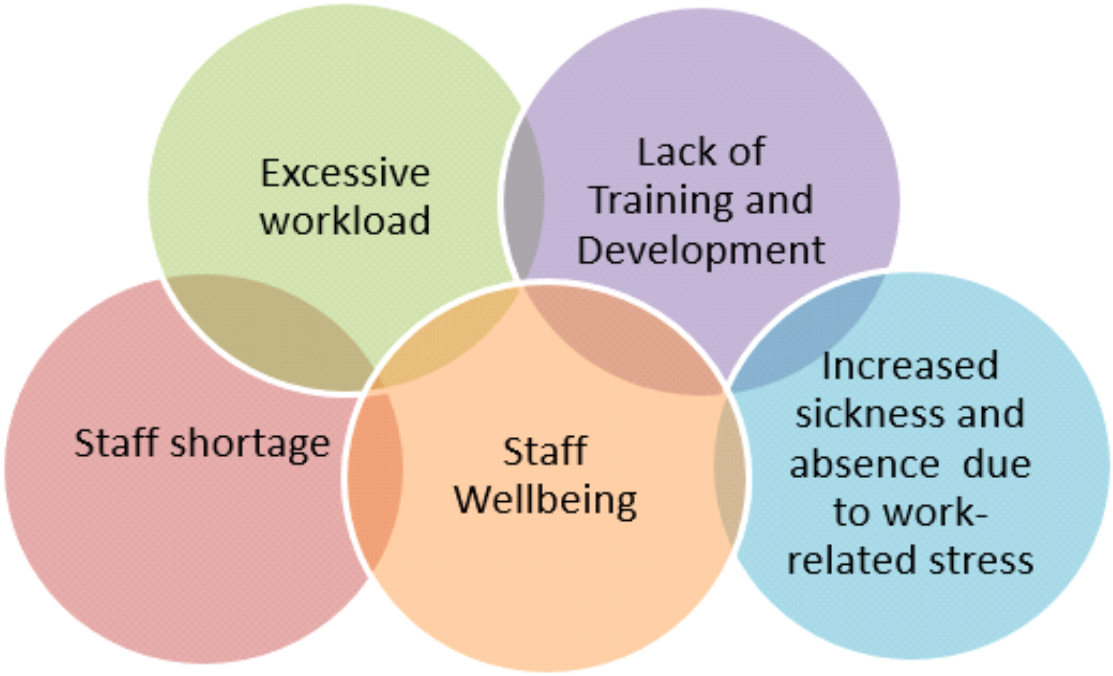


Figure (6.9). Work-related factors affecting outpatient nursing staff wellbeing.

Although questions relating to staff leaving their jobs, was not sought in this outpatient study, some feedbacks suggested that a greater number of the participants expressed some challenges and frustrating situations at work which were completely out of their control. In terms of study triangulation, some elements of the findings from the outpatient study participants' lived experiences were seen in the NHS quantitative staff survey findings. Considering that these studies occurred during the pandemic period, the NHS leaders were expected, by the nature of their role, to show confidence and commitment whilst making decisions during the challenging extreme circumstances (Maak, Pless & Woholgezogen, 2021). Overall, the lack of training, development and career progression opportunities emerged as a significant issue for the outpatient nursing workforce which needs to be addressed to bridge the gap in equality within the Human Resources' organisation of people's development.

6.6 Leadership, Followership and Service Co-production.

One of the modules within my Dprof project includes leadership, followership and transformation and this study explored how service changes within these concepts affect the nursing staff job motivation and wellbeing. There are numerous publications recognising leadership style as key element for quality healthcare delivery during service changes. Although some of the leadership and followership factors were discussed in chapter 2, literatures review, this section examines the findings from the participants' experiences linked with the most appropriate leadership style, while exploring how to enhance staff job motivation and wellbeing.

The principle of incorporating co-production within the outpatient services is relevant as patients with long-term chronic healthcare conditions are managed jointly by the outpatient multidisciplinary team. Coproduction can be intended generally as a way of providing services through the active involvement of professionals, service users and other members of the community (Bovaird, 2007), also, definitions of coproduction vary, and empirical applications differ in a number of respects (Bussu & Galanti, 2018). It was well established that coproduction is a central part of managerial and leadership roles needing collaboration with service users to co-create and co-design services.

However, in terms of improving service quality, patient and staff experience, both service providers and users need to be satisfied. On the contrary, findings from both the qualitative outpatient nursing study and NHS staff survey reports suggest that NHS staff perceived underperformance in their roles due to various indicators. For example, these studies' findings highlighted that, 54.5% of participants attended work while feeling unwell and exactly the same percentage, 54.5% of the participants stated that they, "Can't give level of care to standard I would like' scoring exactly 54.5%" (RCN, Employment survey, 2021 (figure 6.9, page 247). The most recent Nuffield Trust's study on nursing staff leavers, reported 11.5% (Palmer & Rolewicz, 2022), and in this outpatient study, three, out of eighteen participants interviewed (16.6%) had left the researcher's organisation, at the time of writing, a higher level of levers than the Nuffield study. The importance of effective leadership and management cannot be overemphasised in driving service changes and productivity within the healthcare organisations, which is critical to prevent high staff turnover.

Co-designing strategy enables the healthcare professionals to support people maintain their independence and promote their health and social care in North-West London (Morton & Paice, 2016). The outpatient services aim at achieving service quality and efficiency which includes nurse-led activities, such as patients' education, health promotion and empowerment for patients' self-care in the community. Bussu and Galant (2018) highlighted that coproduction often means different things to citizens interested in having more control over services and institutional actors that might be lured by the promise of cutting costs and increased efficiency.

Within the researcher's organisation, coproduction is a process of co-design using integrated care systems and process mapping of patients' care pathways to improve service quality. The outpatient nurse-led clinical activities for example, health improvement and empowerment form part of the service coproduction. Overall, coproduction has the potential to meaningful shared – decision making process which aligns with the healthcare providers values and care preferences. By enhancing people's diverse resources and assets the public sector can allow users to offer a valuable contribution to their community and facilitate a collaborative rather than paternalistic relationship between professionals and users (Fotaki, 2011; Bussu & Galanti, 2018). Numerous studies have emphasised the significance of leadership style and its link to employees' well-being, productivity and healthcare quality (Sjöström & Olsson, 2021). Therefore, NHS leaders and managers need to enhance their knowledge on leadership in the context of crisis management as past experiences are limited in situations like the pandemic (Wong & Cummings, 2007).

While service quality and coproduction are crucial approaches to healthcare (Goodwin, 2016), the workforce factor is a key contributory factor to an organisation's effectiveness and success, hence effective leadership is essential (Hesketh, 2018). The more leadership and followership style focus on people and relationships, the greater the job satisfaction (Cummings et al., 2021), and the better the patient outcomes (Wong et al., 2013). The prominence of leadership in fundamentals of care is now more pertinent than in the past years (Pattison & Corser, 2022), especially with the health events following the global COVID-19 pandemic.

Considering the lived experience as narrated by the participants in this outpatient nurses' study, compassionate leadership which comprises of effective communication, competence, commitment, caring with compassion was deemed more aligned in managing and addressing the identified concerns found in this study. The Department of Health (DH, 2012) contemporary healthcare policy identified compassion within one of the 6Cs core elements of nursing practice as illustrated, figure (6.10).

Figure (6.10). Source: (Stephenson, 2014) – Nursing Times.

Compassionate leadership is described as, a positive impact on patient experience, staff engagement and organisational performance (Bolden et al., 2019), stipulating that, understanding the suffering of others and responding to their needs is culturally appropriate and should apply to both patients and the staff. Board (2012) highlighted that the Department of Health (DH, 2012b; Leigh et al., 2015) contemporary healthcare policy, identified compassion within one of the 6Cs core elements embedded within the culture of nursing practice and NHS organisation (figure 6.10). Based on nursing concept of 6Cs, 'Care is our business,' therefore, the organisation should care for both the patients and the workforce holistically. Findings from this outpatient nursing study showed that there is increasing need for management and leaders to be empathetic and compassionate, leading with compassion can enrich healthcare leadership.

6.6.1 Compassionate Leadership

According to NMC (2018), compassion can be achieved through relationships based on empathy, respect, dignity, described as intelligent kindness within the standards of proficiency. This values can be applied across the NHS organisations to benefit staff and Hewison et al., (2019) advocate for the development of supportive, caring cultures within teams, the organisations and in the entire system when embedded within the 6Cs. Additionally, Shapiro and Stefkovich (2021) conceptualised compassionate leadership through an ethical perspective in dealing with complex dilemmas. Regarding the reduced staff morale found in this outpatient staff study, leadership could help alleviate the situation and increase staff job morale. There are parallels drawn between compassionate care and compassionate leadership and a compassionate culture should be fostered to enable the conditions to be right in order to deliver optimal service delivery (Holmes, 2022). Though compassionate leadership is an ubiquitous term in healthcare, there are existing guidance found across policy in NHS England in years 2014 and 2016 (West et al., 2020).

Effective compassionate leadership among other styles of leadership could have made a difference in supporting and improving staff job motivation and wellbeing, at all times. Similarly, there is clear evidence that compassionate leadership results in more engaged and motivated staff with prominent levels of wellbeing, which in turn results in high-quality care (West, 2021). In view of the above explanations and based on the key themes derived from the outpatient participants' anonymise narratives, compassionate leadership framework was chosen to align as the most appropriate leadership style for supporting outpatient nursing staff during service changes.

6.6.2 Leadership theories for compassionate leadership theoretical framework

The rationale for using a combination of leadership styles was to provide a framework which would holistically meet the wellbeing needs of the employees at work (Evans, 2022). In theoretical terms, compassionate leadership was found to be unique, yet familiar (Shuck et al., 2019), and does not have a consistent theoretical framework, but draws on from a range of similar leadership theories.

Although each of the listed leadership styles are standalone on (table 6.3), a right balance and combination of all into a compassionate leadership style, could be more beneficial.

Table 1. Leadership theories used to provide theoretical framework for compassionate leadership

Leadership theory	Supporting literature
Transformational leadership	West et al (2015); de Zulueta (2015); Ali and Terry (2017); Shuck et al (2019); Willis and Anstey (2019)
Servant leadership	West et al (2015); Quinn (2017); Hewison et al (2018); Shuck et al (2019)
Distributed leadership	Hewison et al (2018)
Authentic leadership	West et al (2015); de Zulueta (2015); Ali and Terry (2017); Vogus and Mcclelland (2020)
Collective leadership	West et al (2017); Hewison et al (2018)

Table (6.3). Source: Leadership Theories Adapted from Evans (2022).

Research points out that using only one style of leadership is not appropriate (Wong et al., 2013), therefore, several elements need to be combined to ensure care processes that achieve patient satisfaction, such as clear standard of care, role expectations, as well as collaboration and coproduction (Jankelavo and Jankelavo 2021). Individuals in managerial and leadership positions should have a duty of care to their employees, therefore should explore all possible leadership styles to achieve service efficiency. Most importantly, first-line nurse managers (FLNMs), who are directly related to subordinate nurses, have a great influence on the staff job motivation and satisfaction (Jankelavo and Jankelavo 2021). Following Francis' report in year 2010, there was increasing focus on compassionate leadership (Pedersen and Obling, 2019), noting how compassion itself should have been in existence in healthcare.

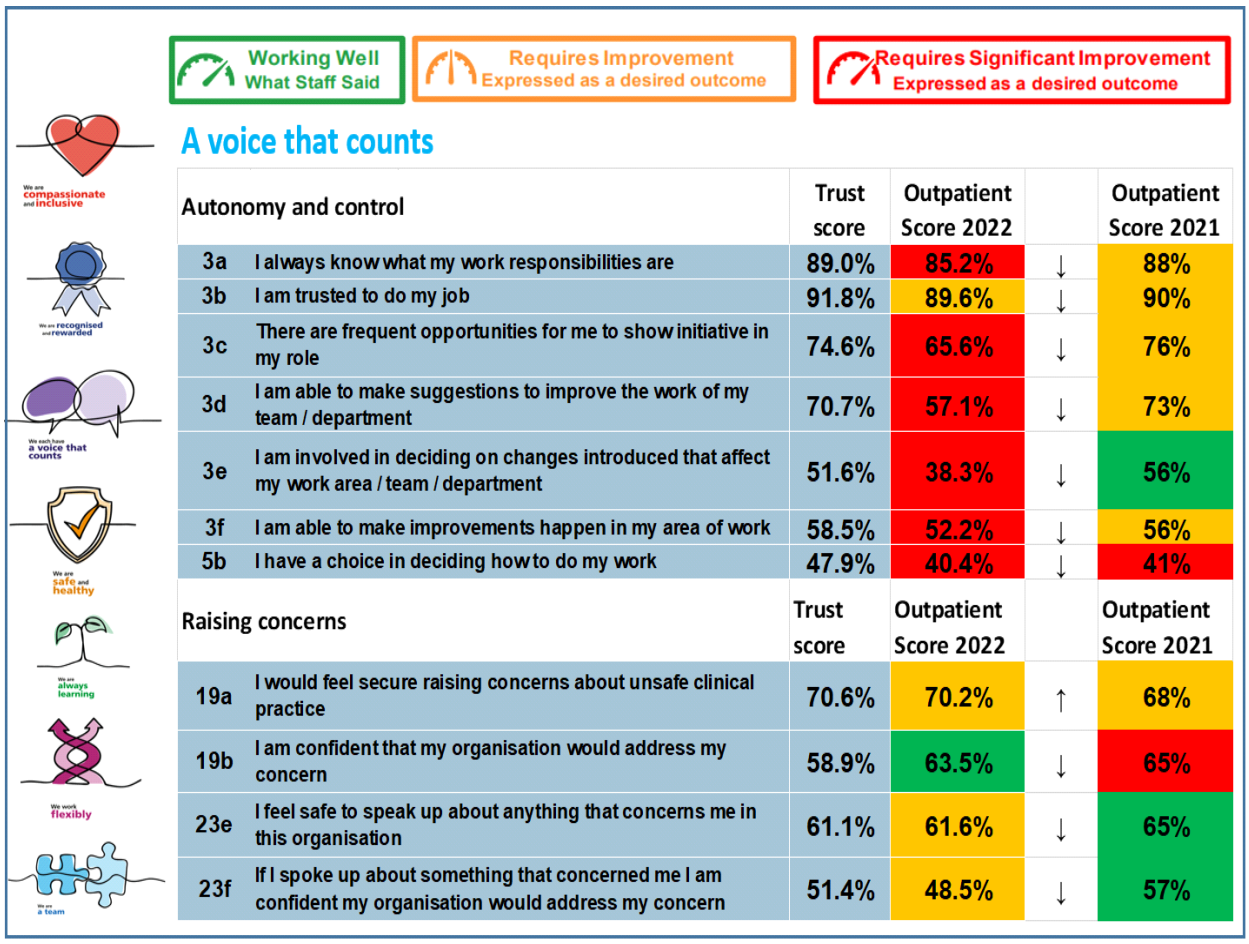
Compassionate leadership involves a focus on relationships management with appropriate support to others, which enable the workforce to feel valued, respected and cared for, so they can reach their potential and do their best at work (Pedersen and Obling, 2019). Also, compassionate leadership within an organisation supports a culture where change and innovation are welcome and supported (West et al., 2020).

Also, NMC (2018) stated that demonstrating effective and compassionate leadership in practice is a requirement for accountability within the nursing profession. Furthermore, effective leadership in healthcare is recognised as a necessity to ensure high quality care and embody support for staff (West et al., 2021). With reference to this study's participants' narratives, establishing a compassionate working environment that prioritises people over rules, regulations, and hierarchies, is crucial to address the gap identified and enhance staff wellbeing at work. Literatures review in chapter 2 of this project discussed the leadership and followership styles and the outpatient service transformation. The four key themes from this study attracted the notion of compassionate leadership as a common denominator for management of service changes in NHS, and the compassionate leadership style has increasingly been studied and promoted in the health care sector.

For example, according to Darzi's Review (DH, 2008) in the Berwick Report (2013), the need for compassionate effective leadership of health and social Care has been a familiar plan in health policy in England. The need for compassionate leadership has been hugely discussed as a way forward to enhance employee well-being at work. The staff 'well-being at work' greatly impact on the quality of employees' motivation and performance in the workplace (Yunus and Munjuri, 2020). The concept of compassionate leadership is truly relevant to all spheres of the healthcare multidisciplinary teams and stakeholders, especially for staff, to enhance staff wellbeing. Social well-being is defined by Chartered Institute of Personnel and Development CIPD (Smith, 2018), as 'employee voice' such as communication, involvement, recognition and other forms of employee engagement 'make a difference' and contribute to healthcare service quality as illustrated on figure (6.11a) below.

Figure (6.11a). Adapted from Smith, Z. (2018).

Below is a snapshot, recent outpatient NHS staff survey reports for the researcher's workplace which shows that significant improvement is required for approximately 90% of the criteria, in order to meet the 'employees' voice that counts'.



Autonomy and control		Trust score	Outpatient Score 2022		Outpatient Score 2021
3a	I always know what my work responsibilities are	89.0%	85.2%	↓	88%
3b	I am trusted to do my job	91.8%	89.6%	↓	90%
3c	There are frequent opportunities for me to show initiative in my role	74.6%	65.6%	↓	76%
3d	I am able to make suggestions to improve the work of my team / department	70.7%	57.1%	↓	73%
3e	I am involved in deciding on changes introduced that affect my work area / team / department	51.6%	38.3%	↓	56%
3f	I am able to make improvements happen in my area of work	58.5%	52.2%	↓	56%
5b	I have a choice in deciding how to do my work	47.9%	40.4%	↓	41%
Raising concerns		Trust score	Outpatient Score 2022		Outpatient Score 2021
19a	I would feel secure raising concerns about unsafe clinical practice	70.6%	70.2%	↑	68%
19b	I am confident that my organisation would address my concern	58.9%	63.5%	↓	65%
23e	I feel safe to speak up about anything that concerns me in this organisation	61.1%	61.6%	↓	65%
23f	If I spoke up about something that concerned me I am confident my organisation would address my concern	51.4%	48.5%	↓	57%

Figure (6.11b). Source: NHS staff survey reports for years - 2021 & 2022, for the researcher's organisation.

According to these findings shown on figure 6.11b, in addition to this study's qualitative findings, significant improvement is required to support outpatient staff for this group of nursing staff to gain autonomy and control at work. Based on literatures review, the outpatient nursing staff experience is under–researched and this qualitative study gave the participants an opportunity to get their voice heard, thereby fulfilling some of their wellbeing needs, in line with Maslow's hierarchy of basic human needs theory.
In view of the outpatient NHS staff survey and this quantitative study's findings, further research is needed to engage the outpatient workforce and have their voices heard.

This outpatient study suggests that most of the participants felt unappreciated and they were seeking organisational values, which includes ‘Kindness’ amongst others, to be embedded in the workplace. The lack of support, compassion, kindness and good relationship management reported by the participants in this study require clear institutional policies to address these shortcomings of healthcare Human Resources management systems. According to the guide for the theoretical model of competent compassion by Papadopoulos et al., (2018), compassion is in the centre of culturally competent practice and compassion in healthcare interactions cannot be understood without considering the cycle of cultural awareness, cultural knowledge, cultural sensitivity and cultural competence (Papadopoulos 2018). Hence, in terms of work-related management, relationship and leadership issues as expressed by the participants in this study, some elements of the theoretical model of competent compassion in practice would have made a difference in the outpatient nursing staff overall health and wellbeing.

A few studies conducted in the UK have highlighted the concerns expressed by nurses regarding the inadequacy of policy and implementation initiatives in addressing the numerous organisational barriers they encounter in their daily work. These barriers include staff shortages, burnout, and high level of staff sickness (Jeong and Shin, 2023). This outpatient nursing study was conducted during the peak of COVID-19 pandemic when healthcare workers, including the participants, were often redeployed to different roles. Consequently, they faced challenges that were like those experienced by their counterparts across the healthcare system.

The redeployment experiences had a profound impact on the participants' physical, psychological, emotional, and mental wellbeing, as reported in the study. As a mark of appreciation during the first nationwide lockdown, millions of people in UK participated in ‘Clapping for Carers’ to show their support for NHS frontline health and social care workers (Manthorpe et al., 2020). Although the nurses acknowledged the recognition of their hard work and commitment at work, most participants in this study felt undervalued in their various roles.

6.7 Personal reflection

The professional doctorate is a transformational process which provided me a great opportunity for critical self-reflection on my work and life. According to Maguire and Eastman (2016), this transformational process of seeing oneself begins to emerge clearer by examining others' lives. I have been working within the UK National Health Service (NHS) for over 30 years, held various roles, from junior level as a registered nurse to leadership and managerial roles. From my experience, frequent service changes within the NHS organisations require staff to work under some constraints and lack of capacity issues, which could lead to anxiety over continuing employment and job security. Given this context, it is challenging for the nursing staff to keep themselves healthy while adapting to the frequent service changes.

It is critical to examine from the nursing staff perspective how the staff could be supported during service changes to improve their personal wellbeing, job motivation and invariably deliver high quality care services. At the start of my DProf programme, in September 2019, COVID-19 pandemic was not known. Dramatically, a couple of months afterwards, the outbreak of COVID-19 was announced which vibrated as a shock wave to the entire world. There were a lot of uncertainty and people had no idea how the pandemic would impact our lives. During the peak of COVID-19, in the year 2020, thoughts such as delaying the potential participants' recruitment process for this study were contemplated. At the time, I was not sure whether interviewing the participants during the crisis would remind the interviewees of the difficult global health situation. As such, I was a bit hesitant to continue with the study which could dig deeper into the participants' emotional state. On the other hand, I thought that the interview could benefit some participants in a form of therapy or a safe space and outlet for them to share their thoughts without the fear of judgement.

Most of the outpatient nursing staff were redeployed at the surge of the COVID-19 pandemic, hence, the timing of this study would be the best opportunity for the staff 'to have a voice', to narrate their lived experiences at the incredibly challenging time. With my counselling knowledge, skills, and experience which I have acquired over the years, I felt prepared to undertake this study which included collecting and analysing data from people's experiences during the pandemic crisis.

Other challenges experienced during the recruitment of participants and interview were the government social distancing guidance, infection prevention control measures, due to the COVID-19 pandemic. The initial plan of a face-to-face participants' recruitment and interview were considered which were invariably abandoned and a virtual process was put in place to protect both the researcher and the participants. Some challenges were encountered, especially with new Information Technology (IT) for staff not familiar with advanced IT. However, the IT team supported and navigated the affected participants through the system over the phone. In the end, the majority of the participants expressed gratitude for taking part in this study which gave them a voice to discuss their lived experience at work, especially at the very challenging period. On reflection, I am pleased that I pursued the study without a delay or gap in the study process, while the momentum was there!

6.8 Summary and conclusion

This outpatient nursing study highlighted the issues encountered by the participants in their respective workplaces. The four key themes generated from the data formed the basis for discussion in this chapter. Coincidentally, this study was conducted during the surge of COVID-19 pandemic. The findings suggest that the impact of service was incredibly challenging and more significant at the surge of the pandemic period; 2020/2021, with challenges faced by the redeployed outpatient nursing staff.

In times of crisis, leadership can make a difference by offering empathy, transparent communication in spite of the competing priorities and other key challenges facing the NHS (Kane et al., 2021) and leaders should explore culture change and be able to lead with compassion. Similarly, Jackson (2021) advocates that NHS staff health and wellbeing is the key to caring for patients, especially following the COVID-19 pandemic. In terms of my own wellbeing, I sought the appropriate services for support. In view of the findings from this study and as RCN safety representative, I strongly advocate for the promotion of people–centred culture and compassionate leadership across all the multidisciplinary teams within the healthcare settings.

Chapter 7: Conclusion and recommendations

7.1 Context

This chapter reviews the research findings and the implications for policy and practice, and how the research topic and questions were addressed. This study investigated the impact of service changes on outpatient nurses and healthcare assistants' job motivation and wellbeing. The contribution to the body of knowledge and the key themes from this study are presented in a suggested framework. Finally, in addressing this study's aim and objectives, some strategic recommendations were made, derived from the findings and recommendation for future research also discussed.

The research questions used were designed to achieve the objectives of this study. The outpatient nursing workforce has been under researched and overlooked over the years. Although this project commenced prior to the onset of COVID-19 pandemic, the data collection occurred during the peak of the pandemic which caused some necessary tweaks and changes in the initial research questions to factor the COVID-19 pandemic. In response to the pandemic, the NHS made significant changes to services where most outpatient nurses were redeployed to the wards. The findings from this study were discussed in chapters 5 and 6 of this thesis which presented some over-arching key themes.

Four key themes were generated from the data as follows: (1) New ways of working with increased nurse-led autonomous activities; (2) lack of TNA; staff training and development which hindered nursing staff career progression opportunities; (3) COVID-19 staff redeployment issues and (4) lack of management and leadership support. Additionally, this qualitative data was triangulated with the NHS Staff Survey (2021-2022). The findings also suggested that there were no designated nurse Education Facilitator allocated to the outpatient departments, hence Training Needs Analysis (TNA) was not available for the participants, who were not at the time of this study, aware of the process. TNA is an essential mechanism for staff to engage in their Continuous Professional Development (CPD) (Dening et al., 2019).

7. 2 Achievement of research objectives

The table (7.1) below illustrates the study methodology utilised to accomplish the goals, to meet the overall research aim and objectives. The table also describes the approaches used to gather and analyse the data to address the goals and objectives.

Overall research aim: To explore the impact of service changes on the outpatient nurses and health care assistants' job motivation and wellbeing, from the staff perspective.			
Research Objectives	**Method of achievement**	**Related chapters in thesis**	**Summary of the chapters in relation to the 3 research questions.**
To identify factors that affect outpatient nurses and health care assistants' job motivation and wellbeing, subsequent to service changes and the unprecedented COVID-19 pandemic.	Interviews & reflective journal	Chapter 5	(1) The factors that affect the job motivation and wellbeing of outpatient staff during the pandemic. - Workload, stress and fear of infection and safety concerns. - Lack of resources and support. - Uncertainty and job insecurity and disruption of work-life balance.
To make recommendations which will inform Human Resource and Senior Management teams, on the impact of service changes on the nurses and health care assistants' job motivation and wellbeing.	Interviews & reflective journal	Chapters 2, 3, 4, 5, 6, 7	(2) To implement the instruction of compassionate leadership to managers will benefit outpatient staff in increased job motivation, reduced stress and improved patient care.
To collaboratively establish strategies and mechanism for supporting the staff to achieve a healthy workplace and job motivation.	Synthesis of research findings	Chapter 7	(3) To explore TNA process within the outpatient departments will establish a robust and effective nurses' development and career progression strategy.

Table (7.1). Research objectives devised to achieve the overall research aim and linked to the research question.

7.3 Overview of key themes and findings

Four key themes figure 7.1, p.262 summed up individual participant's lived experience which highlighted some workplace issues to be addressed. Within the NHS, engagement has come increasingly to the fore hence staff engagement indicator was included on annual NHS staff survey since 2011 (Malenfant et al., 2022), therefore, staff training and development is one of the NHS staff survey indicators. The findings from the outpatient nursing staff study showed the lack of training and development for the outpatient nursing staff which hindered their career development opportunities.

Driscoll et al., (2019) advocate that when nurses' benefit form clinical supervision, training and development, they reflect their effort by being enthusiastic, creative, and focused on propelling their performance to meet organisational goals. To address the issue of lack of training and development programs, the NHS Human Resource Management (HRM) advocates for an integrated system. The education strategy would not only monitor the mandatory trainings for healthcare staff, but to ensure that NHS is part of CIPD policy and strategy discussion by 2025 (England NHS, 2021).

The Management and Human Resource teams have a key role to play to ensure equality is in place for all NHS staff TNA and CPD in line with their respective roles and responsibilities. However, the fourth key theme in the outpatient nursing study highlighted issues around management and leadership support which could have resulted in the unavailability of staff training and development opportunities. Supportively, findings from a study (Lin et al., 2020), indicated that managers' developmental feedback plays a positive regulatory role for the staff to strive at work and the relationship between manager-employee dynamics. On the contrary, a compassionate and positive relationship within managers was found to motivate employees to invest more time, enhance task performance, develop and improve efficiency, fostering a strong bond and mutual reciprocity (Bailey and Burhouse, 2019; Baird and Murray, 2022). To address concerns and the outpatient nursing staff lived experience, reviewing, and adopting appropriate leadership style would facilitate a positive change. There is an urgent need to develop a workplace framework to guide NHS leaders, managers, and human resources teams.

7.4 Research findings and related concepts

The significant findings from this study were factors relating to various service changes and how they impacted on outpatient nursing staff job motivation and wellbeing. In order to address the findings, the root-cause analysis of the identified concerns needed to be understood, as some of the issues could have been prevented by eliminating human barriers at operational and organisational levels.

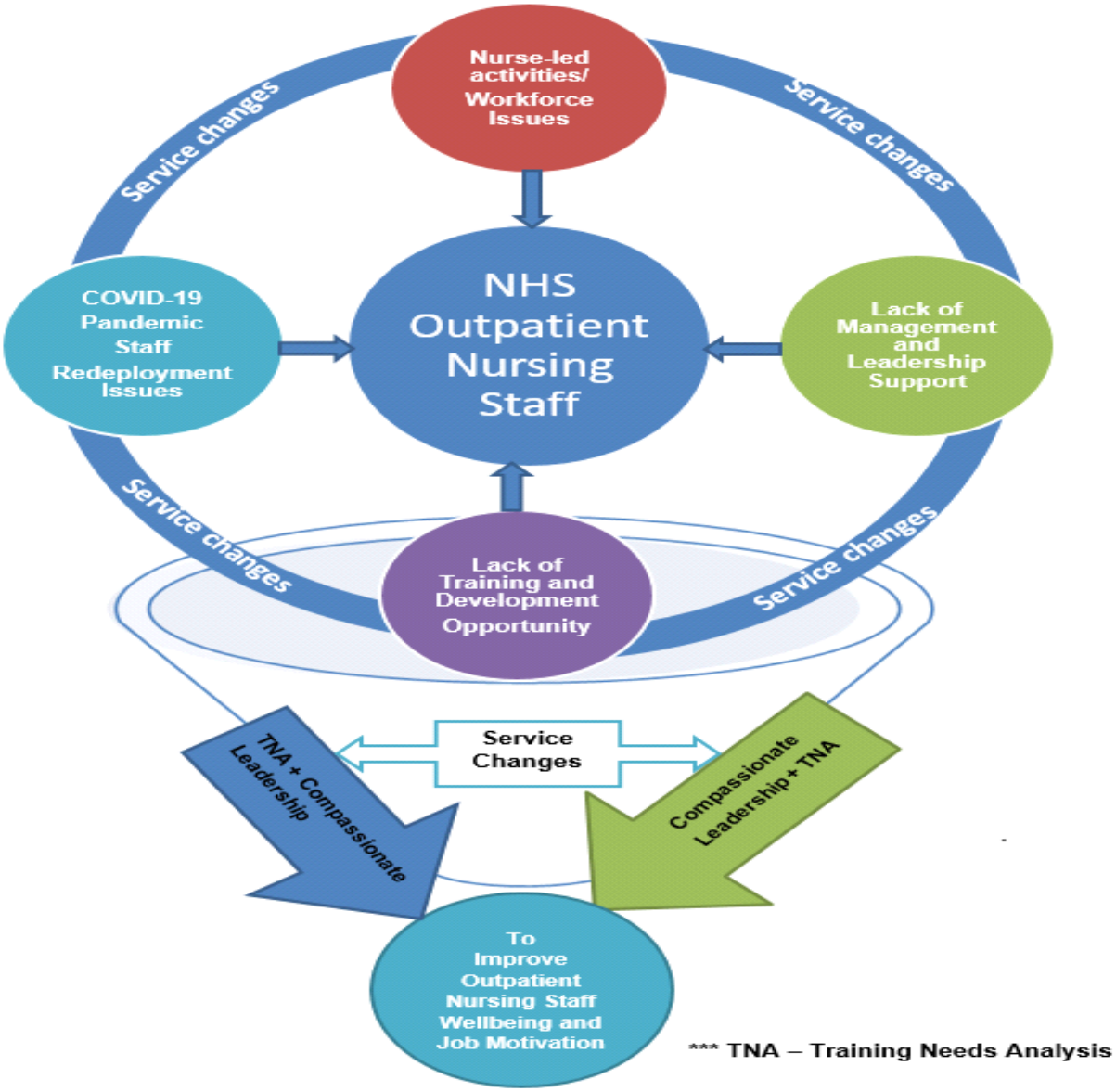


Figure (7.1). Study Key Themes and overarching concepts of Relationship Management and Compassionate Leadership and lack of TNA.

7.4.1 Integrating compassionate leadership and relationship management as an overarching concept for service changes to improve staff job motivation and wellbeing at work

The key themes and concerns experienced by the participants were inter-connected. The common denominators of great concerns reported were lack of training and development due to the absence of TNA and relationship management issues due to lack of compassionate leadership. The key themes identified from this outpatient nursing study are shown in the funnel shaped figure 7.1. This illustration represents the gaps in knowledge on how to improve outpatient nursing staff job motivation and wellbeing, whereby the intertwined compassionate leadership and relationship management are the main factors and strategies and actions to mitigate and close the identified gaps.

7.4.2 Mandatory Compassionate Leadership and Relationship Management Courses for all NHS Managers and Leaders

To foster an innovative culture that provides high-quality, continuously improving care, the managers need to provide timely feedback to all staff in order to verify the fact that compassionate behaviours are being constantly modelled. Based on the interconnection of culture and compassion, Papadopoulos et al., (2021) advocates for practice of culturally competent compassionate leadership, a virtue which implies both a comprehension and ‘a drive to act to reduce the pain of another human fellow’. In the specific context of the outpatient study, the phrase ‘the pain of another human fellow’ resonates with the emotional and psychological distress experienced by some participants. Chapters 5 and 6 discussed instances where individuals felt a lack of compassion, which might have exacerbated their emotional and psychological pain.

By acknowledging these experiences, the statement underscores the significance of addressing the participants' concerns and improving compassion within the outpatient setting and nursing team. It suggests that providing timely feedback to all staff members can help ensure that compassionate behaviours are consistently modelled, and ultimately, foster a culture of compassion.

Literatures on healthcare leaders suggest that leaders who demonstrate a commitment to high quality and compassionate care directly affect clinical effectiveness, patient safety and experience and staff engagement (Klein, 2019). Overall, incorporating timely support can contribute to an innovative and continuously improving healthcare environment and staff job motivation and wellbeing.

7.5 PESTLE Analysis linked to some of the study key themes

In terms of PESTLE (Political, Economic, Social, Technological, Legal, and Environmental) analysis, the findings and recommendations could be identified from the key themes. The increased nurse-led activities form part of the outpatient transformation programme and for sustainability, the nursing workforce's job motivation and wellbeing needs to be improved. A brief PESTLE analysis was drawn as a link and root-cause analysis of some participants' narratives (appendix 20; pages 360 & 361). This framework should be used as a developmental guide and can be further researched. These research findings would be valuable in shaping human resource policy and guiding professional nursing bodies, through the dissemination of this project outcomes.

7.6 Dissemination of findings

Studies could be shared in a variety of ways, such as digitally, where academic publications and conferences are popular. As per the Colaizzi's (1978) seven steps framework of data validation, the preliminary findings were shared with the participants by email, to which they responded (appendix 18b, pages 352-357). Thereafter, meetings were organised with the senior management and other key stakeholders (figure 7.2) below. The final study outcome and recommendations are shared. I attended the organisation's divisional and organisational Education team meetings where I shared the findings and the recommendations from this study.

7.7.1 Change agent: Key stakeholders' involvement

Working in partnership and collaboration, the key stakeholder's involvement as illustrated on the figure (7.2) below were explored at the beginning of this project.

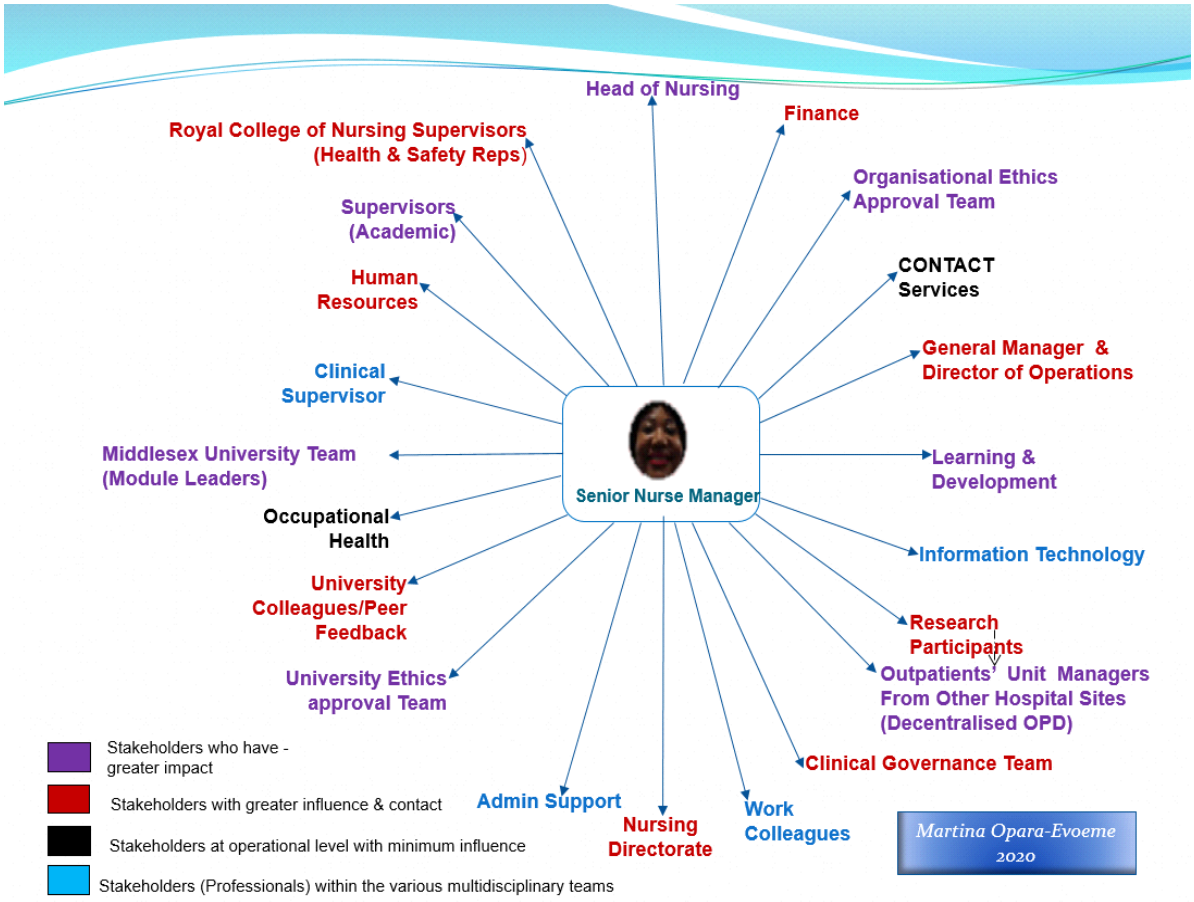


Figure (7.2) Senior Nurse Manager (Insider- Researcher).

Due to my values and passion for staff development and wellbeing, I followed up the agreed actions with the outpatient managers, worked collaboratively with the Education team and this initial action yielded a positive outcome (appendix 21). This study outcome was and still being discussed at every opportunity in various senior nursing management and the wider key stakeholders' meetings to increase awareness of the key issues that need addressing. Presentations at RCN conferences such as autumn learning are planned. It is reassuring that some members of the multidisciplinary team listed on the illustrated key stakeholders are in positions to facilitate the implementation of the recommendations from this study.

The findings are currently being shared with the participants, nurse managers and others already listed. Some of the managers during the findings' presentation expressed that, as humans they were overwhelmed too, by the unforeseen challenges brought about by the pandemic and thus, the unforeseen event was used to test their leadership. However, the situation might increase their confidence, experience and ability to lead through future clinical crises.

7.7.2 Study limitation and challenges

There were some limitations to this study, which took place within multiple hospitals on different sites, in one of the NHS Trusts situated in the inner London region. The restriction placed on movement of people and social distancing during the surge of the COVID-19 pandemic was acknowledged as a constraint and unavoidable challenge (Lobe et al., 2020). This situation limited the researcher's chance of face to face staff engagement and interactions during the early stage of the study. However, this constraint was mitigated by using extensive virtual advertisement through emails and Microsoft Team meetings. Virtual one-on-one interviews were conducted with relevant support from the IT team to ensure the facilities were properly set up. This study was limited to outpatient clinical services and nurses working on the ward were excluded. Hence, the findings may not be representative of the entire outpatient nursing workforce in other UK regions, although the researcher's organisation is one of the largest Healthcare Trust.

7.8 Research findings, recommendations and implications for policy

The challenges encountered by the participants of this project formed the basis for the proposed strategies on table 7.2 (pages 267 & 268), with the summary of identified issues from this outpatient nurses' study, recommendations with the designated stakeholders' responsibilities. To improve the situation and promote a sustainable healthy workplace for outpatient nursing staff, it is recommended to employ the suggested strategies. Given the findings from this study, addressing the identified needs required a multi-pronged strategy involving multiple stakeholders.

While untested, a suggested 'wellbeing framework' (figure 7.1; p.262) aims to tackle the problems identified in this research by using a compassionate collaborative multidisciplinary team approach. Table 7.2 below outlines the recommendations and key stakeholders' responsibilities.

Reference	Themes	Recommendations to stakeholders	Responsibility
See chapter 2 (literature review) and chapter 5 (results); chapters 6 & 7.	<u>Training and Development:</u> Outpatient nursing staff reported lack of access to training and career development opportunities. There were no mechanism for Training Needs Analysis (TNA).	<u>Strategies:</u> • The Human Resource need to build a strong organisational development (OD) capability across services team of the organization and embed training and development as part of workforce strategy. • Identify training needs for all clinical areas and set up a system where TNA is mandatory and monitored. • Use competencies, training and agreed standards to help create a supportive and inclusive learning environment and opportunity so that staff feel confident to access • Implement TNA and CPD across all outpatient clinical settings within NHS organisations.	Human Resources Senior Management Finance Team. Nurse Managers & Learning and Development Team. Nurse Managers & Learning and Development Team. Nurse Managers and Education Facilitators.
See results section chapter 5,6,7	Job motivation and Wellbeing Lack of compassionate Leadership and/or management	• Audit the personal and professional development of outpatient nursing staff and managers being held accountable where staff development is not achieved.	Individual nurses NHS Trusts, Managers

		• A culture of compassionate leadership should be implemented to support cultural change in our organisations. • All NHS managers and Leaders to undertake Compassionate Leadership and Relationship Management as statutory mandatory training.	
See results section Chapter 5.	Outpatient Nursing Staff reported that there was a lack of preparation during their redeployment	NHS Trust should provide training and development as periodic preparedness for all non-critical care nurses in readiness for any service changes, unprecedented major incidents or pandemic.	Management Human Resources and Managers.
See results section Chapter 5.	Outpatient staff reported understaffing and increased staff sickness absence.	• Strategic staff recruitment and retention should be established to reduce staff shortage, burnout and staff turnover rate. • Ensure safer staffing and regular workforce skill-mix reviews to meet service needs.	Management Human Resources and Managers.
See results section chapter 5, 6, & 7.	Continued from understaffing.	• To engage staff at all levels and create an inclusive health and flexible working opportunities. • To explore compassionate leadership in managing staff sickness and absence • Work in collaboration with the organization's Occupational Health team for staff support.	All Nurses Nurse Mangers Occupational Health Team.

Table (7.2). Summary of main findings of the key issues and recommended actions.

Table (7.2) above established the identified key themes and some strategies to mitigate against the challenges and problems found during this study. In order to achieve actions on the set recommendations, it is crucial to:

- Ensure that there is a process in place for staff Training Needs Analysis (TNA).
- Enable and facilitate the nurses' Continuous Professional Development (CPD) plan and regularly monitor progress.
- Embed a regular audit process as a compliance check mechanism to ensure that future training initiatives are more targeted, relevant, and effective in meeting the evolving training needs of the outpatient clinical staff.

In response to evolving outpatient service demands, the changes resulted in the adoption of innovative approaches, such as nurse-led autonomous activities which formed an integral part of the registered nurses' daily responsibilities. However, despite the outpatient nurses' resilience and service innovation, the nursing staff highlighted concerns and limitations within the current system which included lack of management and leadership support. Another major issue reported by the nurses was the lack of Training Needs Analysis (TNA) and Continuous Professional Development (CPD) opportunities. The absence of these critical components hindered the staff's professional development, career progression and growth.

By implementing comprehensive TNA processes, healthcare institutions can identify the specific training requirements of their nursing staff and design tailored development programs to address these needs. Simultaneously, ensuring access to Continuous Professional Development opportunities will enable the nurses to stay up to date with the latest advancements in their field and enhance their expertise. Moreover, it is vital to emphasise that addressing this issue is not solely about individual professional growth but also aligns with broader organisational goals. As a requirement, great emphasis is placed on ensuring that, equality and diversity are fundamental aspect of all corporate strategies within the NHS (Kline, 2014). By prioritising the career development of outpatient nursing staff through effective TNA and CPD initiatives, healthcare institutions can foster an environment that promotes equal opportunities and supports diversity and equality within their workforce.

The lack of Training Needs Analysis and Continuous Professional Development opportunities emerged as a significant obstacle to their career development and job motivation. Recognising the importance of these factors and embedding them into healthcare organisational strategies is critical for addressing the identified concerns thereby fostering an environment of equality and diversity within the NHS. Findings from various research studies within UK highlight the value of a diverse workforce, and of an inclusive organisational culture are deemed crucial for effective team work, and overall benefit to workforce management.

Given the findings of this study, it is evident that job motivation and wellbeing in outpatient services are influenced by several key factors. The identified themes, such as new ways of working, lack of training and career progression opportunities, COVID-19 redeployment issues, and insufficient management support, provided valuable insights into the dynamics affecting healthcare professionals in outpatient settings.
In the context of this study, job motivation can be defined as the internal drive and enthusiasm that outpatient nurses and healthcare assistants experience in response to their work environment, including the autonomy in nurse-led activities, support from line managers, and opportunities for learning and development. It encompasses the intrinsic factors that contribute to a sense of purpose and fulfilment in their roles

7.9 My reflection on undertaking a DProf programme.

My lifetime dream has always been to be a nurse which I passionately pursued from age 16 and I have not looked back since then. However, my family and friends identified my 'blind spot' several years ago and have always reminded me to consolidate my nursing leanings and experience academically, to further benefit the wider nursing population and the NHS. Obtaining a Doctorate will be the best gift that I can give to my parents, especially to my Dad who recently passed away shortly before my Viva oral examination. The findings of this study highlighted some gaps in terms of outpatient staff training, development, and career progression. The wealth of evidence that caring better for staff has multiple benefits has grown as service pressures have increased and the 2019 NHS Long Term Plan acknowledges the crucial importance of caring for staff to improve patient care (Klein, 2019).

My learning process during my research project started with my critical self-reflection, self-awareness and autobiography to establish my positionality as an insider researcher for this study. Eastman and Maguire (2016) explained that, critical thinking or critical reflection is considered to be the basis of autobiography. This study provided me with a better understanding of the outpatient service changes from the staff perspective. Wellbeing goes beyond physical health and extends to the mental and emotional aspects of the participants' professional lives. Undertaking this study during the surge of COVID-19 pandemic increased my resilience in dealing with the complexities of my role, responsibilies and competing priorities at work.

Prior to the start of my research project, I did not realise how demanding outpatients services is, requiring highly skilled nursing workforce. The distinctive findings from this study showed the diversed specialties' clinical nurse-led activities within the outpatient services. I was intrigued with the findings which revealed the role and contributions which the outpatient nursing workforce bring to the NHS organisation. The new knowledge from this research, combined with my passion and drive to support the staff, has empowered me to objectively review the current practice and policies regarding staff training and development within outpatients.

Staff development in the nursing context is defined as the systematic process directed towards the personal and professional growth of nurses and other personnel while they are employees by a healthcare organisation (Ajithakumari & Hemavathy, 2016). Leadership was the overarching factor embedded in the four key themes. Professionally, I would strongly advocate for compassionate leadership to support staff at all levels and according to Dawson (2022), everyone in their areas of responsibilities is a leader. Leadership is often carried out by people who have not had the opportunity to develop the qualities, skills and ability to create the desired impacts (Dawson, 2022).

Overall, my DProf programme was a good experience, although challenging the journey has broadened my knowledge in various disciplines and how to undertake research. The immense support from my Academic Supervisors Dr Sheila Cunningham and Dr Venetia Brown cannot be overemphasised. Most importantly, this study's result may help NHS managers and leaders to have a better understanding of the importance of embedding robust TNA strategies and compassionate leadership in the workplace. Maintaining CPD for all nursing staff is crucial to enhance their personal and professional development and to keep abreast with the current trend in nursing.

7.10 Summary and concluding comments

This chapter discussed whether the research's goals and objectives had been met and provided a summary of its findings and their implications for practise and policy. Based on this project's findings, recommendations have been made, and its contributions to the body of knowledge discussed. Also, a conceptual model of the problems were taken into account and a framework was created to address the identified undesired impact of service changes on the outpatient nursing staff.

Amongst other findings, it is hoped that this outpatient nursing study will create a better understanding of how to support this group of NHS nursing workforce, in terms of career development and progression. As part of professional values to practice effectively and preserve safety (NMC, 2018), the nursing services are expected to be dynamic in response to changing and increasing health care needs. This expectation requires the purposeful and effective development of nursing workforce capability through the established and NHS funded continuing professional development (CPD). An evidence-based approach to TNA is highly recommended, yet, it is the missing step in designing a CPD strategy for service improvement (Holloway et al., 2018). Moreover, the concept of working and learning as work- based learning (WBL) is a creative means of learning using neoteric tools and in-work applications to encourage novel adult participation (Nikolou-Walker et al., 2020). By implementing and embedding robust TNA and WBL strategies within the outpatient services, the nursing workforce' career development, job motivation and wellbeing could be enhanced, thereby increasing the outpatient service quality care.

Conclusively, this study highlights the interconnectedness of job motivation and wellbeing in outpatient healthcare settings, emphasising the need for organisational strategies that foster a positive work environment, support professional development, and address disparities in career opportunities. The redefinitions of job motivation and wellbeing align with the specific context of outpatient healthcare services, providing a comprehensive understanding of the factors influencing the job motivation and wellbeing of nurses and healthcare assistants in this setting.

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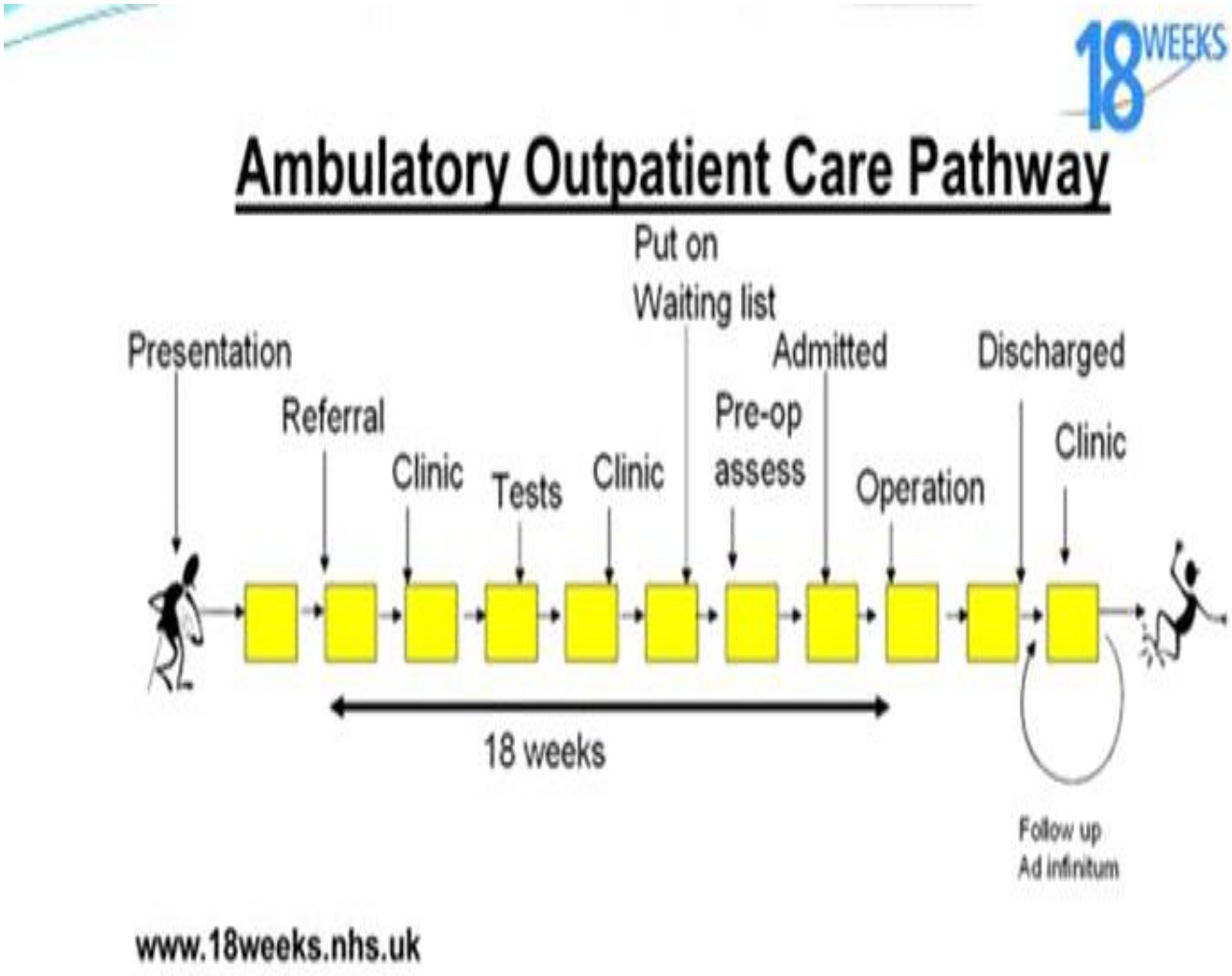
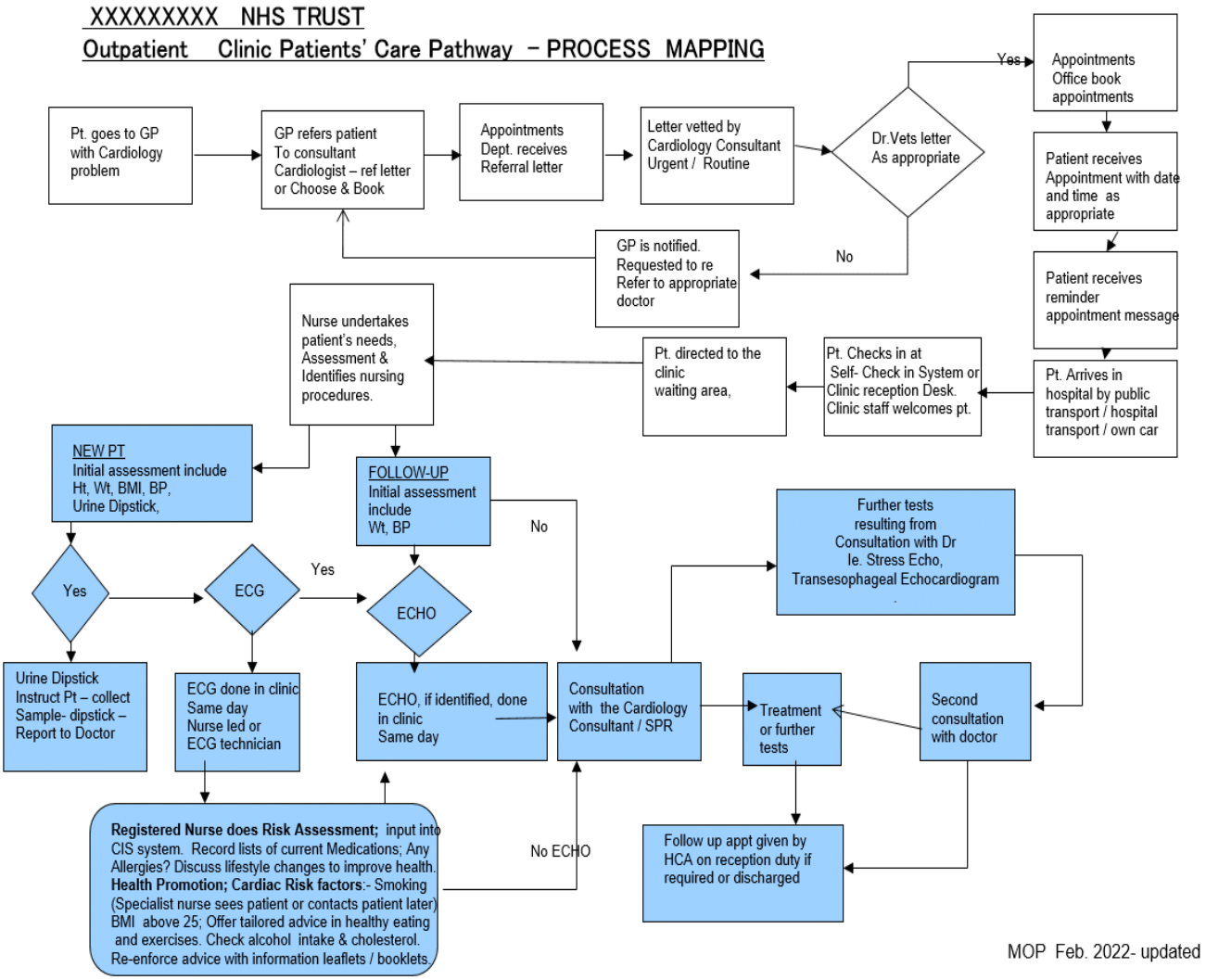
Appendix

Appendix 1 (a) – Outpatient Care Pathways



Appendix 1 (b) – Outpatient Care Pathways



Appendix 2 – Five Research design approaches

Contrasting Foundational Considerations of Five Qualitative Approaches					
Characteristics	**Narrative Research**	**Phenomenology**	**Grounded Theory**	**Ethnography**	**Case Study**
Focus	Exploring the life of an individual	Understanding the essence of the experience	Developing a theory grounded in data from the field	Describing and interpreting a culture-sharing group	Developing an in-depth description and analysis of a case or multiple cases
Type of Problem Best Suited for Design	Needing to tell stories of individual experiences	Needing to describe the essence of a lived phenomenon	Grounding a theory in the views of participants	Describing and interpreting the shared patterns of culture of a group	Providing an in-depth understanding of a case or cases
Discipline Background	Drawing from the humanities including anthropology, literature, history, psychology, and sociology	Drawing from philosophy, psychology, and education	Drawing from sociology	Drawing from anthroplogy and sociology	Drawing from psychology, law, political science, medicine
Data collection form	Using primarily interviews and documents	Using primarily interviews with individuals, although documents, observations, and art may also be considered	Using primarilty interviews with 20-60 individuals	Using primarily observations and interviews, but perhaps collecting other sources during extended firld time	Using multiple sources, sucha as interviews, observations, documents, artifacts
Unit of Analysis	Studying one or more individuals	Studying several individuals that have shared the experience	Studying a process, action, or interaction involving many individuals	Studying a group that shares the same culture	Studying an event, a program, an activity, more than one individual
Data Analysis Strategies	Analysing data for stories, “restorying” stories, developing themes, often using a chronology	Analysing data for significant statements, meaning units, textural and structural description, description of the “essence”	Analysing data through open coding, axial coding, selective coding	Analysing data through description of the culture-sharing group; themes about the group	Analysing data through desription of the case and themes of the case as well as cross-case themes
Written Report	Developiong a narrative about the stories of an individual’s life	Describing the “essence” of the experience	Generating a theory illustrated in a figure	Describing how a culture-sharing group works	Developing a detailed analysis of one or more cases

Appendix 3 (a) Research Advertisement and Email Invitation

Research Participants Needed

Middlesex University London

Exploring The Impact of Service Changes on Outpatients Nurses and Health Care Assistants' Job Motivation.

You are invited to take part in the above study

THE STUDY WILL AIM TO:

- Explore staff views on the level of outpatients nurses' workplace experience of service changes before and during the unprecedented COVID-19 pandemic.
- Evaluate and analyse the effect and experience from the staff perspective.
- Establish and make recommendations on strategies and mechanism to improve a healthy workplace and nurses job motivation and wellbeing.

For details, please contact:
Martina Opara-Evoeme (Researcher) on email: mo935@live.mdx.ac.uk

Academic Supervisors' Contact Details:

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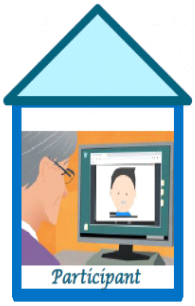
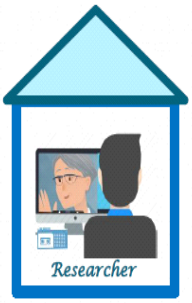
Doctor Venetia Brown
School of Health and Education, Middlesex University,
The Burroughs. Hendon London NW4 4BT
Telephone; 02084116732 Email: V.Brown@mdx.ac.uk

Deadline: Please respond by.....

REQUIREMENTS:

- Outpatients nursing staff.
- Band 5 and 6 (RGNs), and Band 3 (HCAs) Agenda for Change pay bands.
- Must have over 2 years experience in Outpatients and undergone some service changes.





Impact of service changes on outpatients' nurses and health care assistants' job motivation - - MOP

Appendix 3 (b)

Version Number 1

Study Recruitment Email Invitation

Dear xxxx

Re: Research project: Exploring the impact of service changes on outpatients' nursing staff job motivation, from staff perspective.

My name is Martina Opara-Evoeme and I am a D/Prof student in the Health and Education Schools at Middlesex University London. I am working on a research project under the academic supervision of Dr. Venetia Brown and Dr. Sheila Cunningham, University email addresses shown below;
V.Brown@mdx.ac.uk and S.Cunningham@mdx.ac.uk

Given that outpatients' nursing research is underrepresented in the research world and there is a gap in knowledge, this qualitative study is focusing specifically on nurses who work in the ambulatory outpatients' services. The outcome of this study will inform human resource policy making on how to improve outpatients' nursing staff job motivation.

The title of the project is: Exploring the impact of service changes on outpatients' nursing staff job motivation, from staff perspective. I am the study researcher.

I would like to invite you to participate in the study. If you are interested or have any questions, please contact me by e-mail or on bleep 1521. You will be sent a Participant Information Sheet to read and keep (this tells you all about the study) and you will be asked to sign a consent form before participating in the study.

Contact details:

Martina Opara-Evoeme

Telephone; xxxxxx32610; extension 32610 or bleep 1521.
martina.opara@nhs.net

Appendix 4 – Participant Information Sheet

Participant Information Sheet (PIS)

More Than Minimal Risk or High Risk Projects

(Must be used with a Consent Form that is signed by participant and retained by the researcher)

Version Number; 2: 16/07/2021

Participant ID Code: xxxxxxx…….

SECTION 1

1. Project/Study title

Exploring the impact of service changes on outpatient nurses' and health care assistants' job motivation, from staff perspective.

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

The main aim of this research is to understand the impact of service changes on the outpatients' nursing staff job motivation. This research form part of the staff wellbeing strategy with an aspiration to explore the experiences of outpatients' nurses' and health care assistants' job motivation, overall wellbeing at work and subsequently, improve patient experience.

The study will aim to:

- Explore staff views on the level of outpatient nurses' and health care assistants' workplace experience of service changes before and during the unprecedented COVID-19 pandemic.
- Evaluate and analyse the effect and experience from the staff perspective.
- Establish and make recommendations on strategies and mechanism to improve a healthy workplace and staff job motivation and wellbeing.

4. Why have I been chosen?

It is important that the researcher hears from as many participants as possible, nurses who work in the outpatients services that have been chosen to take part in this study. Literature review suggests that, there is a lack of qualitative research linking to services changes and outpatient nurses' and health care assistants'' experience. Example is a recent nurses' research activity within the organisation on nurses' burnout, which specifically invited in-patients' nurses only, for participation and the recruitment started in April 2021. Given that outpatients' nursing research is underrepresented in the research world, there is a gap in knowledge, hence this study is focusing specifically on nursing working in the ambulatory outpatients' services.

The inclusion criteria for this study are; outpatients' nurses' and health care assistants' over 2 years in post, who have experienced some service changes. Nurses on Agenda for Change (AFG) pay band 3**,** health care assistants; band 5, nurses and band 6, nurses. The researcher hopes to interview 8 participants for the pilot study and a total number of 20 participants for the main research interview.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you do decide to withdraw from the study then please inform the researcher as soon as possible, and they will facilitate your withdrawal.

If, for any reason, you wish to withdraw your data please contact the researcher within a month of your participation. After this date it may not be possible to withdraw your individual data as the results may have already been published. However, as all data are anonymised, your individual data will not be identifiable in any way.

The participants are outside the researcher's management remit therefore a decision not to take part in the study will not affect the work relationship. If you decide to take part you will be asked the questions below at the start of your interview to check that you are happy to go ahead with the interview.

6. What will I have to do?

The interview will be take place in the workplace with the researcher either virtually by dialling into a conference call or over the phone. You will be able to choose any of the options that you prefer. If you consent to taking part, you will be asked to complete one interview to last between 45-60 minutes maximum. With your consent, interviews will be audio-recorded.

During the interview, you will be able to describe the impact of service changes on your job motivation and how you think things could be done differently, to improve your job motivation. Care will be taken to protect your identity and that of your designated department. Once the recording has been transcribed, the audio-recording will be destroyed. This will be done by keeping all responses anonymous throughout the process. All your data is confidential and will be processed in accordance with the Data Protection Act (2018).

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor.

7. What are the possible disadvantages and risks of taking part?

Appropriate risk assessments for all procedures have been conducted, and will be followed throughout the duration of the study. It is not anticipated that taking part in this study will pose any risk. However, should you feel touched by any of the questions in the interview, the researcher will pause the interview and recording. The interview will only continue when you indicate to do so.

8. What are the possible benefits of taking part?

We hope that participating in the study will help you. However, this cannot be guaranteed. The information we get from this study may help us to understand the impact of service changes on the nurses. Your experiences will help in the research findings which will inform human resource policy to improve staff job motivation and wellbeing.

9. Safeguarding

All the information you provide will be treated in accordance with the Data Protection Act (2018) and all electronic data will be stored on OneDrive folder, which is the University dedicated storage area with controlled access for research data only. The researcher will comply with the Nursing and Midwifery Council (2018) on confidentiality policy and professional standards of practice for nurses and midwives (NMC, 2018).

The Nursing and Midwifery (NMC) code www.nmc-uk.org/Nurses-and-midwives/The-code/ states that as nurses and midwives 'you must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practicing'.

10. Will my taking part in this study be kept confidential?

The researcher has put a number of procedures in place to protect the confidentiality of participants. You will be allocated a participant code that will always be used to identify any data you provide. Your name or other personal details will not be associated with your data, for example, the consent form that you sign will be kept separate from your data. All paper records will be stored in a locked filing cabinet, accessible only to the researcher, and all electronic data will be stored on password protected OneDrive folder. All information you provide will be treated in accordance with the Data Protection Act (2018).

11. What will happen to the results of the research study?

The results of the research study will be used as part of a Doctorate dissertation. The report will be shared with you and other participants. However, the data will only be accessed by the researcher and her academic supervisors and at no point will your personal information or data be revealed. The results may also be presented at conferences or in journal articles with your permission.

12. Who has reviewed the study?

The study has received full ethical clearance from the Research ethics committee who reviewed the study. The committee is the Middlesex University Health and Social Care Research Ethics Committee (REC).

13. Contact for further information

If you require further information, have any questions or would like to withdraw your data then please contact:

Martina Oparah-Evoeme by e-mail; mo935@live.mdx.ac.uk

If you have any ethical concerns with the study, please contact the supervisors: Dr. Venetia Brown or Dr. Sheila Cunningham on Middlesex University email addresses contact shown below;

Dr Sheila Cunningham <S.Cunningham@mdx.ac.uk>
School of Health and Education, Middlesex University
The Burroughs. Hendon
London NW4 4BT
Telephone; 02084112687

Dr Venetia Brown <V.Brown@mdx.ac.uk>
School of Health and Education, Middlesex University
The Burroughs. Hendon
London NW4 4BT
Telephone; 02084116732

Thank you for agreeing to take part in this study. You (the participant) should keep this "Participant Information with Consent" sheet since it contains important information and the research teams contact details.

Middlesex University Guide to Research Privacy Notice

Privacy notices need to be presented whenever data is collected and should be understandable and accessible. Privacy notices must explain the type and source of data that will be processed. They will also set out the processing purpose, data retention schedules and data sharing. Privacy notices must include details of the subject's rights and who the subject can complain to.

The following example may be used and completed for your research purposes.

Middlesex University Privacy Notice for Research Participants

The General Data Protection Regulation (GDPR) protects the rights of individuals by setting out certain rules as to what organisation can and cannot do with information about people. A key element to this is the principle to process individuals' data lawfully and fairly. This means we need to provide information on how we process personal data.

The University takes its obligation under the GDPR very seriously and will always ensure personal data is collected, handled, stored and shared in a secure manner. The University's Data Protection Policy can be accessed here: https://www.mdx.ac.uk/__data/assets/pdf_file/0023/471326/Data-Protection-Policy-GPS4-v2.4.pdf. Accessed, read, signed off and uploaded on the appropriate section on the ethics application and completion form.

The following statements will outline what personal data we collect, how we use it and who we share it with. It will also provide guidance on your individual rights and how to make a complaint to the Information Commissioner's Officer (ICO), the regulator for data protection in the UK.

Why are we collecting your personal data?As a university we undertake research as part of our function and in our capacity as a teaching and research institution to advance education and learning. ***The specific purpose for data collection on this occasion is to, 'explore the impact of service changes on the outpatients' nursing staff job motivation'***. The study will aim to:

- Assess the level of outpatient nurses' workplace experience of service changes before and during the unprecedented COVID-19 pandemic.
- Evaluate and analyse the effect and experience from the staff perspective.

- Establish and make recommendations on strategies and mechanism to improve a healthy workplace and nurses' job motivation and wellbeing.

The legal basis for processing your personal data under GDPR on this occasion is Article 6(1a) consent of the data subject.

Transferring data outside Europe

In the majority of instances your data will be processed by Middlesex University researchers only or in collaboration with researchers at other UK or European institutions so will stay inside the EU and be protected by the requirements of the GDPR.

In any instances in which your data might be used as part of a collaboration with researchers based outside the EU all the necessary safeguards that are required under the GDPR for transferring data outside of the EU will be put in place. You will be informed if this is relevant for the specific study you are a participant of.

Your rights under data protection

Under the GDPR and the DPA you have the following rights:

- to obtain access to, and copies of, the personal data that we hold about you;
- to require that we cease processing your personal data if the processing is causing you damage or distress;
- to require us to correct the personal data we hold about you if it is incorrect;
- to require us to erase your personal data;
- to require us to restrict our data processing activities;
- to receive from us the personal data we hold about you which you have provided to us, in a reasonable format specified by you, including for the purpose of you transmitting that personal data to another data controller;
- to object, on grounds relating to your particular situation, to any of our particular processing activities where you feel this has a disproportionate impact on your rights.

Where Personal Information is processed as part of a research project, the extent to which these rights apply varies under the GDPR and the DPA. In particular, your rights to access, change, or move your information may be limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we may not be able to remove the information that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. The Participant Information Sheet will detail up to what point in the study data can be withdrawn.

If you submit a data protection rights request to the University, you will be informed of the decision within one month. If it is considered necessary to refuse to comply with any of your data protection rights, you also have the right to complain about our decision to the UK supervisory authority for data protection, the Information Commissioner's Office.

None of the above precludes your right to withdraw consent from participating in the research study at any time.

Collecting and using personal data

The data collection method is through a semi-structured interview. The interview will take place in the workplace with the researcher either virtually by dialling into a conference call or over the phone with the participant.

You will be able to choose any of the two options that you prefer. If you consent to taking part, you will be asked to complete one interview to last between 45-60 minutes maximum. With your consent, interviews will be audio-recorded. Your personal details and details of your work department and location will be anonymised and used to inform the responses in general to the research data collected.

During the interview, you will be able to describe the impact of service changes on your job motivation and how you think things could be done differently, to improve your job motivation.

All electronic data will be stored on OneDrive folder, which is the University dedicated storage area with controlled access for research data only. The researcher will comply with the Nursing and Midwifery Council (2018). Once the recording has been transcribed, the audio-recording will be destroyed. This will be done by keeping all responses anonymous throughout the process. All your data is confidential and will be processed in accordance with the Data Protection Act (2018). Middlesex University Privacy Notice for Research Participants document is also attached on section 7.1c.

Data sharing

Your information will usually be shared within the research team conducting the project you are participating in, mainly so that they can identify you as a participant and contact you about the research project.

Responsible members of the University may also be given access to personal data used in a research project for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your records. All of these people have a duty to keep your information, as a research participant, strictly confidential.

If we are working with other organisations and information is shared about you, we will inform you in the Participant Information Sheet. Information shared will be on a ‘need to know’ basis relative to achieving the research project’s objectives, and with all appropriate safeguards in place to ensure the security of your information.

Storage and security

The University takes a robust approach to protecting the information it holds with dedicated storage areas for research data with controlled access.

Alongside these technical measures there are comprehensive and effective policies and processes in place to ensure that users and administrators of University information are aware of their obligations and responsibilities for the data they have access to. By default, people are only granted access to the information they require to perform their duties. Training is provided to new staff joining the University and existing staff have training and expert advice available if needed.

Retention

Under the GDPR and DPA personal data collected for research purposes can be kept indefinitely, providing there is no impact to you outside the parameters of the study you have consented to take part in.

Having stated the above, the length of time for which we keep your data will depend on a number of factors including the importance of the data, the funding requirements, the nature of the study, and the requirements of the publisher. Details will be given in the information sheet for each project.

Contact us

The Principal Investigator leading this research is;
Martina Oparah-Evoeme

Email address; mo935@live.mdx.ac.uk

The University's official contact details are:

Data Protection Officer
Middlesex University
The Burroughs
London
NW4 4BT
Tel: +44 (0)20 8411 5555
Email: dpaofficer@mdx.ac.uk

Reference:

Nursing and Midwifery Council (2018). The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

https://www.nmc.org.uk/standards/code/ [Accessed 14-07-2021].

Middlesex University London

Appendix 5 – Consent Form

Version Number; 3

Participant Identification Number:

CONSENT FORM

Title of Project: Exploring the impact of service changes on outpatients' nurses' and health care assistants' job motivation, from staff perspective.

Name of Researcher: Martina Oparah-Evoeme

Please initial box

- I confirm that I have read and understand the information sheet dated; 4th August 2021 for the above study and have had the opportunity to ask questions.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without penalty.
- I agree that this form that bears my name and signature may be seen by a designated auditor.
- I agree that my non-identifiable research data may be stored in National Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers.
- I understand that my interview may be taped and subsequently transcribed.

6. I agree to take part in the above study.

Name of participant	Date	Signature
Martina Opara-Evoeme Name of person taking consent (if different from researcher)	4th August 2021 Date	 Signature
Martina Opara-Evoeme Researcher	4th August 2021 Date	 Signature

1 copy for participant; 1 copy for researcher;

Remember that a signed consent form is not required for an anonymous questionnaire, instead the following statement is recommended to be included on the survey questionnaire:

'Completion of this questionnaire is deemed to be your consent to take part in this research.'

Optional; Please indicate as appropriate:

Demographic Variables and Attributes of Participants

	Variables	Working Definitions (Attributes)	Code	Comment
1	Respondent - Type	NHS Registered Nurses (RN) &Healthcare Assistants (HCA)	RTN	
2	Gender	Male/Female/Ohers; please indicate	GDR	
3	Age	Age of Respondents	AGE	Age range; 20-30; 30-40; 40-50; 50 and above
4	Ethnicity	Origin	ETH	
5	Work location	Sites and Clinical Specialities	LOC	
6	Designation	RGN band 5 &6	RGN	
		HCA band 3	HCA	
7	Years of Experience	Length of Service in Outpatients Department	EXP	

Appendix 6 – Letter of Approval Research Ethics Committee – Programme

Middlesex University London

Health and Social Care Ethics Sub-committee

The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 0208 411 5000

12/09/2021

APPLICATION NUMBER: 17847

Dear Martina Ngaonyekamma Oparah-Evoeme and all collaborators/co-investigators

Re your application title: Service changes' impact on outpatients' nurses and health care assistants.

Supervisor: Sheila Cunningham, Veactia Brown

Co-investigators/collaborators:

Thank you for submitting your application. I can confirm that your application has been given APPROVAL from the date of this letter by the Health and Social Care Ethics Sub-committee.

The following documents have been reviewed and approved as part of this research ethics application:

Document Type	File Name	Date	Version
Further details	Research Fieldwork Risk Assessment form - 4-2021 - Martina Opara-Evoeme (1)	29/04/2021	1
Informed Consent Form	Semi-structured interview schedule - Martina Opara -Evoeme - 28-April 2021	04/05/2021	1
Further details	Semi-structured interview schedule - Martina Opara -Evoeme - 28-April 2021	04/05/2021	1
Aims, objectives and hypotheses	Research Project Flow Chart - B - 02- June - 2021 - Martina Opara-Evoeme	02/06/2021	2
Participant Recruitment Information	Demographic Variables and Attributes -10-02-2021 - updated 2-6-2021	04/06/2021	1
Materials	Indicative Research Interview questions - updated June - 2021	04/06/2021	2
Aims, objectives and hypotheses	Research Project Outline Template A - April 2021 - Section 2.4 - 6- 2021	04/06/2021	2
Permission/Agreement Letter	[redacted] - Gatekeeper's doc - July 2021	12/07/2021	July 2021
Permission/Agreement Letter	[redacted] - Gatekeeper's request doc - July 2021	12/07/2021	July 2021
Permission/Agreement Letter	Letter_Gatekeeper Permission - [redacted] - July 2021 (2) request letter	12/07/2021	July 2021
Permission/Agreement Letter	[redacted] Gatekeeper doc - July 2021	12/07/2021	July 2021
Permission/Agreement Letter	[redacted] - Gatekeeper's approval July 2021	13/07/2021	July 2021
Permission/Agreement Letter	Gate keeper approval letter [redacted]	13/07/2021	July 2021

Permission/Agreement Letter	Letter_Gatekeeper Permission - [redacted] - July 2021 - Approval	13/07/2021	July 2021
Permission/Agreement Letter	[redacted] Gatekeeper approval doc - July 2021	13/07/2021	July 2021
Data Protection Declaration	Data Protection Checklist and Declaration Form - Martina Opara - Evoeme - updated July 2021 (5) (2)	13/07/2021	2
Further details	Data Protection Checklist and Declaration Form - Martina Opara - Evoeme - updated July 2021 (5) (2)	13/07/2021	2
Further details	MU Privacy Notice document - Accessed - July - 2021 (2)	13/07/2021	2
Informed Consent Form	Study Recruitment Email Invitation - August - 2021 - Martina Opara-Evoeme	04/08/2021	2
Permission/Agreement Letter	Study Recruitment Email Invitation - August - 2021 - Martina Opara-Evoeme	04/08/2021	2
Participant Recruitment Information	Study Recruitment Email Invitation - August - 2021 - Martina Opara-Evoeme	04/08/2021	2
Participant Recruitment Information	Research Participants Needed - Flyer - August -2021	04/08/2021	2
Informed Consent Form	Participant Information Sheet - version 3 - August - 2021 - 4-08-2021	04/08/2021	3
Informed Consent Form	Health and Social Care Consent Form - Martina Opara - Evoeme — August - 2021 (3)	04/08/2021	3
Participant Recruitment Information	Health and Social Care Consent Form - Martina Opara - Evoeme — August - 2021 (3)	04/08/2021	3
Resubmission Response to Feedback Summary	Resubmission Feedback Summary (2) - 5th August 2021	05/08/2021	2

Although your application has been approved, the reviewers of your application may have made some useful comments on your application. Please look at your online application again to check whether the reviewers have added any comments for you to look at.

RECOMMENDATION: THE PIS SHOULD BE SHOWN IN POINT 14 FONT SIZE.

Also, please note the following:

1. Please ensure that you contact your supervisor/research ethics committee (REC) if any changes are made to the research project which could affect your ethics approval. There is an Amendment sub-form on MORE that can be completed and submitted to your REC for further review.

2. You must notify your supervisor/REC if there is a breach in data protection management or any issues that arise that may lead to a health and safety concern or conflict of interests.

3. If you require more time to complete your research, i.e., beyond the date specified in your application, please complete the Extension sub-form on MORE and submit it your REC for review.

4. Please quote the application number in any correspondence.

5. It is important that you retain this document as evidence of research ethics approval, as it may be required for submission to external bodies (e.g., NHS, grant awarding bodies) or as part of your research report, dissemination (e.g., journal articles) and data management plan.

6. Also, please forward any other information that would be helpful in enhancing our application form and procedures - please contact MOREsupport@mdx.ac.uk to provide feedback.

Good luck with your research.

Yours sincerely

Gordon

Dr Gordon Weller

Chair: Health and Social Care Ethics Sub-committee

Appendix 7 – Gatekeeper permission

Middlesex University London

Date 12th July 2021

XXXXXXXXX
Pre-assessment Outpatients Services
XXXXXXXXXXX Healthcare NHS Trust

Dear xxxxx

Re; Gatekeeper permission

I am writing to ask if you could please kindly give me permission to interview staff within your team in conducting a research study.

The main research project will involve conducting a qualitative research for promoting staff job motivation and wellbeing at work. The title is; **exploring the impact of service changes on outpatients' nurses and health care assistants' job motivation, from staff perspective.**

The study also seeks to identify the factors and then establish strategies and mechanisms to improve the nurses' development, job motivation and wellbeing.

In this study, I will be using interview questions, virtual interview lasting approximately 45 minutes, to collect data from the staff perspective for this study. I have attached copies of the interview questions, data collection tools and consent forms to be used in this research studies for your kind consideration.

Please find the example letter requesting for your response to my request to collect data from the staff. The letter must be signed (not electronically) and written on a headed paper from the organisation.

Please do not hesitate to contact me on mo935@live.mdx.ac.uk. If you require any further information. Thank you for your time and consideration in this matter.

The names of my Middlesex University Academic Supervisors are;

Doctor Sheila Cunningham <S.Cunningham@mdx.ac.uk>
School of Health and Education, Middlesex University
The Burroughs. Hendon
London NW4 4BT
Telephone; 02084112687

Doctor Venetia Brown <V.Brown@mdx.ac.uk>
School of Health and Education, Middlesex University
The Burroughs. Hendon
London NW4 4BT
Telephone; 02084116732

Signature of researcher: _____

Name of researcher: Martina Oparah-Evoeme

Appendix 8 – Pilot Semi-structured interview schedule

Semi--structured interview schedule

1. ***Qualitative semi-structured interview***

Virtual Interview schedules will be based on the demographics such as; location by location, unit by unit. Scheduling of participants' interview slots will be structured following the order in which the participants responded to the interview invitation.

Researcher checks in advance the recording equipment and make sure the computer, and back–up digital recorder and telephone works properly before the interview starts.

2. ***Introduction***

Thank the participant. Establish rapport. Explain the Length of the interview which is 45-60 minutes.

Primary goal: For the participants to give a narrative of their experience ;- 'how they see things the way they see them' more like a dialogue with a focus on their experience, opinions and what they think or feel about the topics covered.

3. ***Verbal consent***

Ask the participant; ***"Would you like to participate in this interview?"***
Written Consent was obtained from the study participants in advance, just to confirm consent before start of interview.

4. ***Background Information***

Overview:
Researcher to briefly give an overview and general information about research background. Researcher to ask the check-list-6 questions on the participant information sheet.

5. ***Interview questions;*** *shown on a separate sheet.*

6. ***Explore thoughts and encourage a dialogue with participants***

Allow participants time to think and explain that they can go back to previous question is recall additional information to discuss.

7. **Conclusion.**

Explain to the participant, what happens with the data collected, analysis, reporting and dissemination of findings.
Thank the participants for their time, participation and the information they shared.

Appendix 9 – Updated Semi-structured interview schedule

Middlesex University London

Semi--structured interview schedule

*1. **Qualitative semi-structured interview***

Virtual Interview schedules will be based on the demographics such as; location by location, unit by unit. Scheduling of participants' interview slots will be structured following the order in which the participants responded to the interview invitation.

Researcher checks in advance the recording equipment and make sure the computer, and back–up digital recorder and telephone works properly before the interview starts.

*2. **Introduction***

Thank the participant. Establish rapport. Explain the Length of the interview which is **20-45 minutes**.

Primary goal: For the participants to give a narrative of their experience ;- 'how they see things the way they see them' more like a dialogue with a focus on their experience, opinions and what they think or feel about the topics covered.

*3. **Verbal consent***

*Ask the participant; "**Would you like to participate in this interview?"***
Written Consent was obtained from the study participants in advance, just to confirm consent before start of interview.

*4. **Background Information***

Overview:
Researcher to briefly give an overview and general information about research background. Researcher to ask the check-list-6 questions on the participant information sheet.

*5. **Interview questions;** shown on a separate sheet.*

*6. **Explore thoughts and encourage a dialogue with participants***

Allow participants time to think and explain that they can go back to previous question is recall additional information to discuss.

7. **Conclusion.**

Explain to the participant, what happens with the data collected, analysis, reporting and dissemination of findings.
Thank the participants for their time, participation and the information they shared.

Appendix 10 – Main Interview Questions

Main Study - Research Interview Questions

No	Questions	Responses / Comments	Data captured on tape recorder.
1	What changes did you experience in your work place in the last 4 years before COVID -19?		
	Can you say something about what caused the changes?		
2	How prepared were you before the specific changes were rolled out?		
	a. How prepared were you during the first surge of COVID-19 pandemic?		
	b. What challenges did you go through at work, with the onset of COVID-19 pandemic?		
3	How did COVID-19 pandemic affect you personally and at your workplace?		
	a. How would you describe the training and development opportunities available to support you in your role?		
	b. How supported and appreciated do you feel at your workplace?		
4	How would you describe your overall work experience in general? a. How would you describe your job motivation before the onset of COVID-19 pandemic and at the present?		
	b. What would you like to discuss that I have not covered?		

** Note; *Service changes are new ways of working or any changes in the patients' care pathway.*

Ref; MOP – Main Study Research Interview Questions – 2021 – Outpatients

Appendix 11 – Research fieldwork risk assessment form

Middlesex University London

Research Fieldwork Risk Assessment

This form is for students and staff undertaking any type of research fieldwork[1]

The Principal Investigator/Supervisor is responsible for completing a risk assessment of their research activities i.e., identifying any potential hazard which could occur during data collection activities and determining appropriate actions to minimise the risk of harm, accident or illness. The results of risk assessments should be shared with all project staff. All team members should be given a copy of the completed risk assessment(s) to ensure that they have a full understanding of all issues identified and addressed.

PLEASE NOTE: applicants completing data collection in an external institution/organization may need to complete and submit the risk assessment documentation provided by the institution/organisation, as required for insurance purposes.

Project Title/ Reference/ID No.	Project Title: Exploring the impact of service changes on outpatient nursing staff motivation, from staff perspective. Reference ID No. 17847	Reference/ID no: 17847
Researcher details:	Name: Martina Opara-Evoeme Student no. if applicable:M00725537	Role: Principal Investigator Principal Investigator
Researcher details:	Name: As above Student no. if applicable: As above	Role: As above
Next-of-kin for	Name: Mr xxxxxxxxxxxxxxxxxxxxxxx	Contact Details: xxxxxxxxxxxxxxx
Next-of-kin for	Name: As above	Contact Details: As above

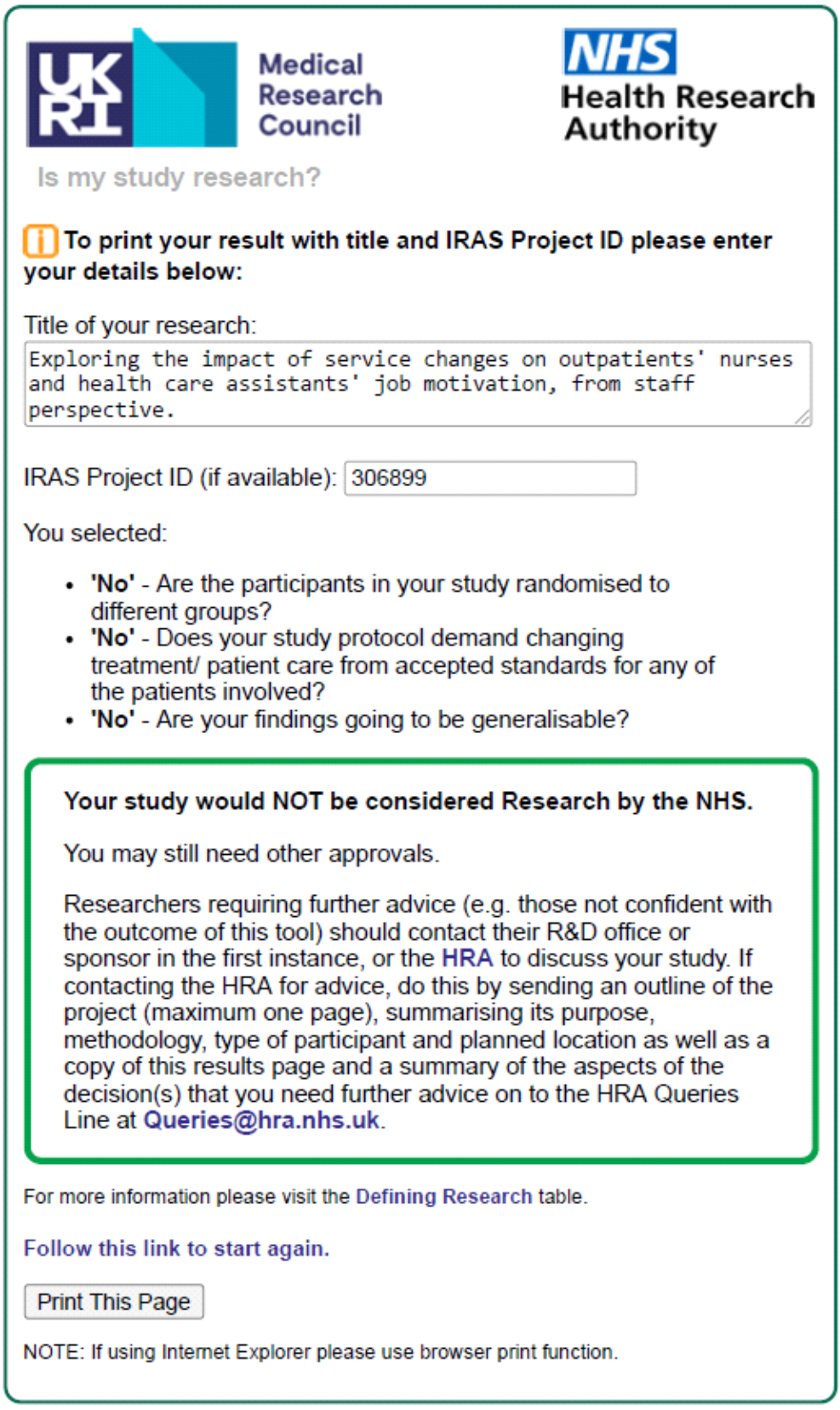
[1] **Fieldwork** is 'any work carried out by staff of students for the purposes of teaching, research or other activities while representing' Middlesex 'University off site'. *(UCEA Guidance on Health and Safety in Fieldwork 2011).*

Date of risk assessment:	28th April 2021	Review Date:	28th April 2022

DECLARATION: By submitting this form you are agreeing to allow us to be in contact with your next-of-kin in the case of an emergency.

********Pages 1-5 completed version of this research field risk assessment form can be located on Middlesex University OneDrive.

Appendix 12 – Decision Tool Report



Medical Research Council

NHS Health Research Authority

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Exploring the impact of service changes on outpatients' nurses and health care assistants' job motivation, from staff perspective.

IRAS Project ID (if available): 306899

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the HRA to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at Queries@hra.nhs.uk.

For more information please visit the Defining Research table.

Follow this link to start again.

Print This Page

NOTE: If using Internet Explorer please use browser print function.

About this tool Feedback Contact Glossary Accessibility

Appendix 13 – Local REC approval/ Approval from the researcher's organization to proceed with the study.

Approval registration number: 665

From: AUDIT >
Sent: 23 November 2021 12:17
To: <martina.opara@nhs.net>
Cc: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Subject: RE: Audit proposal - Outpatients - Staff Service Evaluation Study

Dear Martina,

Your service evaluation project has now been registered with the audit team.

Please see below your registration number:

Title	Registration Number
Exploring the impact of service changes on outpatients' nurses and health care assistants' job motivation, from staff perspective.	**665**

Please remember:

- To include this title and reference number in all further correspondence to the Audit Team.
- To use the report template, which is attached, to record the findings and outcome and return it to the audit team.
- Once you have completed your audit/ service evaluation, to ensure you submit your report to xxxxx.audit@nhs.net after it has been presented to and approved by your department's Q&S Committee.
- If you would like to receive a completion certificate for your project, this is available at request from the audit team once your audit/service evaluation project has been completed and your report sent to the Audit Team.
- If your project has not been completed 6 months after registration or the estimated completion date and we have not received any updates on your progress, we will mark your project as cancelled.

If you have any further questions or queries, please do not hesitate to contact the Audit Team.

Appendix 14 (a)

Steps one and two: Familarisation of data and use of NVIVO12 database tool

The initial thematic clusters were developed through NVIVO12 whereby every answers from the participants for each interview question were inputted on excel document separately. Appendix (20, pages 401-402), Pestle Analysis shows examples from significant narratives that were extracted from the participants' data. Throughout the process, I maintained bracketing to retain the authenticity of the data at the initial analysis of organising the raw transcript of the interview data and the coding or nodes. Categorising the data in form of nodes is the process of subdividing raw information and allocating them in categories as themes (Dey, 1993; Wong, 2008). Initially, eleven clusters referred to as parent nodes were developed using the NVIVO12 software and these parent nodes were thereafter, manually condensed into the final main themes with sub-themes. I carefully read and re-read the raw data and ensured the credibility of the generated themes.

Step three: Formulation of meanings while bracketing preconceptions

The data was categorised by using the highlighting features and meanings were formulated from the highlighted significant narratives. Every essential meaning that were relevant to the phenomenon were carefully identified as they reflect the participants' description. In order to add more value to the participants' lived experience, their emotions were also noted at this stage. The third step of the process is particularly precarious as the reseracher must try to spell out meaning without imposing personal perspective related to preexisting knowledge, expectations, or experiences into the findings (Colaizzi, 1978). In this study, I was conscious not to interpret the interview data with any preconceived notions and ideas hence bracketing was a crucial strategy put in place. Therefore, a descriptive phenomenological analytical approach was chosen instead of interpretive phenomenological analysis where bracketing is optional.

Step four: Clustering identified meanings to themes

After all the meanings were formulated, they were merged into categories which reflected a structure of clusters of themes. These meanings were then grouped into cluster of themes that mirror a certain concern to form a distinctive construct of themes.

According to Mason (2022), each formulated meaning belongs to only one theme cluster that is meaningfully distinct from other structures because, all of the themes are internally converging and externally diverging. Hence, the theme clusters were generated and these were grouped by the researcher into four emergent themes. By integrating the various clusters, the key themes were developed into the final thematic map. The fourth step also required that I resolve any inconsistencies or contradictions in the process in line with Colaizzi (1978)'s suggestion whereby, the second component of the fourth step requires critical description to avoid ambiguity.

Step five: Developing inclusive description of phenomena based on themes

Once the key themes were formulated, each of it were defined into a full and inclusive description of the phenomenon. After which, the entire structure of the phenomenon 'impact of service changes on outpatient nurses' motivation and wellbeing', has been picked. As an iterative process, I reviewed the findings in terms of the depth and extensiveness to provide satisfactory description and to confirm that the thorough description genuinely reflects the experiences of outpatient nursing staff's wellbeing and motivation due to the service changes.

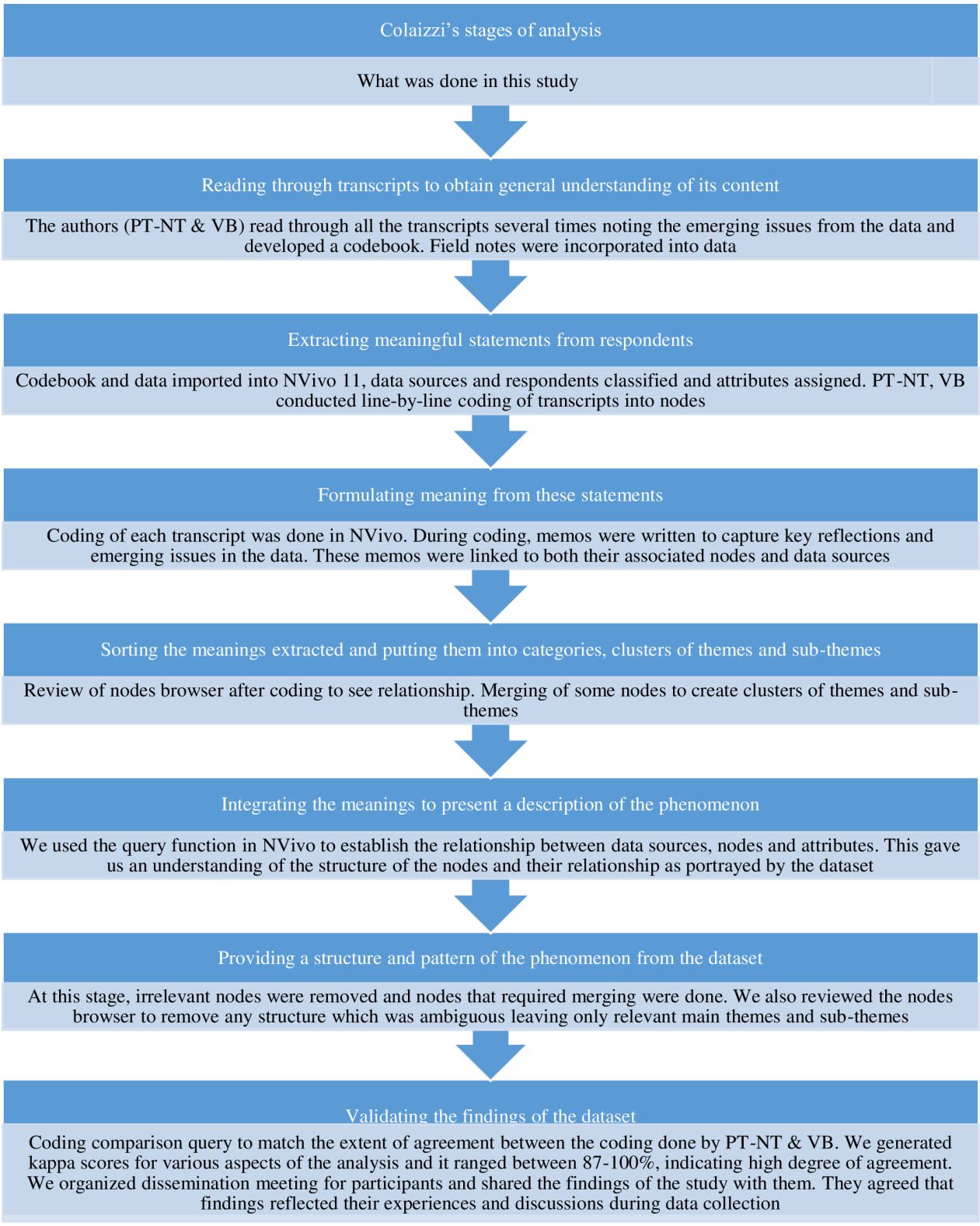
Step six*:* Developing fundamental structure of phenomena

During the review at step five, some repetitions were identified and they were integrated to generate clear relationships between clusters of theme. For example, only one participant worked remotely hence, this single node or experience could not form a theme but was classified under others. The rest of the interview data description were therefore summarised into short and dense statements that captured the important aspect to the structure of the phenomenon. In effect, the sixth step was the reformulation of the entire description into final key themes.

Step seven: Validation of key themes

For this study, Colaizzi's data analytical method requires verification of data, hence the research findings were sent to the participants to ask for validation in line with Colaizzi's strategy for phenomenological analysis, seven stages as illustrated next page, integral to the analysis of research findings (Caretta & Pérez, 2019).

Appendix 14 (b) Example of Colaizzi's strategy for phenomenological analysis.



https://journals.plos.org/plosone/article/figure?id=10.1371/journal.pone.0198915.g001

Appendix 15 – NVIVO certificate

LinkedIn LEARNING

Certificate of Completion

Congratulations, Martina Ngaonyekamma Oparah-Evoeme

NVivo 2018 Essential Training

Course completed on Mar 11, 2022 at 12:40PM UTC • 1 hour 23 min

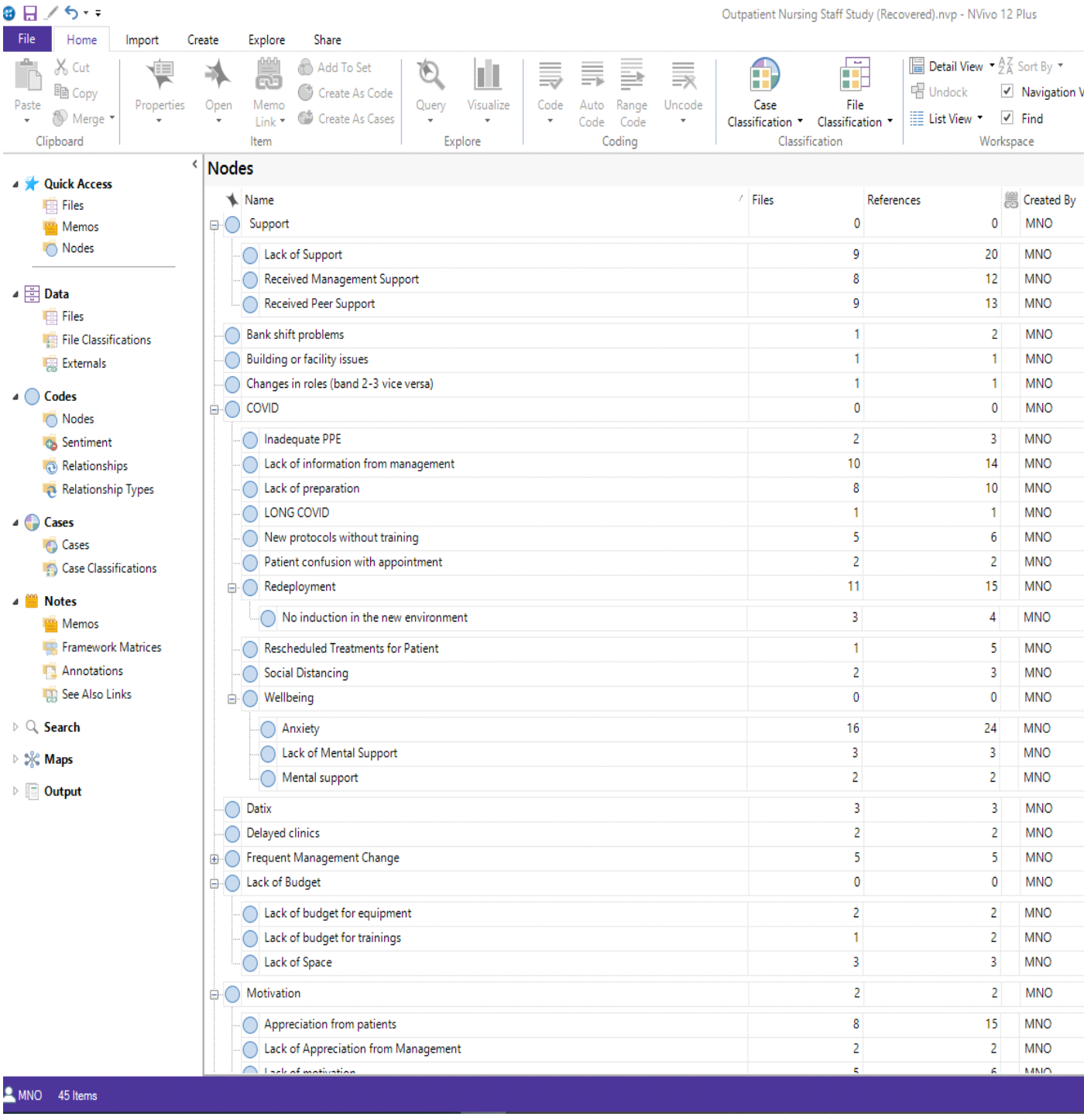
By continuing to learn, you have expanded your perspective, sharpened your skills, and made yourself even more in demand.

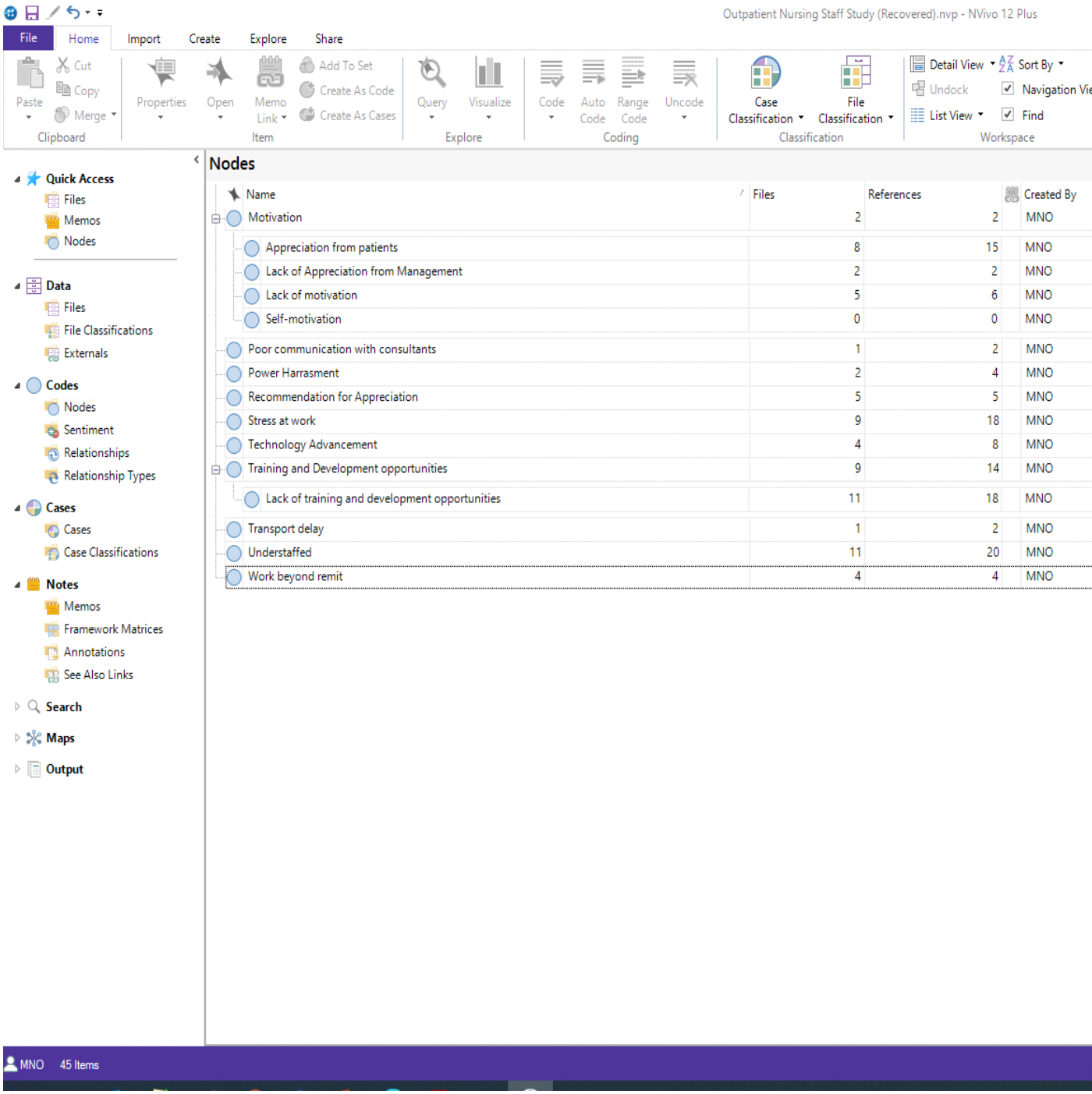
Head of Content Strategy, Learning

LinkedIn Learning
1000 W Maude Ave
Sunnyvale, CA 94085

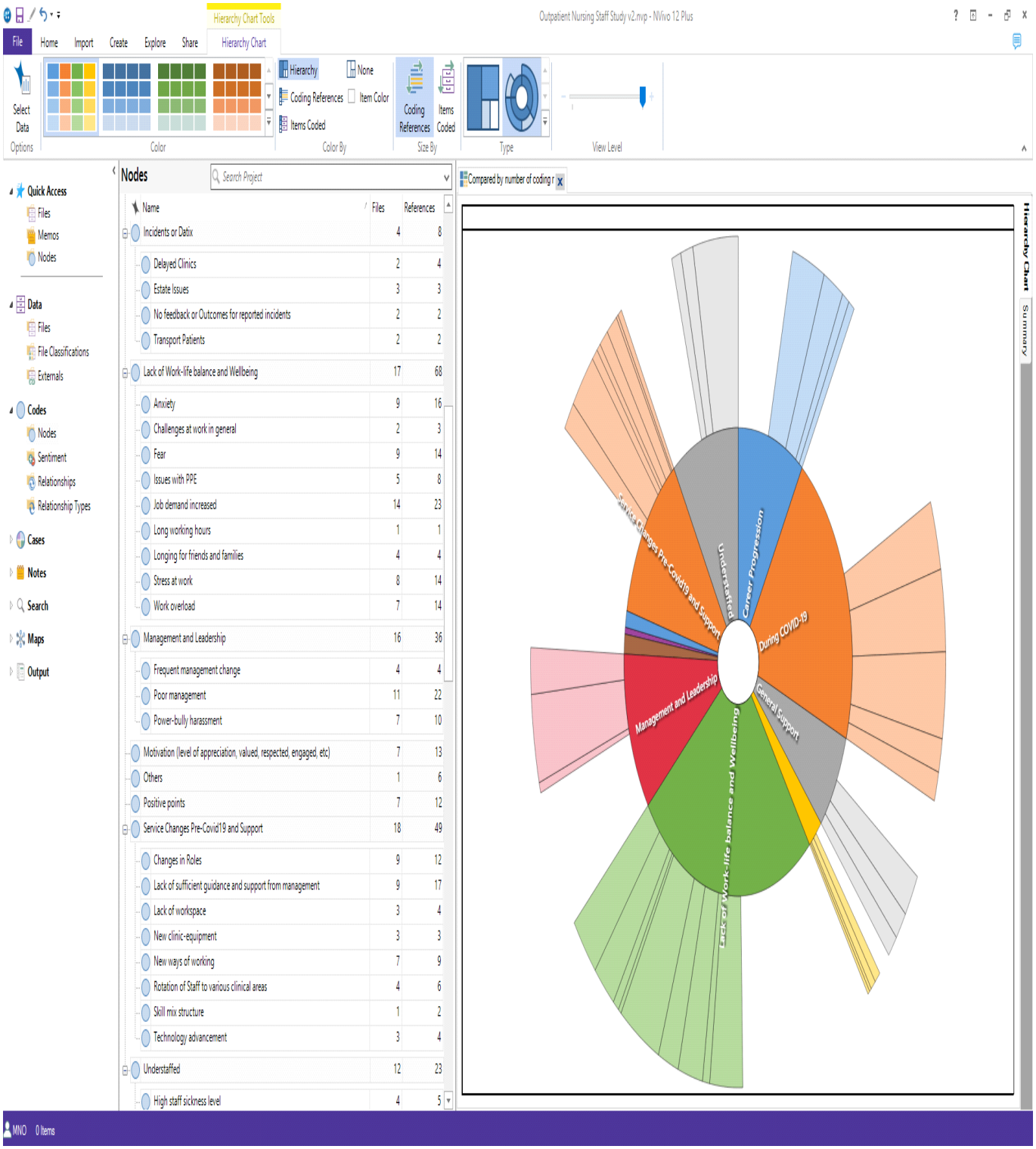
Certificate Id: ARrRU0cLgqKCuPnG_gWg4UdW1GsG

Appendix 16 (a) - NVIVO12 initial themes




Outpatient Nursing Staff Study (Recovered).nvp - NVivo 12 Plus
File
Home
Import
Create
Explore
Share
Paste
Cut
Copy
Merge
Clipboard
Properties
Open
Memo Link
Add To Set
Create As Code
Create As Cases
Item
Query
Visualize
Explore
Code
Auto Code
Range Code
Uncode
Coding
Case Classification
File Classification
Classification
Detail View
Sort By
Undock
Navigation Vie
List View
Find
Workspace
Quick Access
Files
Memos
Nodes
Data
Files
File Classifications
Externals
Codes
Nodes
Sentiment
Relationships
Relationship Types
Cases
Cases
Case Classifications
Notes
Memos
Framework Matrices
Annotations
See Also Links
Search
Maps
Output
Nodes
Name
Files
References
Created By
Motivation 2 2 MNO
Appreciation from patients 8 15 MNO
Lack of Appreciation from Management 2 2 MNO
Lack of motivation 5 6 MNO
Self-motivation 0 0 MNO
Poor communication with consultants 1 2 MNO
Power Harrasment 2 4 MNO
Recommendation for Appreciation 5 5 MNO
Stress at work 9 18 MNO
Technology Advancement 4 8 MNO
Training and Development opportunities 9 14 MNO
Lack of training and development opportunities 11 18 MNO
Transport delay 1 2 MNO
Understaffed 11 20 MNO
Work beyond remit 4 4 MNO
MNO
45 Items

Appendix 16 (b)



Hierarchy Chart of Parent Nodes through the NVIVO12 – Data Analysis tool.

Appendix 17 – Overall key themes generated sent to the participants

Integrating theme clusters into themes	
Theme	**Thematic clusters**
Theme 1: New ways of working	1.1 Skill-mix reviews (changes in roles)
	1.2 Nurse-led activities
	1.3 Working out of scope of their role / Cross sites working
	1.4 Excessive workload
	1.5 Long day shifts, working through break times and weekend clinics
Theme 2: Training and Development Opportunity	2.1. Limited training and career progression opportunities
	2.2 Gap in role competencies for some staff in a particular unit.
	2.3 Lack of proper induction in new role
	2.4 Datix Issues (no feedback/outcome reported)
Theme 3: COVID-19Pandemic Redeployment Issues	3.1 Inadequate PPEs
	3.2 Lack of preparation
	3.3 Family and social life were affected due to self- isolation from family members after work.
	3.4 Issues relating to staff shifts including remote working
Theme 4: Management and Leadership Factors	4.1 Frequent management changes at senior level
	4.2 Lack of support/appreciation
	4.3 Power dynamics a) bullying; top-down b) Undermined c) Felt unsettled – frequently moved to various clinic areas
	4.4 High vacancy leads staffing shortage, which leads to high staff sickness level
	4.5 Stress at work, a) Reduced staff morale b) Uncertain whether to stay in the nursing profession in the future

Appendix 18 (a) ---The main study member check and feedback update was completed on the participants' transcripts.

From: <martina.opara@nhs.net>
Sent: 17 March 2022 17:57
To:
Subject: RE: Staff study interview transcript - Participant's validation

Dear xxxxxxxx,

Thanks for participating in this staff study which is much appreciated.

The attached transcript is a version of the discussion during the interview.

I would like you to confirm whether the content of the transcript reflects the meeting discussion.

Again, I can confirm that all personal identifiable data for this study remains confidential!

Many thanks for your continued support.

Kind regards,

Martina

In response to the email request to all participants, one out of the eighteen participants had some clarification to their own transcript as shown below.

From: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Sent: 23 March 2022 16:24
To: <martina.opara@nhs.net>
Subject: Re: Staff study interview transcript - Participant's validation

Hi Sister, hope you are well! Sorry for my late response. Yes, all are fine. I would like to clarify my answers in few questions below:

Question 1 - I answered no manager. Actually, there was a manager but left. So, when I joined them, the manager was new to the role. Also, no enough Band 6 Nurse and they are hiring. The proportion of number of clinics/patients to number of nurses was low.

Question 2.b - Lack of technical skills to work in different ward in CXH.

Question 3 - Positive is I was able to work in a team with CNS and Consultants. We set up the Plaster Surgery Minor Ops Skin and Plastic Surgery Minor Injuries.

Thank you very much Sister!

Best regards,

xxxxxxxxxxxxxxxxxxxxxxxxxxx

Appendix 18 (b) – Colaizzi's Seventh Step of Phenomenological method – Participants' validation request individual email and feedbacks.

From: <martina.opara@nhs.net>
Sent: 17 March 2022 12:15
To: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Subject: RE: Staff study interview transcript - Participant's validation

Dear XXXXXXXXXX,

Thanks for participating in this staff study which is much appreciated.

The attached transcript is a version of the discussion during the interview.

I would like you to confirm whether the content of the transcript reflects the meeting discussion.

Again, I can confirm that all personal identifiable data for this study remains confidential!

Many thanks for your continued support.

Kind regards,

Martina

(1)

From:
Sent: 18 November 2022 11:00
To: OPARA, Martina

Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Good Morning ,

Thank you for your email.

Sorry for taking long in replying.

I can confirm that all information as showed in attachment included the key themes from my own experience from the study.

Many Thanks

(2)

From:
Sent: 02 November 2022 15:48
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Dear Sr. Martina,

Good afternoon!

Thank you for your e-mail and letting me know the outcome, I really appreciate it.

It's good to know that our concerns/issues been discussed and identified.

I am grateful to be able to participate.

Kind regards,

(3)

From:
Sent: 16 November 2022 15:56
To: OPARA, Martina

Subject: Fw: FW: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Dear Sister Martina,

Thank you for taking me as part of the interview.

Kind regards!

(4)

From:
Sent: 16 November 2022 14:46
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Hi Sister

Thank you for asking me to take part in your study, I am very pleased the Key Themes and the outcome.

Hopefully it will help in the future.

Regards

(5)

From:
Sent: 08 November 2022 14:19
To: OPARA, Martina

Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Dear sister Martina,

Thank you for forwarding the initial findings of the study.

I can confirm that it captured the key points about my experience as discussed in the interview.

Kind Regards,

(6)

From:
Sent: 07 November 2022 15:41
To: OPARA, Martina
Subject: Re: Staff study interview transcript - Participant's validation

Hi Sister Martina, good afternoon and I am so sorry for replying late!

I am happy with my interview transcripts and you can go on to the next phase of your research work.

Take care Sister!

Kind regards,

(7)

From:

Sent: 07 November 2022 15:05
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Dear Martina
Thank you very much for the study and highlighting what outpatients nurses job entails.
IT's good to have some one on our side . It was a privilege to take part in the study .

Best wishes

(8)

From:
Sent: 06 November 2022 16:05
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Hi Martina,

Wishing you well in your health and all your endeavour. Thank you once again for the opportunity of making me a part of your study that envisions to create positive change in the workplace. I do confirm that all the main themes that has been summarized do reflect an objective findings.

About the workforce issues in Theme 1, I can correctly relate specifically about the understaffing, excessive workload and stress at work. This combination of factors are foremost critical in determining staff motivation to work as of my own experience.

On the topic in Theme 2 redeployment during surge of COVID-19, it is in fact true that it took a great toll of everyone especially redeployed staff due to the risk safety issue at work intensified with the status of inadequate PPE, lack of information and preparation of staff.

Theme 3 that generally speaks about the management and leadership factors are quite filled in with in depth honest perception of staff in the crudest level. I do advocate that the unrelenting effort and collaborative support of the management and leaders thus produce a highly valued output for patient care from the team.

And lastly about the last theme dealing with training and development, it was surprisingly very limited during the covid outbreak and I have see my co-staff feeling incompetent when they where redeployed to their new department.

Nurses capabilities are eminently based on a certain set of skills they have specialized with years of experience and moving them to a different area of work makes them ineffectual and feel incompetent or perturbed.

With all the veritable output delivered from your study, I do express great approval and validate the objectivity with this research.

Thank you so much.

(9)

From:
Sent: 02 November 2022 15:48
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Dear Sr. Martina,

Good afternoon!
Thank you for your e-mail and letting me know the outcome, I really appreciate it.
It's good to know that our concerns/issues been discussed and identified.
I am grateful to be able to participate.

Kind regards,

(10)

From:
Sent: 01 November 2022 16:17
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - -2022 - Confidential

Dear Sister Martina,

Thanks for providing your findings. I think you have captured my experience very well. I believe your findings are important since there are many people who might not understand the work and challenges in the outpatient department.

This study will surely be beneficial for us.

(11)

From:
Sent: 31 October 2022 17:23
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - - 2022 - Confidential

Dear Sister Martina,

Thank you for sharing this preliminary study findings with me.

I am glad that I accepted your invitation to participate in this study.

I can confirm that the description of the staff experiences captured and accurately summarised, as attached, is a true representation of the key themes that emerged during the interview.

Thank you very much for this detailed finding and for sharing these preliminary findings with me.

Kind regards,

(12)

From:
Sent: 01 November 2022 14:04
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - - 2022 - Confidential

Dear Sister Martina,

Thank you for your email and the attached document providing initial study findings in key themes only.

I have revised the document and the description of the study's preliminary findings which truly represents the information I provided in the context of our interview.

I can confirm that there is certainly nothing out of context in what you have presented. They all resonate with me as a participant in this study.

I am glad to have taken part in this study.

Kind regards,

(13)

From:
Sent: 01 November 2022 09:19
To: OPARA, Martina
Subject: Re: Staff study participant's validation - Overall Preliminary findings in Key Themes Only - - 2022 - Confidential

Dear Martina,

Thank you for sending me a copy of the transcript. This study will serve as a guide for looking after junior staff. With all the issues and concerns' that was experienced by the staff involved in this study, you managed to come up with the reasons what causes stressed and staff leaving the trust. This is a very good tool to help the Trust to manage and plan the futures of their staff.
Proud to be part of the study.

Congratulations and well done!

Best regards

Validation summary:

Total number of participants were 18.

- 13 participants were contacted and all 13 responded.
- 3 already left the organisation (2 RGNs and 1 HCA)
- 2 on long term sickness – unable to respond.

Appendix 19: Examles of COVID -19 pandemic staff redeployment related issues

Subtheme 1 & 2: Lack of preparation and Inadequate Personal Protective Equipment (PPE): Lack of information and miscommunication

These two sub-themes are inter-linked and the finding showed that 94% of participants highlighted the issues they encountered due to 'lack of preparation' during the surge of COVID-19 pandemic, especially the inadequate supply of PPEs. This issue specifically affected the participants for example, one of the participant stated:

> *"Although some departments don't do that, we have to do it. Because they can cough in whatever. So that was something that we had to get used to. We didn't have adequate PPEs at that time. So we had aprons we were using before. But we didn't have the mask. So before we started seeing patients, we asked for the masks"* **(Participant 1, RN).**

In line with the infection prevention control policy, participant 1 expected the correct PPEs to be readily available for the safe delivery of service, most importantly, to protect both the patients and staff members from contracting and spreading the virus. Another participant stated:

> *"There wasn't much information, we were told we don't have to wear masks. While everyone was saying, we should've been wearing masks. There was not much proper equipment, PPE. And everyone was just walking around, not really knowing what to do" (***Participant 4, HCA).**

Participant 4 was also concerned about not having enough information which seemed to be a knock-on effect from lack of preparation with a ripple effect which led to miscommunication, lack of risk assessment prior to redeployment and staff anxiety and fear of contracting COVID-19. Majority of the participants expressed that the pandemic caused a lot of confusion and stress to almost everyone. A participant said:

> *"Uhhh not prepared at all, I don't think we were prepared as a department. There wasn't much information, we were told we don't have to wear masks. While everyone was saying, they should've been wearing masks. Uhmm there was not much proper equipment, PPE. And everyone was just walking around, not really knowing what really to do. So I don't think our preparation was good at all, in our department anyway. Definitely not so. Not prepared at all"* **(Participant 4, HCA).**

With regards to participant 4's narrative, there seem to be some confusion in terms of appropriateness of the clinical information provided by management, hence the nursing staff felt like there was no structure stating that, "*everyone was just walking around, not really knowing what really to do".* Similar experience was reported by other participants, for example, participant 7 specifically stated:

> *"Not prepared at all for the first stage of COVID-19. <IT issues> Not enough nurses, people were sick, couldn't solve issues out, we were not prepared"* **(Participant 7, RN).**

Lack of information and miscommunication

Many participants (44%) discussed not having enough information on what to do during the surge of COVID-19 and they experienced miscommunication with the instructions from management which was conflicting and the protocols became more confusing. One participant stated:

> *"We've been informed about changes, we've been informed. But we are not, I wasn't prepared because we did not... at that time we didn't have no PPE and there were miscommunication regarding wearing the mask and if PPE was enough. It was a bit stressful. It was a bit stressful. There were not very much preparation for that"* **(Participant 2, HCA).**

Participant 2 felt that the miscommunication about the process to follow during this difficult and challenging period caused the staff work related stress. Similarly, another participant narrated their experience as follows:

> *"And communication was very very much a problem at that time and after a few weeks, it was centralized by our communication uhh portal to email and one guidelines was constructed so we followed one guideline in the end, which was very helpful but first time.. Communication was a big problem and of course many of my workmates go off sick just randomly, and it gives us stress to everyone who's working because they left with the same workload but few people to do it. So I would say, I was so stressed and anxious the first umm first surge. And there was not much support as well at that time. Yeah, cause everyone was busy on just getting on the job"* **(Participant 9, RN).**

Appendix 20: A brief PESTLE analysis was drawn as a link and root-cause analysis of some participants' narratives.

Factor	Description	Examples of participants' narrative
Political	The implementation of the NHS outpatients' transformation initiative to increase patient appointment capacity which led to increased nurse-led activities.	"And one of the doctors requested that the patch clinic to be transferred to our department from their outpatient. I think the one of the reason is so the doctors can have a support from us also, and it would be better for us to uhh stay in the department so we can help each other in the xxxx service also." (Participant 3, RN).
Economical	The significant role of Cost Improvement Plans (CIP) in enhancing service efficiency and reducing expenditure by introducing one-stop-services, which means patient have multiple procedures and consultations in one clinic episode.	"In one particular ward, the nurses have to go to one hospital to another hospital and they got their, the referral that was given was completely different. They didn't need to go there. So this is something what would've impacted on us, because we are short of staff here. And they have to go all the way to another hospital, and they did not need to go. But if the doctor says that there's a patient that needs to be seen, there's nothing we can do. Some patients have to be discharged, they have to be seen urgently. Sometimes we go there, we have to train the nurses or we have to teach the the the patient what to do." (Patient 1, RN).
Social	Staff members working long days and unsocial hours beyond their contracted duty hours, with concerns about employment terms and conditions.	"Personally, I mean my relationship with my wife has changed uhh dramatically during that time cause instead of me having a regular day off a week, like two days a week, it was like me working seven days a week. So when you get home, you're so tired." (Participant 9, RN).

Technological	Introduction of new ways of working, increased digitalization, virtual clinics, and implementation of new information technology systems.	“We’ve had a lot of change experience in my work place. Uhmm firstly, we went paperless regarding to the record notes, patients record notes. We went paperless which made the work easier, time-saving, and easy to access the patients’ information at some point.” (Participant 2, HCA).
Legal	Lack of equality: Some staff were deprived of training which poses risk to both nursing staff and patient since if staff are not knowledgeable, there might be more risk to care.	“So I expected more training which was not happening. I remember I initiated self-initiated training myself when I discovered that nothing was coming forth and I got an email and I got an ah opportunity and I was denied opportunity because they didn't have mentor. I was denied opportunity because they didn't support. So that was very discouraging”. (Participant 16, RN).
Environmental	Some of the staff team spirit got demotivated which led to having a not user-friendly environment that invariably impact on patient experience.	“You felt stuck. You feel like the reality is just a one position thing, and the the same thing we’re doing on the daily basis. But yet you want to have medical years, possibility to be a nurse specialist. It was also delayed. And also making me feel like I may look into other different organization where all these courses are available and follow through”. (Participant 5, RN).

Table 7.3 PESTLE Analysis.

Appendix 21: Staff Continuous Professonal Development (CPD) Approval

From:
Sent: 29 June 2023 10:11
To: OPARA, Martina (IMPERIAL COLLEGE HEALTHCARE NHS TRUST) <martina.opara@nhs.net>
Subject: CPD Funding

Dear Martina,

As previously mentioned, I am glad to say all courses have been approved !

Next step is to fill the Study Release Form.

I know that not all the staff is able to go at the same time.
So could I please ask that only Staff member going in Sep 2023 and Feb 2024 fill the form?

Once staff fill the form, it would need to be completed by xxxxxxxxxx and then sent to xxxxxxxxxxxx@nhs.net and cc me.

Regards,