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THE HOLISTIC EXPLORATION OF THE MULTIFACETED RELATIONSHIP BETWEEN HEALTHCARE PROFESSIONALS' JOB SATISFACTION AND QUALITY OF CARE.

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THE HOLISTIC EXPLORATION OF THE MULTIFACETED RELATIONSHIP BETWEEN HEALTHCARE PROFESSIONALS' JOB SATISFACTION AND QUALITY OF CARE.

by

Moya Lerigo-Sampson

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Authors Declaration and Word Count

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Doctoral College Quality Sub-Committee.

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Abstract

Problem definition: Healthcare is a professional field, which most individuals will encounter at some point in their life, directly or indirectly. In the UK, healthcare organisations are facing significant challenges, including financial pressures, shortages in staffing levels, and changes in the way healthcare is delivered. In addition, patient demand for such healthcare systems has been increasing dramatically year on year, in part, due to societal changes towards unhealthier lifestyles. Consequently, amid such adversities, it is important to understand how these issues are affecting both the providers and receivers of healthcare. Therefore, the current study will explore how healthcare professionals' job satisfaction relates to, and affects, the quality of care staff are able to provide. Unlike the multitude of healthcare research which tends to focus solely on clinical staff - defined here as those who are directly involved in patient care (Department of Health, 2016), the current study will also include staff in non-clinical roles in order to obtain a greater appreciation of the multi-disciplinary aspect of healthcare provision. The main areas under investigation in this study are, understanding the factors which influence healthcare professionals' job satisfaction, determining if there are differences between clinical and non-clinical staff, and to understand the relationship between job satisfaction and quality of care.

Literature: Job satisfaction and quality of care are the two principle concepts being explored throughout this thesis. An extensive review of the literature was carried out in order to establish existing knowledge concerning the individual constructs, as well as how they are related. The review allowed specific gaps to be identified. One crucial area highlighted, was that the links between job satisfaction and quality of care were

significantly absent from the literature. Whilst some connections were evident, the holistic exploration as to how various components interlink appeared to be missing. Instead, analogous links were investigated from other sectors, such as job satisfaction and performance. Accordingly, the literature review chapters included general studies, as well as research based specifically in the healthcare domain.

Method: Due to the relationship between job satisfaction and quality of care being somewhat neglected throughout existing research, the novelty of including a broad participant group, and the critical realist perspective of the researcher; qualitative semi-structured interviews were conducted. The interviews were conducted in two phases, 12 in the first phase and 15 in the second. Participants were recruited from a range of organisations throughout the UK and included a diversity of roles. In particular, an important objective of the study was to ensure that the selection of participants included both clinical and non-clinical staff. Once transcribed, the interviews produced a large amount of data (301 pages), which were analysed using thematic coding.

Findings: A number of aspects relating to healthcare professionals' job satisfaction at work emerged. The key factors included helping patients, teamwork, social network, cognitive aspects, demand and resources, as well as staff management. For the second key area of study, a comparison was made between clinical and non-clinical healthcare staff. In terms of the broad factors that arose, many appeared to affect participants irrespective of whether their roles were classed as clinical or non-clinical. That said, the manner in which these factors influence staff was nuanced. The overarching aim of the study was to explore the relationship between healthcare

professionals' job satisfaction and quality of care. Based on the analysis of the interviews it was suggested that this relationship is reciprocal. Specifically, satisfied employees are more likely to provide a higher level of care, however being able to deliver quality of care also impacts on healthcare professionals' job satisfaction.

Contribution: The study contributes to the job satisfaction literature by identifying several factors which appear to influence a wide range of healthcare professionals' job satisfaction. Based on the data analysis, it has been suggested that the antecedents to job satisfaction can be categorised into three main areas: 1) universal factors, 2) individualistic factors, and 3) job specific factors. The overwhelming consensus across all staff regardless of job setting or role was that the primary factor influencing their job satisfaction was 'helping patients'. The current study suggested that when outcomes of the care or service delivered are more immediate and have a greater impact, this has a greater affect on healthcare professionals' job satisfaction than occasions where gradual changes to a patient occur over time. The study also provided a theoretical contribution by exploring the novel interrelationship between healthcare professionals' job satisfaction and the quality of care an individual is able to provide. The relationship was determined as reciprocal, however, key factors influencing both of these concepts also emerged, these were: staff shortages and time to care. These concerns were found to be prominent across both clinical and non-clinical staff roles. The thesis also contributes to practice through several recommendations and suggestions which aim to improve both healthcare professionals' job satisfaction and the quality of care they are able to deliver.

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List of Abbreviations

A&E	Accident and Emergency
BIAJS	Brief Index of Affective Job Satisfaction
CCG	Clinical Commissioning Groups
CQC	Care Quality Commission
EEA	European Economic Area
EU	European Union
FTE	Full Time Equivalent
GP	General Practitioner
JDI	Job Descriptive Index
MSQ	Minnesota Satisfaction Questionnaire
NHS	National Health Service
WHO	World Health Organisation
UK	United Kingdom

Chapter 1: Introduction

Introduction

The World Health Organisation states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” (WHO, 1948, p. 1). More specifically, the World Health Organisation (WHO) defines a quality healthcare service (or quality of care as it will be referred to throughout this thesis) as efficient, cost effective, and socially acceptable (WHO, 1948). Unfortunately, due to the considerable growth in the worldwide population (Livi-Bacci, 2015) and increasingly unhealthy lifestyles (Imison and Bohmer, 2013), global healthcare provision is under significant pressure (Aiken et al. 2012). The enormity and severity of this issue cannot possibly be addressed through a single PhD thesis. Therefore, the current study will focus on healthcare systems within the United Kingdom (UK). Specifically, it will centre on the most valuable resource within these systems, the staff. Currently, healthcare organisations in the UK are facing significant challenges, including financial pressures, shortages in staffing levels, and changes in the way healthcare is delivered - all of which have substantial implications for both the providers and receivers of care. The current study will therefore explore how these challenges are affecting healthcare professionals’ job satisfaction and how this then relates to, and affects the quality of care these staff are able to provide.

The project itself straddles two key disciplines within business management: human relations and operations. From a human relations perspective, the project will look at topical issues around healthcare staffing and the factors which influence healthcare professionals job satisfaction. From an operations angle, the study will focus on the

concept of quality of care, specifically, what it is, and why it is important. The culmination of the project will look at how these two concepts are interrelated, with the overarching aim of the study being, to explore the complex relationship between healthcare professionals' job satisfaction and quality of care.

This first chapter (introduction) will contextualise the concepts of job satisfaction and quality of care against practitioner and theoretical perspectives. Background information is provided in order to establish clear justification and rationale for the project. Initially, a brief overview of the UK healthcare system will be provided, followed by detailed commentary as to why the concepts of job satisfaction and quality of care need to be considered within current healthcare environments. The introduction chapter will then move on to highlight the objectives of the study, the motivation behind the research, the contribution the findings make to existing literature, as well as providing an outline of the thesis structure.

Overview of Healthcare in the United Kingdom

Healthcare in the UK is predominately provided by the publically funded National Health Service (NHS), with BMI Healthcare, Nuffield, BUPA, Capio Healthcare UK, and HCA International, delivering the majority of the private sector (Senior, 2017, NHS England, 2017). Due to its dominance within the UK healthcare sector, this section of the chapter will focus on the NHS. The year 2018 (year of thesis submission) marks the 70th birthday of the NHS and since its creation, it has undergone numerous transformations (NHS England, 2017). The NHS was introduced across the UK in 1948 and is one of the largest and longest established healthcare systems in the world (NHS, 2016). Funded by the general public through tax and national insurance, this

pioneering system amalgamated specialist disciplines in to one organisation and aimed to provide free medical care to everyone (NHS, 2016). Over the years, the NHS has maintained the same core principles since its introduction; to meet the needs of everyone, to be free at the point of delivery, and to be based on clinical need, not the ability to pay (NHS England, 2017).

The current structure of the NHS at the time of submitting this thesis (July, 2019) is as follows; the overall responsibility for the NHS in England is held by the Secretary of State for Health and Social Care (presently, Matt Hancock, MP). This role provides leadership over the Department of Health, which oversees the strategic management for public health, the NHS, and social care in England. NHS England itself consists of NHS foundation trusts and acute NHS trusts providing ambulance services, emergency care services, as well as mental health services (NHS England, 2017). These in turn are overseen by NHS Improvement, which was founded in 2016 and the Care Quality Commission, CQC (NHS England, 2017).

Contemporary Issues affecting Healthcare Staff

The NHS has dealt with severe financial pressures for some time and unfortunately, these show no signs of improving. NHS providers collectively were expected to be able to ‘balance the books’ during 2017 and 2018. However, this target had to be revised (initially to a £496 million deficit) and despite receiving financial aid from the Sustainability and Transformation Fund, by the end of 2017, the sector reported a deficit of £960 million (Anandaciva et al. 2018).

In June 2016, the UK population voted in a referendum to decide whether the UK should leave or remain a member of the European Union (EU). Commonly, referred to as Brexit, the resulting vote to leave the EU has since had an effect on healthcare provision in the UK. In terms of the financial implications of Brexit, the Nuffield Trust speculated that by leaving the EU, the Government could potentially assign £100 million a week to the NHS, which equates to £5.2 billion a year (Blitz, 2017). However, critics suggest that this cash injection could be directly offset by the economic slowdown after Brexit, which in reality could lead to a £2.4 billion annual reduction in NHS spending in England (Blitz, 2017). The severity of the financial situation that many NHS trusts face in the UK is likely to have a direct effect on healthcare staff through resource availability, recruitment opportunities, staffing levels (discussed in more detail in the next paragraph) and consequently overall morale.

Addressing the issue of staffing levels, the NHS in England employs over one million full-time equivalent (FTE) members of staff. The number of nursing staff has increased by 1.8 per cent from 281,064 FTE's in 2010, to 286,020 FTE's in 2017 (Kings Fund, 2017). Despite this increase, there remains an overall shortage of nurses in the NHS (Finlayson, 2002, Imison, 2017). Health Education England has estimated a shortfall in nursing staff of approximately 8.9 per cent (March, 2015), and has projected that this could rise to 11.4 per cent by 2020 (Kings Fund, 2017). Furthermore, despite the increase of staff numbers in other areas, such as scientific, technical, therapeutic, pharmaceutical, and research, there still remains a deficit of healthcare staff overall. In quarter one of 2017 (January 2017 to March 2017) there were 86,035 advertised vacancies (FTE's) in England (Kings Fund, 2017, NHS Digital, 2017). This concern over staff shortages is supported further by statistics taken from the NHS staff survey,

which in 2016 revealed that only 31 percent of staff ‘agreed’ or ‘strongly agreed’ that there were enough staff at their organisation to allow them to adequately perform their job (NHS Survey Coordination Centre, 2018).

The challenge around staff shortages in the NHS is amplified further by poor recruitment and retention of the workforce. It is likely that this issue stems from staff having to work long hours and receiving low pay. As an example, on average, a junior doctor works 72 hours a week (sometimes up to 100 hours per week) yet the average starting salary of a junior doctor is £22,636, significantly below the national average income (Kaidi and Atun, 2017). Statistics also demonstrate the repercussions of working long hours for little pay, “in 2015, 48 per cent of junior doctors in their second year of training chose to drop out of the NHS” (Kaidi and Atun, 2017, para. 7).

Brexit has already been mentioned in this chapter in relation to financial pressures, but the implications of the decision for the UK to leave the EU are not solely monetary; there could also be potential detrimental effects on healthcare staffing levels too. For example, if the migration of nurses from the European Economic Area (EEA) is limited, statistical modelling from the Department of Health published in the Health Services Journal, predicts that there could be a shortage of nurses in the UK between 26,000 and 42,000 by 2026 (Lintern, 2017). Further statistics reveal that 3,500 nurses with EU nationalities left the NHS in 2016, which is twice the number in 2014 (NHS Digital, 2017), and there has been a decrease in EU nationals registering as nurses in England, with a 92% drop between June 2016 and March 2017 (Financial Times, 2017). Overall, the sheer severity of healthcare staff shortages is evident and something that will need to be explored in the current study.

Due to some of the above mentioned issues that UK healthcare systems face, it could be presumed that job satisfaction and engagement amongst healthcare staff might be low. The NHS Staff Survey is an annual survey developed by two suppliers, the Picker Institute Europe and Quality Health (NHS Survey Coordination Centre, 2018). It is the largest collection of quantitative data regarding opinions of NHS staff. Questions have been developed around a number of themes including, equality, diversity and inclusion, health and well-being, immediate managers, morale (new for 2018), quality of appraisals, quality of care, safe environment and staff engagement.

The survey does not address overall job satisfaction through a single question, instead it asks participants to rate how satisfied they are with various aspects of their job role (there are eight questions in total) using a five point Likert scale (NHS Survey Coordination Centre, 2018). It should be noted that the scoring of this scale in the raw data is as follows (1 = 0, 2 = 2.5, 3 = 5, 4 = 7.5 and 5 = 10, this scoring is reversed for negative questions). An aggregate of these scores has been used to determine overall job satisfaction over the past five years, the same has been done for engagement (however nine questions were used for this theme). Table 1 below shows the national average for job satisfaction and job engagement scores (from 1 to 10, 1 being the lowest and 10 being the highest) over five years (NHS Survey Coordination Centre, 2018). The findings suggest that both job satisfaction and engagement scores have not significantly changed over a five year period. Moreover, it can be argued that the quantitative figures from the NHS survey do little to provide insight as to why these figures are remaining stagnant.

Table 1: Aggregated scores of job satisfaction and job engagement from the NHS Staff Survey from year 2014 to 2018.

Year	Aggregated Job Satisfaction Score	Aggregated Job Engagement Score
2014	5.9	6.8
2015	6.1	7.0
2016	6.1	7.0
2017	6.0	7.0
2018	6.2	7.0

A lack of satisfaction and engagement at work can lead to the recruitment and retention issues, mentioned in the above paragraphs (Shields and Ward, 2001, Sourdif, 2004). The severity of retention in particular, was shown in a 2016 article from the Guardian which quoted that four out of five healthcare workers have considered leaving their job in the NHS (Johnson, 2016). In addition job satisfaction has been shown to impact patient satisfaction (Atkins et al. 1996, Corvino, 2005, Huey-Ming Tzeng and Katefian, 2002, Leggitt et al. 2003, Mycek, 2001). Consequently, understanding the driving forces behind job satisfaction is crucial in preserving staff retention and patient satisfaction.

Contemporary Issues affecting Quality of Care

Having looked at some of the current issues affecting healthcare staff generally, it is also necessary to consider matters relating to quality of care. A crucial catalyst in highlighting the importance of quality of care amongst the general public in the UK was the Francis report, which investigated complaints raised against the Mid Staffordshire Foundation Trust (Francis, 2013). The report found that between 400 and 1,200 patients died as a result of poor care during January 2005 and March 2009 at Stafford hospital (Francis, 2013). The reasons behind this tragedy were primarily due to staff

shortages and low staff morale (Francis, 2013). The repercussions of this severe and very public failure of care was felt throughout the NHS and brought the issue of quality of care to the forefront of both the providers and receivers of healthcare.

In order to understand the various influences on the care provision in the UK, it is useful to begin from a societal perspective. In relation to lifestyles, there is evidence to show that people are becoming more sedentary. Statistics from the British Heart Foundation revealed that 39 per cent of adults in England are physically inactive (British Heart Foundation, 2017). The implications of an increasing sedentary population is that it puts further demand on healthcare systems. In the UK alone, a report published in The Lancet suggested that inactivity attributes to 16.9 per cent of deaths from any cause (Lee et al. 2012). When the UK tabloids obtained the data from this report, comparisons between inactivity and smoking were made with many headlines warning that “inactivity kills as many as smoking” (Triggle, 2012).

Besides a societal shift towards unhealthier lifestyles, life expectancies are also increasing. Analysis of trends in life expectancy estimate that males born in 2030 could live to an average of 85.7 years, with females living to an average of 87.6 years. (NHS Choices, 2015). Developments in medical care and the general improvement in the ability to treat diseases further augments the demand for care through increasing patient numbers (Imison and Bohmer, 2013). Patients are also presenting with more complicated and interrelated healthcare issues, all of which adds stress to an already pressurised healthcare system (Aiken et al. 2012).

This depiction of increasing demand through unhealthier lifestyles, longer life expectancies, and complexity of healthcare problems is not simply anecdotal, figures from several NHS reports have demonstrated a growth in demand. The NHS is treating more patients than ever before, with hospitals experiencing increases in Accident and Emergency (A&E) departments, non-elective admissions, elective admissions, and outpatient attendances (Maguire et al. 2016). For example, between 2003/4 and 2015/16, the total number of admissions to hospital (elective and non-elective) increased by an average of 3.6 per cent (Maguire et al. 2016). "A&E departments alone dealt with record numbers of patients between October and December 2016, when 5.6 million people visited A&E in this three-month period, this is a quarter of a million more than the same period last year" (Matthews-King, 2018, para. 15).

Another key influence on the quality of care provision in the UK is the shift towards a more consumerist approach, resulting in changing power dynamics between consumers and providers (Newman and Vidler, 2006). This can be evidenced by the Patient Choice Scheme, which emerged in 2006 and allowed patients a choice of four or five hospitals, ending the more traditional approach of General Practitioners (GP) referrals (Dixon et al. 2010). This was taken even further in 2008, with the introduction of Free Patient Choice, which gave patients the right to choose any provider that meets NHS standards and can provide the service within the maximum price the NHS will pay (Dixon et al. 2010). Whilst this increased flexibility has important benefits for patients, it adds a level of complexity to the demand management of healthcare services.

Another factor influencing the NHS is the growing expectations from users regarding the quality of care provided. By law, all NHS providers (including hospitals and ambulance services) must register with the Care Quality Commission (CQC). Without registration, providers are not allowed to operate. Unfortunately, the picture regarding the level of care provided by many trusts in the UK is not always positive; a report by the Kings Fund demonstrated that 51 per cent of trust finance directors and 29 per cent of Clinical Commissioning Groups (CCG's) finance leaders maintained that they felt patient care had worsened in their area over the past year (Anandaciva et al. 2018).

Since the late 1990's major policies have been implemented across the NHS in an attempt to raise the standard of quality of care. This approach has been replicated on a global scale too, with the World Health Organisation's 'The World Health Report' and the Institute of Medicine's 'Crossing the Quality Chasm' article, both highlighting the need to deal with competing goals of cost containment and quality improvement (World Health Organisation, 1995, Wolfe, 2001). The two reports concluded that responding to patients expectations was a valued and desired outcome of health systems' performance. Since these reports, efforts to measure patient satisfaction have consequently increased and in some countries, incentives have been adopted to promote patient satisfaction and patient centred care (Groene, 2011). The shift towards greater customer (patient) involvement and choice has been acknowledged in the academic world as well and subsequently catalysed research in this area (Elwyn et al. 2007).

A final aspect to mention which is relevant to the current study and relates to the care staff are able to provide is the move towards the use of multidisciplinary teams and integrated holistic care both within the NHS and healthcare in general (Carter et al. 2003). In 2013, NHS England introduced a programme known as 'Integrated Care and Support: Our Shared Commitment', in order to guide individual Trusts in developing a more integrated service (NHS England, 2018). The report stated that "for health, care, and support to be 'integrated', it must be person-centred, coordinated, and tailored to the needs and preferences of the individual" (NHS England, 2018, para. 2). This movement is also reflected in care models which link services across hospitals, general practices, community services, and social care, in order to provide patients with a more holistic approach to their medical and care needs (Ham and Berwick, 2017). In light of this transition and due to the fact that the majority of healthcare literature focusses solely on frontline staff, another key objective of the current study is to explore opinions from a wide range of healthcare professionals, different organisations, and from both clinical and non-clinical staff – the distinction of which will be outlined in detail in the methods chapter.

Theoretical Issues Underpinning the Study

Definitions of satisfaction generally stem from the Latin root 'satis', which means enough (Crow et al. 2002). It can be described as the fulfilment of ones wishes, expectations and needs. Academically, it is usually researched within a specific context, for example 'life satisfaction' a global cognitive evaluation or appraisal of one's satisfaction with life (Diener et al. 1985, Heller et al. 2006) or 'customer satisfaction' a post consumption or usage evaluation, (Johnson et al. 1995, Kuo et al. 2009, Wirtz and Lee, 2003, Austan et al. 2012, Smith and Lerigo-Sampson, 2016). Although very

differing concepts, the common thread between these notions is that it requires an evaluative element. Despite scientific approaches and attempts in the psychological field to map the neural correlates of satisfaction, it is too vague to be measured by itself, so it needs to be carefully defined and investigated within a specific context.

Momentarily taking a broader outlook, within both the manufacturing and service sectors, there has been a gradual transition from the well-established production orientation, towards the more customer orientated approach of relationship marketing. Consequently, academics and practitioners have shown discernible interest in customer satisfaction (Groonos, 1997, Vargo and Lush, 2004). Customer satisfaction is important as it can have a significant influence on company reputation, customer loyalty, and ultimately market share and profit; it is therefore in a firm's best interest to understand such interactions (Cronin et al. 2000, Tam, 2004, Anderson et al. 2008, Flint et al. 2011). As already alluded to in this introduction chapter, healthcare in the UK has followed this movement and also taken a more (customer) patient-centred approach, aiming to be more responsive to patients' preferences and needs (Laine and Davidoff, 1996, Mead and Bower, 2000).

The transition towards a more patient-centred approach has augmented the need for healthcare systems to demonstrate their performance and one way to capture this information is to use patient satisfaction measures (Wilkin et al. 2001). However, within the healthcare industry there are concerns as to whether providers have the ability to design and implement robust measures of patient satisfaction and there is also a lack of consensus surrounding the ways patients perceive and evaluate services (Williams, 1994, Azam et al. 2012). It has been observed in commercial sectors that customer

satisfaction is an extremely complex construct to measure and is often theoretically (and practically in terms of measurement) confused with service quality. However, some academics have argued that although customer satisfaction and service quality are closely related, they are distinct and unique concepts (Spreng and Mackoy 1996, Sureshchandar et al. 2002, Macdonald et al. 2011, Smith and Lerigo-Sampson, 2016). Therefore, the same is likely to be the case for patient satisfaction and quality of care too (Tam 2004). Additionally, due to patients expectations being strongly influenced by social factors, individuals own health concerns, personal beliefs, and prior experiences, there are questions as to whether the use of patient satisfaction measures are appropriate for capturing quality of care (Linder-Pelz, 1982, Fitzpatrick and Hopkins, 1983). Consequently, the current research proposes to avoid the utilisation of patient satisfaction altogether and instead explore quality of care as a specific concept in its own right and understand the construct based on the interpretations of healthcare staff directly.

Although it has been suggested that staff satisfaction may have a role in influencing overall organisational performance, the relationship between staff satisfaction and clinical quality of care has received little attention (Peltier et al. 2008, Pinder et al. 2013). Analogous relationships have been researched throughout the commercial sector, for example the link between staff satisfaction and service quality (Schleicher et al. 2004, Hartline et al. 2000), but equivalent links (staff satisfaction and quality of care) are somewhat absent from the healthcare management literature. Some studies from the healthcare domain have looked at specific connections, such as staff turnover and quality of care (Leveck and Jones, 1996) staffing levels and quality of care (Needleman et al. 2002) or leadership style and quality of care (Sfantou et al. 2017)

but very few have attempted to look at the holistic relationship between healthcare professional's job satisfaction and quality of care and aimed to capture opinions from a broad workforce, it is this theoretical gap, which the current study seeks to address.

Research Objectives

With a multitude of issues such as finance, staff shortages, and an unhappy workforce facing both the NHS and healthcare systems in general, it is essential that insights are sought directly from healthcare personnel. Therefore, the first research objective of the current study is:

> *To explore factors which influence healthcare professionals' job satisfaction.*

Due to existing healthcare research predominately focussing on clinical, frontline staff, it is important than non-clinical staff are recognised too. A comparison of opinions from these two groups of staff is likely to provide interesting and novel insights into healthcare professionals' job satisfaction. This is also important (as mentioned above) due to the shift towards more holistic and multidisciplinary healthcare systems. Therefore, the second research objective of the current study is:

> *To investigate whether there are differences in opinions between clinical and non-clinical staff.*

Finally, although analogous links between staff satisfaction and service quality have been made throughout research in commercial sectors, the links have not been fully explored in healthcare settings. Therefore the intention here is to see whether this

relationship is evident throughout healthcare too. Consequently, the third research objective of the current study is:

> *To investigate the relationship between healthcare professionals' job satisfaction and quality of care.*

Motivation for the Current Study

There are a number of key factors that have motivated the current research project. Figures suggest that the NHS in England currently employs approximately 1.7 million members of staff, with an annual budget of over £116.4 billion (NHS UK, 2016). As referred to briefly already in this introduction chapter, demand for the NHS and other healthcare systems in the UK has been increasing considerably year on year. In order to protect a workforce which is already stretched, a greater understanding of both the positive and negative elements surrounding their job roles is important, as well as understanding the consequences of such extreme positive and negative experiences. Amid financial and human resource challenges within the NHS system, as well as societal changes towards unhealthier lifestyles and the way people view their healthcare rights, it is perhaps more crucial than ever to understand how these issues are impacting on both the providers and receivers of healthcare.

From a personal motivation perspective, there were two key drivers influencing the choice of study. The first came from practitioner experience, having worked in the NHS for six years in a number of roles, there was a desire to further understand and gain knowledge surrounding the frustrations, challenges, as well as the positive elements that healthcare staff face on a daily basis. In particular, I gained awareness of the

disparity between clinical and non-clinical representation both in practice and in academia. The non-clinicians' voice is often seen as less important or not considered at all compared to clinicians'. Another issue raised by staff across a wide range of pay bands (Bands 2 to 9) was a discontent towards current methods of collecting information around staff's job satisfaction. Conversations with healthcare professionals occasionally led to complaints about the NHS staff survey. In particular, its inability to truly capture opinions of the staff and that the results of the data analysis were not adequately shared across all staff members. In addition, staff felt that if any issues were raised from the annual survey, little was done to implement changes or try to resolve such issues. Therefore, the lack of representation from non-clinical roles and a need to gain a deeper understanding of the issues affecting healthcare staff were catalysts behind the current research.

The second main driver behind the study emerged towards the latter parts of the PhD process. I became a regular customer (ongoing treatment between the months of August 2017 and April 2018) of the NHS, which gave me greater insight to some of the issues healthcare staff face and altered my perspective of the system as a whole. Having been on 'both sides' of the care equation (provider and receiver) there became an even stronger motivation to understand, protect, and improve the working lives of staff who continuously care and look after others.

Contribution

There are a number of ways the current study contributes to the healthcare management literature. Firstly, the study extensively explores the factors that influence healthcare professionals' satisfaction and the findings add support to existing work in this area. However, the timing of this research and the severe issues currently impacting healthcare staff, elevate the significance of these findings further. Consequently, the contribution is not solely theoretical, but of critical relevance to healthcare practitioners too. Through amalgamating much of the existing, and in some ways inconsistent, perspectives of job satisfaction, a greater understanding of this concept is provided. Secondly, another principle objective of the current study is to include opinions from a wide range of healthcare roles, not just frontline staff. This unique comparison between clinical and non-clinical workers is virtually non-existent throughout the literature and therefore significantly enriches knowledge and understanding in this area. Thirdly, the study also aims to understand the relationship between healthcare professionals job satisfaction and quality of care, again a somewhat neglected area of research. In summary, not only will the study provide a significant theoretical contribution, but it will also allow practitioners throughout the NHS and wider healthcare providers to better understand how to manage and motivate their staff. It is proposed that improving staff satisfaction will result in higher levels of quality of care. A lengthier discussion of the thesis contribution (from both a theoretical and practitioner perspective) is provided in chapter ten.

Structure of Thesis

The purpose of chapter one of this thesis, was to provide background information in order to explain and contextualise the study. This has been carried out utilising practitioner and corporate based evidence. To further inform the study, a thorough understanding of previous research also needs to be demonstrated. Therefore, chapters two, three, four, and five will provide a comprehensive review of the literature and an overview of the study's key concepts. The aims of the literature review chapters are to define the main terms, evaluate existing and related work, establish any un-researched areas that require addressing and appraise associated theory. Within the set of review chapters, chapter two will examine job satisfaction from a general perspective, chapter three will then consider specific factors which influence job satisfaction within the healthcare domain, chapter four will consider the concept of quality of care, and chapter five will bring the two constructs of job satisfaction and quality of care together. The information obtained from the literature reviews, will enable the study's methods to be established and these will be outlined in chapter six. Chapter seven will reveal how the data was coded and analysed. Chapter eight identifies the key findings from the collected and analysed data. In chapter nine, these findings will be discussed in detail and linked back to previous research. Finally, chapter ten will confirm how the study has contributed significant knowledge and theoretical understanding of the concepts, as well as make recommendations to practitioners as to how the findings can be used to inform and enhance the working lives of the healthcare workforce.

Chapter 2: Job Satisfaction

Introduction

As outlined in the introduction chapter of this thesis, chapter two will provide an extensive review of existing research and literature exploring job satisfaction from a general perspective. The review will aim to conceptualise the overall structure of job satisfaction by amalgamating existing theoretical perspectives. The study of 'attitudes' towards work materialised at the turn of the 20th century; during this time, psychology was immersed in a behaviourist movement, underpinned by a positivistic philosophy, where only observable behaviour was taken into account and unobservable events were disregarded (Skinner, 1974). Amid this era of experimental psychology a number of pioneering studies emerged.

Thorndike (1917) was one of the first to investigate 'work' and in particular, its relationship to productivity, he concluded that, the lack of a break affected the individuals' enthusiasm and interest in completing a task, rather than the actual quality and quantity of the work (Thorndike, 1917). Another seminal piece of work in this area was the Hawthorne Studies, which looked at environmental factors and their impact on productivity (Roethlisberg and Dickson, 1939, Mayo, 1949). These key connections and findings paved the way for further studies exploring work attitudes and specifically, the link between satisfaction and performance. The studies sparked a deluge of research into job satisfaction itself and it remains one of the most researched 'attitudes' in modern management. "Employees' have attitudes or viewpoints about many aspects of their jobs, their careers, and their organisations; however, from the

perspective of research and practice, the most focal employee attitude is job satisfaction" (Saari and Judge, 2004, p.395-396).

Ordinarily, job satisfaction is researched within disciplines such as industrial-organisational psychology, social psychology, organisational behaviour, human resource management, sociology, and organisational management (Cranny et al. 1992). Understanding the concept of job satisfaction is crucially important from both an employees and employer's perspective. On average, a person spends one third of their adult life, working (World Health Organisation, 1995). Many individuals also define themselves by their profession and career (Singh and Tiwari, 2012). Furthermore, the level of an individual's job satisfaction can impinge on other areas of their life, potentially affecting their overall health and well-being (Gruneberg 1979, Fisher, 2000, Brown et al. 2012). A large meta-analysis of 485 studies revealed significant links between job satisfaction and a person's mental and physical health status (Faragher et al. 2005). From an industry perspective, job satisfaction is significant as it can influence fundamental business outcomes such as performance (Silvestro and Cross, 2000, Yoon and Suh, 2003, Yee et al. 2008), organisational citizenship behaviour (LePine et al. 2002), and organisational profit (Staples and Higgins, 1998, Koys, 2001, Harter et al. 2002). In the service domains, there is strong empirical support for the link between employee satisfaction and customer satisfaction, which in turn has a positive influence on overall profit (Homburg and Stock, 2004, Luo and Homburg, 2007).

This review will now look at how job satisfaction is defined within the literature, which theories have underpinned the understanding of job satisfaction, and how it is structured as a theoretical construct. The subsequent literature review chapter (chapter 3) will then provide a more focused look, concentrating predominately on healthcare professionals and the specific factors which have been identified as influencing their job satisfaction.

Definitions of Job Satisfaction

As established in the introduction section of this chapter, the concept of job satisfaction has been studied for approximately 100 years, so definitions are extensive and varied. Locke, a particularly influential academic in this area of research, defined job satisfaction as “a pleasurable or positive emotional state, resulting from the appraisal of one's job or job experiences” (Locke, 1976, p. 1300). This was adapted a decade later to, “the achievement of one's job values in the work situation, results in the pleasurable emotional state known as job satisfaction” (Locke and Henne, 1986, p. 21). Both of these definitions are interesting as they pre-date the now accepted influence of ‘affect’ on job satisfaction, however, Locke astutely refers to an emotional input as being relevant. This theme was continued with the definition by Cranny et al (1992) “an affective (that is, emotional) reaction to a job that results from the incumbent's comparison of actual outcomes with those that are desired” (p. 1).

As the theoretical understanding of the concept of job satisfaction evolved, inevitably so did the definitions. At the turn of the 20th century, definitions started to include the additional evaluative aspect of job satisfaction “a positive (or negative) evaluative judgment one makes about one’s job or job situation” (Weiss, 2002, p175). This

definition is also supported in the psychology literature, where the assertion is that “an attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour” (Eagly and Chaiken, 1993, p. 1). The rest of this chapter will reveal how and why these definitions have transpired through an expansion of conceptual understanding and empirical evidence.

Theoretical Underpinning of Job Satisfaction

Early Job Satisfaction Theories

In order to ascertain a deep understanding of the concept of job satisfaction an appreciation of the theoretical development is required. Some of the earliest perspectives associated with job satisfaction emanated from motivational theories; perhaps the most recognised of which is Maslow’s Hierarchy of Needs. Maslow (1943) proposed that human needs are ordered, with the most basic, physiological needs at the lower end, and self-actualisation needs at the higher end. The desire to reach and satisfy each level of ‘need’ determines an individual’s behaviour. Once a stage is adequately fulfilled, an individual can then move on to the next level (Maslow, 1943). Relating this model to a work context, lower-order requirements to obtain food, shelter and safety, act as drivers for an individual to seek employment (Wolf, 1970). If these needs are met, the individual may strive towards the higher-order needs and pursue occupations that satisfy their self-esteem and fulfilment needs (Wolf, 1970). There are several critics of Maslow’s hierarchy, who claim that the model assumes that all employees are alike and therefore driven by the same principles (Graham and Messner, 1998, Basset-Jones and Lloyd, 2005). Furthermore, some state that the argument behind the theory is lacking in empirical data to support the claims (Vroom,

1964, Wahba and Bridwell, 1976). Despite these concerns, this theory has been highly influential and inspired a range of additional theories related to job satisfaction.

Building on from Maslow's work, Theory X and Theory Y, were proposed by McGregor (1960). These theories relate to how managers perceive the attitudes of their workers (and how naturally motivated they are, or not) which consequently determines the managerial approach adopted. Theory X proposes that employees are essentially indolent and without intervention or coercion from the managerial team, organisational goals will not be met (Kopelman et al. 2008). Alternatively, Theory Y suggests that employees are indeed committed, ambitious, and willing to achieve organisational goals. Therefore, the responsibility of managers is to provide a supportive network in order for individuals to achieve their full potential (Kopelman, et al. 2008). Although some companies, such as IBM and General Electric successfully implemented strategies based on these two theories (Latham, 2012) as with Maslow's Hierarchy of Needs, the lack of empirical support for Theory X and Theory Y may explain their demise in acceptance amongst academics.

The two factor theory (also known as the dual-factor theory or motivator-hygiene theory) proposed by Herzberg et al. (1959) also takes into account the motivational element of job satisfaction and therefore again builds on the earlier work of Maslow. It employs a bilateral approach, proposing that job satisfaction and job dissatisfaction are not two extremes of a continuum; rather they are distinct and separate constructs (Herzberg et al. 1959, Ewen, 1964, House and Wigdor, 1967, Bassett-Jones and Lloyd, 2005). It has been suggested that there are particular determinants of each dimension that are unique to each one. For example, the key components of job

satisfaction are referred to as ‘satisfiers’ or ‘motivators’ and include aspects of the work itself and sequential rewards, such as, achievement, recognition and responsibility (Herzberg et al. 1959, Ewen, 1964, House and Wigdor, 1967). The key components of job dissatisfaction are referred to as ‘dis-satisfiers’ or ‘hygiene factors’ and these are associated with an individual's relationship with the environment, for instance, company policy, supervision, salary, and relationships with co-workers (House and Wigdor, 1967, King, 1970). Supportive researchers of this theory claim that they have replicated Herzberg’s results, however, it is worth highlighting that most of these have also adopted the same methodological approach (Schwartz et al. 1963, Saleh 1964). Some backing has arisen from the realm of positive psychology, which focuses on the study of human strengths and wellbeing rather than human weaknesses and depressions (Sachau, 2007). Friedlander and Walton (1964) concluded that the motives behind staying with an organisation (satisfiers) are different to the motives behind leaving an organisation (dis-satisfiers). Furthermore, Halpern (1966) found that satisfiers contribute more to overall job satisfaction than dis-satisfiers. However, Herzberg’s theory is not without critics. After reviewing the literature, House and Wigdor (1967) concluded that there is little empirical support for the Two-Factor theory. Additionally, Ewen (1964) carried out a factor analysis of a 58-item attitude scale and found that many of the components actually operated in the reverse direction to that which had been predicted by Herzberg’s original theory. Likewise, some factors have been shown to simultaneously act as satisfiers and dis-satisfiers (Dunnette et al. 1967, Wernimont, 1972). This theory is now considered by many researchers in organisational psychology as outdated and whilst it is often referred to within the job satisfaction literature; developments around the structure of job satisfaction means it has been superseded.

Demographics and Job Satisfaction

Delving into the broader job satisfaction literature, demographic factors have been explored in relation to job satisfaction; predominately, the research here focuses on gender and age. Some studies investigating gender differences across job satisfaction have shown that women tend to exhibit higher levels of satisfaction at work than men (Bartol and Wortman, 1975, Hodson,1989, Clark, 1997, Asadullah and Fernandez 2008). The proposed reasoning behind such discrepancies include the suggestion that some women may place a different emphasis on work in comparison to other aspects of life, such as family responsibilities, and that they utilise different personal expectations in evaluating their jobs (Bartol and Wortman, 1975). Other proposals are that men may be more willing to vocalise dissatisfaction with work because of different socialisation behaviours (Hodson, 1989) and that women have lower expectations of the workplace and are consequently more satisfied than men (Lambert, 1991). In contrast however, Goh et al (1991) and Okpara et al. (2005) found the opposite, that male employees are more satisfied than their female counterparts (Okpara et al. 2005, Okpara, 2006). Women were found to be paid less and were less satisfied with significant areas of their jobs. It its worth mentioning however, that these latter studies have examined staff in specific job roles, namely teachers and accountants, therefore the generalisability of the findings may be questionable.

Considering the focus of the intended workforce for the current thesis, it was important to also examine the link between gender and job satisfaction using literature from healthcare settings. Zawacki et al (1995) reported that male nurses tend to be slightly more satisfied across a number of work related characteristics (skill variety, task identity, task significance, autonomy and feedback) than female nurses. The

suggested reasoning behind this gender difference is that women may find it harder to balance their work life alongside other family commitments (Zawacki et al. 1995). Furthermore, female nurses may not be as prepared or supported when they transition into managerial roles compared with their male counterparts (Zawacki et al. 1995). Females consequently face greater role ambiguity. This particular gender difference was replicated in a study by Fielding et al. (1995) who found that female doctors had poorer ratings of job satisfaction than male doctors. However, the article fails to offer conclusive suggestions as to why this might be. As with the broader literature looking at gender and job satisfaction, findings are varied, with further studies finding no differences between genders (Siu, 2002).

Several studies have investigated age and its relationship with job satisfaction (Hulin, and Smith, 1965, Kalleberg and Loscocco, 1983, Lee and Wilbur, 1985, Hochwarter et al. 2001, Jalal Sarker et al. 2003). Some research has concluded that this relationship is u-shaped, therefore, job satisfaction is high relatively early in a person's career, it then drops after some time, before increasing again as people near retirement age (Clark et al. 1996, Hochwarter et al. 2001). The principle behind this is that employees early on in their careers have high expectations and limited experience from which they can draw comparisons, as people move through their careers, those earlier, high expectations may not be met initially, leading to a decline in satisfaction. However, as an individual's career progresses even further, employees may gain more rewarding job roles, which can again increase satisfaction (Clark et al. 1996, Hochwarter et al. 2001). As with gender, despite some studies finding a relationship between age and job satisfaction, others have revealed no relationship. For example, in one study looking at hotel staff, age itself did not predict job satisfaction, but tenure

did, so those employees who had been in a role for several years had built up experience, stability, and relationships with co-workers (Sarker et al. 2003).

In terms of the relationship between age and job satisfaction amongst healthcare staff, a study looking specifically at age and generational differences between healthcare staff members, revealed some useful insights. Significant differences among the three generations of registered nurses were found for overall job satisfaction and five specific job satisfaction components (Wilson et al. 2008). The study examined nurses classed as Baby Boomers (born 1946–1964) Generation X (born 1965–1979) and Generation Y or Millennials (born 1980 onwards). Nurses in Generations X and Y reported a significantly lower level of overall job satisfaction than nurses in the Baby Boomer cohort. For overall job satisfaction and specific satisfaction components, no differences were found between Generation X and Generation Y participants. There were differences between Generation X and Y and Baby Boomer with factors such as pay and benefits, scheduling, praise and recognition, and control and responsibility. Despite some inconsistencies within the literature, demographics have been shown throughout the included studies as potential antecedents to job satisfaction, in that they may shape, or in some way determine the level of job satisfaction experienced by an individual due to differences in socialisation, job experience levels, and expectations.

Dispositional and Personality Theories of Job Satisfaction

The dispositional theory states that job satisfaction is to some extent, determined by an individual's characteristics (Staw and Ross, 1985, Bowling et al. 2006). For example, some studies have attempted to connect specific traits of the Five-Factor

model of personality to job satisfaction. The Five-Factor model represents dimensions of human personality, which include openness (willingness to try new activities), conscientiousness (being aware of one's own actions and the consequences of their behaviour) extraversion (being sociable, talkative, and demonstrating confident behaviour) agreeableness (being friendly, co-operative, and considered more likeable) and neuroticism (persistent worriers who are fearful, feel anxious, and over-think situations) (Digman, 1990). In one particular study, neuroticism, extraversion, and conscientiousness were found to closely relate to job satisfaction (Judge et al. 2002). Extraversion and conscientiousness were positively related to job satisfaction, whereas neuroticism was negatively related. However, other studies looking at the same factors have revealed mixed results, which suggest correlations such as these may have to be viewed with discretion (Furnham and Zacherl, 1986, Judge et al. 2002).

Personality itself has previously been explored in relation to job satisfaction (Furnham and Zacherl, 1986, Strümpfer, et al. 1998, Judge et al. 2000, Judge and Bono, 2001, Bono and Judge, 2003, Lounsbury et al. 2003). In particular, the dispositional theory (mentioned above) states that job satisfaction is somewhat determined by an individual's characteristics (Staw and Ross, 1985, Bowling et al. 2006). In other words, people can be predisposed to having either positive affectivity or negative affectivity, which in turn translates into emotions and feelings towards certain objects (Judge and Hulin, 1993, Connolly and Viswesvaran, 2000, Ilies and Judge, 2004, Thoresen et al. 2003, Piccolo, et al. 2005, Fenton-O'Creevy et al. 2011, Judge and Kammeyer-Mueller, 2012). For instance, positive affective people tend to feel more enthusiastic, alert, and optimistic, whereas, negative affective people feel more anger, contempt,

fear, and nervousness (Watson et al. 1988). Positive and negative affect have also been directly associated with global job satisfaction in that people who score high on positive affectivity scales have higher job satisfaction than those who score high on negative affectivity scales (Watson et al. 1988, Connolly and Viswesvaran, 2000, Thoresen et al. 2003, Bowling et al. 2006). The reasoning behind this is that positive affective (PA) individuals tend to remember the positive aspects of their work environments, whereas individuals with negative affectivity (NA) traits, tend to remember the negative aspects of their work environment (Bowling et al. 2006). Furthermore, PA employees tend to have more positive views of themselves and the world in general, whereas NA employees tend to have critical opinions of themselves and their environments (Thoresen et al. 2003).

Additional support for the dispositional theory has arisen from the finding that job satisfaction tends to be relatively stable across an individual's lifespan, even if the occupation or employer changes (Staw and Ross, 1985, Dormann and Zapf, 2001). Some research has even suggested that there might be a genetic predisposition to job satisfaction. One particular study conducted on monozygotic twins who were raised apart from early childhood, revealed that the sets of twins had significantly consistent job satisfaction levels (Arvey et al. 1989). On the contrary, other studies have revealed that personality traits simply do not have a powerful or consistent enough association with job satisfaction (Furnham, et al. 2002). Critics of the dispositional theory also state that even if different personality traits have been shown to be related to job satisfaction, there is little theoretical explanation as to how or why these associations have occurred (Spector, 1997). There appears to be two main viewpoints regarding the link between personality and job satisfaction, the first suggests that job satisfaction is

simply an output of one's psychological disposition, (Staw and Cohen-Charash, 2005) the second contends that environmental features are also vital determinants of job satisfaction (Gerhart, 1987). Critics of this psychologically based dispositional theory would suggest that the linkage between personality and job satisfaction alone, disregards other potentially important factors such as the organisation, managerial aspects, relations with colleagues and the job itself.

In terms of studies which have looked specifically at the links between personality and job satisfaction amongst healthcare staff, one such example explored a range of potential influencers on nurses job satisfaction and one of the strongest associated factors in this studied sample was the personality trait 'positive affectivity'. The results revealed that nurses who had a positive outlook on life demonstrated higher levels of job satisfaction (Chu et al. 2003). This finding was replicated by a study in a similar setting, which found that personality variables such as optimism, self-esteem, self-efficacy, and negative affectivity were all related to Taiwanese nurses' job satisfaction (Chang et al. 2010).

One of the few studies to look at job satisfaction across a range of healthcare roles also found that job satisfaction depends partly on various personality dimensions as opposed to being influenced solely by job characteristics. This study found that those members of staff who exhibit positive affectivity are more likely to be satisfied with their roles, even after other variables such as job characteristics and environmental factors are controlled (Agho et al. 1993). Further research has examined the link between specific personality traits (such as hardiness) and job satisfaction. One such study found that 'high-hardy nurses' tend to be more committed to their work, deal with stress

better, and experience greater job satisfaction (Judkins and Rind, 2005). It can therefore be suggested that personality traits may in some way act as antecedents in determining the level of job satisfaction experienced by individuals.

Values, Norms, Expectations, and Job Satisfaction

This section of the review will explore job satisfaction research, which has been underpinned by theoretical notions such as values, norms, and expectations. A key related concept to job satisfaction, identified through some literature is an individual's values (Blood, 1969, Kalleberg, 1977, Knoop, 1994). "Values operate at a societal, organisational, and individual level" (Grojean, et al. 2004, p.226). Values can be defined as the ideals and beliefs that an individual maintains towards life in general, or specific stimuli (Rokeach, 1973). Furthermore, personal values can influence choices and behaviours, as well as shape attitudes (Altun, 2002, Glazer and Beehr, 2002, Bellou, 2010). In the career development literature, there is both conceptual and empirical support for the link between an individual's values and their occupational choice (Duff and Cotgrove, 1982, Brown, 2002, Knafo and Sagiv, 2004). The implication therefore, is that there may be a common value profile associated with particular occupations.

One related theoretical model in this area is the values-attitudes-behaviour hierarchy, which states that values influence behaviour via attitudes (Homer and Kahle, 1988). This particular model has been utilised in several areas within the field of psychology as well as marketing and consumer behaviour (Allen et al. 2002, Jayawardhena, 2004). It has also been specifically explored in relation to work values and job satisfaction (Drummond and Stoddard, 1991, Vansteenkiste et al. 2007, Ravari et al.

2012). It has been argued that work values are a source of motivation and therefore such values are likely to influence both a workers' attitude and behaviour towards various work related factors (Vansteenkiste et al. 2007).

Work values themselves can be divided into components and in some studies, a distinction between extrinsic and intrinsic work values has been made (Centers and Bugental, 1966, Taris and Feij 2001, Hegney et al. 2006). Examples of identified extrinsic work values have included, pay, rewards for skills and experience, having good co-workers, always having a job available, opportunities for progression, working hours, and the safety of the workplace (Centers and Bugental, 1966, Taris and Feij 2001, Hegney et al. 2006). Intrinsic values have included interesting work, opportunity to use a particular skill or talent, feeling of satisfaction, job variety, job autonomy, and morale (Centers and Bugental, 1966, Taris and Feij, 2001, Hegney et al. 2006). In terms of relating this to existing theory, these extrinsic and intrinsic value factors are also similar to the 'satisfiers or motivators' and 'dis-satisfiers or hygiene' factors proposed in the two factor theory, which was outlined earlier on in this chapter (Herzberg et al. 1959, Ewen, 1964, House and Wigdor, 1967, King,1970).

Additional work has revealed that the shared values workers have at a wider level can influence job satisfaction. For instance, Valentine et al. (2011) found that corporate ethical values can unify employees and are positively associated with job satisfaction, (Valentine et al. 2011). A significant connection has also been found between value congruence and nurse job satisfaction (Kramer and Hafner, 1989, Vandenberghe, 1999, Verplanken, 2004). The notion of shared or congruent values, may have some

relation to equity theory, which is based on the premise that people have a propensity and yearning for equality (Adams, 1965). Equity theory implies that all employees should receive a fair and equitable reward in return for their contribution towards the job (Pritchard et al. 1972). As social beings, people will naturally engage in a comparison process between their own inputs and outputs (for example, education level and pay) and their fellow colleagues (Pritchard et al. 1972, Carrell and Dittrich, 1978, Mitchell and Mickel, 1999). Anxiety and distress will develop if an individual perceives themselves to be over or under valued in relation to others and they will seek to rectify this imbalance (Carrell and Dittrich, 1978, Huseman et al. 1987).

Advocates of equity theory claim a causal link between equity, satisfaction, and turnover. However, researchers who have attempted to affirm such links point out that, although empirical data supports the notion that employee perceptions of equitable treatment is a strong predictor of absence and turnover, it is much weaker for job satisfaction (Dittrich and Carrell, 1979). The assumption remains that people will engage in activities to reduce disparity and any subsequent dissatisfaction; but equity theory does little to address job satisfaction directly (Landy, 1978). In addition, equity theory has been shown to have less relevance and has been criticised for failing to recognise individual and situational differences (Mowday, 1991). Shore (2004) stated that since the development of equity theory, societal values have changed significantly and people aren't necessarily content with receiving the same as others. This is further supported by studies revealing people are not necessarily dis-satisfied when their outcomes (e.g. pay) are inconsistent with other colleagues. There is a tendency for this to be unidirectional however, so there is a preference for being over-rewarded

compared to being equitably rewarded and dis-satisfaction remains when an individual is under-rewarded compared to their contemporaries (Pritchard, 1969, Shore, 2004).

Amongst much of the sociology literature, there has also been a suggestion that norms and expectations can play a part in the formation of job satisfaction (Arbour et al. 2014). The rationale behind this link is that experiences in our early life can potentially influence the aspirations and expectations we develop in adulthood (Clark, 1997, Ross and Reskin 1992), which in turn shape the social processes and conventions generated by individuals themselves (Brown et al. 2012). Furthermore, it is suggested that people utilise a comparative framework when making evaluative judgements (such as judgements around job satisfaction) and again, these are influenced by a person's past experiences or expected future circumstances (Clark, 1997). Individuals therefore gain satisfaction when their situation is better than expected, but experience dissatisfaction when it falls below what they expect, regardless of their actual objective circumstances (Brown et al. 2012).

The relationship between norms and expectations and job satisfaction have also been supported by psychological theories, which state that job satisfaction may not solely depend on the objective circumstances that workers experience in their jobs, but also on subjective elements such as individual aspirations, expectations, or feelings of entitlement (Michalos 1985, Perales and Tomaszewski, 2016). Consequently, it has been suggested that people may make comparisons at differing levels, for example, at the broadest level, norms and expectations may emerge from reference points in relation to other countries or societies, whilst at a more immediate level, people may

make comparisons against family, friends, and neighbours (Perales and Tomaszewski, 2016).

In addition to norms and expectations stemming from broad influences, it is also possible that they emerge from the job and the individual workplace itself too. In particular, research has demonstrated that when workers start a new position of employment, they are likely to have a set of prior norms and expectations; after time these will either be met or unmet (Porter and Steers, 1973, Lam et al. 2003). This links to the 'actual-aspirational gap' model, which postulates that the closer people's actual experienced conditions are to their subjective aspirations and expectations, the higher their ratings of satisfaction will be (Campbell et al. 1976). The link between expectations and job satisfaction can also be seen when comparisons are made against other dimensions, for example demographics. As previously discussed, some studies have reported that women have higher job satisfaction than men. One interpretation of this finding is that this difference does not necessarily reflect the fact that women's jobs are actually better than men's, but rather, they have lower expectations due to entrenched societal norms (Clark, 1997).

Job Characteristic Theories

The final section of this chapter exploring the theoretical underpinning of job satisfaction will look at the notion of job characteristics. A general job characteristics model itself, developed by Hackman and Oldham (1975, 1976) specifies that job satisfaction will occur when three 'critical psychological states' in the individual employee are present; namely, experienced meaningfulness of the work, experienced responsibility for the outcomes of the work, and knowledge of the results of the work

activities. These three ‘states’ can be broken down further into five dimensions. Experienced meaningfulness of the work is achieved through skill variety, task identity, and task significance, experienced responsibility for work outcomes arises from autonomy, and finally, knowledge of results occurs via regular, quality feedback (Hackman and Oldham 1975, 1976, Fried and Ferris, 1987). These links suggest that organisational and managerial practices are also important to job satisfaction and despite advocates of the dispositional theory, it further rationalises the argument that job satisfaction is influenced by factors beyond personality alone.

A meta-analysis by Loher et al. (1985) investigated the above job characteristics and found that autonomy had the greatest effect on employee job satisfaction, followed by job variety and job feedback, with job significance and job identity having the lowest impact. Another study found that job satisfaction had a positive relationship with job variety, job significance, and feedback (Chiu and Chen, 2005). Further studies have suggested additional job characteristics which may be important, for example, task significance and career development have been shown to also influence job satisfaction (Wright and Kim, 2004). Other supporters of the job characteristics theory include DeVaro et al. (2007) who utilised a large secondary data set (2,191 respondents) to show that the model strongly predicts performance outcomes and worker satisfaction. This relationship has also been supported using structural equation modelling in a study that tested the mediating effect of job characteristics between work environment and job outcomes (Kim et al. 2009). Enhanced job characteristics were shown to increase job satisfaction through the mediating negative effect of role ambiguity, and the positive effect of work involvement and supervisory support (Kim et al. 2009).

Generally, compared to many of the other theories mentioned previously in this chapter, the criticisms of the job characteristics model have been both fewer in number and less harsh. However, it has still been noted that research utilising this model has yielded inconsistent results, ignored social influences, and sometimes fails to consider contextual or situational characteristics (Roberts and Glick, 1981, Loher et al. 1985). One counter argument to this is that many of these replicated studies often omit the three 'critical psychological states' from empirical investigations and instead attempt to directly link the five core job characteristics (or dimensions) to the outcomes, ultimately producing erroneous results (Behson et al. 2000).

With the above in mind, it was again necessary to look at the healthcare specific literature dominating this area. In terms of studies examining the job characteristics developed from the Hackman and Oldman model, one study found that nurses' job satisfaction is positively affected by task clarity, skill variety, possibilities for growth, and feedback (Jansen et al. 1996). As the interest in this area has progressed, so has the understanding of the potential 'job characteristics' that may influence a healthcare worker's job satisfaction and in particular the diversity of these job specific characteristics has increased over time. Job specific factors or characteristics, which have been associated with job satisfaction in healthcare settings include: access to training (Bartlett, 2001, Shields and Ward, 2001, Bjørk et al. 2007, Gardulf et al. 2008, Touranheau, 2010, Atefi et al. 2015), working in a team (Opie, 1997, Adams and Bond, 2000, Cortese, 2007, Gardulf et al. 2008, Chang et al. 2009, Kalisch et al. 2009, Kalisch, et al. 2010, Al-Dossary et al. 2012), staff management (Aiken et al. 2011, Li and Lambert, 2008, Lu et al. 2005), being able to deliver quality of care (Nolan et al. 1994, McNeese-Smith, 1999, Peltier et al. 2008, Chang et al. 2009), interactions with

colleagues (Blegen, 1993, Irvine and Evans, 1995, Dunn et al. 2005, Bjørk et al. 2007, Cortese, 2007, Utriainen and Kyngäs, 2009) and the hospital environment (Topf and Dillon, 1988, Adams and Bond, 2000, Aiken et al. 2013).

It seems that the implication for the current study is that there is some evidence to suggest that job characteristics can be important predictors of workers' job satisfaction. However, these may not be the only influences on job satisfaction itself. The growing understanding gained from the literature is that none of the 'factors' in their own right can completely explain a person's job satisfaction, instead job satisfaction arises from a complex interplay between some, or all of these factors – demographics, personality, values, norms and expectations, as well as the situational job specific characteristics of the role itself. Overall, it appears that the best way to ascertain which job characteristics influence staff the most, is to determine them directly from the participants involved. It will be down to the current study to explore whether any of these factors mentioned above arise through conversations with the selected workforce and in particular whether there are differences between clinical and non–clinical roles. Furthermore, it will aim to determine whether any of these factors also influence quality of care.

Structure of Job Satisfaction

The preceding section of this chapter provided an overview as to how the theoretical understanding of job satisfaction has developed and evolved over time. Whilst useful in that it provides a historical background and contextualisation of the thesis, an integration of these somewhat standalone perspectives is required (Unterrainer et al. 2013, Perales and Tomaszewski, 2016). Consequently, the following section will

attempt to consolidate these theories, which span across disciplines such as psychology, sociology, organisational psychology, and economics, in order to develop an overall understanding of job satisfaction.

Weiss and Cropanzano (1996) proposed that emotions and moods influence job satisfaction. Specifically, events within the work environment determine our attitudes towards our job via both cognitive and affective means (Glasø et al. 2010). Weiss and Cropanzano (1996) argue that workplace events trigger affective responses, which accumulate over time; they influence attitudes such as job satisfaction, which in turn impact upon workplace behaviour, such as absenteeism, turnover, and productivity (Weiss and Cropanzano, 1996, Weiss et al. 1999). Additional studies have supported these links both theoretically and empirically, for example the theory was corroborated when applied to a call centre setting. A study by Wegge et al. (2006) revealed that specific elements of the job, for example autonomy, impacted on workers mood and emotions, which in turn influenced their job satisfaction. Furthermore, it was reasoned that job satisfaction is an evaluative judgement (Wegge, 2006, Fisher, 2000, Judge and Kammeyer-Mueller, 2012).

Consequently, in accordance with academics from a range of backgrounds and the previously explored theories within this chapter, it can be suggested that job satisfaction is defined as an ‘attitude’ (Kalleberg and Loscocco, 1983, Weiss 2002). Therefore, the structure of attitude formation needs to be understood. Originally, attitudes were thought to consist simply of an ‘affective’ or emotional component, however, subsequent models have taken in to account cognitive and behavioural elements too, forming the classic tripartite model (affective, cognitive, and behavioural)

of attitudes (Thurstone, 1928, Campbell, 1963, Eagly and Chaiken, 1993, Ng and Feldman, 2010). The 'affective' component includes emotions and feelings, whereas the 'cognitive' component is formed from beliefs and judgement (McGuire, 1969, Breckler, 1984, Chaiken and Stangor, 1987, Brief and Robertson, 1989, Edwards, 1990, Fisher, 1998, Verplanken et al. 1998, Weis et al. 1999, Weis et al. 2002). The behavioural aspect reflects people's tendency to behave in a certain way, based on their affect and cognitions towards an object (Breckler, 1984, Fisher, 1998, Huskinson and Haddock, 2006, Judge and Kammeyer-Mueller, 2012). When an individual's attitude is favourable towards a particular object, their behaviour is also likely to be more favourable towards that object (Ng and Feldman, 2010). The implication therefore, is that affective experiences and cognitive beliefs about an object provide essential information that allows an overall evaluation to be made; this in turn influences behaviour (Ajzen, 1991, Ajzen, 2001, Crano and Prislin, 2011, Judge and Kammeyer-Mueller, 2012). In terms of the conceptual understanding of job satisfaction, both affective and cognitive information provide the situational context to the evaluation and therefore the overall level of job satisfaction.

One of the main issues in this area however, is that affect and cognition are not easily separable. Studies from neuropsychology have shown that although different structures within the brain are responsible for cognition (thinking) and affect (feeling), they are inextricably linked (Duncan and Barrett, 2007). It is difficult therefore, for these concepts to be separated in a practical (and measurable) way (Judge and Kammeyer-Mueller, 2012). In a major review of research into the relationships between emotions and cognition, Phelps (2006) concludes that understanding the role and significance of emotion is critical to understanding cognition and that emotion is central to our

cognitive functioning. Consequently, the current study will not aim to explicitly measure or ascertain which factors are ‘affective’ or ‘cognitive’ elements, instead it will aim to understand the overarching factors which influence healthcare professionals job satisfaction.

In summary, from the extensive examination of the job satisfaction literature, it is proposed that job satisfaction is an attitude comprising of affective and cognitive elements. These intertwined elements of affect and cognition lead to an explicit appraisal or evaluation of a particular object - in this case job satisfaction (Weiss and Cropanzano, 1996, Fisher, 2000, Weiss and Schank, 2000, Weiss, 2002). However, the extensive review of the literature has also suggested that there are a number of factors which influence an individual’s job satisfaction. These include demographics, personality, values, norms and expectations as well as specific characteristics or ‘antecedents’ of the job itself. The sources of academic literature which support each of the connections can be seen in Table 2.

Table 2: Factors which have been shown to influence job satisfaction coupled with a summary of the literary support.

Factor	References to Support Concepts
DEMOGRAPHICS	Hulin, and Smith, 1965: Bartol and Wortman, 1975: Kalleberg and Loscocco, 1983: Lee and Wilbur, 1985: Hodson,1989: Coh and Koh, 1991: Lambert, 1991: Fielding et al. 1995: Zawacki et al. 1995: Clark et al. 1996: Clark, 1997: Hochwarter et al. 2001: Siu, 2002: Sarker et al. 2003: Okpara et al. 2005: Okpara, 2006: Asadullah and Fernandez, 2008: Wilson et al. 2008.
PERSONALITY	Staw and Ross, 1985: Furnham and Zacherl, 1986: Gerhart, 1987: Watson et al. 1988: Arvey, et al. 1989: Digman, 1990: Judge and Hulin, 1993: Judge et al. 1997: Spector, 1997: Strümpfer et al. 1998: Connolly and Viswesvaran, 2000: Judge et al. 2000: Dormann and Zapf, 2001: Judge and Bono, 2001b: Furnham et al. 2002: Ilies and Judge, 2002: Judge et al. 2002: Lounsbury et al. 2003: Thoresen et al. 2003: Piccolo et al. 2005: Staw and Cohen-Charash, 2005: Bowling et al. 2006: Fenton-O'Creevy et al. 2011: Judge and Kammeyer-Mueller, 2012.
VALUES	Herzberg et al. 1959: Ewen, 1964: Adams, 1965: Centers and Bugental, 1966: House and Wigdor, 1967: Blood, 1969: King,1970: Pritchard et al. 1972: Rokeach, 1973: Kalleberg, 1977: Carrell and Dittrich, 1978: Duff and Cotgrove, 1982: Huseman et al.1987: Homer and Kahle, 1988: Kramer and Hafner, 1989: Drummond and Stoddard, 1991: Knoop, 1994: Mitchell and Mickel, 1999: Vandenberghe, 1999: Taris and Feij 2001: Allen et al. 2002: Altun, 2002: Brown, 2002: Glazer and Beehr, 2002: Grojean, et al. 2004: Jayawardhena, 2004: Knafo and Sagiv, 2004: Verplanken, 2004: Hegney et al. 2006: Vansteenkiste et al. 2007: Bellou, 2010: Valentine et al. 2011: Ravari et al. 2012.
NORMS AND EXPECTATIONS	Porter and Steers, 1973: Campbell et al.1976: Clark 1997: Hodson, 1985: Michalos, 1985: Ross and Reskin, 1992: Lam et al. 2003: Warr, 2007: Clark et al. 2008a: Brown et al. 2012: Arbour et al. 2014: Perales and Tomaszewski, 2016.
JOB SPECIFIC ANTECEDENTS	Hackman and Oldham, 1975: Hackman and Oldham, 1976: Roberts and Glick, 1981: Loher et al. 1985: Fried and Ferris, 1987: Fox and Feldman, 1988: Topf and Dillon, 1988: Blegen, 1993: Nolan, et al. 1994: Irvine and Evans, 1995: Jansen et al. 1996: Opie 1997: McNeese-Smith, 1999: Adams and Bond, 2000: Behson et al. 2000: Bartlett, 2001: Shields and Ward, 2001: Wright and Kim, 2004: Chiu and Chen, 2005: Dunn et al. 2005: Lu et al. 2005: DeVaro et al. 2007: Cortese, 2007: Bjørk et al. 2007: Warr, 2007: Gardulf et al. 2008: Li and Lambert, 2008: Peltier et al. 2008: Chang et al. 2009: Kim et al. 2009: Utriainen and Kyngäs, 2009: Kalisch et al. 2010: Touranheau, 2010: Aiken et al. 2011: Al-Dossary et al. 2012: Aiken et al. 2013: Atefi, et al, 2015.

Conclusion

The aim of this opening literature review chapter was to determine how job satisfaction has been defined, as well as establish how theories underpinning job satisfaction have evolved over time. The chapter has provided a historical overview of the job satisfaction literature, spanning from influential research by Thorndike (1917) and Maslow (1943), which catalysed research into attitudes at work; through to studies, which suggest that job satisfaction arises via evaluations influenced by both affective and cognitive information (Weiss and Cropanzano, 1996, Judge and Kammeyer-Mueller, 2012). Furthermore, the culmination of insight from this review has determined that there are a number of factors which impact on job satisfaction, namely, demographics, personality, values, norms and expectations, as well as job specific antecedents.

Chapter 3: Job Satisfaction amongst Healthcare Staff

Introduction

The origin of studies investigating job satisfaction amongst healthcare staff is harder to identify than the generic research into job satisfaction, which was referred to in the previous chapter (chapter two). That said, a number of articles were published in the American Journal of Nursing around the turn of the 20th century, which initially, focussed on private nurses (Carr, 1901, Dock, 1909, Dokken, 1938). These articles tended to comprise of anecdotal reports or letters to the editors, describing the duties of private nurses, and exploring areas such as working hours, shift patterns, and poor wages. In the 1950's and 1960's further research examining job satisfaction amongst nurses and physicians emerged (Nahm, 1940, Retting et al. 1958). Some of these started to consider associated factors such as relationships with colleagues, (Hofling, 1966) and stress (Menzies, 1960). From the mid-1980s onwards, the burgeoning research related to nurses and physicians' job satisfaction, parallels the increase in demands on the staff members roles.

In hospital environments, nurses are the primary carers for patients, helping to treat the sick 24 hours a day, 365 days a year (Menzies, 1960). Predominately, nurses and doctors are faced with the stresses of continual patient care more so than any other roles in healthcare (Menzies, 1960). This may be the main reason that these roles are consistently the primary focus of existing research. However, in many healthcare settings, there are a multitude of other roles, including healthcare assistants, occupational therapists, physiotherapists, psychologists, and ambulance service members, to name but a few, who are also considered as clinical, frontline staff.

Furthermore, there are non-clinical and service support roles, which although may involve little patient contact, still play a vital part in the overall patient experience and service. Many of these non-clinical staff members are not included in the healthcare research and it is this substantial gap, that this thesis seeks to address, by examining job satisfaction across a range of healthcare roles and organisations.

Whilst chapter two has looked at the general structure of job satisfaction and included broad literature from multiple sectors, the aim of chapter three, is to narrow the focus by solely concentrating on the healthcare job satisfaction literature. In particular, chapter three will explore the specific factors or 'antecedents' which have been shown to influence healthcare professionals' job satisfaction. The narrative developed from a detailed review of the literature in chapter two suggested that the structure of job satisfaction is attitudinal; so both cognitive and affective information are used to make an evaluation around an individual's job satisfaction. Other factors such as demographics, personality, values, norms and expectations were also shown to influence a person's job satisfaction. However, there is also evidence that there are a number of job specific antecedents to healthcare professional's job satisfaction, so these will subsequently be discussed.

Antecedents to Healthcare Professional's Job Satisfaction

Access to Training

Access to training has been shown to relate to nurses job satisfaction and organisational commitment in a number of studies (Bartlett, 2001, Shields and Ward, 2001, Bjørk et al. 2007, Gardulf et al. 2008, Touranheau, 2010, Atefi et al. 2015). Specifically, it has been shown that employees who receive training, report higher levels of organisational commitment (Bartlett, 2001). However, this relationship between access to training and commitment to the organisation is likely to be moderated by job satisfaction (Bartlett, 2001). In a large survey of almost 9000 nurses, Touranheau (2010) found that training and educational opportunities had a significant impact on job satisfaction, which in turn provided impetus and dedication towards the job role. Furthermore, Bjørk et al. (2007) found that nurses who had a day or more per month, scheduled for professional development, had significantly higher scores of job satisfaction compared to those nurses who had less than one day a month for training. Another study found that training and career advancement opportunities had a substantially stronger impact on job satisfaction compared to pay or workload (Shields and Ward, 2001).

Access to training and professional development opportunities benefit the individuals, the organisations they work for, and the wider nursing community (Bjørk et al. 2007). Despite this, some studies have shown that due to long working hours, engaging in professional education and development on the job, it is not always possible (Gardulf et al. 2008). It has been suggested that practical ways to overcome this would be to offer activities such as a journal clubs, chances to join different committees and

workshops, and allow nurses time away from their day to day roles to attend such activities (Atefi et al. 2015).

Working in a Team

Healthcare is highly interdisciplinary in nature and therefore it would seem intuitive that working in a team would influence job satisfaction, but this link has also been supported by empirical data. Several studies have found that teamwork, relationship with colleagues, and perceptions of higher levels of staffing adequacy leads to greater job satisfaction (Opie 1997, Adams and Bond, 2000, Cortese 2007, Gardulf et al. 2008, Chang et al. 2009, Kalisch et al. 2009, Kalisch et al. 2010, Al-Dossary et al. 2012). Although a vast amount of work has been carried out in this area, it wasn't until 2008 that two researchers Xyrichis and Ream, proposed the need for both a conceptual understanding of teamwork and clarity and consistency in definitions. A concept analysis using literature spanning thirty years revealed that teamwork in healthcare is a "dynamic process involving two or more healthcare professionals with complementary backgrounds and skills, sharing common goals, and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care" (Xyrichis and Ream, 2008, p239).

Teamwork has also been shown to have an impact (potentially moderated by job satisfaction) on patient care. For instance, Rafferty et al. (2001) found that departments where staff scored high on a measure of teamwork, also scored high on job satisfaction, measures of quality of care, perceived quality improvement, and confidence that patients could manage their care when discharged. The implications of successful teamwork, which is achieved through good communication, strong

interpersonal relationships, and a cohesive group, is faster, safer, and more efficient patient care (Makary et al. 2006, Bjørk et al. 2007, Atefi et al. 2014). Throughout some of these studies, explicit characteristics of an 'effective team' have been identified and these include trust, backup, team orientation, and strong leadership (Kalisch et al. 2009, Kalisch et al. 2010). Other factors which have been identified are supportive work environments, open communication, group cohesion, and shared decision-making (Cox 2003, DiMeglio et al. 2005, Xyrichis and Ream, 2008, Wyatt and Harrison, 2010).

As mentioned in the introduction of this chapter, most research looking at job satisfaction in healthcare tends to focus on nurses and this is also the case for the factor of 'teamwork'. However, one particular study, which utilised a wider view of 'teams' compared nurses, surgeons, and anaesthesiologists' perceptions of teamwork and job satisfaction. Here the findings were less straight forward. Although the relationship between teamwork and job satisfaction remained, the level of contentment with physician-nurse collaboration was stronger amongst the physicians than the nurses (Makary et al. 2006). This is likely to be a result of fundamental differences between nurses and physicians job roles and activities (Makary et al. 2006). Not only does this finding highlight the complexity of interdisciplinary teamwork in healthcare, but also the importance of a key aim of the thesis, understanding how factors influence healthcare staff across a wide range of job roles.

The Job Itself

For some roles, such as nursing, the intrinsic nature of the job has been shown to influence job satisfaction (Lundh, 1999). However, 'the job itself' is a very difficult notion to describe, as even within the same sector, it is likely to vary considerably according to an individual's particular job role. That said, some studies have found commonalties across healthcare disciplines. Through discussions with nurses, Cortese (2007) highlighted a number of activities within the job itself, which related to nurses' job satisfaction. These included being able to provide effective treatment, variety in the type of task performed, contributing to patients' diagnosis, and involvement in organisational matters that may improve the overall experience of patients (Cortese, 2007). As can be seen, there is a common theme amongst these activities, all of which also happen to have a direct impact on patient care.

To some extent job content, also relates to workload in terms of pressure from additional tasks, role conflict, and balancing clinical and paperwork based activities (Tovey and Adams, 1999). Although two distinct factors, workload and stress are inter-connected, and both have been examined in relation to job satisfaction. Many studies have found that workload has a significant impact on job stress, which in turn influences the levels of nurses' job satisfaction (Marshall et al. 1997, McNeese-Smith 1999, Seo et al. 2004, Zangaro and Soeken, 2007, Li and Lambert, 2008). Although occupational stress has been found to be a determinant of job satisfaction of nurses, workload isn't always the primary factor (Blegen, 1993, Tovey and Adams, 1999, Lu et al. 2007). Other issues include the lack of support at the organisational level (Atefi, et al. 2015) the emotional trauma of dealing with sick and dying patients (Ingebretsen and Sagbakken, 2016), increased patient loads (Zangaro and Soeken, 2007)

inadequate resources (Linzer, 2009, Atefi et al. 2014) and low job control (Healy and McKay, 1998, Lambert et al. 2004b).

In terms of workload, it seems a delicate balance is required in order to reach optimum satisfaction. Staff members complain that nurse shortages often lead to heavy workloads (Price and Mueller, 1986b). However, work underload can also lead to low levels of satisfaction. The importance of having interesting activities within the job has been mentioned (Nolan et al. 1994) with staff members having low job satisfaction if they feel bored or unchallenged (Price and Mueller, 1986b, McNeese-Smith, 1999, Seo et al. 2004).

Health and Well Being

Studies looking at the links between health and well-being and job satisfaction have explored these concepts from both the mental and physical perspective. As with much of the research in this area, the predominant staff group investigated are nurses. Stress and burnout are recurring themes within the literature under this umbrella term of 'health and well-being'. For example, in a number of studies, job stress was shown to be the most influential factor on job satisfaction, demonstrating that increased levels of stress were associated with lower levels of job satisfaction (Bratt et al. 2000, Tabak and Orit, 2007). Furthermore, in a regression model for job satisfaction, the Nurse Stress Index score used by Flanagan and Flanagan (2002) was shown to be the most important aspect explaining job satisfaction, above and beyond nursing experience, age, and shift work (Flanagan and Flanagan, 2002). Burnout has also been associated with negative mental and physical health, which in turn were significantly related to both job satisfaction and turnover intentions (Healy and McKay, 2000, Faragher et al.

2005, Piko, 2006, Laschinger, 2012). From a psychological well-being perspective, factors such as empowerment, engagement, motivation, and self-determination, have been shown to lower job stress and therefore increase job satisfaction (Laschinger et al. 2001, Bartram et al. 2004, Begat, et al. 2005).

Staff Management

Throughout the human resource management literature, one of the most researched and established factors influencing job satisfaction in healthcare is staff management (Aiken et al. 2011, Li and Lambert, 2008, Lu et al. 2005). The underpinning factors of this umbrella term include skills mix, working hours, communication, and level of autonomy and these have all been associated with job satisfaction and the effectiveness of health services (Adams and Bond, 2000, West, 2001, Purdy et al. 2010, Aiken et al. 2012, Aiken et al. 2013, Cho et al. 2014).

Autonomy within healthcare environments has been linked to elements such as freedom, control, and participation (Zangaro and Soeken, 2007, Hayes et al. 2010). Some researchers have only found a moderate correlation between autonomy and job satisfaction (Loher et al. 1985, Zangaro and Soeken, 2007). Others concur that autonomy is one of the most significant job satisfaction determinants (Fung-kam, 1998, Seo et al. 2004, Bjørk, et al. 2007). The discrepancies could be down to demographic factors such as age, tenure, and education status, for example Dunn et al. (2005) found that nurses with a lower level of education considered autonomy to be less important in providing job satisfaction than nurse's with a higher level of education (Li and Lambert, 2008).

Another issue within the realm of staff management, which also links to job satisfaction, is the level of involvement with decision making. This has been reflected in nurses' desire to have greater participation in decisions affecting patient care (Adamson et al. 1995, Cortese, 2007). Good communication and a social leadership approach, which promotes an open atmosphere has also been shown to positively contribute to nurses' job satisfaction (Boumans and Landeweerd, 1993). Furthermore, a feeling that managers have a sound comprehension, understanding of the responsibilities and pressures staff face in the workplace, were also found to be important factors for pharmaceutical staffs' job satisfaction (Ferguson et al. 2011).

Many studies have also shown a link between managerial and organisational factors and their impact on staff satisfaction and clinical outcomes of care (West, 2001, Anderson, et al. 2003). It has been shown that some hospitals, which are deemed to have high quality care also seem to 'magnetically' attract and retain their staff (Upenieks, 2003, Laschinger et al. 2003). It is perhaps no coincidence that the structures of these hospitals are characterised by a flat organisational configuration, where frontline staff have a strong position within the executive management team (Adams and Bond, 2000, Aiken at al. 2000). Research from the Magnet Recognition program suggests that a visible nurse executive and involvement of nurses throughout the organisation in decision-making are 'best practices' (Aiken et al. 2012, Aiken et al. 2013). In addition it has been shown that workers respond positively to attention received from their managers, as well as the feeling that their superiors have an interest in their work (Roethlisberg and Dickson, 1939; Mayo, 1949).

Being able to deliver Quality of Care

The ability to deliver quality patient care is another factor that has emerged as having a significant relationship with job satisfaction (Nolan et al. 1994, Peltier et al. 2008, Chang et al. 2009). In a content analysis of several semi-structured interviews it was revealed that patient care was in fact the greatest cause of job satisfaction (McNeese-Smith, 1999). Due to the qualitative nature of this particular research, descriptions of this particular relationship revealed some key themes. The staff liked being able to provide good care, they were satisfied when they were able to meet the patient needs and they took pride in being able to identify specific problems and perhaps go above and beyond the call of duty (McNeese-Smith, 1999). Another qualitative study revealed additional themes. Developing a strong relationship with both patients and their families was considered important, as was receiving expressions of gratitude and acknowledgment. Staff members also reported feeling satisfied when communication of a professional kind took place and they were able to give useful information regarding the patients' diagnosis or treatment (Corteste, 2007). Perhaps more so with qualitative studies, there is the concern that respondents are giving socially desirable answers. If nurses feel they are expected to deliver quality patient care, then this might explain why it is such an important factor in this study. Despite this caution, there are numerous studies reporting a link between job satisfaction and being able to provide patient care (Moyle et al. 2003, Begat et al. 2005) the feeling of making a difference to the patients (Cortese, 2007, Morgan and Lynn, 2009) and knowledge that patients receive due care and attention (Dunn et al. 2005, Hayes et al. 2010).

Other related concepts to providing quality care include the timeliness of such processes. For example, the time available to complete tasks and provide direct clinical care was pivotal to satisfaction (Hayes et al. 2010). If the care is seen to be delivered efficiently and effectively, it is likely to result in positive outcomes, which again has been connected to job satisfaction. Seeing patients get better and go home, contributing to the curing process, and making a difference to patients all contributed to nurses' satisfaction (Newman and Maylor 2002, Begat al. 2005, Dunn et al. 2005, Perry 2005, Cortese, 2007, Utriainen and Kyngäs, 2009, Atefi, 2014).

The relationship between being able to deliver care and job satisfaction has not only been shown in hospital environments, but also for community and nursing home nurses too. For example, a study examining community district nurses found that caring for patients was the fundamental aspect of the nurse's work and this opinion was held by nurses across different grade bands and rankings (Stuart et al. 2008). Similarly, in a study conducted in a nursing home, a common theme to emerge regarding job satisfaction was the feeling of meeting the needs of the residents and a genuine desire to care for the elderly (Cherry et al. 2007).

Interaction with Colleagues

Colleague and co-worker interaction has also emerged through previous studies as a strong determinant of job satisfaction (Blegen, 1993, Irvine and Evans, 1995, Dunn et al. 2005, Bjørk et al. 2007, Cortese, 2007, Utriainen and Kyngäs, 2009). Related themes that consistently transpire include: the idea of building friendships, rapport with other members of staff, working as a team, and group cohesion (McNeese-Smith, 1999, Adams and Bond, 2000, Kovner et al. 2006, Mrayyan 2006, Bjørk et al. 2007,

Utriainen and Kyngäs, 2009, Zangaro and Johantgen, 2009). This also coincides with the notion of cooperation being crucial in delivering patient care (Tovey and Adams, 1999).

Social integration has been shown to have a positive effect on the psychological well-being of individuals by providing resources for support, as well as meaning and purpose (Decker, 1997, Berkman, et al. 2000). Another emergent theme related to interaction with colleagues was that of acknowledgment, appreciation, and trust (Cortese, 2007). This applied not only to co-workers but also to patients and their relations too. Factors that lead to dissatisfaction in this area included an unpleasant atmosphere, which appeared to be a symptom of poor communication, failure to involve staff and inflexible attitudes (Nolan, et al. 1994).

Relationships between nurses and physicians have been examined extensively, due to their working proximity. It has been suggested that successful nurse-physician collaboration is a key predictor of job satisfaction, as it not only improves working relationships but also patient outcomes (Adams and Bond, 2000, Dechairo-Marino et al. 2001, Zangaro and Soeken, 2007). In reality, opinions regarding nurse-physician relationships are varied. In a large study examining nurses opinions across twelve European countries, it was found that whilst the vast majority of nurses in every country reported that physicians and nurses have good working relationships, a sizeable proportion of nurses in all of the countries also reported that a lot of teamwork between nurses and physicians are absent in their work settings (Aiken et al. 2013).

Other factors to emerge in this area include the idea of solidarity and collaboration and these in particular have been found to contribute to both job satisfaction and motivation to stay in the organisation among Norwegian nurses (Bjørk et al. 2007). These were supported further from a qualitative study where nurses reported cooperation, professional support, and working together as a group as key factors of colleague interaction (Cortese, 2007). These studies reflect the importance of the working atmosphere to the nursing profession and as healthcare in general is such a multi-disciplinary industry, it seems intuitive that working relationships would play an integral part to staff members' job satisfaction.

Interaction with Managers

Leadership and relations with supervisors have also been linked to job satisfaction. One particular study concluded that a social leadership style contributed the most to job satisfaction (Boumans and Landeweerd, 1993). This style incorporates tenets such as an open environment, where communication and staff well-being are critical. The emphasis on the importance of good leadership and personal relations within the workplace has been supported by many others (Mayo, 1949, Tovey and Adams, 1999, Seo et al. 2004, Hayes et al. 2010). It has also been implied that employees who have a good working relationship with their supervisors may actually perform better and this in turn, equips the manager to better develop constructive and positive performance evaluations of staff (Lincoln and Kalleberg, 1990, Seo et al. 2004).

As with many of the other factors related to job satisfaction, there are sub-themes which have arisen through the concept of interaction with managers. These include the idea of feeling supported, the importance of managers taking into consideration staffing issues, and not neglecting to address any arising problems (Decker, 1997, Seo et al. 2004, Coomber and Barriball, 2007, Atefi et al. 2014). In contrast, a poor relationship with line managers and a lack of communication have been shown to be major contributors to staff leaving their jobs (Ferguson et al. 2011). As well as the above, it has been shown that good leadership must include trust, clear vision and consistent behaviour, all of which in turn influence nurses' job satisfaction (Tsai, 2011).

Staff Turnover

Due to the financial pressures and budget constraints healthcare organisations face, nursing numbers are decreasing rather that increasing to meet patient demand (Dunn et al. 2005). The relationship between staff turnover and job satisfaction is a particularly interesting one. Studies have shown that nursing staff shortages have a mutual negative relationship with job satisfaction (Zarea et al. 2009). In other words they are related to each other in a reciprocal manner, in that low job satisfaction causes nurses to leave their jobs, whilst the nursing shortage decreases job satisfaction (Zarea et al. 2009).

There are many issues associated with staff turnover, which translates into staff shortages. For example, many nurses become emotionally exhausted due to the sheer demands of the job, which in turn causes low job satisfaction (Aiken et al. 2002). Managers often struggle to ensure departments have adequate human resources available, often meaning that the nurse to patient ratio is low, which again impacts job

satisfaction (Hayes et al. 2010). In a qualitative study, looking at job satisfaction, the dialogue associated with high staff turnover and low staffing numbers included ‘fear of making a mistake’ ‘being overloaded’ ‘chaos’ and ‘dangerous’ (Wilson et al. 2008). The severity of this issue is obvious and yet again, this short synopsis of studies in this area highlights how many of these factors are intertwined.

Having sufficient staff both in terms of quantity and in terms of skills mix have been shown via several studies to relate to nurses job satisfaction. The Ward Organisational Features Scale was used in a study of NHS nurses and a significant relationship between sufficient staff and job satisfaction was reported (Adams and Bond, 2000). These findings were further supported in another study some 14 years on, which showed that perceptions of adequate staffing, number of patients cared for, and skill mix were associated with greater job satisfaction (Kalisch and Lee, 2014). This relationship has also been found amongst healthcare staff outside of the traditional hospital environment. For example, a study looking at nurses in care homes showed that inadequate staffing levels was felt to be a major contribution to staff satisfaction (Cherry et al. 2007).

Hospital Environment

Another issue which has arisen within the literature looking at job satisfaction, is the physical environmental surroundings. If the facilities available are substandard and the healthcare staff are unable to provide the level of care expected, this understandably causes frustration, which in turn manifests into low job satisfaction (Adams and Bond, 2000, Aiken et al. 2013). The environment can be considered in many ways, but some of the more common issues to arise are availability of equipment, staffing levels, and

time management (Tovey and Adams, 1999). It seems from the content analysis of the nurses' interviews, the preferred environment is fast paced, wholesome, safe, pleasant, and varied (McNeese-Smith, 1999). Other factors such as the air quality, noise, and light, have also been shown to have a significant impact on staff health (Topf and Dillon, 1988). Out of all the factors discussed in this chapter, hospital environment appears to have the least substantial influence on job satisfaction, however, as with the other factors raised in this chapter, further investigation during the present study is required.

The Organisation

The notion of 'the organisation' has been researched in relation to job satisfaction in its own right, but there are clearly overlaps with some of the other factors already discussed in this chapter. As with many of these other factors, 'the organisation' encompasses a number of sub-themes. These include organisational culture, support from the organisation, and communication, all of which will now be evaluated in this section. Several studies have shown support for the links between organisational culture, which is usually defined as the shared beliefs and values within an organisation, (Schein, 1985, Schwartz and Davis, 1981) and job satisfaction (Tzeng et al. 2002, Seo et al. 2004, Li and Lambert 2008, Tsai, 2011). One particular study found that organisational culture and job satisfaction was mediated via organisational commitment. In other words, a positive organisational culture induced greater commitment from staff and therefore more satisfaction at work (Tsai, 2011). A more recent study, which used structural equation modelling, found that the two concepts (organisational culture and job satisfaction) were mediated by inter-professional teamwork (Körner et al. 2015). It seems the interlinking variables here are still

somewhat unclear. Looking more specifically at the links between culture and job satisfaction, it has been shown that particular types of cultures are more conducive to job satisfaction, for example cultures which foster respect, empowerment, fairness and opportunities for personal growth, positively influence job satisfaction (Spence-Laschinger, 2002, Upenieks, 2003, Bellou, 2010).

Generally, there is consensual support amongst the articles reviewed that organisational culture itself has a direct association with work attitudes such as job satisfaction. This has been shown empirically by three studies in particular looking at mental health workers (Aarons and Sawitzky, 2006) and nurses (Tzeng et al. 2002). Gifford et al. (2002) specifically examined the relationship between unit organisational culture, nurses' quality of work life, and job satisfaction. They postulated that there is often a 'cultural norm' for hospital environments to be impinged by bureaucratic issues, and this can have a negative effect on nurse's job satisfaction. As expected, the findings of the study demonstrated that at the unit level, organisational culture does influence nurses' quality of working life and consequently their job satisfaction (Gifford et al. 2002). In a similar way that the values held by healthcare staff need to align with their colleagues and the organisation they work in to ensure they are satisfied with their roles, it seems that the norms and expectations of the individual also need to correspond with their place of work, which further adds to the discussion in the overall structure of job satisfaction in chapter two.

Another important issue which emerged, relates to the feeling of being heard and supported. In a survey of 421 nurses in Iran, 78% of nurses felt their hospital administration did not respond to employees' concerns (Atefi et al. 2015). This feeling of a lack of support has been echoed throughout other healthcare staff groups too. For example, a study looking at community pharmacists showed that staff were unhappy with their jobs as they felt unsupported and pressurised by the organisation to meet sometimes unrealistic targets (Ferguson et al. 2011). This was further aggregated by the fact that staff also felt micromanaged and lacked autonomy in their roles (Ferguson et al. 2011).

Finally, communication has also been associated with the organisation itself (as well as with the managers and other colleagues). In the study mentioned above, which examined pharmacists' job satisfaction, some staff felt as though the managers of their organisations failed to communicate effectively with employees regarding issues that affected their day to day working lives (Ferguson et al. 2011). Communication and job satisfaction has also been shown to be significant in other studies, with facets such as supervisor engagement, communication climate, and personal feedback being related most strongly to job satisfaction (Pincus, 1986). In a study looking at paramedic staff, it was suggested that managers need to be able to recognise and appreciate exactly what type of information is valued by employees as well as the quantity, quality, and transmission method of that information (Carriere and Bourque, 2009).

Summary of Antecedents to Healthcare Professional's Job Satisfaction

From the detailed scrutiny of the general job satisfaction literature (chapter two) it was proposed that factors influencing job satisfaction can be organised into a number of categories including; demographics, personality, values, norms and expectations, and job specific antecedents. This classifying approach is in line with other academics work too, for example, Brown et al. (2012) stated that job satisfaction can be seen as the product of two categories of factors, 1) personal characteristics, and 2) job characteristics (Brown et al. 2012, Perales and Tomaszewski, 2016). Whilst it seems that affective processes (emotions and feeling) and cognitive processes (beliefs and judgements) are involved with our evaluation of job satisfaction (Connolly and Viswesvaran, 2000, Thoresen et al. 2003), these other categories play a vital role in shaping our overall attitude towards work.

Addressing all of the outlined categories of factors mentioned above is beyond the scope of this study. It is also crucial to situate the comprehension of job satisfaction within a specific context. Consequently, this chapter (three) has focussed on the 'job characteristics' or 'job specific antecedents' category (as they will be termed in this thesis) which influence job satisfaction amongst healthcare professionals. A summary of these, along with the literary support for each link can be found in Table 3.

Table 3: Examples of previously established job specific antecedents to healthcare professionals' job satisfaction.

Main Theme	Sub Themes	Evidence from the literature
Access to training	• Educational opportunities • Professional development	Bartlett, 2001: Shields and Ward, 2001: Bjørk et al. 2007: Gardulf et al. 2008: Touranheau, 2010: Atefi et al. 2014
Working in a team	• Teamwork • Relationship with colleagues • Staffing adequacy	Opie, 1997: Adams and Bond, 2000: Rafferty et al. 2001: Cox, 2003: DiMeglio et al. 2005: Makary et al. 2006: Bjørk et al. 2007: Cortese, 2007: Xyrichis and Ream, 2008: Gardulf et al. 2008: Chang et al. 2009: Kalisch et al. 2009; Kalisch, et al. 2010: Wyatt and Harrison, 2010: Al-Dossary et al. 2012: Atefi et al. 2013.
The job itself	• Providing effective treatment • Variety of task • Contributing to patients diagnosis • Workload • Stress	Price and Mueller, 1986b: Blegen, 1993: Nolan, et al.1994: Marshall et al. 1997: Healy and McKay 1999: Lundh, 1999: McNeese-Smith 1999: Tovey and Adams, 1999: Lambert et al. 2004b: Seo et al. 2004: Cortese, 2007: Lu et al. 2007: Zangaro and Soeken, 2007: Li and Lambert, 2008: Linzer, 2009: Atefi et al. 2014: Li et al. 2014: Atefi et al. 2015.
Health and well being	• Stress • Burnout • Physical injuries	Bratt et al. 2000: Healy and McKay, 2000: Laschinger et al. 2000: Flanagan and Flanagan, 2002: Kalliath and Morris, 2002: Bartram et al. 2004: Begat et al. 2005: Faragher et al. 2005: Piko, 2006: Tabak and Orit, 2007: Laschinger, 2012.
Staff management	• Skills mix • Working hours • Communication • Autonomy • Involvement with decision making	Roethlisberg and Dickson, 1939: Mayo, 1949: Loher et al. 1985: Jones, 1990: Boumans and Landeweerd, 1993: Adamson et al. 1995: Fung-kam, 1998: Adams and Bond, 2000: West, 2001: Anderson et al. 2003: Laschinger, 2003: Upenieks, 2003: Seo et al. 2004: Dunn et al. 2005: Lu et al. 2005: Bjørk et al. 2007: Cortese, 2007: Li and Lambert, 2008: Hayes et al. 2010: Ferguson et al. 2011: Mohr et al. 2011: Purdy et al. 2010: Zangaro and Soeken, 2007: Aiken et al. 2011: Aiken et al. 2012: McHughetal et al. 2012: Aiken et al. 2013: Cho et al. 2014.
Being able to deliver quality of care	• Meet patient needs • Making a difference • Delivery of efficient and effective care	Nolan et al. 1994: McNeese-Smith, 1999: Newman and Maylor, 2002: Moyle et al. 2003: Begat al. 2005: Murrells et al. 2005: Perry 2005: Cherry et al. 2007: Corteste, 2007: Dunn et al. 2005: Morgan and Lynn, 2009: Peltier et al. 2008: Stuart et al. 2008: Chang et al. 2009: Utriainen and Kyngäs, 2009: Hayes et al. 2010: Atefi, 2014.
Interaction with colleagues	• Building friendships • Rapport with other members of staff • Working as a team • Group cohesion	Blegen, 1993: Nolan et al. 1994: Irvine and Evans, 1995: Decker, 1997: McNeese-Smith, 1999: Tovey and Adams, 1999: Adams and Bond, 2000: Aiken et al. 2013: Berkman et al. 2000: Dechairo-Marino et al. 2001: Dunn et al. 2005: Kovner et al. 2006: Mrayyan, 2006: Bjørk et al. 2007: Cortese, 2007: Utriainen and Kyngäs, 2009: Zangaro and Johantgen, 2009.
Interaction with managers	• Leadership style • Feeling supported	Mayo, 1949: Lincoln and Kalleberg, 1990: Boumans and Landeweerd, 1993: Decker, 1997: Tovey and Adams, 1999: Seo et al. 2004: Coomber and Barriball, 2007: Hayes et al. 2010: Ferguson et al. 2011: Tsai, 2011: Atefi et al. 2014

Staff turnover	• Skills mix • Staff shortages	Aiken et al. 2002: Dunn et al. 2005: Wilson et al. 2008: Zarea et al. 2009: Hayes et al. 2010.
Hospital environment	• Availability of equipment • Staffing levels • Time management	Topf and Dillon, 1988: McNeese-Smith,1999: Tovey and Adams, 1999: Adams and Bond, 2000: Aiken et al. 2013.
The organisation itself	• Organisational culture, • Support from the organisation • Communication	Pincus, 1986: Spence-Laschinger, 2002: Tzeng et al. 2002: Scott, et al. 2003: Upenieks, 2003: Seo et al. 2004: Gifford et al. 2002: Aarons and Sawitzky, 2006: Li and Lambert, 2008: Carriere and Bourque, 2009: Bellou, 2010: Ferguson et al. 2011: Tsai, 2011: Atefi, et al. 2015: Körner, et al. 2015.

Conclusion

This literature review has explored many of the established job specific antecedents that have so far been linked to, or suggested as influencing job satisfaction. Despite such a saturated field of literature, the picture in terms of which factors influence job satisfaction is unclear and there are inconsistencies amongst the research (Zangaro and Soeken, 2007). The understanding thus far appears to indicate that the specific dimensions of job satisfaction may vary according to the industry and job role. Therefore, one of the primary aims of the current study is to ascertain which factors presently influence job satisfaction in UK healthcare workers. Reports over the last several decades have indicated a severe shortage of healthcare professionals (Hassmiller and Cozine, 2006, McNeese-Smith and Nazarey, 2001). Therefore, understanding the key determinants of job satisfaction and how these might impact on the service is vital. In addition, the study aims to broaden the participants included. The existing research in this area predominately focuses on nurses and doctors. As already stated in this thesis, there are a multitude of roles within healthcare that tend to get overlooked, yet healthcare systems are moving more and more towards an interdisciplinary system, and a holistic approach to patient care and treatment. Therefore, it is imperative that the working lives and interrelations of all healthcare staff are considered, not just those on the frontline.

Chapter 4: Quality of Care

Introduction

As acknowledged in the introduction of this thesis, the current research straddles two disciplines, human relations and operations. Whilst the previous two literature review chapters have explored job satisfaction under the umbrella discipline of human relations, chapter four now turns to the operational side, looking at quality and, more specifically quality of care. As already alluded to in the introduction chapter, quality of care is a highly topical issue (Mainz, 2003, Francis QC, 2013, Pinder et al. 2013, Mannion et al. 2015). In the UK, NHS hospitals are under immense pressure politically and financially, yet there is still a requirement to ensure high quality of care is provided to all. In particular, there has been a drive to improve effectiveness and efficiency as well as develop sound measures of these key concepts (Campbell et al. 2000, Stelfox and Straus, 2013).

Healthcare quality or quality of care, is a complex concept to define (Donabedian, 1980). This is illustrated by the diversity of viewpoints surrounding quality of care and the fact that the information required will differ according to the stakeholder concerned; be it the whole organisation, healthcare staff, policymakers, or patients (Donabedian, 1980, Wilde, 1994, Stelfox and Straus, 2013a). For example, physicians will have a different level of experience and understanding of the healthcare systems and processes that influence the quality of patient care provided compared to the general public (Blendon et al. 2001). There are also differences in the way stakeholders will use such information. For instance, hospitals require information regarding the quality of care provided and the outcomes achieved in order to adhere to regulatory standards, make continuous improvements, and do so cost-effectively (Stelfox and Straus, 2013a). Patients may use information on quality to add political pressure and to drive

improvements in particular areas, as well as to inform individual decisions about their healthcare provision (Stelfox and Straus, 2013a). In summary, the overall aim of this chapter is to initially examine the concept of 'quality' from a general perspective, before moving to a more focussed consideration of quality of care. The definition and use of current quality care indicators within the NHS will be briefly reviewed. All of the above will allow establishment of the most appropriate means of capturing and understanding the concept of quality of care.

Quality

In order to understand the concept of quality of care, it is useful to firstly examine how quality has been defined in other industries. It's been stated that quality is "the single most important force leading to the economic growth of companies in international markets" (Feigenbaum, 1982, p22). There are several definitions, which have been proposed by academics and the most appropriate is arguably dependent on perspective. Garvin proposed that there are five main approaches to quality, transcendent, product based, user based, manufacturing based, and value based. These have been summarised below (see Table 4) (Garvin, 1984, Forker et al. 1996).

Table 4: Perspectives of Quality

Approach	Distinguishing Elements
Transcendent	Innate excellence
Product Based	Quantity of desired attributes
User Based	Satisfaction of consumer preferences
Manufacturing Based	Conformance to requirements
Value Based	Affordable excellence

As well as the differing perspectives making the concept of quality difficult to define, the dynamism of the business environment also needs to be taken into consideration. In particular, the shift over recent decades from the traditional product-dominant logic, towards a service-dominant approach has meant that even traditional manufacturers have been required to explicitly ‘servitise’ their operations and recognise that products are only one aspect of the value proposition for their customers (Neely 2008, Vargo and Lusch, 2008). In other words, the increased importance of the service sector has led to changes in the way academics and practitioners have defined and approached quality (Reeves and Bednar, 1994). Whilst for some of the more traditional manufacturing companies, definitions of quality such as ‘ensuring zero defects’ (Crosby, 1979) may still have some relevance, aspects of quality associated with the ‘user’ or ‘value’ based approaches will also have significance in that the quality may need to be defined by the consumer. This has led to further definitions of quality, including - the extent to which a product or service meets and / or exceeds a customer's expectations (Gronroos, 1990, Zeithaml et al. 1996). The above discussion has implications for the current study in that in order to truly understand the concept of quality in healthcare, the appreciation of differing perspectives of quality need to be considered. Although a general understanding of quality is a useful start, ideally, quality needs to be understood within a specific context. Therefore, the following sections of this chapter will look at quality within healthcare (referred to from now on as quality of care).

Theoretical Overview of Quality of Care

As with the term ‘quality’, the definition of ‘quality of care’ varies depending upon the perspective, be it from shareholders, managers, employees, or the general public. The World Health Organisation defines a quality healthcare service as efficient, cost effective, and socially acceptable (Sajid and Baig, 2007). Being socially acceptable can be seen as a way of incorporating the perspective of the patient and is concurrent with the commercial sector where customers are seen as key drivers in delivering quality of care (Institute of Medicine, 1999, Azam et al 2012). Compared to other service industries, quality in healthcare can be a difficult concept to evaluate. This is predominantly due to the fact that the users themselves are highly involved with the service. Quite often the relationship between patient and provider can be long-term, fraught with emotional ramifications and some patients may be simply too ill to be in a position to evaluate the service (Hekkert et al. 2009). It has also been suggested that some aspects of the system are difficult for patients to assess due to the technical aspects of medical procedures. Despite these hurdles, patients’ feedback is invaluable and should still be used as a way of improving service quality (Suki et al. 2011).

Due to the difficulty in accurately evaluating quality of care, it has become standard practice to fragment it into various dimensions. The three key models that consistently emerge throughout the literature are the Institute of Medicine model (Institute of Medicine, 2001) the access and effectiveness model (Campbell et al. 2000) and Donabedian’s (1988) system-based approach model, which divides healthcare into structures, processes and outcomes; all of which will now be reviewed in detail.

Institute of Medicine Six Dimensions Model

'To err is human' was a report published by the Institute of Medicine, which stated that as many as 98,000 people a year die as a result of medical errors that could have been prevented (Institute of Medicine, 1999). In response to this report, health professionals, state policy makers, organisation managers, governing boards, and consumers were brought together, in order to create a model that would enable all stakeholders to commit to a national improvement of the healthcare system as a whole (Institute of Medicine, 2001). This particular model proposed six key dimensions that constitute quality healthcare: effective, efficient, accessible, patient-centred, equitable, and safe (Institute of Medicine, 2001). The following dimensions are highlighted in the Crossing the Quality Chasm report as key components of a 21st Century Healthcare System (Institute of Medicine, 2001, p5-6).

Effective: healthcare should be evidence-based and make significant improvements to individuals as well as the general population's health.

Efficient: healthcare should avoid wasting valuable resources both tangible and intangible.

Equitable: healthcare must be convenient and geographically logistical for all and not vary in quality because of such individual differences.

Patient-centred: healthcare must take in to account the individual needs of patients, whether this is demographic, religious, or cultural.

Timely*:* healthcare must avoid lengthy waiting times and harmful delays for both those who receive and those who give care.

Safe: healthcare must ensure that risks for users are minimal.

Although the original report by the Institute of Medicine sparked a deluge of research and practitioner interest in to the importance of patient safety and quality of care, it is difficult to determine whether significant improvements have indeed been made (Stelfox et al. 2006). In the UK, the fact that quality of care remains such a topical area due to many of the pressures mentioned in the introduction chapter of this thesis (for example financial issues, increasing demand from patients, and staff shortages) despondently suggests that there is much more to do in order to rectify this issue.

Access and Effectiveness Model

Campbell et al. (2000) speculated that there are two key dimensions to quality of care: access and effectiveness. Awareness of the importance of access to healthcare stems from observations made by Florence Nightingale in the Crimean war. It was noted that the biggest determinant of soldier mortality was the distance to the nearest hospital (Maxwell, 1984). Access can therefore be referred to as the physical and geographical distance from healthcare facilities. It also encompasses availability, which is the extent to which the healthcare system provides the required facilities and services (Campbell et al. 2000). A service also needs to be comprehensive, cover the needs of everyone, as well as offer provider continuity and affordability (Campbell et al. 2000).

Effectiveness refers to the extent to which the care has met the needs of the individual and is composed of clinical and interpersonal components (Campbell et al. 2000). Clinical or knowledge-based care can be seen as the extent to which a treatment or service adheres to the patients expectations, as well as professional standards of care (Donabedian, 1990, Sackett, et al. 1996). The effectiveness of interpersonal care stems from an appreciation of the uniqueness of care and an awareness that individual circumstances and the complexity of a patients needs must be considered (Stewart et al.1995). Although useful, the access

and effectiveness model is rather simplified and many argue that there are more dimensions to quality of care that should be acknowledged. In the original paper by Campbell et al. (2000) reference was also made to the fact that healthcare can be divided into structure, process and outcomes, which also coincides with Donabedian's model, which will be discussed next.

Structure, Process and Outcomes Model

Perhaps the most well-established model of quality of care is the systems-based approach, which takes in to account structures, processes, and outcomes of healthcare (Donabedian, 1980, Donabedian, 1988, Campbell et al. 2000). Structure, refers to the characteristics of the healthcare system that impact on the ability of said system to meet the healthcare needs of the patients and the community (Mainz, 2003). It includes physical characteristics such as resources, facilities, equipment, and money (Idvall et al. 1997). The availability of supplies, support services, and human resources has been shown to directly impact on the ability of healthcare staff to provide high quality care (Bond et al.1989, Robinson et al. 1989). This further links to the discussion which was presented in chapter three of the current thesis, in which it was suggested that being able to deliver good quality of care was an important factor in influencing a person's job satisfaction. Consequently, any issues which impinge on this ability, such as shortage of supplies, low staffing levels, lack of education and qualifications, as well as an imbalance in the overall skills mix, also affect the persons' job satisfaction (Mainz, 2003). At the highest level, is the organisational structure, which includes the way services are organised, for example, opening hours, the methods used to book appointments, ward layout, and available contact time between nurses and patients (Seelye, 1982, Donabedian, 1988).

Processes include what is actually done through giving and receiving care. In other words, the procedures used by patients in seeking care as well as the techniques used by practitioners to diagnose and administer treatment (Donabedian, 1988). Processes can be divided further still, for example, technical care and interpersonal care (Donabedian, 1988, Steffen, 1988, Irvine, 1990, Utsugi-Ozaki et al. 2009). Technical or clinical care refers to the application of some medical diagnosis or treatment (Donabedian, 2000). These are processes that should be carried out efficiently and against highly scrutinised and standardised measures. It should also encompass the necessity and appropriateness of care (Kahan et al. 1994, Brook, 1994). Interpersonal care considers the interaction between healthcare staff and its users (Donabedian, 2000). Key interpersonal skills for staff working in care professions include excellent communication, ability to build trust, empathy, sensitivity, and humanness (Donabedian, 1988, Carmel and Glick, 1996).

Outcomes refer to the effects of care, they may incorporate a patients improved awareness and knowledge about their health, a change in their behaviour, as well as the overall satisfaction with their care (Donabedian, 1988, Irvine, 1990). An outcome is not always positive and in some cases deterioration of disease or even mortality are unfortunate, but potential outcomes. The use of such outcomes is controversial; if the expected outcome is inevitable death for example, many feel that this is an inappropriate measure (Thomas et al. 1993). Consequently, a more realistic definition could be, an outcome is “an expected change in predetermined factors such as the patient's behaviour, health status, or knowledge following the completion of nursing care” (Bond and Thomas, 1991, p. 1494). Campbell et al. (2000) combined Donebedian’s systems-based approach to healthcare, with the accessibility and effectiveness components to create a holistic model of the dimensions of ‘quality of care’ (Campbell et al. 2000, p1615).

It should be highlighted that in order for processes to be considered as safe and satisfactory, they must specifically link to desirable outcomes (Donabedian, 1966, Campbell et al. 2000). Such established relationships are known as evidence-based process indicators, which have been 'outcome validated' (Mainz, 2003a). It is possible, however, for both structures and processes to impact on the final outcomes, either directly or indirectly (Campbell et al. 2000). Donabedian's structure, process and outcomes model remains the most highly influential and commonly used approach in classifying quality of care.

Measures of Quality of Care

Whilst the above three theoretical models of quality of care are well established throughout the literature, it is necessary to explore how quality of care is assessed and measured within the UK, and specifically, the NHS. Figure 1, reveals the three main areas from which a vast array of data is collected, they include clinical effectiveness, patient safety, and patient experience. Within each area, there are further standards or quality indicators that are collected via numerous bodies and frameworks.

Figure 1: Overview of quality assurance indicators, measures, and frameworks used throughout the NHS, England.

Quality Indicators

Quality indicators (QI's) are one of the many tools used to measure quality of care, however a vast array of methods are used, with no consensus as to the best type (Stelfox and Straus, 2013a). Healthcare quality indicators include norms, standards, and other direct qualitative and quantitative measures used in determining the quality of healthcare (National Library of Medicine, 2014). Another definition from academia is "a measure that can be used as a guide to monitor and evaluate the quality of important patient care and support service activities" (Idvall et al. 1997, p.7). The main aim of quality indicators is to compare actual patient care against a standard, ideal criteria. This information can then be used for quality improvement, accountability, and research (Stelfox and Straus, 2013a). Quality indicators can also be classified in terms of the systems based-approach model referred to earlier, in that they measure either structure, process, or outcomes (Idvall et al. 1997).

Quality indicators can occur at different levels, for example, ward level, department level, hospital level, as well as nationally (Idvall et al. 1997). Indicators can be organised into three categories: activity indicators, which measure how frequently an event happens, quality indicators, which are based on a judgement about the quality of care provided, and performance indicators, which monitor performance (such as the use of resources) without any necessary inference to quality (Campbell et al. 2002). The suitability of indicators, usefulness, and impact, will depend on the aims of the measurement. Whilst some indicators can be used for multiple purposes, this is not universally the case. Perhaps the starkest contrast is between measurement for improvement (eg, benchmarking against peers) and measurement for judgement (eg, for performance assessment and management) in pay-for-performance schemes, or for patient choice (Freeman, 2002).

Many performance indicators provide useful feedback on specific aspects of complex healthcare systems, however, providing a summary indicator encompassing multiple processes related to a meaningful outcome has proven a challenge (Pinder et al. 2013). It has been suggested that as a minimum prerequisite, all measures should be tested for acceptability, feasibility, reliability, sensitivity to change, and validity (Campbell et al. 2002). Acceptability, refers to the acceptance of the measure from experts as well as those it is measuring, for example doctors, nurses, and patients (Stelfox and Straus, 2013a). Feasibility, means it must relate to a wide enough patient population to allow comparisons to be made, therefore, unusual cases that occur in less than 1% of cases should be excluded (Mainz, 2003). Reliability, is the extent to which a measurement with an indicator is reproducible and therefore it should be able to make comparisons between organisations or practitioners (Campbell et al. 2002). Sensitivity to change, refers to the fact that measures must also be able to detect changes in quality of care in order to discriminate between and within subjects (Campbell et al. 2002). Finally, validity is the degree to which the indicator

measures what it is intended to measure, i.e. the result of a measurement corresponds to the true state of the phenomenon being measured (Mainz, 2003).

Indicators are used in several ways, to make comparisons between different healthcare facilities, to support professional accreditation, and to provide information for patient choice (Mainz, 2003). Indicators that are based on standards of care may arise from evidence-based medicine archives (such as the Cochrane Collaboration or the Centre for Evidence Based Medicine) or derived from the Delphi method, whereby a panel of health professional experts determine the appropriate benchmarks (Mainz, 2003). However, it is important to realise that indicators themselves are not a direct measure of quality, due to its multi-dimensionality (Mainz, 2003). It is necessary therefore, when comparing outcome data, to adjust for other potential confounding factors (Mainz, 2003).

It has been argued that measuring and publishing healthcare outcomes are important if improvements in quality of care are to be made. The coalition government outlined in their White Paper report, Liberating the NHS, a proposal to concentrate on measuring outcomes as opposed to process targets (Department of Health, 2010). There are numerous organisations and bodies with a responsibility to carry out independent measures of the quality of care provided by the NHS. Together they provide a vast array of quality indicators, the list is extensive and a full evaluation of every single one is beyond the scope of this review. However, the key organisations and main quality indicators have been summarised and can be found in Appendix 1.

Patient Satisfaction and Experience

The interest in obtaining perceptions and experiences from patients in the UK can be traced back to 1983 and the NHS Management inquiry, which aimed to ascertain how well services were being delivered (Williams, 1994). In 2000, the National Plan for the NHS made patient feedback tools mandatory and required the findings to be published (Wilkin et al. 2001). Despite patient satisfaction being a highly recognised technique to measure quality of care, there are several contentions surrounding it's usage. Firstly, due to the unpredictability of health, patient expectations are likely to be transient in nature (Staniszewska and Ahmed, 1999, Hanefeld et al. 2017). Secondly, patients may lack the medical knowledge necessary to give credible evaluations (Manary et al. 2013). Thirdly, patient satisfaction measures may possibly capture aspects of 'happiness' which are influenced by other factors, but unrelated to the care being provided (Manary et al. 2013). Fourthly, patients may not always know what they want or are unable or willing to disclose such information, particularly, if the circumstances are unfamiliar (Azam et al. 2012). Fifthly, there is little evidence that patient satisfaction data is the most appropriate for quality improvement (Crow et al. 2002). The final criticism of the use of patient satisfaction measures is that empirical results tend to reveal high levels of patient satisfaction. This is contrary to many qualitative studies such as in-depth interviews indicating negative experiences and perceptions not reflected in the questionnaires (Collins and Cathain, 2003).

A consequence of the above issues surrounding patient satisfaction as a measure of quality of care, is that in the UK, there has been a shift towards patient experiences. This is due to the fact that in some circumstances, high levels of patient satisfaction are genuinely linked to high quality medical care, however in other circumstances, high levels of patient satisfaction are actually due to low expectations, unnecessary treatments, or a lack of understanding (Greaves et al. 2012, Fenton et al. 2012). A study comparing patient

satisfaction and patient experience across nine different primary care trusts in England found that measures relating to patients' experience differentiated more effectively between practices than measures of patients' satisfaction (Salisbury et al. 2010). The idea being that experience questions allow a truer reflection of the actual experience rather than subjective judgments of care (Salisbury et al. 2010). Further research has shown that patient experience is positively associated with clinical effectiveness and patient safety, and therefore adds support to the argument that patient experience should be utilised as the preferred indication of quality healthcare as opposed to patient satisfaction (Doyle et al. 2013). In line with this, reports of subjective qualitative patient experiences are becoming more utilised over objective quantitative assessments of patient satisfaction (Elwyn et al. 2007).

Subjectivity of Quality of Care

Whilst models and measures of quality of care have been proposed throughout the healthcare literature, the range of dimensions that can be seen above indicate the multitude of approaches in understanding and measuring this concept. Due to such diversity, along with the potential difficulties of measuring quality of care within the required settings, for the purpose of the current study, the decision was made to not measure quality of care using existing objective instruments. Instead, in line with the exploratory approach of the study and the novelty of the relationship between job satisfaction and quality of care, it was decided that determining how quality of care is viewed from the perspective of healthcare workers themselves is essential. The justification for taking such a subjective approach to the concept of quality of care is further supported by key points raised in other studies. As already outlined in this chapter, from the end users perspective there are some significant issues. Firstly, different types of care environments are associated with different expectations and needs of patients (Wilde et al. 1994). Secondly, the quality of care

dimensions captured and evaluated in many instruments and audits are not quality issues identified as important by patients and relatives, such as individualisation of care, patient-focused care, and care being related to patient needs (Attree, 2001). Thirdly, it has been argued that the understanding of quality of care develops over time and is based on patient experience and therefore cannot be captured after a single interaction (Hanefeld et al. 2017). Finally, a true understanding of quality of care requires contextualisation via social norms, relationships, trust, and values (Hanefeld et al. 2017).

From the perspective of healthcare workers, another reason that quality of care will not be measured utilising objective instruments is that often, patient and professional assessments differ. This is due to patients' inability to fully understand the technical elements of clinical processes and procedures in order to judge them accurately (Cleary and McNeil, 1988). Not only can differences emerge between staff and patients ratings of quality of care, but there can also be discrepancies amongst healthcare staff themselves. For example, significant differences were found between nurses and managers on perceptions of the work environment and quality of care, with managers rating these concepts higher than lower grade staff (Gormley, 2011).

Additionally, the very nature of services, such as healthcare are considered to be perishable, (Regan, 1963, Sasser et al. 1978), they are simultaneously produced and consumed (Regan, 1963, Sasser et al.1978), and intangible (Sasser et al. 1978) making objective measures inadequate to capture the full complexity of such services. It has also been proposed that there is a shortage of studies addressing how professional healthcare staff perceive the quality of care offered, so this is something the current study aims to address (Arnetz, 1999). Consequently, by fully embracing the subjective nature of quality of care from a diversity of healthcare workers perspectives, the study may help to progress the

existing methods of capturing and understanding the concept, as well as understand how it links to job satisfaction.

Conclusion

The concept of quality of care is difficult to define and measure. This is due to the subjective nature of quality of care, as well as the fact that the contextual information surrounding the concept is likely to be interpreted differently according to the stakeholder concerned (Donabedian, 1980). The concept of quality of care is often represented as a dimensional model, fragmenting it into specific elements. Examples of key models, which are often cited throughout the literature are the Institute of Medicine model (Institute of Medicine, 2001) the access and effectiveness model (Campbell et al. 2000) and Donabedian's (1988) system-based approach model. Although these models demonstrate theoretical understanding, the instruments and measures used in practice are extensive and varied. In the UK alone, numerous bodies are responsible for collecting data on quality of care and these tend to focus on areas such as clinical effectiveness, patient safety, and patient experience.

Due to the diverse range of theoretical dimensions of quality of care as well as issues associated with measuring the concept, it was decided that the current study would not assess quality of care using existing objective methods (or quality indicators). Instead, in line with the exploratory approach of the study and the novelty of the relationship between the concepts, quality of care will be understood from the perspective of the healthcare professionals.

Chapter 5: Relationship between Job Satisfaction and Quality of Care

Introduction

So far the literature review chapters in this thesis have focussed on job satisfaction and quality of care as individual concepts. Chapter two examined job satisfaction from a broad perspective and revealed how theoretical and structural comprehension of job satisfaction has evolved. Chapter three looked at potential antecedents to job satisfaction and employed a more precise approach by focusing on healthcare environments. Chapter four reviewed the quality of care literature. The aim of chapter five is to now unify some of this information and consider how the constructs of job satisfaction and quality of care are potentially related. The organisation of this chapter will begin by looking at the literature from non-healthcare industries, exploring the analogous relationships of 'job satisfaction and performance' or 'job satisfaction and service quality', before moving to the more specific focus of job satisfaction and quality of care.

Evidence from Non-Healthcare Industries

Within the realm of social science there has long been interest in the links between job satisfaction and specific outcomes or work behaviours. One such example (already referred to in chapter two) is the seminal work of the Hawthorne Studies, which aimed to determine influences on productivity (Roethlisberger and Dickson, 1939, Mayo, 1949, Vroom, 1964, Judge et al. 2001, Zelenski et al. 2008). Other studies have examined and found support for the links between job satisfaction and specific business outcomes such as customer satisfaction (Heskett et al. 1997, Homburg and Stock, 2004), profit (Heskett et al. 1994, Yee et al. 2008), and employee turnover (Griffeth et al. 2000, Van Dick et al. 2004).

Throughout the human resource literature, the link between engagement and performance has been an important and emerging premise. Engagement is seen as the level of commitment someone demonstrates towards an organisation (Shaw, 2005) or, as the amount of effort someone devotes to their work (Frank et al. 2004). Further definitions take a psychological perspective of engagement, which according to Rothbard (2001) incorporates attention (cognitive presence and time one spends on thinking about the role) and absorption (level of focus towards the job role). Distinctions have also been made between 'job engagement' and 'organisational engagement' (Saks, 2006). In terms of the relationship between engagement and business outcomes, a study by Harter et al. (2002) concluded that job satisfaction and engagement were related to business outcomes, including customer satisfaction, productivity, profit, and employee turnover. It was suggested that a causal model should be developed to explore the links between employee satisfaction, employee engagement, and subsequent outcomes such as these (Harter et al. 2002).

In the service industries, employees often represent a company's brand and therefore have a pivotal role in shaping the customer's overall perception of service quality (Parasuraman et al. 1985, Parasuraman et al. 1988, Hartline and Ferrell, 1996). Service employees have a difficult task as they are 'caught in the middle' between the organisation itself and the end customer. Not only are they required to meet productivity targets and other performance related measures the organisation requires, but also to satisfy and fulfil the customer needs and perceptions of service quality (Yee et al. 2008). That said, it is established amongst the service literature that satisfied employees are more committed and willing to serve customers; they also tend to be more involved in their organisations and strive to deliver a higher level of service quality (Loveman, 1998, Silvestro and Cross, 2000, Yoon and Suh, 2003, Yee et al. 2008). This suggestion that job satisfaction can enhance service quality is

also supported by social exchange theory. The concept of social exchange theory, which is grounded in economics, suggests that relationships or exchanges between individuals aim to balance rewards and costs (Homans, 1961). Applying this theory to the context of the work environment insinuates that there is a two-way relationship between employer and employee. If an employer offers pay and favourable working conditions that enhance employee satisfaction, these employees will naturally tend to reciprocate their employers actions by being more committed and working harder, which ultimately leads to a higher level of service quality (Wayne et al. 1997, Flynn, 2005, Yee et al. 2008).

Another related theory is the service-profit chain developed and modelled by Heskett et al. (1994). It builds on the concept of internal service, which stems from an internal marketing perspective, viewing employees within the firm as internal customers and suggests that satisfying the needs of these 'customers' can help drive employee satisfaction as well as organisational objectives (Berry, 1981; Grönroos, 1981). The service-profit chain states that a 'chain' of relationships will ultimately result in positive profits; so if a firm has high internal service quality, this will ensure the employees are satisfied, this in turn means employees are more likely to be both loyal and productive. Productive employees lead to greater external service quality and offer greater value to the customers, which enhances customer satisfaction and loyalty, which in turn translates into profits for the company (Heskett et al. 1994). These links are particularly critical in high-contact service industries such as retail, hospitality, legal services, and consulting (Hallowell and Schlesinger 2000). Whilst, the NHS in the UK is essentially akin to a not-for-profit organisation (the very ethos of the organisation is that healthcare is free at the pint of delivery) the theoretical notions underpinning the service-profit chain add further support for the exploration of the relationship between job satisfaction and quality of care.

In the service literature, there is strong evidence to suggest that both the service climate and internal service are related to overall service quality and the external customer experiences (Schneider et al. 1998, Hong et al. 2013, Sharma et al. 2016). The term service climate refers to employee perceptions of the practices, procedures, and behaviours that are rewarded in relation to customer service and service quality (Schneider et al. 1993). There is also evidence to suggest that service climate and customer related outcomes (e.g. satisfaction and intentions to repurchase) are linked (Ehrhart et al. 2011). If the service climate is positive, in that the importance of the service delivery is consistently communicated throughout internal practices and procedures, employers are more likely to perceive that the service is important and this will in turn reflect their behaviours towards customers (Ehrhart et al. 2011). Employees' perception of the internal service depends on how they perceive the departments outside of their own, affecting the overall organisations performance. Furthermore, the employee-employee interactions within a large organisation (the internal service) determines the effect of employee-customer interactions and therefore customer outcomes (Scheinder et al. 1998). In summary, from this overview of the literature from other industries, it seems there is abundant evidence to support the links between job satisfaction and specific outcomes and work behaviour. Therefore, applying this link to the context of healthcare, the current study will explore healthcare professionals job satisfaction and quality of care.

Evidence from the Healthcare Sector

In a similar vein to the other literature review chapters within this thesis, the approach has started broadly, looking at analogous links in other industries, for example the link between job satisfaction and performance and job satisfaction and service quality. However, it is now essential to examine similar links within the specific context of healthcare. Although it has been suggested that staff satisfaction may have a role in influencing overall organisational

performance, the relationship between staff satisfaction and clinical quality of care has received considerably less attention (Peltier et al. 2008, Pinder et al. 2013). This in part may be due to the subjective nature of quality of care and the difficulty in creating robust measures, however, it does not mean this relationship should be ignored. Whist the holistic exploration of the relationship between healthcare job satisfaction and quality of care is a novel idea, motivating the present study and providing the theoretical contribution underpinning this PhD, there are some studies, which have examined similar, or comparable links. Although 'performance' and 'quality of care' are evidently not the same theoretical constructs, there are similarities between them and therefore understanding the relationship between staff satisfaction and performance is important. A handful of studies have revealed a close relationship between job satisfaction and performance amongst nurses (Judge et al. 2001, Al-Ahmadi, 2009, Nabirye et al. 2011, Gurkova et al. 2011, Platis et al. 2015).

Other related studies looking at both nurses and doctors, have shown that the level of job satisfaction among medical professionals has a positive impact on patient compliance with medical treatment and medication (Melville, 1980, Weisman and Nathanson, 1985, DiMatteo et al. 1993, Tzeng and Ketefian, 2002). Whilst, this specific notion again does not precisely equate to 'quality of care', the positive behaviour and influence on the patient can be seen as a component of good care. Additional studies exploring other comparable links include a study showing that higher satisfaction amongst nurses is linked to better safety, shorter length of stay, and higher patient satisfaction (Weisman and Nathanson, 1985). Physician job satisfaction has been associated with safer prescribing practices as well as greater patient trust and confidence in their physician's ability (Melville, 1980, DiMatteo et al. 1993, Grembowski et al. 2005). Another study looking specifically at physicians, revealed that those that were more satisfied generally, were better at communicating and were more empathetic toward their patients (Haas et al. 2000). All of these studies combined provide

support for the potential link between healthcare professionals' job satisfaction and quality of care, but despite these strong suggestions from the literature, the exact concepts themselves are virtually unexplored, particularly across the variety and diversity of roles within the healthcare domain, which the current study aims to address.

Research which has examined relationships that are conceptually more comparable to that being studied in the current thesis include the following. Some studies looking at the 'nurse quality, patient care chain' have consistently confirmed a relationship between nurse satisfaction and patient satisfaction (Newman and Maylor, 2002, Newman et al. 2001, Leggat et al. 2010). Similar findings were found in another study looking at doctors job satisfaction, here a link between physician job satisfaction and quality of primary care was found, but not between job satisfaction and health outcomes (Grembowski et al. 2005). Links between work satisfaction and quality of patient care have also been suggested in a study of General Practitioners (Grol et al. 1985), and amongst nurses working in nursing homes where a positive association between satisfaction and quality of care was found (Redfern et al. 2002). In comparison, a study based in Japan found no association between physician satisfaction and technical quality of care. Any discrepancies of findings between these studies are likely to be due to the differing measures of quality of care being used across the studies (Utsugi-Ozaki et al. 2009). This adds further support to the current study using subjective captures of the concept of quality of care in order to fully explore its relationship with healthcare professionals' job satisfaction.

Conclusion

The final chapter in the literature review series of this thesis has attempted to build on the stand alone research concerning the concepts of job satisfaction and quality of care and instead explore studies, which have in some way looked at analogous relationships. The culmination of the previous five chapters conclusions suggests that both intuitively, and as demonstrated in other industries, it is likely that a health worker who is more satisfied with their professional role, will provide higher quality of care (Maben et al. 2012). The proposal based on the extensive review of the literature is that job satisfaction not only enhances the quality of care staff provide, but when a high level of care is delivered, this also increases job satisfaction. In other words, the relationship between job satisfaction and quality of care is reciprocal. This idea will underpin the entire PhD thesis and will be re-addressed in the findings and discussion chapters. From the data analysis and the exploration of these relationships within healthcare settings, it is likely that complexities relating to these concepts will emerge and require further understanding and research.

Chapter 6: Methods

Introduction

The aim of Chapter 6, Methods, is to delineate and justify the chosen techniques used in the data collection stage of the current research project. Initially, the broad philosophical approach of critical realism, which underpins the project, will be discussed. Reasoning behind the use of an exploratory, inductive and qualitative approach will be provide, including specific rationalisation behind the use of semi-structured interviews, as opposed to alternative techniques. Next, the chapter will describe the participant sampling and selection process, including the necessary ethical considerations required. Finally, a detailed overview of the specific data collection techniques, transcription, coding, and analysis processes will also be provided.

Research can be defined as the empirical and analytical practice of contributing to knowledge (Mertens, 2005). One of the earliest forms of knowledge acquisition was theology, which examined the natural order of the world in relation to the divine. However, this belief system was challenged in the third century by Greek philosophers such as Socrates, Plato, and Aristotle, who concluded that the world could be understood more accurately through a process of systematic and logical reasoning called Rationalism (Howell, 2012). The antithesis to this philosophy was Empiricism, which became more established in the seventeenth century and pioneered by British philosophers such as Locke, Berkeley, and Hume (Howell, 2012). Although in their truest form these philosophical viewpoints are perhaps now considered archaic, these fundamental tenets have shaped modern scientific investigation. In terms of the current study, the next section will explicitly identify how the researchers own philosophical stance has fashioned the data collection processes.

Research Paradigm – Critical Realism

The term ‘paradigm’ can have numerous connotations, but in short, a paradigm can be seen as a shared belief system that influences the way researchers pursue knowledge and interpret their findings (Kuhn 1963). The key distinguishing factor in the various definitions of paradigms, is the generalisation of that belief system; so in the broadest sense it can be seen as an all-encompassing way of experiencing and thinking about the world (Guba and Lincoln, 1994). Alternatively, it could represent the shared beliefs within a specific discipline of researchers and a consensus regarding both the questions that need to be addressed and the most appropriate procedures for answering these questions (Morgan, 2007, Kuhn, 2012). The most appropriate explanation in relation to the current thesis is - a paradigm encompasses an individual’s view of ontological, epistemological, and axiological assumptions (Ritzer 1975, Guba and Lincoln, 1994, Morgan, 2007).

Four commonly used paradigms of research inquiry include positivism, post-positivism, critical theory, and constructivism, which represent the full scope of the ‘philosophical continuum’ (positivism being at one end and constructivism at the other) (Guba and Lincoln, 1994, Howell, 2012, Easterby-Smith et al. 2015). In order to ascertain the most appropriate methods to use within a research project, the philosophical underpinnings must be established. Each philosophical paradigm is generally associated with a particular methodology, which in turn dictates the most appropriate methods to be used. Generally, a positivistic paradigm will most commonly utilise a quantitative methodology, whereas a constructivist paradigm will usually adopt a qualitative methodology (Glesne and Peshkin 1992, Silverman, 2013). Although many research papers are explicit in the development of their use of methods, some fail to underpin their choice to a particular paradigm (Carter and Little, 2007). It can be argued that a lack of justification may highlight flaws in both the processes used and the underlying theoretical basis.

The main established paradigms in research tended to veer towards one ‘side’ of the philosophical continuum, taking either a positivist or constructivist approach (Collier, 1994). However, around the 1970s and 1980s an alternative paradigm emerged – critical realism, which started to infiltrate several social science disciplines (Bhaskar, 1979, Danermark, et al. 2002). Philosophical paradigms or approaches such as critical realism are guided by the researchers own view of the world, including ontology (nature of reality) epistemology (nature of knowledge) and axiology (values). So this ‘novel’ approach of critical realism effectively amalgamated the ontological and epistemological aspects of positivism and constructivism (Fletcher, 2017). An overview of these concepts (ontology, epistemology, and axiology) in relation to the critical realism methodology being used in this current study will now be provided.

Ontology

Ontology is concerned with an individual’s perception of reality (Collis and Hussey, 2013, Howell, 2012). Those researchers who consider an objective, positivist approach recognise that knowledge is based on concrete reality that can only be discovered through observation and measurement (Morgan and Smircich, 1980). Pure objectivists believe that the relationship between humans and the surrounding environment is based on causal laws, which can be used to explain patterns of behaviour (Easterby-Smith et al. 2015). This particular philosophical approach dismisses subjectivity, such as thoughts, feelings, and beliefs (Collis and Hussey, 2003). However, the argument put forward by modern researchers is that because social science often includes very subjective environments or concepts, it is often impossible to control all of the potential variables, which helps to maintain absolute objectivity. At the other end of the philosophical continuum is the constructivist perspective, which assumes a relationship between the mind and the external world (Howell, 2012). The basis of this philosophy is that human experience is viewed as

the key source of data, as opposed to observations and measurements made from physical phenomena. The extreme subjectivist's view would propose that there is no reality outside of our own minds, instead, it arises from our consciousness (Morgan and Smircich, 1980).

In order to relate the concept of ontology to the current study, it is necessary to understand the critical theorist's position on reality. Critical theorists argue that the objective-subjective divide, mentioned by the philosophical perspectives above, is superfluous and in fact socially contrived (Archer et al, 1998). So rather than viewing reality as purely objective or subjective, critical realism combines elements of both (Denzin and Lincoln, 2011). From an ontological perspective critical realism implies that there is a real world that exists independently of our perceptions, theories, and constructions, however we can't necessarily access or measure this reality directly; furthermore, our understanding will always be influenced by some form of perspective or bias (Bhaskar, 1979, Danermark, et al. 2002, Fletcher, 2017). The suggested strength of critical realism therefore is that it goes beyond the positivists' and constructivists' oversimplified perspectives of reality and instead purports that there are potentially differing, but equally valid perspectives of reality (Maxwell, 2008).

Due to the assimilation of positivist and constructivist philosophical perspectives, it is reasoned that critical realism does not necessarily have to be restricted to a specific set of methods, instead, it is viewed as a general methodological framework in itself (Easterby-Smith et al. 2015). This is important for the current study as although there are objective measures available to capture both the concepts of job satisfaction and quality of care, the value in terms of understanding these concepts comprehensively, is likely to emerge from the emotions, feelings, and beliefs of individuals, all of which cannot possibly be compartmentalised into a set number of measurable variables.

The researcher's own ontological perspective and alignment with critical realism, underpins and validates the choice of a qualitative approach, as gaining opinions from the participants in a way that fully supports different perspectives of the 'reality' of job satisfaction and quality of care was essential to the current study. It was also deemed important to allow potential similarities and variances in opinions, thoughts, beliefs, and general attitudes towards such phenomenon (which stem from different experiences of these 'realities') to transpire.

Epistemology

The study of knowledge and in particular, how and why information is acquired, is referred to as epistemology (Benton and Craib, 2001). Knowledge itself can be interpreted in more ways than one, but there are primarily two distinctive types: 'explicit' i.e. knowledge that and 'tacit' i.e. knowledge how (Nonaka, 1994). In other words, a person may acquire an understanding of the physical mechanics behind a moving car (knowing that) but may not be able to drive it (knowing how). Indeed the whole purpose of the social sciences in particular, is to be constantly sceptical in the hope that further research and testing will lead to greater insight. It has been suggested that within social science research, epistemology should take precedence over ontology, whilst others believe the opposite (Toren and de Pina-Cabral, 2009). Perhaps a more realistic argument is that ontology, epistemology, and methodology are complex notions that are inter-related, in that epistemology is defined by ontology and methodology is influenced by both ontology and epistemology. Furthermore, the relative weightings of each of these elements and their influence should be ascertained by the researcher.

The epistemology of critical realism suggests that social systems are inherently interactive and open, in addition, some knowledge can be closer to reality than other knowledge (Maxwell, 2012, Fletcher, 2017). Consequently, the use and analysis of qualitative data is considered an appropriate method of accessing and developing an understanding of these differences (Fade, 2004). Furthermore, as the relationship between staff satisfaction and quality of care is a relatively novel area and as an exploratory perspective was required, a qualitative approach was deemed the most appropriate method within this methodological framework in order to gain originality in knowledge and insights.

Axiology

Axiology, which stems from two Greek words ‘axios’ (meaning worth) and ‘logos’ (meaning reason) is a branch of philosophy concerned with value considerations, more specifically, ethics and aesthetics. In comparison to the above mentioned disciplines of ontology and epistemology, axiology is a relatively new area of study in its own right (Hart, 1971). Axiology in relation to modern social science was given a new lease of life by a researcher named Hartman who categorised the concept of ‘good’ into three ‘axiological’ dimensions, intrinsic, extrinsic, and systemic values (Hartman, 1961, 1962, 1967). Hartman (1967) argues that humans value everything in accordance to one, or a combination, of these three dimensions. Applying this notion to research, axiology can help to assess and determine the role of the researcher’s own values in shaping a study’s aims, objectives, the methods used, ascertaining the value in the results and findings themselves, as well as establishing what is fundamentally worthwhile (Creswell, 2012).

The axiological perspective of critical realism asserts that research should be value laden; the researcher can be biased by worldviews, culture, and upbringing, inevitably affecting the research findings (Saunders, 2009). In the current study, the researcher's own industrial experience, as well as a value set that seeks to use research as a way of improving both the working lives of healthcare staff and the patients' journey, directly influenced the choice of topic itself. It is virtually impossible to be involved in such a project for five years and not have personal occurrences shape the outcomes and findings of the data collection.

Although, the philosophical stance of the researcher is imperative in the metaphysical sense and the underpinning of critical realism as a philosophical approach is in direct alignment with the researcher's ontological, epistemological, and axiological views and beliefs, it is also useful to evaluate the traditional perspectives and methods used within the specific subject area. The current research also takes into account that the very nature of social science is often messy and complex and unlikely to create clean, straightforward conclusions (Creswell, 2012).

Table 5: Summary of the philosophical underpinnings of Critical Realism – the paradigm underpinning the current study - adapted from Saunders (2009).

Critical Realism	
Ontology: Researchers view of the nature of reality.	Objective – reality exists independently of human thoughts and beliefs or knowledge of their existence (realist) but is interpreted through social conditioning (critical realist).
Epistemology: Researchers view of the nature of knowledge.	Observable phenomena provide credible data / facts. Phenomenon create sensations which are open to misinterpretation. Focus on explaining within a context(s).
Axiology: Researchers view of values.	Research is value laden – researcher is biased by world views, culture and upbringing, which will impact on the research.
Data Collection: Methods frequently used.	Methods chosen must fit the subject matter. They can be quantitative or qualitative.

Development of Data Collection Methods

This section of the chapter will reveal how the chosen methods for data collection evolved throughout the project duration and in line with the development and understanding of the research topic itself. The researchers' initial intent was to explore the link between quality of care and patient satisfaction. However, having completed a review of the literature in this area, it was determined that the links between quality of care and patient satisfaction were well established. Several studies have revealed that in order to increase patient satisfaction, it is important to improve the overall quality of care provided (Zineldin, 2006, Badri et al. 2009, Aliman and Mohamad, 2013). As mentioned in chapter four, the strong theoretical connection between quality of care and patient satisfaction has led to the latter being used as an indicator and a measure of quality of care. However, there are many critics who suggest this should not be the case. Although patient satisfaction is related to, and influenced by quality of care, they are individualised concepts (Newman et al. 2001, Newman and Maylor, 2002). Whilst there is much evidence to suggest that patient satisfaction (and patient experience) is influenced by quality of care, as mentioned in chapter five, the rather neglected connection throughout the literature is the impact that job satisfaction has on quality of care. Consequently, the author decided, the most effective way to understand this connection is to focus the study on healthcare staff rather than patients.

At this stage in the project development process, the focus of exploring the links between healthcare professionals job satisfaction and quality of care was now concrete. However, the development of the most appropriate methods was still in progress. Guided by the critical realist approach of the researcher, it was necessary to choose methods which appropriately aligned with the subject matter. In preparation for this, current job satisfaction measures were researched and evaluated, and it was determined that job satisfaction is generally measured either as a global concept, using a single item measure, or as a multi-faceted

concept, where a number of components are either summed or weighted to determine people's satisfaction with specific elements of the job (Locke, 1969).

The measurement of global job satisfaction using a single item approach originates from the Faces Scale, which presents participants with a series of faces representing a range of emotions, including happy, sad, and angry (Kunin, 1955). Participants are asked to select the face that best represents how they feel about their jobs (Kunin, 1955). Whilst some single-item measures have been argued to be acceptable measures of overall job satisfaction (Scarpello and Campbell, 1983, Wanous and Lawler, 1972), the main counter argument to using single item measures is that they cannot possibly capture all of the variables which may influence a person's job satisfaction and therefore the level of insight obtained is minimal (Nagy, 2002).

The alternative approach to using global scales of job satisfaction is to measure specific components of job satisfaction. Three principle scales, which are often utilised include, The Job Descriptive Index (JDI), the Brief Index of Affective Job Satisfaction (BIAJS), and the Minnesota Satisfaction Questionnaire (MSQ). The JDI scale was developed to capture job satisfaction in a wide variety of settings (Smith, 1969). The instrument has consistently been shown to be valid and reliable, as well as demonstrate situational and organisational applicability (Kinicki et al. 2002). However, the major criticism of this scale is that it is solely cognitive in nature and therefore does not take into account the affective elements that may influence job satisfaction. In contrast, the BIAJS is purely an affective measure (and does not take into account cognitive aspects). The scale is also very brief, consisting of just four items (Thompson and Phua, 2012).

Having carried out extensive research on the potential measures of job satisfaction, which could have been utilised or adapted for the current study, it appears that despite job satisfaction being a well-established, mature concept, many of the existing scales have limitations. The scales often lack a theoretical underpinning and do not necessarily capture the true attitudinal structure of job satisfaction (Nagy, 2002, Van Saane et al. 2003, Thompson and Phua, 2012). The use of quantitative scales, which aim to capture other job attitudes such as organisational commitment, have also been criticised for lacking construct validity (Westen and Rosenthal, 2003, Ashman, 2006). These issues coupled with the fact that the present study seeks to investigate job satisfaction in relation to quality of care, which is a novel and unexplored area, suggests that a qualitative approach is the most suitable. This also supports the critical realist's philosophical viewpoint of utilising the most appropriate methods to address the concepts under investigation.

Methods Utilised in the Current Study

As outlined from the above discussion, as the understanding of the topics under investigation evolved, it was evident that although the concepts of job satisfaction and quality of care are generally well researched as individualised notions, there are significant issues with existing measures of both. From practitioner experience, the researcher has encountered much criticism around existing measures of job satisfaction in the NHS and therefore utilising alternative approaches seemed prudent. Furthermore, due to the unexplored nature of the relationships under investigation (namely, the impact of healthcare professionals' job satisfaction on quality of care), the philosophical guidance of critical realism, and the importance of utilising the most appropriate methods for the subject matter, meant that an exploratory qualitative approach was chosen as the most suitable option.

Qualitative studies contrast to quantitative studies in that they aim to establish patterns observed in a data set as opposed to quantifying magnitudes (Bryman and Bell, 2015, Creswell, 2017). Qualitative research allows for the formulation of ideas and such techniques within this realm are flexible in order to encourage the exploration of themes and topics, something that was deemed essential for the current project (Creswell, 2012). The methods that fall under this category don't allow for large groups of the population to be sampled. Instead, greater depth of insight is obtained from a smaller group and often this technique is used to develop ideas and hypotheses for quantitative research (Tashakkori and Teddlie, 2003). Qualitative data collection methods are generally unstructured and include interviews, focus groups, and observations (Creswell, 2012). Qualitative methods, such as interviews, enable researchers to be sensitive to respondents' meanings and interpretations (Coyle and Williams, 2000). Furthermore, in terms of the research discipline being explored, it has been argued that qualitative research contributes just as significantly as quantitative research, when considering aspects such as patient care and health service provision (Leung, 2015).

Further justification for using a qualitative approach comes through its ability to capture both objective and subjective factors, which quantitative scales don't always allow (Tashakkori and Teddlie, 2003, Creswell, 2012). Although numerous factors related to job satisfaction have emerged throughout previous research as outlined in the conceptual model (Figure 2) a key contributory element of the study to existing literature was to ascertain if a) these factors emerged amongst a wider workforce (both clinical and non-clinical) and b) if they are relevant considering the current climate.

Semi-Structured Interviews

In terms of the primary data collection for the current study, qualitative semi-structured interviews were chosen as the sole data collection method and a full justification of this decision now follows. A useful definition of an interview is a consultation, usually between two people, in which prepared questions are asked by an interviewer to a respondent who provides answers (Frey and Oishi, 1995). Interviews are the most widely employed method in qualitative research (Sandelowski 2002, Creswell, 2012, Bryman and Bell, 2015). The adaptable nature of the interview process encourages participant's opinions and thoughts to emerge naturally (Bryman and Bell, 2015).

One of the primary motives for using interviews as the data collection method was to provide an exploratory platform for staff to discuss the main themes underpinning the research project, as well as offer them a rare opportunity to voice their opinions on such matters. Interviews were chosen as the main qualitative data collection process, as opposed to other methods, for example focus groups, to ensure participants responses could be kept confidential. Due to the topics under discussion, there was a possibility that sensitive issues might arise, therefore, in order to ensure participants felt comfortable and reassured during the process, conducting one-to-one conversations with a single interviewer, as opposed to a larger group of people, was considered most appropriate (Kitzinger, 1995). Furthermore, the study was interested in exploring the opinions of individuals regarding the concepts as opposed to understanding group dynamics or the interactions between healthcare professionals (Kitzinger, 1995).

Although an exploratory approach to the study was taken, the three research objectives cover broad issues. Consequently, in order to maintain a degree of focus the interviews were carried out using a 'semi-structured' approach and a pre-set list of questions, which can be seen in Appendix 2 (Bryman and Bell, 2015). After several interviews were completed, some themes emerged as more frequent and relevant than others. Furthermore, additional factors arose which hadn't been previously considered, therefore to some extent the interviews were reflective and adaptive in nature and questions evolved slightly as the interviews progressed.

Development of Interview Questions

The research took an exploratory, inductive approach underpinned by a critical realist perspective to ascertain and establish greater understanding of the two broad areas and how they interrelate. In practice, this meant that the questions began with a fairly open ended approach, before moving to a more structured manner as the interviews progressed. The interview questions themselves were developed in order to address the main themes as well as the research objectives. Consequently, the questions were generated based on the following areas:

1) **Introduction:** These included general demographic questions as well as straightforward questions pertaining to the participants' job role. These questions not only provided contextualisation, but also helped to establish rapport with the participant.
2) **Job Satisfaction:** Questions here were based on ascertaining which factors staff thought influenced their job satisfaction.
3) **Quality of Care:** Questions here were based on ascertaining which factors staff thought influenced the quality of care they able to give.

4) **Relationships between Staff Satisfaction and Quality of Care:** Questions here focused on how these concepts relate to each other, as well as which factors participants thought influenced them.
5) **Improvements:** Questions here asked participants to make suggestions as to how they thought both staff satisfaction and quality of care could be improved in their areas.
6) **Conclusion:** The final section gave participants an opportunity to add anything they wanted to in relation to the themes discussed or indeed anything else they felt was important.

Non-Probability Sampling

Unlike quantitative studies “there are no computations or power analyses that can be done in qualitative research to determine the minimum number of sampling units required” (Sandelowski, 1995, p. 179). Instead, the aim should be to ensure that the sample size is small enough to gain depth of understanding of the concepts, yet large enough to provide novelty to the issues being explored (Sandelowski, 1995). Reviews of academic articles and book chapters looking at sampling numbers in qualitative research usually make recommendations in the range of 5 to 50 participants as adequate (Mason, 2010). Other academics have suggested that “the size of a sample depends on (a) the aim of the study (b) sample specificity (c) use of established theory (d) quality of dialogue, and (e) analysis strategy” (Malterud et al. 2016, p.1). One approach is to continue to develop material and collect data (for instance further interviews) until no further themes are found, i.e. data saturation. Therefore, to some extent sampling is guided by an element of subjectivity combined with researcher experience in that the data is assessed and analysed in relation to the aims and objectives of the research. In other words, data collection ceases when the researcher has established that no further novel information or deeper understanding will

emerge (Sandelowski, 1995). Whilst the idea of reaching data saturation is commonly accepted amongst qualitative researchers, there is little guidance as to how this should be implemented practically (Guest et al. 2006). In reality, it is not possible to truly know when data saturation has been reached, instead a 'feel' that no further themes or ideas are emerging is required. Consequently, a degree of common sense coupled with familiarisation of the data and themes was utilised to determine when data collection should conclude.

For the current study, participants were recruited using purposive stakeholder sampling. Purposive sampling is a common technique used within qualitative methods and a useful way to gain insight from a wide range of roles, as well as cover a broad demographic (Cresswell, 2012, Bryman and Bell, 2015). Within the purposive sampling technique itself, it is possible to use a number of approaches. In order to ensure a balance of clinical and non-clinical roles, and diversity across the job roles themselves were included, a typical case approach was utilised (Bryman and Bell, 2015). The technique of purposive sampling has also been used in other qualitative studies involving healthcare staff providing further legitimacy of this choice (Ferguson et al. 2011, Atefi et al. 2014). It was decided that participants would be recruited on a voluntary basis and would not receive any incentive for taking part in the interviews. This conclusion was made in order to avoid the 'incentive effect' which states that paid participants are more likely to give unreliable and biased responses (Head, 2009).

Ethical Considerations and Recruitment

Ethical approval was obtained for this study from the University of Plymouth ethics committee. One of the hurdles met during this project was gaining access to the desired sample. Originally, the plan was to conduct the study using staff from a single local NHS Trust. However, although ethical approval was gained from the University of Plymouth and the Research and Development department of the chosen hospital initially gave approval,

at some point, a U-turn was made and the Trust decided it would not allow the study to be carried out. The primary reason given was that the questions asked during the interviews may detract or confuse staff members completing the Trusts own staff satisfaction questionnaire. Another Trust was approached and access was also denied. Consequently, the criteria for participants had to be broadened to include healthcare staff from multiple organisations, including private and non-private institutions. The recruitment process was therefore based on the researcher's industry contacts, networking, and word of mouth.

In order to adhere to standard ethical guidelines, it was crucial that the interviews did not place the participants under any stress or pressure. The interviewer monitored any signs of participant discomfort and was ready to terminate if necessary, however, this was not required during any of the interviews. All participants were informed both verbally and in writing that they had the right to withdraw from the study at any stage. Any participant wanting to withdraw from the study would have all forms of their data destroyed. All participants recruited for the interviews were given a full briefing through a participant information sheet (see Appendix 3) as to the purpose of the study, including the key aims and objectives. If the participants agreed to take part and continue with the interviews, they were asked to sign a consent form (see Appendix 4). All participants also received a full verbal debrief, which reiterated the studies objectives, re-stated the participants right to withdraw at any time, as well as give detailed information about how the data collected would be treated and stored.

Participants

Most studies looking at job satisfaction within healthcare tend to focus on specific roles, particularly frontline staff such as doctors and nurses. The justification for choosing such groups is straightforward as doctors and nurses make up a significant proportion of

healthcare staff and are directly in contact with patients. However, as part of the second research objective, (and as a major contributing element to the literature) the current study wanted to also include opinions and experiences of healthcare staff who work in a wider range of roles and departments, particularly as some staff who are 'behind the scenes' or classed as non-clinical staff are often disregarded in such investigations. Although some studies have looked at distinct groups of healthcare roles, such as lab technicians (Lundh, 1999) and hospital pharmacists, (Ferguson et al. 2011) there remains a paucity of research surrounding those staff classified as non-clinical. This is despite the fact that these staff members and their job role responsibilities play a significant part in the patient's journey and overall care.

It is at this point that a comprehensive distinction between clinical and non-clinical roles should be provided. The term 'clinical' refers to those staff who treat patients, or provide direct patient care of any type (Department of Health, 2016). The term 'non-clinical' refers to those staff who's work may support patient care, but the work does not provide direct diagnosis, treatment, or care for the patient (Department of Health, 2016). The difference in terms of definitions of clinical and non-clinical staff might seem fairly simple – in reality, due to the changing nature of job roles and the delivery of care itself, the distinctions are becoming more distorted. Furthermore, there are non-clinical and service support roles, which although may involve little patient contact, still play a vital part in the overall patient experience and service. Many of these non-clinical staff members are not included in the healthcare research and it is this substantial gap that this thesis seeks to address.

A bar chart has been created to demonstrate how the NHS categorises the variety of job roles across the organisation. This data has been taken from a report provided by NHS Digital (2018). The data is useful in that it shows the breakdown of staff roles within the NHS,

and in particular highlights the vast number of roles which are not doctors, nurses and midwives (total number of doctor, nurse and midwife roles combined = 418,243, total number of non-doctor, nurse and midwife roles combined = 785,460) hence providing further justification of the inclusion of participants from other healthcare roles too. However, the chart does little to clarify the clinical / non-clinical distinction, for example within the 'scientific, therapeutic and technical' category, some of these roles will be classed as clinical and some as non-clinical. Consequently, for the purpose of this study, the distinction between these will be made based on the Department of Health's definition stated earlier (see paragraph above) and whether the participant directly treats or provides care to patients.

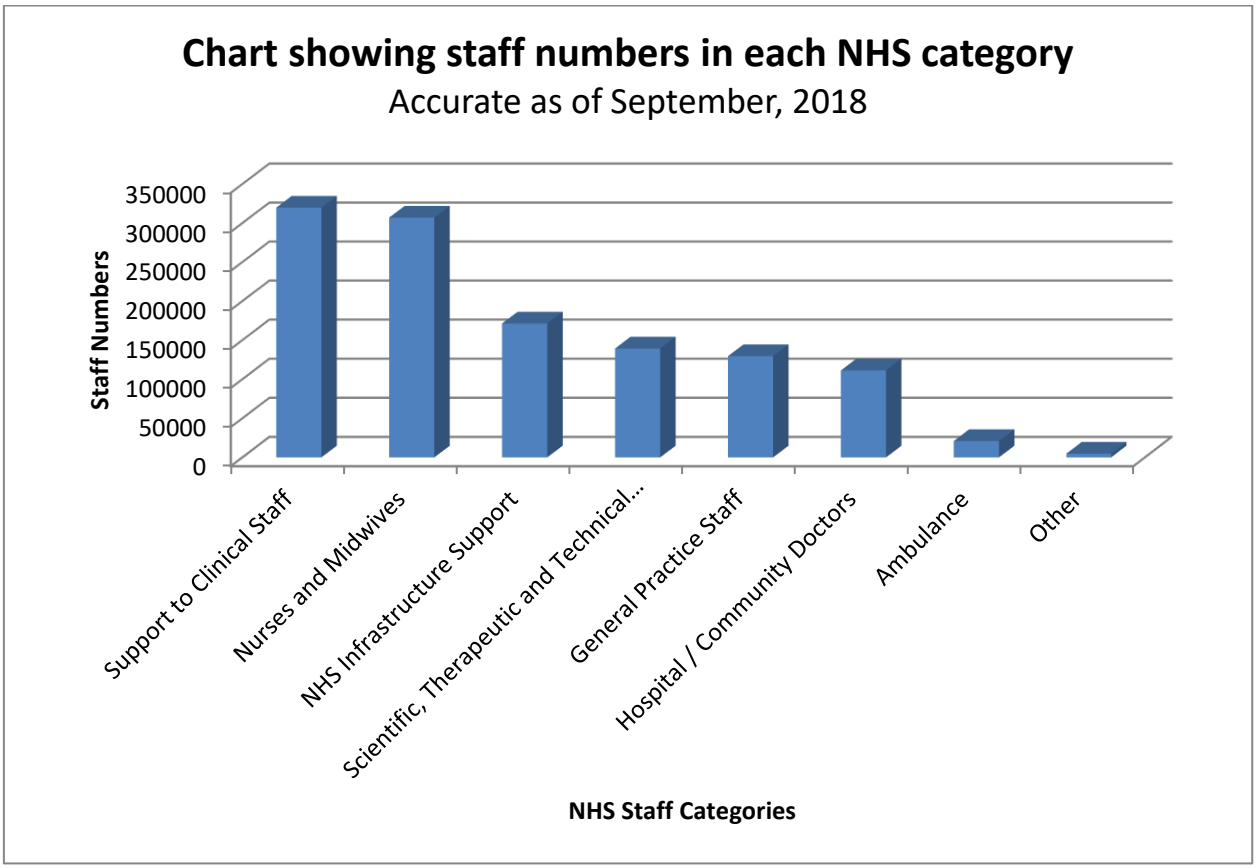

Figure 2: Categorisation of job types within the NHS according to statistics from NHS Digital (2018).

As already indicated throughout the previous chapters and in the above paragraph, in order to fully understand job satisfaction within healthcare organisations, an important aim of the study was to include a range of views from diversified healthcare job roles. Consequently, the author needed to select participants who represented both clinical and non-clinical staff, but were also a 'typical' member of staff (Higginbottom, 2004). The sample therefore needed to include a wide range in terms of organisations, demographics, tenure, background, job roles, and pay grades. In order to adhere to the ethical guidelines stated by the University of Plymouth, participants under the age of eighteen or any adults considered as a vulnerable person were excluded from this study.

In terms of the practical steps utilised to recruit participants a number of techniques were utilised. Initially, the researcher's industry connections were used. Having worked in the healthcare sector as a practitioner for approximately six years (in two different NHS Trusts) a number of contacts had been made and these were fully explored. In addition, due to the NHS being such a prolific employer in the UK, further participants were recruited from direct or indirect friends. Advertising was also used through social media channels and via a recruitment stall at a Continuing Professional Development event for Healthcare Professionals at Exeter Racecourse (June, 2016).

In line with one of the principle objectives of the research project to include opinions from a broad range of healthcare staff, the participant's job roles varied considerably. Participants had both clinical and non-clinical roles. The exact breakdown of participant specific job roles and whether they are classed as clinical or non-clinical can be seen in Table 6 and 7. However, in summary the participants included six nurses, five doctors, five laboratory staff, four managers, four individuals from specific disciplines, one ambulance care assistant, one midwife and one theatre practitioner. Although no statistical analysis has been carried out

to compare the job roles and responses given by the participants, clear and distinct factors did emerge across the concepts being explored. This suggests that despite some minor role specific differences, generally the factors that influence staff satisfaction and the quality of care provided, were similar across the population of interviewed healthcare workers. This finding will be further considered in the discussion chapter (chapter eight).

Table 6: Summary of participant demographic information, including age, job role area and level of clinical classification.

Participant Age		**Area of Job Role**		**Clinical Level**	
Average	38.15	Nurses	6	Clinical	16
Standard Deviation	11.04	Doctors	5	Non Clinical	11
		Laboratory Staff	5		
		Managers	4		
		Specialists	4		
		Ambulance Staff	1		
		Midwives	1		
		Theatre Staff	1		
TOTAL			**27**		**27**

Table 7: Detailed overview of participant demographic information, including age, job role, level of clinical classification and duration (in minutes) of each interview.

Participant ID Number	**Age**	**Job Role**	**Role**	**Duration of Interview (mins)**	**Process**
SSCQ0	35	Staff Nurse	Clinical	15	Face to Face
SSCQ00	39	Staff Nurse	Clinical	14	Face to Face
SSCQ001	33	Junior Doctor	Clinical	27	Telephone
SSCQ002	29	Psychological Well Being Practitioner	Clinical	44	Face to Face
SSCQ003	36	Drug Worker	Clinical	44	Face to Face
SSCQ004	39	Area Manager	Non-Clinical	73	Face to Face
SSCQ005	38	Cleft Lip and Palate Coordinator	Non-Clinical	21	Telephone
SSCQ006	33	Operating Department Practitioner	Clinical	33	Face to Face
SSCQ007	43	Service Line Cluster Manager	Non-Clinical	45	Face to Face
SSCQ008	47	Midwife	Clinical	61	Telephone
SSCQ009	46	Assistant Technical Officer	Non-Clinical	24	Face to Face
SSCQ010	32	Registrar	Clinical	37	Telephone
SSCQ011	54	Risk Control Officer	Non-Clinical	27	Face to Face
SSCQ012	57	Advanced Nurse Practitioner	Clinical	39	Face to Face
SSCQ013	34	Biomedical Scientist	Non-Clinical	56	Face to Face
SSCQ014	26	Foundation Doctor	Clinical	44	Telephone
SSCQ015	27	Medical Laboratory Assistant	Non-Clinical	47	Telephone
SSCQ016	38	Senior Assistant Technical Officer	Non-Clinical	29	Telephone
SSCQ017	47	Research Nurse	Clinical	42	Telephone
SSCQ018	33	Biomedical Scientist	Non-Clinical	40	Telephone
SSCQ019	30	Ambulance Care Assistant	Non-Clinical	26	Telephone
SSCQ020	30	Registrar	Clinical	22	Telephone
SSCQ021	32	Audiologist	Clinical	20	Face to Face
SSCQ022	61	Staff Nurse	Clinical	49	Telephone
SSCQ023	49	Consultant (Psychiatry)	Clinical	36	Telephone
SSCQ024	36	Development Manager	Non-Clinical	29	Telephone
SSCQ025	26	District Nurse	Clinical	24	Telephone

Data Collection

The interviews themselves utilised broad questions addressing the two main topics of staff satisfaction, quality of care, as well as the interlinking relationship. Twenty-seven interviews were conducted in total between the dates of 25/01/16 and 23/01/17. They included twelve interviews in the first phase and fifteen interviews in the second phase. On average, the interviews lasted for 36 minutes, with participant SSCQ00 having the shortest interview at 13 minutes and 38 seconds and participant SSQC004, having the longest interview at 73 minutes and 16 seconds. The total length of recorded time across all 27 interviews was 968 minutes (16.1 hours). The duration of each individual interview can be seen in Table 6. The complete data set of 27 interviews produced a large amount of raw data in the form of interview transcripts (146,840 words, 301 pages).

Phase 1 – Interviews

The interviews were conducted in a variety of locations. The first two interviews (SSQC0 and SSQC00) were carried out in the participants' own home, the rest of the other face-to-face interviews (with the exception of SSQC011 - conducted at Derriford Hospital, Plymouth and SSQC21 - conducted at Yay! Koffee & Laundry, Plymouth) were carried out in a private room (Cookworthy Building, University of Plymouth). Interviews conducted via 'telephone' were a combination of recorded mobile phone conversations (carried out in the same private room mentioned above) or via the software 'Go To Meeting'. The latter was conducted via a Portable Computer in the researchers' office, which was based in the Cookworthy Building, University of Plymouth.

The first two interviews conducted helped to ensure that the questions in the interview schedule a) were understood by the participants and b) generated suitable responses. Once completed it was evident that the specific questions had been fully understood by the two participants, and they had generated relevant and appropriate answers, therefore no changes were made to the main interview questions themselves. Instead, a conscious effort to encourage fuller / more expansive answers from the participants was made. Overall, the first two interviews provided insight into better interviewing technique and reassurance that the interview schedule was appropriate.

Despite the fact that the interview schedule remained the same throughout all 27 interviews (a full outline of the schedule can be seen in Appendix 2) the duration of the interviews did differ quite considerably (the first two in particular were much shorter than the rest of the interviews). The reasons behind such variation in interview duration can be explained by the following. Firstly, due to the initial inexperience of the researcher in carrying out interviews, it is possible that inadequate probing questions were used in the initial interviews. Secondly, some participants were not particularly forthcoming with information, whilst others, readily and contentedly provided detailed answers and spent time reflecting on their work practices. Thirdly, the environments where the interviews were conducted varied from informal settings (participants own home) work environments (such as a hospital) and other locations (remote from either home or a work environment). Therefore, whilst the researcher did everything to ensure the participants were as relaxed as possible, the setting may naturally have had some influence on how willing the participant was to share information.

Due to the inductive, exploratory approach underpinning the research, although a semi-structured guide was used for all of the interviews, if participants wandered off the main topics, a conservational approach was adopted in order to encourage a deeper understanding of the concepts (Creswell, 2017). In the first phase of data collection, twelve interviews were completed. The interviews were then transcribed and analysed (these processes are outlined in much further detail later on in chapter seven). From the analysis, it was decided that the questions in the interview schedule were enabling appropriate and in-depth responses to materialise. However, although strong consistencies were developing amongst the factors that influence job satisfaction, as this area is already fairly well established amongst the literature, it was deemed important to focus and put greater emphasis on the links between staff satisfaction and quality of care. Consequently, although no changes were made to the main questions themselves, if necessary, the interviewer included further probing questions to gather greater depth of information surrounding the links between the two key factors (staff satisfaction and quality of care).

Phase 2 – Interviews

As referred to above, consistent factors emerged for staff satisfaction and quality of care relatively quickly within the first phase of the interviews. For the current research, the crucial area of interest in terms of the contribution to knowledge was to understand how staff satisfaction and quality of care are interrelated. Therefore, during the second phase of interviews, questions regarding staff satisfaction and quality of care remained for confirmatory purposes, but the interviews also used further probing questions to explore the interlinking variables between staff satisfaction and quality of care in greater depth. In the second phase of data collection, fifteen interviews were completed. As mentioned above, minimal changes were made to the interview schedule, however as the interviewer gained

more insight, knowledge, and improvements in general interviewing techniques, the exploratory structure of the interviews grew and richer data emerged.

From the data analysis process (which is outlined later in chapter seven) it became evident that at around the 20th interview very similar themes were emerging, however further interviews were carried out to ensure the study captured data from both clinical and non-clinical staff and to be certain that nothing further was being added. After 27 complete interviews, it was decided that adequate data had been collected. Few novel themes were emerging and the importance in terms of effort was ascertaining, establishing, and understanding how the themes interlinked, consequently, data collection ceased.

Transcription

For the first twelve interviews, transcripts were produced singlehandedly by the researcher, using the original audio recordings. Recordings were taken by a Dictaphone for the face to face and telephone interviews and the 'Go to Meeting' software was used for interviews conducted remotely. Once the transcripts had been completed they were checked twice against the audio recordings to ensure they matched exactly. This process enabled data immersion and the researcher gained significant familiarity of the data, which subsequently helped with the analysis phases (Vaismoradi et al. 2013).

For phase two of the interviews (fifteen interviews), transcripts were completed by a professional transcription service. In order to ensure the highest level of accuracy as well as allow data absorption, the researcher listened to the remaining fifteen interviews numerous times and checked them against the professionally typed transcript. Several errors and incomplete sections were present, so the researcher was able to make the necessary

corrections and amendments. Once the transcripts of the interviews had been completed, the manual coding could commence (see Chapter 7).

Validity, Reliability and Generalisability

Due to the terms validity, reliability, and generalisability stemming from quantitative research, there are ongoing debates amongst academics as to whether these terms are appropriate within qualitative research (Noble and Smith, 2015). On one side it is argued that these traditionally quantitative criteria are not suitable for qualitative research, however, others feel there is some applicability (Johnson, 1997). A brief overview of how these concepts, from a traditional terminology perspective and a more specific qualitative perspective have been considered in the current study will consequently be provided.

In order to ensure validity of the data analysis the interviews were conducted in two phases (as described above) and a process of checking and re-checking of codes occurred. Once all the interview transcripts has been analysed individually (both in phase one and in phase two), a final check was carried out. The raw data were reduced to the participants responses only and checked against the codes that emerged during both phase one and phase two of the coding process (McNeese-Smith, 1993). After this validation check, any additional themes which materialised were added to an Excel spreadsheet. Once all the themes and subthemes had been identified, it was necessary to go back through the data in order to find all of the relevant quotations that would support each theme. The categories and themes that were identified from the first phase of interviews were therefore continually tested and revised through analysing succeeding interviews.

One way of viewing validity in qualitative research, which perhaps deviates a little from the 'traditional' or 'quantitative' perspective is to consider it as the 'appropriateness' of the tools and processes used (Leung, 2015). This includes everything from the research question, the specific methods used, sampling techniques, and the way the data is analysed (Leung, 2015). In order to ensure the research question and methodology were appropriate, the current study underpinned these using the critical realist ontological and epistemological viewpoints of the researcher, which have already been discussed in this chapter. In terms of the sampling process, the use of purposive sampling, meant the required participant sample was determined prior to the commence of data collection (Bryman and Bell, 2015). Using purposive sampling, also links to one of the key study objectives, namely, trying to get a balance of opinions across both clinical and non-clinical roles. All of the above demonstrate the validity or appropriateness of the methodological processes.

Reliability in qualitative research is considered to be akin to consistency (Leung, 2015, Noble and Smith, 2015). The steps involved in both the data collection and analysis also need to be clear and transparent. Whilst nuanced conversations across participants are often sought in exploratory qualitative research, patterns and commonalities in the potential explanations of concepts are also important. In order to ensure consistency within the data set, continuous comparisons are essential (Leung, 2015). The coding process (which is outlined in detail in the next chapter) incorporated checking and re-checking to ensure consistency occurred.

In terms of generalisability, again in relation to qualitative research, the important aspect here is the scope of applicability of the data from one situation (for example organisation) to another. Qualitative data by its very nature can sometimes be restricted by a smaller sample size and to the settings the data collection was carried out in, but that does not detract from the importance or value of that data (Bryman and Bell, 2015, Sekaran and Bougie,

2016). Qualitative research also aims to reflect the diversity of a given population, purposively aiming to highlight potentially important differences between participants and or settings (Barbour, 2001). However, it has also been argued that it is possible to generalise from a few cases if the data analysis captures the concepts under study and aids in theoretical developments, so in other words the data can be used to generalise to theory, rather than to populations (Collis and Hussey, 2013, Bryman and Bell, 2015). Lincoln and Guba (1985) offered alternative terminology to demonstrating rigour within qualitative research, namely truth value, consistency and applicability. Table 8, outlines a comparison of the terminology and criteria used to evaluate qualitative research, along with a summary of how the current study has addressed these issues (Noble and Smith, 2015).

Table 8: Overview of how the current study has addressed issues of rigour, adapted from Noble and Smith (2015).

Quantitative research terminology	**Proposed alternative terminology**	**Evidence from current study**
Validity	**Truth Value** - appreciation that multiple realties exist	• Choice of methods underpinned by critical realist philosophy. • Use of purposive sampling. • Clear presentation of the range of participants perspectives.
Reliability	**Consistency** - trustworthiness of methods	• Steps in methods and decision making is transparent. • Audio recordings check and double checked.
Generalisability	**Applicability** - consideration as to whether the findings can be applied to other contexts and / or groups.	• Use of diverse range of healthcare roles and a comparison across clinical and non-clinical roles.

Conclusion

The aim of chapter six, methods, was to provide justification to the chosen techniques used in the data collection stage of the current research project. The philosophical approach of critical realism, which underpins the project, was discussed and linked to the usage of an exploratory, inductive, qualitative approach. Guided by the critical realist approach of the researcher, it was necessary to choose methods which most appropriately aligned with the subject matter. The fact that existing quantitative scales have limitations and often lack a theoretical basis (Nagy, 2002, Thompson and Phua, 2012) coupled with the novelty of the concepts under study, a qualitative approach was determined as the most suitable. The justification for using interviews as the data collection method stems from the need to provide an exploratory platform for staff to discuss the main themes underpinning the research project, as well as offer them an opportunity to voice their opinions on such matters. A further advantage of interviews as opposed to other methods (for example focus groups) is that it allows confidentiality. The semi-structured interview questions themselves were developed in order to address the main themes as well as the research objectives.

Participants were recruited using purposive stakeholder sampling in order to ensure a diversity of job roles were included (Bryman and Bell, 2015). Consequently, the author needed to select participants who represented both clinical and non-clinical staff, but were also a ‘typical’ member of staff (Higginbottom, 2004). Ethical approval was obtained for this study from the University of Plymouth ethics committee. Twenty-seven interviews were conducted in total, twelve interviews in the first phase and fifteen interviews in the second phase. Once completed, each interview was transcribed, coded, and then analysed (the process of which are included in the next chapter). This methods chapter has also outlined how the research ensured academic rigour through validity, reliability and generalisability.

Chapter 7 – Coding and Analysis

Introduction

In qualitative research, the coding and analytical processes are fundamental to the final results and outcomes, so a thorough reprise of each analytical step is outlined (Thomas and Harden, 2008). The exploratory approach, which underpins the current study meant that the analysis needed to be data driven as opposed to being based on existing literature or theory alone. However, as mentioned in the previous chapter (chapter six – methods) the very nature of a critical realist perspective means an appreciation that the researcher is unable to completely separate themselves from prior knowledge and understanding and it is possible that some of this prior experience will frame the analytical process (Braun and Clarke, 2006).

It has been suggested that thematic analysis is not bound to any particular methodological position and can be utilised as a tool across differing philosophical perspectives (Boyatzis, 1998, Braun and Clarke, 2006). Consequently, thematic analysis, enabled the researcher to develop compound interpretations of reality, in this case, the phenomenon of healthcare professionals' job satisfaction and quality of care themselves. Considering the researchers ontological stance, it was also an appropriate technique allowing both an accurate reflection of the surface level of reality determined by the participants', as well as a more in-depth expose of reality from the researcher's interpretation of the data analysis. Thematic analysis was also considered the most appropriate coding technique for a study that sought to uncover participants interpretations of the concepts from a broad perspective (Marks and Yardley, 2004). The technique allowed for a systematic approach to data analysis by considering the frequency of a theme against the context of the entire data set (Joffe and Yardley, 2004). Thematic analysis is also flexible in nature, allowing the researcher to unpick

the relationships between concepts and then make comparisons as further data is obtained (Braun and Clarke, 2006). All of the above were deemed important and relevant to the current study.

Overview of Codes and Themes

The practical steps in the analysis itself involved scrutinising every line of each interview transcript and adding a comment next to the appropriate text, each time the researcher felt a significant word or code had been mentioned by the participant. Although the research took an exploratory, inductive approach, the codes chosen needed to address at least one of the research objectives and / or bring meaning and understanding to the concepts being examined (Joffe and Yardley, 2004). Once a code had been identified, it was entered into an Excel spreadsheet, which enabled themes and subthemes to be identified and organised. It has been suggested that the way many qualitative studies describe how themes 'emerged' or were 'discovered' implies a passive and perhaps data driven analytical process, and it ignores the active role the researcher has in identifying patterns that might be of interest (Braun and Clarke, 2006). Consequently, in line with the critical realist perspective, the researcher aimed to adopt both a passive and an active approach to coding. The researcher purposively (active process) retrieved words and phrases of text, which were considered relevant to each interview question posed to the participants. However, the identification of codes was also data driven (passive process), in that any piece of text, which appeared to have potential applicability to the questions, was also given a code. Therefore, codes and themes which materialised were based on the language used by the participants themselves.

In the first phase of interviews, as identified in the methods chapter (chapter six), 12 interviews were carried out and then analysed. After this, a further 15 interviews were carried out in phase two and these transcripts were subsequently analysed. After all 27 interviews had been completed the entire data set was combined into one document and then re-analysed to ensure that nothing in the text / data had been missed. This also ensured reliability and stability of themes.

The coding process began from general concepts (staff satisfaction, quality of care, relationships, and improvements) as well as responses to the interview questions and research objectives. Due to the scope of the primary concepts being explored, namely, staff satisfaction and quality of care, as well as the ranging job roles of participants, the original resulting codes from the combined data set were expansive, with 109 codes being established in total (see Table 9). It was therefore necessary to aggregate these codes into broader themes. Codes were compiled and organised into themes, by grouping similar codes together. Due to the extensive volume of data (16.1 hours of recording, in the form of interview transcripts equalling 146,840 words or 301 pages), the full coding process has been included in a technical appendix (pages 251-302). However, the following five tables (Tables 9,10, 11, 12 and 13) demonstrate how the development of themes derived from the original codes.

Table 9, shows the complete list of original codes (column two, n=109) created in the completed data analysis of all 27 interview transcripts. These can be seen alongside the related concept under investigation (column one) and the frequency of the codes occurrence throughout the data set (column three).

Table 9: Complete list of original codes identified from the data analysis against the area of research interest and along with the frequency of the codes occurrence.

Area of Research Interest	***Codes***	***Frequency***
Positive factors influencing staff satisfaction	Helping patients	27
	Making a difference	14
	Positive health outcomes	10
	Saving / improving lives	9
	Building rapport / relationships	9
	Sense of pride	3
	Caring for people	3
	Teamwork	12
	Looking after patients together	3
	Pulling together	3
	Multi-disciplinary element	3
	Team spirit / friendship	2
	Learning from each other	1
	Building a team	1
	Meeting people	8
	Feeling accomplished	8
	Colleagues	7
	Feeling supported	6
	Variety	6
	Challenge	5
	Learning	5
	Responsibility	4
	Pay	3
	Work life balance	3
	Autonomy	3
	Culture	2
	Career progression	1
	Problem solving	1
	Stability of job	1
	Supervision	1
Negative factors influencing staff satisfaction	Time to care	9
	Staff shortage	8
	Lack of support / recognition	7
	Staff management	7
	Increased demand / complexity	6
	Paperwork	6
	Lack of decision making	5
	Lack of funding / budget	5
	Politics	5
	Communication	3
	Pressure / stress	3
	Managing people	3
	Working beyond role	3

	Junior doctors contract	2
	Work life balance	2
	Conflicting priorities	2
	Monotony	1
	Environment	1
	Workload	1
	Expectations of patients	1
	Delivering bad news	1
	Long hours	1
Positive factors influencing quality of care	Communication	4
	Team support	4
	Staff levels	4
	Funding	1
	Decision making	1
Negative factors influencing quality of care	Staff shortage	11
	Demand / workload	6
	Stress	3
	Tiredness	3
	Other departments	2
	Leadership	2
	Equipment issues	1
	Decision making	1
	Business outcomes	1
	Feeling undervalued	1
Level of care provided	Individual level positive	13
	Departmental level positive	10
	Departmental level negative	6
	Goodwill	9
Dimensions of care	Patient focus	7
	Efficient / effective	4
	Empathy / understanding	1
	Environment and resources	1
	Signs and symptoms	1
	Safe outcomes	1
	Atmosphere	1
	Science and art	1
Staff satisfaction and quality of care	Positive relationship	12
	Negative relationship	12
	No relationship	3
	Breaking Point	9
Quality of care and staff satisfaction	Positive relationship	11
	Negative relationship	4
Areas for improvement	More resources	11
	Feeling supported / appreciated	9
	Communication	8
	Training	8
	Staff involvement / decision making	7
	Better leadership / management	7

	Meetings	5
	Working conditions	5
	Supervision / feedback	4
	Improved technology	4
	Culture	3
	More time to care	3
	Funding	2
	Team building	2
	Amenities / perks	2
	External services	1
	Paperwork	1
	Best practice	1
	Skills mix	1
	Self-care	1
Additional important themes which emerged	Media portrayal	5
	Resistance to change	2
	Importance of caring for the carers	2
	Whistleblowing	2

In order to make sense of the responses from the participants, the resulting 109 raw codes needed to be organised and aggregated. Consequently, the second phase of the analysis involved grouping similar codes together to form themes. Using an Excel spreadsheet and a colour coding technique, all codes which covered the same topic, were grouped and then an overarching ‘theme name’ (column two of Table 10) was assigned to each grouping. The codes were therefore combined into broader themes, yet still organised around the main areas of interest; staff satisfaction, quality of care, relationships, and areas for improvements (see Table 10). All codes, which originally came under the ‘staff satisfaction’ area of interest were coloured pink, all codes which were originally under the area of ‘quality of care’ were coloured purple, ‘relationship’ codes (between staff satisfaction and quality of care) were coloured blue, and codes which were related to ‘improvements’ were coloured green. Any additional points raised that did not fit neatly into these new themes were coloured yellow under the theme, ‘serendipitous finds’.

Table 10: Grouping of codes based on similarity of topic and organised based on staff satisfaction, quality of care and areas for improvements.

Area of Interest	***Theme***	***Codes***
Staff Satisfaction	**Helping patients**	Helping patients
		Making a difference
		Positive health outcomes
		Saving / improving lives
		Sense of pride
		Caring for people
		Delivering bad news
	Teamwork	Building rapport / relationships
		Teamwork
		Looking after patients together
		Pulling together
		Multi-disciplinary element
		Team spirit / friendship
		Learning from each other
		Building a team
	Social Network	Meeting people
		Colleagues
		Feeling supported
		Culture
		Politics
	Cognitive Aspects	Feeling accomplished
		Variety
		Challenge
		Learning
		Responsibility
		Autonomy
		Career progression
		Problem solving
	Demand / Resources	Work life balance
		Time to care
		Staff shortage
		Increased demand / complexity
		Lack of funding / budget
		Pressure / stress
		Workload

		Working beyond role
		Work life balance
		Expectations of patients
		Long hours
		Conflicting priorities
	Staff Management	Supervision
		Lack of support / recognition
		Staff management
		Managing people
		Lack of decision making
		Communication
	Others	Pay
		Paperwork
		Junior doctors contract
		Stability of job
		Monotony
		Environment
Quality of Care	**Demand / Resources**	Staff levels
		Funding
		Staff shortage
		Demand / workload
		Stress
		Tiredness
	Staff Management	Communication
		Decision making
		Other departments
		Leadership
		Decision making
		Business outcomes
		Feeling undervalued
	Dimensions of Care	Patient focus
		Efficient / effective
		Empathy / understanding
		Environment and resources
		Signs and symptoms
		Safe outcomes
		Atmosphere
		Science and art
	Level of care provided	Individual level positive
		Departmental level positive
		Departmental level negative

		Goodwill
	Other	Equipment issues
		Team support
Relationships	**Staff satisfaction and quality of care**	Positive relationship
		Negative relationship
		No relationship
		Breaking Point
	Quality of care and staff satisfaction	Positive relationship
		Negative relationship
Improvements	**Demand / Resources**	More resources
		More time to care
		Funding
		Skills mix
	Staff Management	Supervision / feedback
		Meetings
		Feeling supported / appreciated
		Communication
		Staff involvement / decision making
		Better leadership / management
		Team building
		Culture
		Training
		Working conditions
		Improved technology
	Other	Amenities / perks
		External services
		Paperwork
		Best practice
		Self-care
Additional	**Serendipitous Finds**	Media portrayal
		Resistance to change
		Importance of caring for the carers
		Whistleblowing

The next stage of the analysis was to group the codes based on the new overarching ‘themes’ as opposed to just staff satisfaction, quality of care, relationships, and areas for improvement. This part of the analysis was crucial to the overall agenda of the thesis, in that it would allow an understanding of which factors influence both staff satisfaction and quality of care. At this stage 13 codes were dropped (pay, paperwork, junior doctors contract, stability of job, monotony, environment, equipment issues, team support, amenities / perks, external services, paperwork (also a duplicate), best practice and self-care). Any code which had only been referred to by one or two of the participants were put under the theme ‘other’ (as seen in Table 10). Therefore, at this stage any codes, which fell under these ‘other’ categories were eliminated, as these were factors that were only mentioned by a very small proportion of participants.

The next table (Table 11) shows how themes were created (column one) based on the aggregation of codes from all the areas of interest combined (staff satisfaction, quality of care, relationships and improvements). As an example, if you look at the theme ‘staff management’ in Table 11, a number of codes were collated under this theme which were originally in response to questions regarding staff satisfaction (pink) quality of care (purple) and improvements (green).

Table 11: Grouping of codes based on new overarching 'themes'.

Theme	***Codes***
Helping patients	Helping patients
	Making a difference
	Positive health outcomes
	Saving / improving lives
	Sense of pride
	Caring for people
	Delivering bad news
Teamwork	Building rapport / relationships
	Teamwork
	Looking after patients together
	Pulling together
	Multi-disciplinary element
	Team spirit / friendship
	Learning from each other
	Building a team
Social Network	Meeting people
	Colleagues
	Feeling supported
	Culture
	Politics
Cognitive Aspects	Feeling accomplished
	Variety
	Challenge
	Learning
	Responsibility
	Autonomy
	Career progression
	Problem solving
Demand / Resources	Work life balance
	Time to care
	Staff shortage
	Increased demand / complexity
	Lack of funding / budget
	Pressure / stress
	Workload
	Working beyond role
	Work life balance
	Expectations of patients
	Long hours
	Conflicting priorities
	Staff levels
	Funding
	Staff shortage
	Demand / workload

	Stress
	Tiredness
	More resources
	More time to care
	Funding
	Skills mix
Staff Management	Supervision
	Lack of support / recognition
	Staff management
	Managing people
	Lack of decision making
	Communication
	Communication
	Decision making
	Other departments
	Leadership
	Business outcomes
	Feeling undervalued
	Supervision / feedback
	Meetings
	Feeling supported / appreciated
	Communication
	Staff involvement / decision making
	Better leadership / management
	Team building
	Culture
Dimensions of Care	Patient focus
	Efficient / effective
	Empathy / understanding
	Environment and resources
	Signs and symptoms
	Safe outcomes
	Atmosphere
	Science and art
Level of care provided	Individual level positive
	Departmental level positive
	Departmental level negative
	Goodwill
Staff satisfaction and quality of care	Positive relationship
	Negative relationship
	No relationship
	Breaking Point
Quality of care and staff satisfaction	Positive relationship
	Negative relationship
Serendipitous Themes	Media portrayal
	Resistance to change
	Importance of caring for the carers
	Whistleblowing

The final stages of the analysis involved condensing the codes further into eleven final themes and fifty-seven sub-themes. Any codes, which had only been referred to briefly and had a similar meaning, were grouped together for instance, under the theme ‘social network’, culture and politics were initially separated, but due to their infrequency within the data set and their similarity in terms of discussion, these were grouped together. Furthermore, any duplicate codes were eliminated, for example under ‘staff management’ the code communication appeared twice as it was referred to in relation to both staff satisfaction and quality of care. Table 12 shows the first phase of the condensing process and Table 13 shows the final result of themes and subthemes.

Table 12: First phase of condensing codes and subthemes.

Theme	***Codes***
Helping patients	Making a difference
	Positive health outcomes
	Saving / improving lives
	Sense of pride
	Caring for people
Teamwork	Teamwork
	Building rapport / relationships
	Looking after patients together
	Pulling together
	Multi-disciplinary element
	Team spirit / friendship
Social Network	Meeting people
	Colleagues
	Feeling supported
	Culture
	Politics
Cognitive Aspects	Feeling accomplished
	Variety
	Challenge
	Learning
	Responsibility
	Autonomy
Demand / Resources	Work life balance
	Time to care / Workload / Long hours
	Staff shortage / Staff levels / More resources
	Increased demand / complexity
	Lack of funding / budget
	Pressure / stress
	Working beyond role
	Conflicting priorities
	Tiredness
Staff Management	Lack of support / recognition
	Staff involvement / decision making
	Managing people
	Communication / Meetings
	Feeling supported / appreciated
	Communication
	Supervision / feedback
	Other departments
	Better leadership / management
Dimensions of Care	Patient focus
	Efficient / effective

	Empathy / understanding
	Environment and resources
	Signs and symptoms
	Safe outcomes
	Atmosphere
	Science and art
Level of care provided	Individual level positive
	Departmental level positive
	Departmental level negative
	Goodwill
Staff satisfaction and quality of care	Positive relationship
	Negative relationship
	No relationship
	Breaking Point
Quality of care and staff satisfaction	Positive relationship
	Negative relationship
Improvements	More resources
	Feeling supported and appreciated
	Communication
	Training
	Staff involvement /decision making
	Better leadership /management
	Meetings
	Working conditions
	Supervision / feedback
	Improved technology
Serendipitous Themes	Media portrayal
	Resistance to change
	Importance of caring for the carers
	Whistleblowing

Table 13: Final stage of the analysis revealing eleven final broad themes and fifty-seven subthemes.

Theme	***Sub-themes***	
Helping patients	Making a difference	Positive health outcomes
	Saving / improving lives	Sense of pride
	Caring for people	
Teamwork	Building rapport / relationships	Looking after patients together
	Multi-disciplinary element	Team spirit / friendship
Social Network	Meeting people	Colleagues
	Feeling supported	Culture / politics
Cognitive Aspects	Feeling accomplished	Variety
	Challenge	Learning
	Responsibility	Autonomy
Demand / Resources	Time to care / workload	Staff shortage
	Increased demand / complexity	Lack of funding / budget
	Pressure / stress	
Staff Management	Communication / feedback	Staff involvement / decision making
	Better leadership / management	Feeling supported / appreciated
	Managing people	
Dimensions of Care	Patient focus	Efficient / effective
	Empathy / understanding	Environment and resources
	Signs and symptoms	Safe outcomes
	Atmosphere	Science and art
Level of care provided	Departmental level positive	Individual level positive
	Departmental level negative	Goodwill
Staff satisfaction and quality of care	Positive relationship	Negative relationship
	No relationship	Breaking Point
Quality of care and staff satisfaction	Positive relationship	Negative relationship
Improvements	More resources	Feeling supported and appreciated
	Communication	Training
	Staff involvement /decision making	Better leadership /management
	Meetings	Working conditions
	Supervision / feedback	Improved technology

Conclusion

This chapter (seven) has outlined the coding and analysis processes that were conducted throughout this study. The exploratory approach, which underpinned the research meant that the analysis needed to be data driven as opposed to being solely based on existing literature. However, the very nature of a critical realist perspective means an appreciation that the researcher is unable to completely separate themselves from prior knowledge and experience, therefore some subjectivity will be inevitable and will likely frame the analytical process. Thematic analysis was chosen as the most appropriate technique for a study investigating participants interpretations of the concepts from a broad perspective (Marks and Yardley, 2004). In terms of coding, in line with the critical realist perspective, the researcher aimed to adopt both a passive and an active approach. The researcher both purposively retrieved words and phrases of text, but also allowed codes to emerge from the data itself too.

In the first phase of interviews, 12 interviews were carried out and then analysed. After this, a further 15 interviews were carried out in phase two. After all 27 interviews had been completed the entire data set was combined into one document and then re-analysed to ensure that nothing in the text / data had been missed. This also ensured reliability and stability of themes. Initially, from the coding process, 109 raw codes emerged, so it was necessary to organise and aggregate these. From entire coding and analysis process outlined in this chapter, the final number of themes which emerged were eleven, with fifty-seven sub-themes. The next chapter (eight) will discuss the significance of these themes and sub-themes in-depth.

Chapter 8 – Findings

Introduction

The aim of chapter eight is to summarise the findings obtained from the data collection and analysis phases of this study, which were outlined in the previous chapter (seven). As demonstrated, the coding and analysis resulted in eleven final broad themes and fifty-seven subthemes (these are again presented below, Table 14). The proceeding narrative provides a detailed overview of the eleven broad themes namel: helping patients, teamwork, social network, cognitive aspects, demand and resources, staff management, dimensions of care, level of care provided, the relationship between staff satisfaction and quality of care, the relationship between quality of care and staff satisfaction and improvements.

Each of the eleven themes, which emerged throughout the active and passive analysis will be considered in detail based on the researchers own interpretations of the data. Evidence in the form of participant quotes will be used to support these explanations. This section will predominately focus on the findings of the current study, and whilst some literature is briefly referenced, a deeper discussion of the themes and how they relate to the overall research objectives and existing literature will be provided in the following chapter (chapter nine – discussion).

Table 14: Final stage of the analysis revealing eleven final broad themes and fifty-seven subthemes.

Theme	***Sub-themes***	
Helping patients	Making a difference	Positive health outcomes
	Saving / improving lives	Sense of pride
	Caring for people	
Teamwork	Building rapport / relationships	Looking after patients together
	Multi-disciplinary element	Team spirit / friendship
Social Network	Meeting people	Colleagues
	Feeling supported	Culture / politics
Cognitive Aspects	Feeling accomplished	Variety
	Challenge	Learning
	Responsibility	Autonomy
Demand / Resources	Time to care / workload	Staff shortage
	Increased demand / complexity	Lack of funding / budget
	Pressure / stress	
Staff Management	Communication / feedback	Staff involvement / decision making
	Better leadership / management	Feeling supported / appreciated
	Managing people	
Dimensions of Care	Patient focus	Efficient / effective
	Empathy / understanding	Environment and resources
	Signs and symptoms	Safe outcomes
	Atmosphere	Science and art
Level of care provided	Departmental level positive	Individual level positive
	Departmental level negative	Goodwill
Staff satisfaction and quality of care	Positive relationship	Negative relationship
	No relationship	Breaking Point
Quality of care and staff satisfaction	Positive relationship	Negative relationship
Improvements	More resources	Feeling supported and appreciated
	Communication	Training
	Staff involvement /decision making	Better leadership /management
	Meetings	Working conditions
	Supervision / feedback	Improved technology

Overarching Themes

Helping Patients

The primary factor that all (n=27) participants mentioned as influencing their job satisfaction was being able to help patients, within this theme, various aspects arose. Many of the participants mentioned the importance of being able to make a difference to people (Cortese 2007, Morgan and Lynn 2009, Atefi et al. 2014). For some, this was through directly and physically caring for patients or people going through a difficult time. For others, such as non-clinical staff, satisfaction was gained through knowing that their work was indirectly helping patients to get better or improving the delivery of the care and service.

CLINICAL

> ***SSQC006:*** *It's nice to be able to help people.*
>
> ***SSQC010:*** *I mean the whole reason I became a doctor is because I enjoy kind of looking after people, so when someone is sick, when they come into hospital and they are having a really difficult time in their lives and to be able do something for them.*
>
> ***SSQC012:*** *You could start to help people to see things differently, maybe to become functional again.*

NON-CLINICAL

> ***SSQC009:*** *It can be chaotic but very rewarding knowing that, even at that remote distance, we are helping make people's lives better when they're having a really, really bad time but you've had a role to play in that.*
>
> ***SSQC011:*** *I think when we actually have made a difference and you've got an improvement.*
>
> ***SSQC024:*** *The best day in the office are the ones where we were working for something and something does come through, so the statistics show we actually made a positive benefit.*

Other participants were slightly more specific about how they gained rewards from helping people, some mentioned saving patients' lives and observing positive health outcomes as providing a source of job satisfaction. For example, seeing patients recover, get better, or see changes in their overall physical and mental health statuses (Newman and Maylor 2002, Begat al. 2005, Dunn al. 2005, Perry, 2005, Cortese, 2007, Utriainen and Kyngäs, 2009, Atefi, 2014).

CLINICAL

> ***SSCQ00:*** *The fact that you can see patients get up and get better.*
>
> ***SSQC001****: I enjoy being able to make a difference.*
>
> ***SSQC023:*** *I think if I make a really good connection with a family and get a good joint understanding of what the difficulties are and how to move forward, I find that really satisfying.*
>
> ***SSCQ025:*** *I enjoy say the palliative care side of things as well, with people in their own homes.*

NON-CLINICAL

> ***SSQC004:*** *Most people go in to it [healthcare] because they care; they don't necessarily do it for the money.*
>
> ***SSQC019:*** *I really like it when we get to see patients regularly and you get to see them improving. That's definitely the best part of the job - you see them progressively get better.*

The exploratory nature of this qualitative study encouraged a deeper consideration of some of the comments and themes, which arose. Whilst the participants talked about the idea of helping patients, some alluded to the fact that, the degree of improvement to patients' health may actually correspond with the level of job satisfaction obtained. For instance, one participant mentioned the fact that they gain more satisfaction from seeing particularly poorly patients get better quickly, than seeing patients stabilise gradually over a longer period. These comments were interpreted as highlighting an interesting perspective as to the way

healthcare staff gain satisfaction from providing care. It seems there are two key elements, 1) the degree of impact they can have on the patients' care, and 2) the immediacy of that care. Intuitively, this makes sense, the more extreme or obvious the improvement in the patient, the greater the reward to the staff member(s). This concept has been termed as the 'impact / immediacy effect of delivered care' and will be discussed in detail in Chapter 9. As far as the researcher is aware, this is a novel and substantial finding and one that adds further contribution to the literature as well as raising an area for further investigation.

> ***SSQC014:*** *For the ones that get better and improve over weeks I don't get the same satisfaction as the ones that have got really, really bad and then get a little bit better over a few hours if that makes sense. It sounds awful and a bit selfish but it's usually because I've moved on and they've moved on so I never get to see them. I don't get to get to see the things that have happened over weeks, I get to see the things that have happened over hours.*
>
> ***SSQC021:*** *Seeing people's faces light up when you fit them with hearing aids as well. It's lovely, I've cried before. I've had patients hug me, I've had patients just being so overwhelmed that they just can't stop saying, "Thank you." That part is amazing.*

Considering all participants worked in a healthcare setting, it is perhaps unexpected that only three participants specifically mentioned the element of 'caring for someone' as providing them with job satisfaction. However, the difference between 'caring for someone' and 'helping patients' (referred to above) is likely to be a semantic difference only. Furthermore, it is necessary to mention that many of the staff interviewed do not directly treat or even see patients regularly, yet all of the participants stated that 'helping patients' or 'making a difference to patients' was an important factor in influencing their job satisfaction, even if they did not specifically refer to 'caring' (Cortese 2007, Morgan and Lynn 2009, Atefi et al. 2014).

Teamwork

Another broad theme and factor related to job satisfaction and quality of care, which emerged from the participants data was teamwork. Several prior studies have found that teamwork and relationships with colleagues leads to greater job satisfaction, so the finding of the current study adds to this body of literature (Opie 1997, Adams and Bond, 2000, Rafferty et al. 2001, Cortese 2007, Gardulf et al. 2008, Chang et al. 2009, Kalisch et al. 2009, Kalisch et al. 2010, Al-Dossary et al. 2012). Participants in the current study referred to the importance of working within a team, ensuring that the team has shared goals such as having the patients interest at the core of what they do, and the importance of being able to discuss issues amongst colleagues. These notions can be demonstrated through the participants' comments below.

CLINICAL

> ***SSQC008:*** *If you need somebody to support you in your decisions, to chew things over with, there's always somebody there.*
>
> ***SSQC020:*** *The days when I've been working in a team often the on call days, the team that are looking after a sick patient. I find that very rewarding as well.*
>
> ***SSQC023:*** *I really like team-working and really like interacting with other specialties.*

NON-CLINICAL

> ***SSQC005:*** *I do like the team a lot and I do think everybody works really well together and at the heart of that it is genuinely in the best interest of the patients.*
>
> ***SSQC015:*** *As far as I'm concerned, it is the entire part of the lab. The lab would be useless if we didn't work as a team.*
>
> ***SSQC024:*** *I do like working in a team, if you get banter in a team, it makes your day go a bit quicker and you actually learn from each other as well.*

The results of the data analysis also showed that the idea of collectively helping patients was not solely down to the immediate colleagues in the participants' departments. As the delivery of care requires such an interdisciplinary approach, many participants referred to the importance and benefits of working with colleagues from wider teams. Whilst some members of staff were very positive about these multidisciplinary and interdepartmental relationships, others vented frustration regarding issues that are out of their control. Some referred to problems, which can arise when working relationships break down and the consequential affect this has on their ability to deliver quality of care.

POSITIVE

> ***SSQC001:*** *I also enjoy the kind of interface I think between mental health and physical health.*
>
> ***SSQC023:*** *I really like team-working and really like interacting with other specialties because I work in a hospital environment, so I work with lots of different other specialties as well.*

NEGATIVE

> ***SSQC017:*** *It would be nice if the whole system worked as well as our little bit of it….places like pharmacy and places like radiology services have an impact on our patient's experience which is completely out of our control.*
>
> ***SSQC022:*** *You asked them to move, because a patient is in the wrong place and they need much more specialist care than can be given, and their attitude is, "We don't care really." That's a classic example of where the quality of care being delivered to that patient is actually impinged upon.*

The latter quotes by participant SSQC017 and SSQC022 demonstrate the annoyance which can occur when an individual feels as though they personally are carrying out work to a high standard, but the overall care provided can suffer due to problems throughout the wider team. As referred to in the introduction chapter of this thesis, the move towards a more holistic approach in many healthcare environments, increases the challenges associated with working in larger teams (some of which may be physically remote to an individual's workplace). Whilst some staff are very protective of their immediate departments, a lack of

understanding and / or appreciation of what other healthcare roles entail may lead to the attitudes of 'we don't really care' or 'it's not our problem' which were referred to by participant SSQC022. This issue also demonstrates how factors such as 'teamwork' not only influence healthcare professionals job satisfaction but also the quality of care they feel they are able to provide, so these concepts are likely to be connected. Overall, from the comments made, the importance of healthcare staff being able to build strong relationships both within and across departments is evident (D'Amour et al. 2005, Petri, 2010).

An additional sub-theme, which emerged within the broader theme of teamwork, was the idea of team spirit and friendship. Most of the participants who referred to this theme suggested that a unified team spirit was conducive to job satisfaction and quality of care, for example the quote from SSQC003 (McNeese-Smith, 1999, Utriainen and Kyngäs, 2009). This is in comparison with another member of staff (SSCQ00) who suggested that working relationships do not necessary require colleagues to be best friends, however staff do need to get on as a working unit to ensure adequate care can be provided.

> ***SSCQ00:*** *Ultimately you're there as a working unit as long as the unit is working then that's fair enough, like you don't necessarily have to be best buddies with everybody for it to work.*
>
> ***SSQC003:*** *The team feeling in the office is hugely important, if you have a nice feel in the office and a bit of banter and comradery then that's hugely important.*

This raises an interesting point as to why such a difference in opinion like this may occur across individuals who work in healthcare. The contrasting comments between participant SSCQ00 and SSQC003 could be due to some of the notions explored earlier on in this thesis. In chapter two, it was suggested that factors such as demographics, personality, values, norms and expectations, may all shape the way an individual evaluates their own job satisfaction, so any differences like the example provided here, could be due to these factors.

Social Network

A number of points, which emerged from participants, were categorised under the broad theme of social network, these included culture, politics, support from colleagues, and involvement with decision making. In the current study, participants did allude to the idea that organisational culture can influence job satisfaction, however they described some of the more intangible aspects of culture such as atmosphere, pleasantness, and openness (Nolan et al. 1994, Tzeng et al. 2002, Lundh, 2003, Tsai, 2011, Körner et al. 2015). There was also the suggestion that the development of a pleasant culture was the responsibility of the department itself who had the capacity to address any negative issues. Some participants referred to culture negatively and mentioned that a single person or small group of people can influence the overall culture and spirit of the team or department. Other interviewees specifically referred to bullying behaviours, which arose from both fellow colleagues, as well as those in leadership roles.

POSITIVE

> ***SSQC003:*** *The department issues can be dealt with by the department regarding culture and the atmosphere at work, so encouraging pleasantness in the office. Feeling comfortable being who you are in the office is what I think is quite important.*
>
> ***SSQC004:*** *It's about having a culture of transparency and honesty.*

NEGATIVE

> ***SSQC013:*** *It's just human nature to have a moan about different people. I think sometimes when that gets a bit over bearing, if you've got one person who's particularly negative all the time, it can bring the team down.*
>
> ***SSQC019:*** *Other things I don't like we have some management that are needlessly picking on people sometimes. Yeah, that's not very nice.*

Some participants also referred to ‘politics’ which in itself is a slightly vague concept. The participants in the current study however mentioned their annoyance at issues ranging from ‘politics’ within their immediate departments as well as ‘governmental politics’ (McNeese-Smith, 1999).

> ***SSQC006:*** *I personally don’t really get annoyed by a huge amount, but there’s a lot of people I know who get annoyed with the politics of the place and the management*
>
> ***SSQC008:*** *The bureaucracy of the management structure, the politics of the management structure, not just locally but stretching all the way up to Westminster.*

In addition to working together collegially, the notion of feeling supported by colleagues also emerged (Decker, 1997, Seo, et al. 2004, Coomber and Barriball, 2007, Atefi et al. 2014). Again, whilst the majority of participants were very positive about the support they had within their departments, two participants did raise negative issues. These comments are linked to the issue of bullying, which unfortunately, is not an uncommon subject amongst nursing studies (Quine, 1999, Heponiemi et al. 2014).

POSITIVE

> ***SSQC002:*** *It’s a good bunch of people and they’re hugely supportive.*
>
> ***SSQC003:*** *Just feel that someone’s taking seriously what you said and I think that hugely affects how you feel about your job.*

NEGATIVE

> ***SSQC008:*** *In my workplace there is definitely a culture of bullying.*
>
> ***SSQC010:*** *It’s just quite a punitive atmosphere.*

In the present study participants also stated how the social element is important in regards to decision making and being able to discuss concerns and problems with each other as a team. As already mentioned, because healthcare is such a multidisciplinary field, it seems intuitive that working relationships would play an integral part to staff members' job satisfaction and link to the quality of care staff are able to provide. Although the theme of social network is closely related to the previously discussed theme of 'teamwork' from the comments made by participants, the social network within healthcare departments goes somewhat beyond simply 'working in a team'. It encapsulates the human desire (for many people) to want to share experiences and support one another, particularly when faced with challenging situations, which many healthcare professionals do encounter regularly.

> ***SSQC002:*** *My colleagues are great, I do love them and they're really helpful to have around.*
>
> ***SSQC003:*** *I think that in itself enables a better service on an individual level if you're able to kind of off load and discuss and review and analyse your own conduct, I think you must be able to provide a better service.*
>
> ***SSQC008:*** *If you need somebody to support you in your decisions, to chew things over with, there's always somebody there.*

Cognitive Aspects

A number of factors influencing job satisfaction raised by participants were related to cognitive aspects such as training, learning, autonomy, responsibility, and variety. Throughout the interviews, four participants referred to the importance of training within their roles (Lashinger et al. 2003).

CLINICAL

> ***SSQC001:*** *I enjoy the academic side of the job.*
>
> ***SSQC007:*** *It's quite nice to learn from other healthcare providers.*
>
> ***SSQC018:*** *I enjoy the progression of my career and the training, which is really important for me.*

SSQC004: *I obviously enjoy the training side of it loads.*

Another factor which emerged under the umbrella theme of cognitive aspects was the idea of being able to learn within the job role. In a similar way that some participants liked to be presented with a challenge, other participants stated that they liked to be stretched and pushed in terms of learning. Several participants referred to the academic, learning, and teaching elements of their roles as providing them with job satisfaction (Lashinger et al. 2003, Atefi et al. 2014). Four of the participants interviewed were doctors so for these members of staff, learning is a crucial element, allowing them to maintain their knowledge of relevant research and medical practice.

SQC018: *I enjoy some lectures which are provided externally or internally as well.*

SSQC023: *I like attending teaching sessions and teaching myself.*

Although attending courses and learning was seen as an important factor to some participants, in the current study a couple of the interviewees demonstrated frustration towards wanting to attend training sessions, however due to demands on their role and staff shortages, many were unable to do so. This is a prime example of how several of these broader themes relate to one another, the issue of demand and resources (discussed in the next section) impacts many of the other issues raised by participants.

SSQC010: *You were supposed to go to 70% of teaching sessions and I think I probably went to 5% because I could just never ever get away from the job.*

SSQC014: *I think quality of training is really important too … if people can't get into theatres to do their training to become surgeons, that's really important, if you literally can't get trained to do your job that's a huge issue.*

Five of the healthcare staff interviewed referred to the importance of responsibility and autonomy in their job roles (Loher et al. 1985, Fung-kam, 1998, Seo et al. 2004, Bjørk et al. 2007, Zangaro and Soeken, 2007). Two interviewees raised the importance of being able to manage their own time and workload. Another mentioned that they gained satisfaction from working night shifts and as a sole worker, having responsibility for that particular department.

CLINICAL

> ***SSQC012:*** *I liked the degree of autonomy that I had. I liked being able to manage patients from start to finish myself.*
>
> ***SSQC014:*** *I get to sort of manage my time; I get to be really flexible.*

NON-CLINICAL

> ***SSC007:*** *It's nice to take responsibility for a service line, what's difficult sometimes is I guess the influence that you can have within the business direction within a hospital.*
>
> ***SSQC013:*** *I enjoy having the responsibility, it's really significant. Especially when I used to do night shifts and you'd be the only one there.*
>
> ***SSQC024:*** *The thing that I really enjoy is it's quite autonomous.*

Some interviewees specifically mentioned variety as influencing their job satisfaction. This was raised both in terms of the tasks they have to do as well as the types of patients they see (Kovner et al. 2006, Li and Lambert, 2008). Variety was deemed important to participants' job satisfaction as it provided interest and it ensured that staff were able to maintain their competencies and training, which in itself can have a positive influence on job satisfaction (Nolan et al. 1994, Cortese, 2007).

> ***SSQC001:*** *I really enjoy the variety of the work, so no one person is the same.*
>
> ***SSQC013:*** *If you do what you're meant to do which is rotate through the different areas, then you get variation. That in itself should give you some level of job satisfaction, because you're maintaining your competencies across the different areas.*

In a similar way that variety helped to keep participants interested in their job roles, facing challenges or overcoming difficulties was also mentioned as providing staff with satisfaction. However, it was noted that the 'challenges' had to be balanced, so if the role were to become too challenging then it would be likely to actually diminish job satisfaction (Price and Mueller, 1986, McNeese-Smith, 1999, Seo et al. 2004).

> ***SSQC003:*** *The job itself, if it interesting, bit challenging, but not too challenging.*
>
> ***SSQC017:*** *When you do something that's difficult and that turns out successful, that's quite satisfying.*

Demand and Resources

A crucial topic which was discussed amongst the majority of participants was the issue of demand and resources, in particular, having sufficient staff both in terms of quantity and in terms of skills mix (Upenieks, 2003, Hayes et al. 2010, Atefi et al. 2014). Within the current study the linkage between staff shortages and skills mix was not only shown to have an effect on participants' job satisfaction, but it was also a significant factor in the delivery of quality of care. As with job satisfaction, the impact of staff shortages on quality of care isn't simply a matter of numbers - it is a complex issue, which incorporates ensuring that staff have time to attend training, they have time to learn from other colleagues, and that departments have the appropriate skills mix required at any given time (Adams and Bond, 2000). These concerns are evidenced by the quotes from participants below and one in particular who noted that the skills mix in his department could potentially put patients at risk, therefore the severity of this issue is blatant and needs addressing urgently. As with many of the themes that emerged throughout the data analysis, this issue was raised by both clinical and non-clinical staff.

CLINICAL

> ***SSCQ00:*** *What don't I like, is the fact that we haven't got any staff. It's very bottom heavy so lots of junior staff so that puts the patient at risk.*
>
> ***SSCQC006:*** *It is a lot more difficult up on the wards where they are obviously just too stretched to be able to give the care to everybody all of the time.*
>
> ***SSQC022:*** *You cannot provide good care if you don't have enough staff to provide it.*

NON-CLINICAL

> ***SSQC011:*** *I used to have admin support. So I'm now doing all those roles and you think…it's quite soul destroying because we're told accreditation and quality is key and yet there's less and less resource going into it.*
>
> ***SSQC015:*** *We're short staffed on the weekends as well so they always ask for volunteers to work more weekends.*

Another important factor to transpire from the data was the time participants had to care for patients. This also links closely to other factors such as staff shortages, workload and demand as well as the first and primary factor mentioned in this chapter, being able to help patients. Although helping patients was the participants' priority, many voiced annoyance due to the demand and resource restrictions, which hinder their ability to deliver the level of care they would like to give (Campbell et al. 2000).

> ***SSQC002:*** *I think sometimes you know I've rushed people or I've not been with them the way I want to.*
>
> ***SSQC010:*** *Quite often I feel like I'm so busy that I can't do as good a job for people that I would like to.*
>
> ***SSQC014:*** *I always feel I don't do my complete best because I've got other pressures, other patients to see. So it means I can't do as good a job as I'd like to do or be as thorough as I'd like to be.*
>
> ***SSQC020:*** *Often when there's just been too much to do, you come home thinking that you've given people bad care and you haven't done the best you can do. Usually not because I've necessarily done the wrong thing, but it's usually because I haven't had time to do things properly or I haven't been able to get the help I need from someone else.*

Specifically, the participants interviewed referred to the fact that demand in terms of patient volume has been increasing over time, which coupled with a decrease in staffing levels, puts significant pressure on those within the system. Comments also evolved around the fact that patient demand isn't merely attributed to volume, but also the complexity of patients' needs. A few of the interviewees mentioned external factors that have influenced this increased complexity, such as longer life expectancies and unhealthy lifestyles of the general population (Harper, 2014).

> ***SSQC007:*** *We've probably seen a 10% rise year-on-year, for the last few years and that becomes particularly challenging.*
>
> ***SSQC008:*** *As a society we're a bit more sedentary than we used to be, we don't eat as well as we used to and that has a knock-on effect to the women's health.*
>
> ***SSQC012:*** *The increase in the number of patients, who had serious mental health issues, for me, was overwhelming. And I actually didn't like what it was making me feel like, because when you've seen a third suicidal patient in the space of an afternoon, it's not right.*
>
> ***SSQC023:*** *I think the overriding thing is about supply and demand really. Probably, everyone's aware that demand has increased massively, and the supply in terms of staffing has decreased massively.*

As well as volume and complexity, the unpredictable nature of healthcare was mentioned by one participant. Whilst many areas in healthcare are appointment based and relatively predicable, services such as accident and emergency and midwifery are very unpredictable, which not only highlights the intricacy of healthcare itself, but also the arduous and formidable task of having to manage more than one service line in any one healthcare organisation.

> ***SSQC008:*** *Sometimes you will have eight women in labour and then three days will go past and nobody will have a baby, so it's a very ebb and flow kind of service, you can't predict it.*

A final factor relevant to this theme, which was mentioned by three participants, was a sense of feeling accomplished. So whilst high demand, complexity, and workload appear to have a negative effect on participants' job satisfaction, when participants felt they had achieved and accomplished everything they wanted to do within a particular time frame, this had a positive effect on job satisfaction (McNeese-Smith, 1999).

> ***SSQC012:*** *You felt like you'd done a day's work at the end of it. That's rewarding, isn't it?*
>
> ***SSQC018:*** *When there's a lot of things to do which have to be done, like ticked off, I really feel satisfied at the end of the day if all of the things I've managed to do, I've managed to fit them within those working hours. That's really good.*
>
> ***SSQC019:*** *If I come home and I say, "I've had a good day today." It's usually because we've had time to do all the work that we've been asked to do.*

Some of the factors that participants deemed to influence their job satisfaction can be seen as outcomes of the job itself. Most participants stated that their job roles provide a poor work life balance, which therefore impedes on their job satisfaction (Cortese et al. 2007). As an example, one participant (SSCQ00) who stated they do have a good work life balance has chosen to work part time in order to achieve that.

> ***SSCQ00:*** *Work life balance, I've reduced my hours and now it's better.*
>
> ***SSQC001:*** *I dislike the balance, the poor work life balance.*
>
> ***SSQC004:*** *The other things that are factors to me is around work life balance and about how the organisation accepts that.*

Two of the participants also mentioned the necessity of looking after one's own health and well-being whilst working. They stated that over time, they had learnt the importance of taking time out to have breaks, food, and drink, in order to ensure they are able to perform at their optimum. Both of these participants are experienced and they talked about trying to

lead by example to more junior staff who may feel more pressure to work non-stop without taking breaks and therefore in danger of experiencing ‘burnout’, all of which have been shown to have potential detrimental long-term effects on individuals’ health and well-being (Wallace et al. 2009).

> ***SSQC022:*** *When I first started, sometimes I didn't get a break at all. Probably nine times out of 10, I take it now and I take it because I know I am not young any longer and I need my break. I need to sit down. I need to have a drink. I need to have something to eat and I need to regroup and rethink. Some of the younger ones, I'm always pushing them to go off to break and they say "I've got too much to do." And I say, "You'll work better if you just have a chance to sit down." Even if you take a small break, you come back and you can refocus and you're better for it and that's just something over the years that I've worked out.*
>
> ***SSQC023:*** *I’ve actually taken a couple of career breaks, specifically to learn to look after myself. In my 40s, I've come to the conclusion I've got to heal the healer, as it were, I got to start really learning how to treat myself as well as I treat others. That really paid off. It’s been really, really useful. As senior staff, if we're mature enough to actually realise that we need to look after ourselves, and we can model that.*

Although a separate and distinct factor to workload, stress, can be seen as an inter-connected variable in that it can be caused form a high workload, which in turn impacts on job satisfaction (Tabak and Orit, 2007, Zangaro and Soeken, 2007, Li and Lambert, 2008, Wilson, 2008). In the current study some of the issues relating to stress which were raised included working long hours, dealing with intense demands, and having to make important decisions with significant consequences. These negative triggers of stress also then led the participants to be less satisfied (Blegan, 1993, Leveck and Jones, 1996, Lu et al. 2007).

> ***SSQC0:*** *There is a lot of pressure. I think the long hours are quite difficult so long days and nights and that puts a strain on all of us I think.*
>
> ***SSQC020:*** *It varies; the on calls are usually very stressful. It's often very busy you’re getting calls from lots of different people often multiple bleeps at the same time trying to respond to different things. I think the thing I like least is probably the stress particularly when you're trying to make difficult decisions either, whether that's how you manage a patient or often it's, the consequences if you make the wrong decision are pretty big, so actually its very stressful having to make those decisions.*

As well as a feeling of stress, three participants also referred to the fact that being physically and mentally tired from working long hours meant that sometimes they were unable to perform at their optimum. This was seen as an important factor influencing the quality of care staff are able to give (Shirom, et al. 2006, Van Bogaert et al. 2009).

> ***SSQC001:*** *You worry that you're not in the best position to give the best care because you're tired, you're stretched.*
>
> ***SSQC014:*** *I guess on a longer term I remember doing a string of 12 days and I was leaving late every single day by hours and at the end of that I don't think I made any mistakes, but actually in that job I think I made mistakes, because I was so tired and stressed and stuff.*
>
> ***SSQC020:*** *I know I'm probably not at my best because I know when I drive home after that shift it's always a bit hairy and I'm tired and I'm grumpy. I'm sure that does influence on the care I give and my interactions with other staff. I think that's-- the care I give is probably mostly influenced by either having too much to do or being tired at the end of a long shift. Obviously, you try and not let it effect the care you give, but ultimately I'm sure it does.*

Another related factor here, which was mentioned by participants and can be seen as an outcome of the job was pressure. Two out of three interviewees who directly referred to 'pressures' were junior doctors, they mentioned the pressure of having to make extremely important decisions, deal with high workloads, as well as meet with the pressures and demands of being in highly competitive roles.

> ***SSQC0:*** *There is a lot of pressure. I think the long hours are quite difficult so long days and nights and that puts a strain on all of us I think.*
>
> ***SSQC014:*** *I don't think, like the pressure. I think that I would enjoy it a lot more if I had maybe half the amount of work I have to do … I have to perform really well. That's a lot of pressure whereas other people they've not got that pressure they can walk into a job and not worry about it.*

Staff Management

Like many of the other themes discussed in this chapter, the concept of staff management had several tones of conversation related to this factor. Communication was one particular area raised by interviewees and was referred to as an influencing factor to both job satisfaction and quality of care. There were mixed feelings amongst participants as to the quality of communication in their respective departments, however what was agreed upon is that good communication was important to both job satisfaction and quality of care. Having the chance to discuss issues, problems and ways of working were all linked to proving a better service and as well as improving team morale.

> ***SSQC002:*** *Communication in my opinion is appalling unfortunately. One day we had three back-to-back really badly worded emails saying that we weren't doing this, and we weren't doing that, and we weren't meeting this target, and could people do more work. We're all open to change; it's just if it was communicated in a more supportive way.*
>
> ***SSQC003:*** *I think that [referring to team meetings] in itself enables a better service on an individual level if you're able to kind of off load and discuss and review and analyse your own conduct, I think you must be able to provide a better service.*
>
> ***SSCQ005:*** *We do have social events things like that, so I think that does help team morale and regular sort of team meetings, there is good communication.*

Three interviewed participants highlighted the fact there can often be communication breakdowns within department, these can occur vertically across similar roles or horizontally between different hierarchical layers of management. It seems from the comments made by the interviewees, this breakdown of communication is not purely down to the frequency of the message, it can also be due to the language used and / or the way in which the message is communicated. For example, one participant mentioned that some of the emails she received from senior managers can be 'badly worded' and that during face to face communication opportunities, the body language used had also been very negative with

staff ‘turning their backs’ to other colleagues (Boumans and Landeweerd, 1993, Lashinger et al. 2003, Ferguson et al. 2011).

> ***SSCQ002:*** *First and foremost probably communication, when you’re in a room with therapists let alone just human beings there is a way to communicate.*
>
> ***SSCQ007:*** *Try and communicate as much as we can in terms of what’s happening, keeping them engaged. We’re reasonably good at communicating within the department but you know it can always be improved.*
>
> ***SSCQ009:*** *Communicate more rather than handing out diktats, communicate, ask people questions, you know a monthly email just for feedback would be nice.*

A second issue highlighted by participants relates to organisational and departmental culture (Tzeng et al. 2002, Seo et al. 2004, Li and Lambert, 2008, Tsai, 2011). In terms of communication, it was regarded as important to some interviewees to feel comfortable in their environment so that they could discuss day to day matters both in their immediate department as well as the wider interdisciplinary team. Furthermore, this relates back to the previously discussed notion that teams should avoid working in silos and develop a greater appreciation of the larger organisational issues and challenges. Some of the practical elements that staff referred to as being helpful were regular staff meetings, this is despite the fact that a number of participants mentioned that sometimes, due to staff shortages or conflicting priorities these either failed to occur or had been purposively stopped. There were however often inconsistencies as to how these are carried out, so the level of communication and the productiveness of the team brief are often dependent on the person(s) carrying them out.

This really does highlight one of the major complexities of the healthcare sector, often conflicting priorities and the need to ‘get the day job done’ mean that actually sometimes very important parts of the job get neglected. Whilst this might not affect the patient care immediately, it can have a long-term detrimental effect through lack of planning,

deterioration of staff understanding, appreciation of departmental and organisational goals, wider team issues, and ultimately job dissatisfaction.

> ***SSQC0:*** *Communication I would say is the key, yes people seem a bit too busy to communicate with you really.*
>
> ***SSCQ001:*** *Full team meetings a little more often.*

In relation to communication, it was interesting to get the perspective of a senior cluster manager. One aspect that this participant raised completely voluntarily was the fact that some of the information fed down from the executive level, such as financial data or key performance indicator results can be difficult for staff to hear due to the negative implications. His particular trust is in a significant financial deficit and therefore feeding that back to staff can potentially be very demoralising. This of course raises another interesting debate as to what information should and should not be communicated to lower grade staff. In summary, it is clear that the quality of communication is not necessarily down to frequency, instead it is important that the dialogue is appropriate, useful, and that messages are conveyed in a supportive and understanding manner.

> ***SSQC007:*** *It influences you day-to-day, how you feel about the system; it's very difficult to kind of talk that through sometimes with your teams.*

The notion of appreciation and recognition was shown to relate to staff satisfaction. Several of the participants indicated that a lot of their work does not seem to be appreciated or recognised by senior management staff (Roethlisberg and Dickson, 1939, Mayo, 1949, Jones, 1990, Tzeng, 2002a). Furthermore, it was mentioned that healthcare staff frequently work above and beyond their job roles yet it seems this is also not recognised or appreciated and in some cases, is taken for granted. One participant (SSQC010) in particular, stated that sometimes departments do not provide even the most basic amenities for staff to get food and drink during unsociable hours, which further demonstrates the lack of appreciation,

recognition, and understanding from managers as to what the staff have to deal with. It would seem that this particular area is one that could potentially make a huge difference to staff satisfaction. Additional support, recognition, and appreciation from senior staff are likely to have a significant impact towards the job satisfaction of healthcare staff and potentially reduce turnover (Lashinger et al. 2003).

> ***SSQC002:*** *I don't feel very supported, I don't feel very appreciated at all. It's really upsetting when I think about it because the job that we do is emotionally intense. Any experience you've built up over the years isn't really acknowledged.*
>
> ***SSQC010:*** *If you're working night shifts and you find out that you haven't even got anywhere to heat up food or you can't buy food overnight; just practicalities, just looking after you as a human being.*
>
> ***SSQC014:*** *I think just a simple, thank you for staying hours late, I think that's really important.*
>
> ***SSQC019:*** *I think I'd be more satisfied if I did get some thanks for when I do go over and above what we're supposed to be doing.*

A related point to the idea of feeling supported, is the involvement staff have in decision making (Adamson et al.1995, Cortese, 2007). Generally, the perception gained from the participants in this area was that they had little involvement with the decision making that occurs in their departments. This not only causes frustration, but there was also a feeling that some of the decisions made by managers are not always realistic and can sometimes be detrimental to delivering good care. Furthermore, the participants interviewed felt that they had little or no involvement when changes are considered (Adamson et al. 1995, Cortese, 2007). Despite many of the healthcare staff being very experienced and competent, decisions regarding processes and changes often have to go through several layers of management, which is not always conducive to efficient practice. Furthermore, there is often no (or poor levels of) communication when these changes are brought in, so although many staff are content for changes to occur, it is the manner of implementation and lack of

communication surrounding it that is often viewed negatively. The lack of faith and trust in employees to make decisions not only has an effect on healthcare staff satisfaction but it also has an inevitable effect on the quality of care too as processes become inefficient and slowed down by bureaucratic systems.

> ***SSQC002:*** *No I think that's what it comes down to, there is no decision-making for us, and we're not really included. A lot of it was you just have to change this and there was no say in it, but that was really hard and anxiety provoking for us as practitioners.*
>
> ***SSQC003:*** *Instead of letting the front line staff have an opportunity to discuss how they think they could get to those budgets and targets, they just come in and tell you we're doing this.*
>
> ***SSQC022:*** *I do have a bit of a problem with the hierarchy. I think there are far too many at the top dictating this that and the other and maybe they actually need to come onto the ward and do a bit of work. See what we're doing because sometimes I think their expectations are unrealistic.*
>
> ***SSQC025:*** *I'm in a bit of middle point really, so people will bring their problems to me and I can't make any changes without running anything past the team manager.*

Following on from the importance of decision making was the specific mention of leadership and leadership style. The quotes below from the participants further support the notion of ensuring the management style is participative, as this has a positive influence on both staff satisfaction and quality of care (Leveck and Jones, 1996, Tsai, 2011, Atefi et al. 2014).

> ***SSCQ001:*** *People in senior positions, if they are lacking in personality and experience, there can be a lack of leadership at times which can result in a breakdown of a team.*
>
> ***SSQC004:*** *If you have an autocratic manager it does have an adverse effect on quality.*
>
> ***SSQC010:*** *I see it in the nursing staff, their leadership is quite negative, so for example there are people who are told off in the middle of the ward, nurses who are kind of pulled up on things right in the middle of the ward, in front of patients in front of other staff, you can imagine how that makes you feel, it's just quite a punitive atmosphere.*

From the perspective of those in leadership positions themselves, two senior managers referred to the fact that they find it difficult to balance business targets with patient care requirements (Upenieks, 2003, Hutchinson and Purcell, 2010). This could potentially mean that even those managers who are considered to have good leadership skills by their staff, may still face criticisms or problems due to these conflicting priorities.

> ***SSQC004:*** *The balance between quality and business because often if you want more quality it involves additional costs.*
>
> ***SSQC007:*** *So I think the kind of firefighting nature of the role is difficult, certainly conflicting priorities so they can change.*

Two interviewees raised the noteworthy point that sometimes healthcare staff in managerial roles find certain aspects of their job particularly challenging. On occasions, staff are asked to step into management roles even though they may be formally clinically based, and / or have limited knowledge, experience, and support during such transitions. This finding is something that has been relatively unexplored in the literature and therefore requires further investigation, however a few studies looking predominately at doctors, who have transitioned into managerial roles have highlighted issues they have subsequently faced, a crucial one being role identity. These findings suggested that clinicians naturally identify with their clinical role and find it difficult to identify with their managerial role, which can lead to reduced performance and confidence (Spehar et al. 2015). Other problems can evolve around clinicians assuming roles which are ambiguous (Fitzgerald, 1994).

> ***SSQC005:*** *So I think I've never really wanted to go into staff management, but that's just part of the job and I kind of ended up just doing this job when the last person left because I was the assistant. I'm quite an easy-going, laid back person and I don't think I've got the sort of authority side of staff management down very well.*
>
> ***SSQC025:*** *I don't enjoy the people management so much within the team that can be difficult. I'm a bit of middle point really so people will bring their problems to me and I can't make any changes without running anything past the team manager and sometimes when that's not coming directly from the staff nurse themselves.*

The data from the current study supports and enhances the idea that strong leadership are essential in ensuring staff are satisfied within their roles and that the quality of care provided is high. However, more needs to be done to provide managers with the tools they require to build harmonious relationships with other staff members.

Dimensions of Care

As referred to in chapter four, the concept of quality of care has been explored extensively and several dimensional models have been proposed (Donabedian, 1988, Campbell et al. 2000, Institute of Medicine, 2001). Whilst these are useful and have enabled discussions with participants around quality of care, an important aspect of the current study was to consider quality of care from the participants' point of view. From these conversations, three key areas emerged, namely, ensuring a patient focus, being efficient and being effective.

Seven participants mentioned the importance of having a patient focus or patient centeredness culture and thought that quality of care is about creating an ethos within the healthcare department that has the patient at the heart of everything. This particular dimension is certainly an intuitive factor and it is also a dimension within the Institute of Medicine model (see chapter four) which states that quality of care should be "patient-centred and take in to account the individual needs of patients, whether this is demographic, religious or cultural" (Institute of Medicine, 2001, p.5-6). It also links to the primary factor that participants mentioned as having a positive effect on their job satisfaction, helping patients.

> ***SSQC004:*** *It's about an ethos within a staff team of person centeredness. So actually the people that you support are at the centre of everything you do.*
>
> ***SSQC017:*** *You have to be there, you have to pay attention to them, and you have to listen to them. You have to address their particular personal concerns. … You've really got to engage with people.*

Four of the participants referred to efficiency as being important to quality of care (Campbell et al. 2000, Institute of Medicine, 2001). Participant SSQC007, made the point that quality of care, itself can be as simple or as complex as you make it, but generally, patients want to be seen quickly, get the necessary professional treatment, and return home as soon as possible. Another participant who also referred to efficiency, highlighted awareness again of the complexity of healthcare in that often, extra or multiple services are involved in the delivery of care, therefore, any measures of quality would need to take this into account.

> ***SSQC002:*** *Listening and not judging and being able to follow up on their care and call in extra services if needs be and you have to be able to do that efficiently and effectively.*
>
> ***SSCQ007:*** *Patients want to come in, be seen quickly, get treated and go home.*

Although the above factors were fairly common amongst the participants interviewed, it seems at least from the comments made by the healthcare staff in this study, that quality of care is very subjective. A diverse range of responses transpired when interviewees were asked 'what is quality of care?' This is somewhat understandable considering the range of roles that the participants work in. One participant suggested that quality of care can be as unique as the patient receiving the care. So what is deemed as quality of care may differ from patient to patient or even day to day for an individual patient, depending on how their condition and illness develops.

> ***SSQC020:*** *That's a difficult one. I think that really varies on your patient because actually what is good quality of care for one patient may not be for another patient**.** Some patients are very happy to come in, have their investigation done and go home but actually for a lot of patients particularly, the elderly, you realise that it's not necessarily about making their pain better, but a lot of it is about wanting to talk to someone.*

Some of the more unique dimensions which emerged from the interviewees included empathy, understanding, an ability to pre-empt deteriorating health, intangible aspects such as the atmosphere within a place, and the fact that it is a combination of science and art.

> ***SSQC002:*** *Being empathic and non-judgemental.*
>
> ***SSQC004:*** *If people are giving people eye contact, if they're smiling, there's a vibe, a positive vibe in the house, if people are laughing if there's music playing, just little things.*
>
> ***SSQC008:*** *Good healthcare is about spotting when things are going to go wrong*
>
> ***SSQC023:*** *Just a combination of science and art if you like.*

Level of care provided

Participants were asked to talk about and describe the current level of care provided by both themselves as individuals, and by their department or organisation as a whole. At an individual level, all participants who were asked the question 'How do you feel about the level of care you provide?' stated that they were content with the level of care they are able to give, some examples of these statements are provided below. Many of the healthcare staff interviewed felt that they offer the best possible care they can, regardless of other factors. In fact some also stated how they go above and beyond what is expected of them and work extra hours, however, they are happy to do so, as they feel it will have a positive impact on the patients.

CLINICAL

> ***SSQC001:*** *I think that on an individual level I feel that the level of care I provide is the best that I can.*
>
> ***SSQC002:*** *Well I'm doing the best I can do, I really do believe that.*

NON-CLINICAL

> ***SSCQ007:*** *I think actually the quality of care provided by the clinicians and the nursing staff is excellent. So you know when they're with the patients, you'd put their life in their hands, they are really, really good.*
>
> ***SSCQ009:*** *I think by and large we provided a very good service; it was an incredibly busy place.*
>
> ***SSQC011:*** *I think pathology as a whole is very good. It's virtually seamless for most of the work we do.*
>
> ***SSQC016:*** *I go in and I literally don't stop. From the time that I get there, I can honestly say, I push myself. You know I'm missing my tea breaks, I'm going home late, I'm digging deep to get them. But I'm happy with that. I want to do what needs doing.*
>
> ***SSQC019:*** *For myself, I do my job to the best of my ability with the experience of my job, I know what's expected with me and what care I can provide and I do that as well as I can.*

In relation to the level of care provided individually, the idea of goodwill was mentioned by several participants who referred to the fact that many healthcare staff work above and beyond their job role (either in terms of time or responsibilities) for no extra pay and often for very little recognition or appreciation. Some interviewees mentioned that the expectation to go above and beyond their job role came from external pressures, others stated the pressures were internally based and the desire to want to help patients.

> ***SSQC019:*** *We frequently get asked by our management to do things that we're not necessarily supposed to.*
>
> ***SSQC020:*** *It's just expected that you're going to stay to finish off your job and if there's a sick patient you stay and of course we would, we're human beings and we're not going to walk out when someone is unwell.*

This essentially leaves healthcare staff in a paradoxical situation. The participants in the current study stated that they often feel unable to leave patients or colleagues during difficult times and may be tempted to work longer hours in order to complete particular tasks. However, this can then result in staff feeling tired, stressed, and pressured, which as demonstrated through the comments made above, can then potentially have a detrimental

effect on the quality of care they are able to provide. A few participants also hinted that going above and beyond often becomes the norm and embedded in the culture (Lu et al. 2007).

> ***SSQC006:*** *The last thing you're going to do is go and leave that patient on the operating table or refuse to do a patient that has been waiting a year for it, so they use guilt a lot to make people do things which obviously, it gets to a point where you just become angry because you are taken advantage of.*
>
> ***SSQC023:*** *As you know, people say that healthcare depend on goodwill. And it's the same with all public services and people will, and they do, but ultimately, it's not actually good for anyone because those staff actually do get-- it's not sustainable at the point.*
>
> ***SSQC024:*** *I definitely believe within the NHS, and especially within my team, a lot of the things are generated on goodwill, wanting to do a good job and going above and beyond. A lot of people on the team work a lot of extra hours.*
>
> ***SSQC025:*** *There is an expectation that until all tasks are finished you keep going, you go above your required time.*

Whilst discussing the notion of goodwill a few participants referred to the idea that there can actually be an unfortunate disadvantage to staff working above and beyond their job role. For example, if a department has an unfilled vacancy, the remaining staff will often work extra hours to cover that vacancy in order to minimise service disruption and to maintain the care provision. However, this can sometimes mask the need for that vacancy and if the management deem the department as coping without said vacancy, they may decide not to recruit in order to save costs. This can lead to the remaining staff in the long term being severely stretched, dissatisfied and burnout (Gillespie and Melby, 2003, Piko, 2006, Zarea et al. 2009).

> ***SSQC013:*** *But the system, if you cope for long enough, they then do turn around and say, "Well, you've had that vacancy for that long. Do you really need somebody?" That is very wrong because you don't see the level that people are being pushed to in that period of time; whether it's down to goodwill, or just whatever.*
>
> ***SSQC020:*** *It's just; they rely on lots of goodwill off staff. And actually I think if we all left on time and didn't stay to do the extra things and they'd probably find that things would fall apart.*

The current study has termed this issue, the ‘goodwill dilemma’ in that the very caring nature of healthcare staff wanting to help patients by going beyond their job role, can sometimes inadvertently have a long-term detrimental effect on the service and care provision. This finding is a major contribution to the healthcare and sociology literature and is a key theme, which deserves further investigation. To the author’s knowledge, the idea that if goodwill is taken to extremes, it can actually have a negative effect on both the individual and departments performance is something that has not yet been substantially explored.

Relationship between staff satisfaction and quality of care

Throughout the interviews, there was a resounding agreement from all participants that these two factors do relate to each other. Specifically, it was suggested that the relationship is reciprocal. In other words, those staff who are satisfied with their jobs are likely to deliver a much higher quality of care than those people who are tired, stressed, pressurised, and don’t have support from their colleagues or managers. However, as already identified, being able to deliver good quality of care is also in itself an influencing factor of job satisfaction itself. When participants felt they had helped a patient or achieved the level of care they wanted, that then provided a source of job satisfaction. The data below are just a few examples of comments made from the interviewees, which support these links. A full list of comments made can be seen in the technical appendix (Page 296-301).

1. Job satisfaction influenced quality of care:

   SSQC003: *If you’re satisfied you come in with a better frame of mind, if you’re satisfied your service provision is better.*

   SSQC013: *I think the more positive people are, the happier people are; the better they work and the better quality work you get out of them.*

   SSQC022: *I think if you're working in a happy culture where there isn't criticism and blame, then you're going to be more able to function better and be more helpful to patients.*

2. Quality of care influences job satisfaction:

   SSCQ00: *If I care for my patients well then I come home feeling that I did that well, I feel happy, job satisfaction, yes.*

   SSQC004: *I would say that there is a direct link between quality and satisfaction.*

   SSCQ008: *When I feel able to give the care that I want, I feel very satisfied with my job.*

In terms of the first relationship (job satisfaction influencing the level of care provided) which arose throughout the conversations, one aspect mentioned was 'breaking point' and the fact that some healthcare staff are physically and mentally pushed to such an extent within their role that it leads to tiredness, stress, anxiety, and other health-related problems and ultimately can mean staff require sick-leave. This then impacts on the level of care provided as staff are not able to perform at their optimum and / or other staff may have to take on extra tasks whilst the individual is absent.

> ***SSQC001:*** *I see in healthcare time and time again, people burning out and levels of stress it has such a massive impact on your ability.*
>
> ***SSQC008:*** *I will be clear with you the changes that have happened in our trust and to my role over the last two years have led me now to be on long-term sick through stress and anxiety.*
>
> ***SSQC024:*** *I actually ended up getting really ill, ended up being in hospital. I think genuinely, I was completely wiped out.*

However, some participants in the current study viewed 'breaking point' from slightly different perspectives. Some participants mentioned that the job itself, which involves working long hours, results in exhaustion and stress and if sustained can lead to a 'breaking point' in the level of care that they are able to provide, and can even lead to mistakes being made. So despite healthcare staff striving to deliver a high quality of care, it is possible that if they are pushed to extremes, mistakes will occur. The breaking point being referred to in

the examples below was the breaking point in the quality of care being able to be delivered (Lockley et al. 2007).

> ***SSQC008:*** *If you get worn down and worn down eventually something's going to break. People are going to snap, they're going to bite people's heads off, they're not going to be able to answer bells and when they've answered the fifth bell in the last five minutes for somebody who just needs you to turn the light off or something, it can be so frustrating.*
>
> ***SSQC014:*** *So I think, we were so stressed that things can get missed, or not done inappropriately and not necessarily putting people's lives at risk but mistakes can be made. I think if people aren't able to cope then the level of care is quite poor.*

Another aspect of 'breaking point' insinuated by a few participants was the fact that sometimes staff may come to a point where they feel they are unable to deliver an appropriate or safe standard of care and therefore chose to leave the job role itself (Dunn et al. 2005, Zarea et al. 2009). Again, this highlights the sheer complexity and propinquity of many of these concepts.

> ***SSQC012****: One of my colleagues moved more to a strategic role rather than seeing patients. For me, I saw a job elsewhere and thought, "Well, I'll take this opportunity", because I couldn't have done it for much longer and it wasn't about quality, there comes a point when you can't offer the safe work, safe quality and then you stop.*
>
> ***SSQC014:*** *But there are breaking points and I know, well actually I know lots of people who have moved out of a specialty and chosen a different career path because they've found it too stressful and I think there is always that option available to me and I know that so.*

Three participants did suggest that staff satisfaction does not have a significant impact on the quality of care they provide. These participants did not necessarily refute the link between staff satisfaction and quality of care generally, but they stated that they endeavour to put any negative feelings or dissatisfaction aside in order to ensure the patients get a consistent level of care.

SSCQ00: *Because I should be giving the same standard of care regardless of whether I'm feeling good mood, bad mood.*

SSQC019: *I wouldn't say it affects the way I treat the patients themselves when they're there… you deliver the care to the patient as best you can and then try to put everything else to one side.*

SSQC022: *I wouldn't say just because I'm having a bad day, I would take that out on a patient.*

In terms of the second relationship, (quality of care influencing job satisfaction) the previous sections in this chapter have already revealed that participants in the current study gained job satisfaction from being able to help patients, make a difference to people's lives, see improved physical and mental health outcomes and have adequate time to care. Furthermore, this reciprocal link was seen as relevant to both clinical and non-clinical staff.

Although at the individual level all participants were positive about the level of care they provided, when they were asked about the level of care provided by their respective departments and organisations, the opinions were more varied ranging from positive to negative. What was apparent was that all of the participants felt that the reasons for any 'poor care or service' were down to issues that are out of their immediate control such as staffing levels, resources, structure of the organisation, and poor management.

SSQC0: *There's issues regarding resources, you know maybe we haven't quite got enough.*

SSQC001: *So you are imposed I think by the greater structure of the organisation.*

SSQC010: *I'm not very happy with the level of care they get. It's a ward which I don't think it's particularly well managed.*

Improvements

An additional area of findings which arose throughout the interviews was that of improvements, specifically how the participants felt that improvements in their area could be made. One of the more frequently referred to aspects that (n=11) participants stated was necessary to improve both staff satisfaction and quality of care was increasing resources. A few participants mentioned equipment resources as being necessary, but predominately, increasing human resources was regarded as a priority. Here, participants referred to increasing both staff numbers and improving the skills mix.

> ***SSQC019:*** *Our vehicles are currently falling to pieces …we've got 8 vehicles off the road at the moment waiting for repairs.*
>
> ***SSQC023:*** *I mean it's an obvious thing really. Staffing and getting that right staff and the right staff mix and the right numbers of staff really, so that it creates a job that's doable.*

Another aspect, which (n=9) participants mentioned would improve both job satisfaction and quality of care was to feel more supported and appreciated by other colleagues, particularly those in managerial positions. The importance of feeling supported and appreciated by managers has already been referred to in this chapter as contributing to participants job satisfaction, so the importance of this factor should not be taken lightly. Furthermore, the financial cost of managers showing appreciation and thanks to their more junior staff is zero, what it does require is a cultural shift and a change in mind-set for some healthcare leaders.

> ***SSQC010:*** *I think it's always important to feel supported by your immediate seniors and I've been in previous departments where I felt like the people I was working for just didn't appreciate me at all and sometimes it's just simple things like knowing your name. It's quite demoralising when you've worked and they just aren't appreciating all the effort you've put in.*
>
> ***SSQC019:*** *I think I'd be more satisfied if I did get some thanks for when I do go over and above what we're supposed to be doing. For instance, "Oh yesterday you were half an hour late back, cheers for doing that, it really helped us out". That sort of thing. That would have an immediate positive effect on just about everything.*

Communication, which was raised by eight participants, was seen as another potential way to improve both job satisfaction and quality of care and links back to the comments made earlier (under the theme of staff management). Here participants not only referred to the frequency of communication as an issue, but also the manner in which messages are conveyed. An understanding of how some of the themes and subthemes connect is also developing, as arguably, good communication and feedback aids in the feeling of being appreciated and supported by managers.

> ***SSQC0:*** *Communication I would say is the key, yes people seem a bit too busy to communicate with you really.*
>
> ***SSCQ009:*** *Communicate more rather than handing out diktats, communicate, ask people questions, you know a monthly email just for feedback would be nice.*
>
> ***SSQC016:*** *I think communication is the key. I think they need to ask the people who run it more.*

The final key area related to improvements, which some (n=8) of the participants referred to was training. Here, staff referred to issues such as the regularity of training, the quality of training, and the ability to attend training. Again, this has already been referred to in this findings chapter. Under the broad theme of cognitive aspects, being able to attend training sessions was seen as an important factor in providing job satisfaction, particularly, for those in medical roles, such as doctors and junior doctors where the requirement to keep clinical knowledge up to date is essential.

> ***SSCQ003:*** *Training on a reasonably regular basis to keep up with governmental changes, NHS changes, organisational changes within the NHS and department changes, plus your own qualification. So it's hugely important that that's a continual thing, but again because everybody is under pressure that sort of gets pushed to one side quite quickly, which then affects job satisfaction because you don't feel safe and secure in what you are doing.*
>
> ***SSQC010:*** *You were supposed to go to 70% of teaching sessions and I think I probably went to 5% because I could just never ever get away from the job.*

Conclusion

The aim of this chapter was to explain in-depth the relevancy of the key themes, outline the various nuanced conversations, which arose around each theme and to provide evidence (participant quotes) to support these findings. The analysis of the data revealed eleven key themes and fifty-seven subthemes related to both staff satisfaction and quality of care. The eleven key themes, which emerged were: helping patients, teamwork, social network, cognitive aspects, demand / resources, staff management, dimensions of care, level of care provided, the link between staff satisfaction and quality of care, the link between quality of care and staff satisfaction and improvements.

The primary factor that all (n=27) participants mentioned as influencing their job satisfaction was being able to help patients. Many of the participants mentioned the importance of being able to make a difference, either through directly and physically caring for patients or through knowing their work was indirectly helping patients to get better or improving the delivery of the care and service. Teamwork was another key theme and participants in the current study referred to the importance of working within a team, ensuring that the team has shared goals, such as having the patients interest at the core of what they do, and the importance of being able to discuss issues amongst colleagues. Although the theme of social network is closely related to that of ‘teamwork’ from the comments made by participants, the social network within healthcare departments seems to go beyond simply ‘working in a team’ and extends to the shared experiences healthcare professionals encounter. Another crucial theme, which was discussed amongst the majority of participants was the issue of demand and resources, in particular, having sufficient staff both in terms of quantity and in terms of skills mix. This was shown to have an effect on participants’ job satisfaction, as well as the delivery of quality of care.

In terms of the relationship between staff satisfaction and quality of care, there was a resounding agreement from all participants that these two factors do relate to each other. Specifically, it was suggested that the relationship is reciprocal. In other words, those staff who are satisfied with their jobs are likely to deliver a much higher quality of care than those people who are tired, stressed, pressurised and don't have support from their colleagues or managers. However, as already identified, being able to deliver good quality of care is also in itself an influencing factor of job satisfaction itself.

Chapter 9 - Discussion

Introduction

The aim of chapter nine is to explore in-depth the fundamental elements, which arose from the data analysis and findings, as well as connect these to existing research. As revealed in the preceding chapter, a wide range of themes and sub-themes were established from the interviews and subsequently, these need to be jointly understood in order to emphasise the contribution of this thesis. The participants interviewed in this study referred to a relatively large number of broad themes, eleven in total: (1) helping patients (2) teamwork (3) social network (4) cognitive aspects (5) demand / resources (6) staff management (7) dimensions of care (8) level of care provided (9) relationship between staff satisfaction and quality of care (10) relationship between quality of care and staff satisfaction (11) improvements. All of these themes have been discussed in detail in chapter eight. However, there were some specific factors within these broad themes, that came up repeatedly and more frequently than others; and in relation to both job satisfaction and quality of care. The determination of these principle factors was based on both the frequency of occurrence within the data, as well as the depth of discussions, which transpired. As can be seen in Table 15, the top two associated elements which were related to job satisfaction were 1) helping patients and 2) teamwork, the top two associated elements relating to quality of care were 3) staff shortages and 4) time to care. Consequently, these themes / sub-themes will form the basis of this discussion chapter.

Table 15: Overview of the most predominant factors (determined by frequency of occurrence) which emerged in relation to both job satisfaction and quality of care.

Concept	Theme / Sub-theme	Frequency
Job Satisfaction	Helping Patients	27
	Teamwork	12
Quality of Care	Staff Shortage	11
	Time to Care	6

As well as focussing on the main elements which arose from the study's findings, it is also important at this stage, that the data analysis is linked back and considered in relation to the original research objectives.

The research objectives of the study were:

1) To explore factors which influence healthcare professionals' job satisfaction.
2) To investigate whether there are differences in opinions between clinical and non-clinical staff.
3) To investigate the relationship between healthcare professionals' job satisfaction and quality of care.

Chapter nine is subsequently structured as follows. Firstly, in order to address research objective one, the key factors, which were deemed important to healthcare staff satisfaction will be discussed. Secondly, in order to address research objective two, comparisons will be made between clinical and non-clinical staffs perspectives. Thirdly, in order to address research objective three, the interrelationship between staff satisfaction and quality of care will be considered.

Research Objective 1

To explore factors which influence healthcare professionals' job satisfaction.

In chapter three of the thesis, a careful scrutiny and understanding of prior literature was undertaken. From this review it was determined that the key influences towards a person's job satisfaction often include demographics, personality, values, norms and expectations, as well as job specific characteristics, or as termed throughout the current research – job specific antecedents. The latter of these categories of 'influences' formed the focal part of the current study in that the aim was to determine the job specific antecedents to job satisfaction amongst healthcare professionals. The findings revealed that the two most prominent factors which emerged as influencing healthcare professional job satisfaction were 'helping patients' and 'teamwork'. Consequently, these elements are discussed in detail in order to develop and deepen the conceptual understanding.

Helping Patients

In the current study, the main theme that every participant [n=27] mentioned as providing them with job satisfaction was helping patients This was regardless of job role and whether their positions were classed as clinical or non-clinical. In terms of comparing this to established antecedents throughout existing research, this factor is akin to being able to deliver good care (Nolan et al. 1994, McNeese-Smith, 1999, Peltier et al. 2008, Chang et al. 2009). As mentioned in the findings chapter (eight) of this thesis, the difference between the use of the terms 'helping' and 'caring' for patients was purely semantic and perhaps driven by the fact that some of the participants interviewed had non-clinical roles. Further comparable concepts associated with helping patients, which have been found in other studies include, developing a strong relationship with both patients and their families (McNeese-Smith, 1999) providing useful information regarding patients' diagnosis or

treatment, the feeling of meeting the needs of the patients, and a genuine desire to care (Cherry et al. 2007). All of which were also raised by the interviewed participants.

The notion of helping others has been explored previously in other disciplines. Broadly, some evolutionary psychologists have contended that peoples' motivation for helping others is hedonistic (Cialdini et al. 1997, McCamant, 2006). However, the alternative proposal is that humans naturally value the welfare of others, therefore satisfaction can be derived purely from helping someone else. This is referred to as the empathy-altruism hypothesis (Batson et al. 1990, McCamant, 2006). Determining whether the participants interviewed in the current study gained job satisfaction from helping patients through hedonistic or altruistic means is beyond the scope of this study. That said, the diversity in language captured by participants could suggest that the underpinning motivation may not be universally consistent (Haigh, 2010). It is also possible that the drive to help people is not due to one single discreet element, instead, the motivation may fall somewhere on a continuum between altruistic and hedonistic means. Furthermore, it may be that for healthcare staff, this fundamental instinct to help patients, depends on the particular situation and is dynamic in nature. The fact that all participants interviewed in this study mentioned that helping patients provides a source of job satisfaction, could suggest that there are broader (universal) issues influencing staff happiness at work that go beyond specific job characteristics, this important finding will be explored further a bit later in this chapter, in relation to the second research objective.

From the comments made by the participants and the analysis of the data, the current study's findings suggest that healthcare staff may share common values. This notion has also been substantiated by work in occupational psychology, which supports the idea that people enter jobs for a particular reason. Furthermore, it also highlights the importance of person-job (or person-organisation) fit (Kristof, 1996) which is underpinned by need,

motives, and value theories (Giauque et al. 2012). Such theories propose that person-organisational fit can be achieved through “congruence between characteristics of an individual (values, goals, skills) and characteristics of an organisation (goals, values, resources, culture)” (Giauque et al. 2012, pp.177). In other words, work satisfaction arises when a person obtains a job which fulfils specific values deemed important to said individual (Taylor, 2007). An additional and relevant concept, which adds further support to the idea of shared values amongst healthcare staff, is referred to as public service motivation. This states that people who feel attracted to working in public organisations behave in particular ways, in order to support the organisational values and strategies as well as their own personal needs (Giauque et al. 2012). This consequently adds theoretical support to the findings of the current study, that there may be wider shared antecedents to job satisfaction amongst healthcare staff, such as helping patients, as well as job specific elements.

Teamwork

Teamwork arose as another key factor in influencing the interviewed staffs job satisfaction (Opie, 1997, Adams and Bond, 2000, Makary et al. 2006, Bjørk et al. 2007, Cortese 2007, Gardulf et al. 2008, Chang et al. 2009, Kalisch et al. 2009, Kalisch et al. 2010, Al-Dossary et al. 2012, Atefi et al. 2013). The implication of good teamwork, which is achieved through appropriate communication, strong interpersonal relationships, and a cohesive group network, is not only a factor which influences job satisfaction, but it has also been shown to enhance quality of care (Makary et al. 2006, Bjørk et al. 2007, Atefi et al. 2013). A few studies have shown that the team climate, the way people work together and having a collaborative approach, all expedite the level of care that staff are able to be provide (Cambell et al. 2001, Rafferty et al. 2001, Upenieks, 2003, Atefi et al. 2014). In the current study, although teamwork had a strong influence on job satisfaction, participants also alluded to its impact on care too. Staff members referred to the fact that they are able to look

after patients together and if situations were particularly difficult having other people to rely on can improve and enhance your own performance.

The importance of ensuring such teams are ‘effective’ in the work place is also well established (Cox, 2003, DiMeglio et al. 2005, Xyrichis and Ream, 2008, Kalisch et al. 2009, Kalisch et al. 2010, Wyatt and Harrison, 2010, Atefi et al. 2013, Körner et al. 2015). As mentioned in chapter three of this thesis, studies determined explicit characteristics of an ‘effective team’ which included trust, backup, team orientation, and strong leadership (Kalisch et al. 2009, Kalisch et al. 2010). Further factors involve supportive work environments, open communication, group cohesion, and shared decision-making (Cox, 2003, DiMeglio et al. 2005, Xyrichis and Ream, 2008, Wyatt and Harrison, 2010). Whilst participants in the current study were not explicitly asked what they thought makes an effective team, some referred to similar elements above, such as having support and shared decision making.

As with many of the themes which emerged in the current study, there were subtle variances of discussion amongst participants. A particularly interesting comment made by one participant involved the idea of healthcare staff working collectively towards a common goal. This notion of co-worker support and help is not necessarily in itself a novel finding, as previous studies have referred to this (McNeese-Smith, 1999, Wallace and Lemaire, 2007, Zangero and Soeken, 2007). That said, the researcher’s interpretation of some of the participants comments lead to a slightly more innovative proposal, in that the uniqueness of many job roles (such as the ones in healthcare) means that it is often difficult for outsiders to fully appreciate what the roles actually entail, both from a cognitive and affective perspective. Therefore, the shared empathy, understanding, and knowledge of what fellow colleagues encounter on a daily basis may also be an important factor, which helps to

enhance the working relationships between healthcare staff. A similar notion has been proposed in the sociology and human resource literature, where it is recognised that shared cognition is a critical driver of team performance. In particular, shared mental models, team situation awareness, and communication have all been acknowledged as important factors in the way teams perform (Salas et al. 2008). This viewpoint also resonates with one particular comment made by a participant who noted the importance of teams and departments working together in order for them to appreciate what the other has to go through and in his words, ensure they are not 'working in silos'.

Another interesting point, which arose from the data analysis and findings, is the fact that although most participants generally talked positively about working in a team, there were some distinctive comments made amongst the interviewees regarding teams and teamwork. For example, some expressed frustration towards other departments outside of their immediate area and the issues that can arise when the larger service breaks down. Again, this is an area, which has been explored relatively less than some of the other issues raised by the current study. However, some articles have looked at the importance of organisational learning in collaborative work and the requirement for good awareness and understanding of all the key players' roles and responsibilities within the team (Greenhalgh, 2008). In the present study, participants referred to incidents where other departments had been short-staffed or busy and highlighted the inevitable knock-on effect this has to the care and service that they are able to provide. Furthermore, whilst most participants referred to the importance of friendship and camaraderie amongst teams, one particular interviewee stated that a successful team does not necessarily require staff to be 'best friends' at work. It is very likely that these slightly nuanced levels of opinions and variety of responses may arise from differences in personality, values, and experiences. In regards to linking this to a conceptual and theoretical understanding, whilst there are consistencies across the board

regarding some factors which influence job satisfaction, the overall understanding from the current study is that there may be other antecedents to job satisfaction that differ across healthcare workers, possibly due to differing personalities, values, norms and expectations (Staw and Ross, 1985, Huskinson and Haddock, 2006, Judge and Kammeyer-Mueller, 2012, Schlett and Zieglar, 2014).

Research Objective 2

To investigate whether there are differences in opinions between clinical and non-clinical staff.

One of the crucial areas of interest to this study and the second main research objective was to investigate whether clinical and non-clinical staff have similar or differing opinions regarding job satisfaction and quality of care. This is an important issue and one that has been virtually unexplored in the literature. As alluded to throughout this thesis, most existing studies looking at job satisfaction and quality of care in healthcare settings, whether quantitative or qualitative, focus on frontline staff such as nurses and doctors. There are a few studies, which have looked at specific non-clinical roles, for example laboratory staff (Lundh, 1999) and pharmacists (Ferguson et al. 2011) but generally, these non-clinical healthcare members are largely unrepresented within the literature. Furthermore, to the author's knowledge, this is the first attempt to provide a detailed comparison of clinical and non-clinical staffs' opinions on job satisfaction and quality of care. Consequently, a significant contribution of the current study was to not only include non-clinical staff as a somewhat overlooked group, but to also explore whether the factors that influence their job satisfaction are consistent with clinical personnel.

Based on the findings of the data analysis, the factors, which emerged as influencing many of the participants were largely based around helping patients [n=27]; including making a difference to patients [n=14], improving their overall health outcomes [n=10], and saving lives [n=9]. Other factors, which were deemed important across a large majority of the sampled interviewees, were working in teams [n=12], building rapport with patients and colleagues alike [n=9], as well as having adequate time to care for patients (or in the case of non-clinical staff, adequate time to deliver their service line) [n=9]. A comparison of the data obtained from both clinical and non-clinical staff revealed that even staff that do not directly treat or meet patients frequently, mentioned that a crucial factor influencing their job satisfaction was being able to help patients and make a difference. Therefore, from the analysis and interpretation of these findings, it is suggested that despite there being a considerable range of job roles within healthcare, there are some key factors, which influence job satisfaction across the board. In this case, being able to help patients and having enough time to care for patients (or time to deliver the relevant service line).

Intuition and empirical evidence both support the notion that clinical staff gain satisfaction from being able to help patients (McNeese-Smith, 1999, Newman and Maylor, 2002, Begat al. 2005, Dunnet al. 2005, Perry, 2005, Cortese, 2007, Morgan and Lynn, 2009, Utriainen and Kyngäs, 2009, Atefi et al. 2014). However, as already demonstrated above, non-clinical participants in the present study also declared that being able to help patients and make a difference to others were factors that influence their job satisfaction. These staff members referred to aspects such as knowing that they were helping to improve a particular service line and being involved in care pathways or projects, which would ultimately improve the quality of care. So in these circumstances, although the ‘help’ being referred to is often indirect and not immediate, making a difference was a universal, motivating factor which provided all of the healthcare staff interviewed with job satisfaction. More specifically, other

non-clinical participants explained how they are very conscious that their particular service lines are essential in assisting clinicians. For instance, participants who worked in laboratories mentioned that the tests they conduct are used by doctors to make significant treatment and care decisions. Another interesting point raised by some of the laboratory staff interviewed was the fact that they often purposively 'humanise' the samples. In other words, they consciously think of the patient behind each sample and understand that in an indirect way they are helping to make a difference to that person's health outcomes. Existing studies support the link between 'being able to help patients' and nurses' job satisfaction (Newman and Maylor 2002, Moyle et al. 2003, Begat al. 2005, Dunn al. 2005, Murrells et al. 2005, Perry, 2005, Cortese, 2007, Utriainen and Kyngäs, 2009, Atefi, 2014). What is unique about the results of the current study is that this primary job satisfaction factor of helping patients was found to be consistent across all job roles, including both clinical and non-clinical staff. This is a significant finding and contribution of the current study in that there may be 'universal' factors, which influence healthcare professionals, job satisfaction regardless of their specific job roles.

Some of the antecedents to job satisfaction were mentioned by more than just one or two of the participants, but not as many as some of the other factors referred to above. For example, some participants interviewed mentioned that elements of a strong social network are important to their job satisfaction. Examples here included meeting people [n=8], working with colleagues [n=7], and feeling supported by both peers and senior management [n=8]. However, some of the participants interviewed are at times required to work individually and therefore these factors may not be quite so crucial all of the time. In fact, the staff who do regularly work by themselves, referred to the fact that they gain satisfaction from knowing they are solely responsible for the running of a service line [n=4] and the sense of achievement this brings when they do so successfully [n=8]. Some of the other factors

mentioned by a few participants were cognitive elements such as variety [n=6], challenges [n=5], and learning [n=5]. This further highlights the fact that there are likely to be a number of job satisfaction antecedents that are only important to some individuals.

For some of the healthcare staff interviewed, being able to have variety in their roles, face challenges, and learn were important, if not essential elements to their job role and therefore their job satisfaction. However, for other participants, the day-to-day tasks carried out were deemed adequate and the need or desire to learn and develop within their roles is simply not a priority for them. As with the factors above, it seems these differences do not depend on whether the person is classed as clinical or non-clinical, but rather their specific job role. The interpretation of this finding is that although there may be antecedents to job satisfaction that are pertinent to all healthcare staff (termed above as 'universal') there will also be other factors that are more 'individualistic'. Moreover, the factors that are important to such individuals may not depend on whether they have clinical or non-clinical roles, but rather the type of job they have, along with other aspects such as personality, values, norms and expectations. Some of the antecedents to job satisfaction which emerged were only mentioned by one or two of the participants. These included aspects such as the specific day-to-day tasks people engage in, as well as issues that are unique to certain job roles. The participants who were interviewed purposely had ranging job roles and therefore the assortment of codes that could be mentioned here are extensive, however some examples include: sense of pride [n=3], autonomy [n=3], conflicting priorities [n=2], junior doctors contract [n=2] and building a team [n=1].

The interpretation of the above findings and discussion suggests that overall, although the healthcare staff interviewed had differing job roles, with distinct and varying sets of job specific factors, the participants shared sufficient commonalities across many antecedents of job satisfaction. Therefore, in terms of using this to develop a conceptual model of healthcare professionals' job satisfaction, based on the current study's findings, it seems the antecedents to job satisfaction can actually be categorised into three main areas: 1) universal factors, 2) individualistic factors, and 3) job specific factors. The current study proposes that the universal factors affect the majority of healthcare staff regardless of job role. At the next level down healthcare staff may share some similarities in antecedent factors, but are 'individualistic' potentially explained by personality traits, values, norms, and expectations. These factors may not simply differ between clinical and non-clinical domains. Finally, there are job specific factors, which may unique to specific job roles within healthcare.

The process of classifying factors in the way the current study has, resemblances a few existing studies looking at job satisfaction. For example, in a study by Irvine and Evans (1995) they proposed a model of job satisfaction based on economic, structural, and psychological factors. In a study based on nurses in Hong Kong, Siu (2002) developed a model of antecedents to job satisfaction, which included demographic variables, organisational climate variables, and finally psychological distress variables. Finally, a model developed by Cohrs et al. (2006) suggested that job satisfaction amongst university educated professionals is influenced by situational, dispositional, and interactive factors. Figure 3, below provides a visual representation of healthcare professionals' job satisfaction based on the current study's analysis and findings.

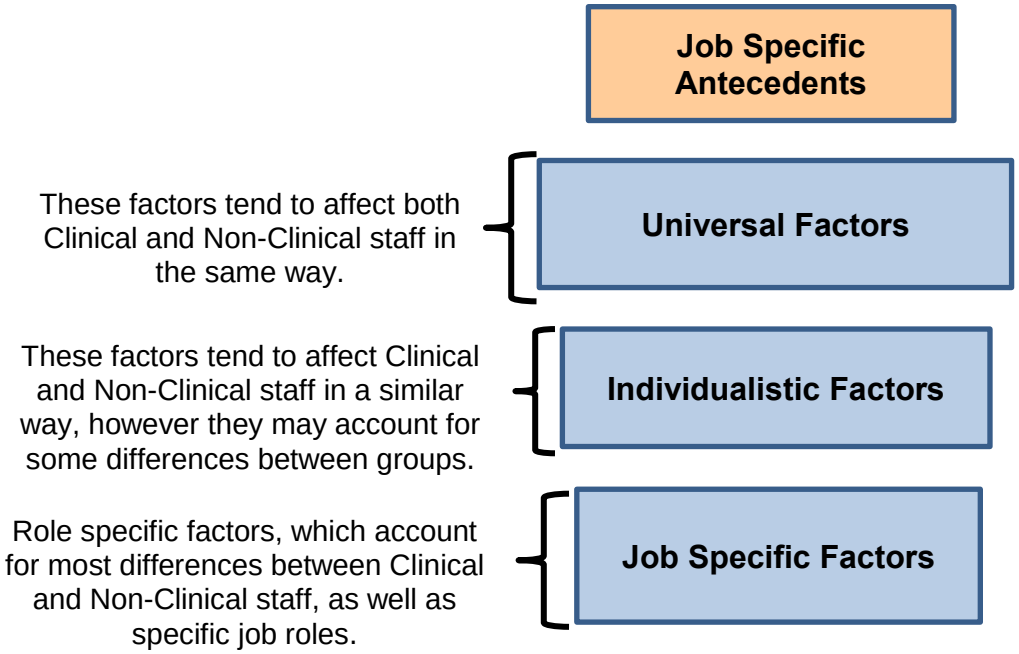

Figure 3 Job satisfaction model for healthcare staff based on the data analysis of the current study, which reflects the systemisation of job satisfaction antecedents.

In terms of the categorisation process of each of factors into the three groups (universal, individualistic and job specific) the frequency of occurrence is unique to the sampled participants. The grouping of factors from a different sample of healthcare staff could result in slightly different outcome as the sample size is not large enough to make such generalisations. However, the important contribution to job satisfaction theory here is firstly, the understanding that there are some key factors that seem to influence healthcare staff across a range of roles, and secondly, that within specific industries, there will be factors that influence staff satisfaction, which are shared across many differing job roles and others that are unique to individual job roles.

Table 16, reveals how some of the original codes related to staff satisfaction can potentially be organised based on the suggested three tier system (not all have been presented here, a full list can be seen in the technical appendix (Page 262-263). The categorisation of each factor has been based on frequency of occurrence within the data set, so those factors mentioned by many participants (nine participants or more) are seen as universal factors, those mentioned by a few participants (five participants or more) are seen as individualistic and those factors only referred to once or twice have been categorised as job specific characteristics. Therefore, it needs to be said that these categories are somewhat arbitrary in terms of the frequency of occurrence and their classification. They have been categorised based on the authors interpretation in order to demonstrate this classification process. Further research needs to be carried out in order to a) verify whether similar factors appear amongst a similar (or larger) healthcare group and b) whether their frequency of occurrence is the same as the sampled group here. Due to the diversity of the job roles included in this study, similar findings are likely, however the important interpretation from the current research and the contributing element to the literature, is that whilst some factors influencing job satisfaction are likely to be universal across all healthcare job roles, there will be unique factors that are specific to individual roles.

Table 16: Sub-themes, which were retrieved from the data analysis correspond to the three tier categorisation of antecedents to healthcare staff job satisfaction.

Categorisation of Antecedents to Job Satisfaction	**Examples of codes which could come under each category**	**Frequency of occurrence within the data set**
Universal Factors	Helping patients	27
	Making a difference	14
	Teamwork	12
	Positive health outcomes	10
	Saving / improving lives	9
	Building rapport / relationships	9
	Time to care	9
Individualistic Factors	Meeting people	8
	Feeling accomplished	8
	Colleagues	7
	Feeling supported	6
	Variety	6
	Challenge	5
	Learning	5
	Responsibility	4
Job Specific Factors	Sense of pride	3
	Autonomy	3
	Conflicting priorities	2
	Junior doctors contract	2
	Building a team	1

Interestingly, although there are clear similarities between clinical and non-clinical staffs' primary source of job satisfaction, the one striking difference which emerged, links back to the proposed concept of 'the impact / immediacy effect of delivered care' mentioned earlier in Chapter 8. It could be suggested from the data that clinical staff seemed to gain satisfaction when the improvement to the patient was both of high impact and happened immediately. However, for non-clinical staff due to the (sometimes) physical distance from the patients, the improvement outcome might be of lower impact (less obvious) and over a longer period of time (immediacy), but it would still provide these members of staff with job satisfaction.

Figure 4 provides a visual representation of this proposal, which has been termed the 'impact / immediacy matrix of delivered care'. The horizontal axis represents the level of explicit impact that the quality of care or service provides. Therefore, for those staff directly treating patients, particularly in acute areas, the impact of the care / service will be much more obvious than that of a member of staff working in a laboratory setting. The vertical axis represents the immediacy of the quality of care or service provided. The current study proposes that situations where the outcomes of the care or service delivered is more immediate will have a greater impact on staffs' job satisfaction than those occasions where gradual changes to a patient may occur over time. In terms of linking this to clinical (C) and non-clinical (NC) staff, the points where 'optimum' job satisfaction occurs may differ due to the differing nature of the job roles and proximity to the patients being treated.

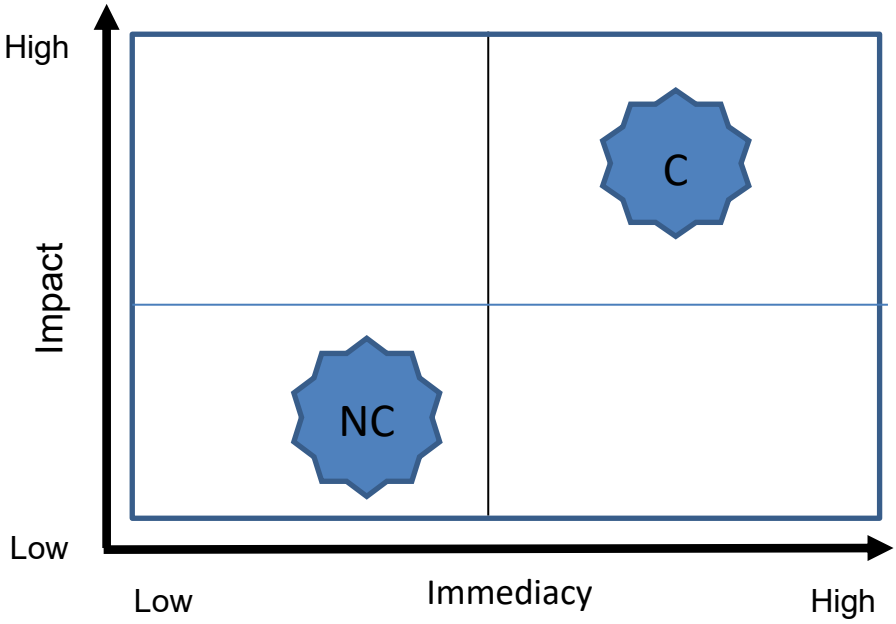

Figure 4: Demonstration as to how a) job satisfaction can arise from knowing the care (or service) provided is having an immediate and significant impact on the patient (customer) and b) a visual representation of the potential differing points within the matrix where clinical (C) and non-clinical (NC) staff reach job satisfaction.

Due to the qualitative nature of this study, the relatively small sample size, and the complex nature and range of job roles included, it would be erroneous to group all clinical and non-clinical staff into such categories. As referred to in Chapter 6 (methods) the purpose of this study is not to generalise across populations but to provide theoretical inferences. Applying this to the current study's findings, some non-clinical roles do involve some interaction with patients, and a few of these participants mentioned the satisfaction they gain from knowing they had directly spoken to and helped a patient with a problem. Notwithstanding, the proposed theoretical model above is based on the noteworthy and novel findings of this study that the 'impact and immediacy' of care provided is likely to influence the job satisfaction of healthcare professionals, which prompts further investigation. Additionally, the proposed model could potentially be applied to a whole range of service sectors such as education, hospitality, as well as the entertainment industry.

Research Objective 3

To investigate the relationship between healthcare professionals' job satisfaction and quality of care.

Another essential contributing element of the current PhD thesis to existing literature was to understand how the concepts of staff satisfaction and quality of care are linked. As referred to in chapter five, although the relationship between employee satisfaction and performance is well established in many industries (Harter et al. 2002, Mohr et al. 2010, Schneider et al. 2003), the link between healthcare job satisfaction and quality of care has been relatively overlooked. Consequently, participants were asked to provide thoughts on the relationship between their own job satisfaction and the quality of care they are able to provide.

As already referred to in the findings chapter of this thesis (chapter eight) there were two potential directional relationships between the main concepts under study, 1) job satisfaction influences quality of care and 2) quality of care influence job satisfaction. The data analysis revealed support for both of these links. Overall, there was a consensus amongst participants' that job satisfaction does impact on the quality of care or service a person is able to provide. So those staff who are more satisfied with the job role itself and the day to day aspects, will be able to provide more for the patients and essentially perform their job role better. If people are dissatisfied, or unhappy, or stressed in their work, this will hamper their ability to provide the necessary care or service.

In terms of quality of care influencing job satisfaction, again the relationship appeared to be confirmed by the participants. So being able to deliver good quality of care (or service) provides healthcare professionals with job satisfaction (Nolan et al. 1994, Peltier et al. 2008, Chang et al. 2009). As already mentioned, the primary factors that all participants' mentioned as providing them with job satisfaction is being able to help patients, so this also

adds further support to this theoretical relationship. Reversely, a lack of pride in the quality of service and perceived inability to provide a service at appropriate levels have been shown as reasons for dissatisfaction (Adams and Bond, 2000). Numerous studies have reported a correlation between being able to provide patient care and job satisfaction (Moyle et al. 2003, Begat et al. 2005, Murrells et al. 2005). In such studies nurses have reported that seeing patients get better and making a difference to patients contributed to their job satisfaction (Newman and Maylor, 2002, Begat al. 2005, Dunn et al. 2005, Perry 2005, Cortese, 2007, Utriainen and Kyngäs, 2009, Atefi, 2014).

Whilst the links between staff satisfaction and quality of care (in both directions) appear to be well substantiated by the participants who were interviewed, the aim was to also gain an understanding of the interrelationships between themes. As mentioned earlier on in this thesis chapter, the dominant factors relating to job satisfaction were 1) helping patients and 2) teamwork. The dominant factors relating to quality of care were 3) time to care and 4) staff shortages, however these latter factors were also mentioned frequently in relation to job satisfaction too. Consequently, the next section of this discussion chapter will examine how these two factors impacted on both healthcare professionals job satisfaction and the quality of care they are able to provide.

Table 17: Overview of the two factors (determined by frequency of occurrence) which emerged in relation to both job satisfaction and quality of care

Concept	Theme / Sub-theme	Frequency
Job Satisfaction	Staff Shortage	8
	Time to Care	9
Quality of Care	Staff Shortage	11
	Time to Care	6

Time to Care

A crucial element that many of the participants referred to was the time they had available to care. The two main factors, which influenced this, were staffing levels and patient demand. In departments where there are staff shortages and an inadequate skills mix, the time staff have available to care for patients diminishes, having a negative impact on both staff satisfaction and quality of care (Attree, 2001). Just as staffing levels is not simply a matter of having adequate numbers of staff, the volume of patients is not the only factor in terms of demand; the complexity of said demand also needs considering. Several participants in the current study mentioned that more and more patients are presenting with multifaceted needs, for instance, one participant, a midwife, alluded to the fact that the women she has seen throughout her career have become gradually unhealthier. This in turn means the patients require a more comprehensive, holistic approach to their care and treatment. Whilst demand in terms of increasing numbers is one thing, the complexity of patients' needs intensifies the demand in much more convoluted way. It means the care has to be more interdisciplinary and potentially engage staff from a variety of departments and specialists.

Overall, there was a resolute feeling amongst participants that the time available to see and treat patients is not always acceptable. In turn, this can cause unnecessary stress, pressure, and reduce both staff satisfaction and the quality of care they are able to provide. The lack of time spent with patients was seen to be a consequence of staff shortages, paperwork, and increasing demand, and in some circumstances significantly hindered the staff and their general caregiving abilities and decision-making (Aiken et al. 2012). These concerns were raised not only amongst frontline staff who worked in areas such as Accident and Emergency, acute medicine, and on hospital wards, but also in other areas such as laboratories and mental health. The data therefore seems to support the proposal that

healthcare departments desperately need more staff to allow greater time to deal with the complex nature of patients, otherwise the quality of care inevitably suffers (Duffield et al. 2011). That said, whilst the links between staffing levels and quality of care have been empirically supported, the solution is not entirely straightforward. An extensive systematic review of the literature looking at nursing levels and patient outcomes hinted that skills mix is potentially more of an important issue then staffing numbers alone, however further research is required to better substantiate this notion (Griffiths et al. 2016).

Demand and resources emerged as another key theme within the current study. This links to the issue of staff turnover, which is discussed extensively throughout the literature reviewed in chapter three (Aiken et al. 2001, Dunn et al. 2005, Hayes et al. 2010, Wilson et al. 2008, Zarea et al. 2009). In the current study, whilst participants did not always mention 'turnover' specifically, they did refer to issues around staff shortages and how this can impact on job satisfaction. This finding replicates previous work, where nurse staffing (low levels) has been shown to have adverse effects on nurses job satisfaction (Aiken et al. 2012, Aiken et al. 2013).

Statistics from a variety of sources also support the concerns of the interviewees, particularly regarding increasing numbers of patients. For example total hospital admissions increased by 28% between 2006 and 2016 (Friebel, 2018) and whilst numbers of doctors and nurses have increased slightly, employment rates in other roles, such as healthcare scientists and mental health nurses have declined (NHS Confederation, 2017). It should also be noted that the percentage increase in doctors and nurses is small in comparison to the increase in patient demand (NHS Confederation, 2017). Further statistics can be seen in Table 18.

Table 18: Statistics regarding NHS activity and NHS staff.

Statistic	Source
The total number of outpatient attendances in 2015/16 was 89.436m, an increase of 4.4% on the previous year (85.632m).	NHS Digital (2017)
There were 10,934 additional HCHS doctors (FTE) employed in the NHS in March 2017. In the past year the number has increased by 2.29%.	NHS Confederation (2017)
There were 3,910 more NHS nurses and health visitors (FTE) across HCHS in March 2017. In the past year the number has increased by 0.18%	NHS Confederation (2017)

Another issue relating to demand, resources, and staffing levels is that of workload and stress. Many of the studies reviewed earlier have found that workload has a significant impact on job stress and therefore nurses' job satisfaction (Price and Mueller, 1986b, McNeese-Smith, 1999, Bratt et al. 2000, Seo et al. 2004, Dunn et al. 2005, Cortese, 2007, Tabak and Orit, 2007, Zangaro and Soeken, 2007, Li and Lambert, 2008, Wilson, 2008). An increase in workload and more specifically, a high patient to nurse ratio, again impacts job satisfaction (Hayes et al. 2010). This finding also emerged throughout the current study.

Staff Shortage

A final key theme associated with both job satisfaction and quality of care, which emerged from the data was that of staff shortage. In terms of the current study's findings, the first important element within this overarching theme was staffing levels. From the comments made by the interviewees, it can be suggested that issues relating to staffing levels are not simply a matter of numbers. Whilst the ratio between staff and patients is important, the skills mix of a particular team appears to be equally significant according to the participants'

remarks. Empirically, these links have been shown in other studies and specific scales have been developed to capture such relationships, for example, the Ward Organisational Features Scales was used in a study of NHS nurses and a significant association between sufficient staff and job satisfaction was reported (Adams and Bond, 2000). These findings were reinforced further in another study, some fourteen years on, which showed that perceptions of adequate staffing, number of patients cared for, and skill mix were associated with greater job satisfaction (Kalisch and Lee, 2014). This relationship has also revealed itself in healthcare staff outside of the traditional hospital environment. For example, a study looking at nurses in care homes showed that inadequate staffing levels was felt to be a major contribution to staff dissatisfaction (Cherry et al. 2007).

Anecdotally, it can often be heard that healthcare departments have a disproportionate amount of senior staff to lower grade staff. Although several participants did substantiate this notion, others also highlighted the danger of having too many junior staff and not enough senior staff. In these scenarios, the service delivery and level of care provided can be jeopardised, as the junior staff simply do not have the skills, experience, or expertise to deal with the more complex cases. This potential reduction in quality of care not only puts patients at risk, but it also has a detrimental influence on healthcare staffs' job satisfaction. It has been suggested that public employees, who view their job roles as a way to help the less fortunate, or as a personal duty to help others (self-sacrifice) will encounter more frustration when confronted with organisational constraints, such as inadequate staffing levels, that don't allow them to fulfil their personal aspirations (Giauque et al. 2012). Analysis of data from another qualitative study looking at job satisfaction, revealed comments associated with low staffing numbers and included phrases such as 'fear of making a mistake' 'being overloaded' 'chaos' and 'dangerous' (Wilson et al. 2008). Similarly, staff shortages and in particular, nurse to patient ratios, have been associated with higher patient mortality rate

(Cho et al. 2014). The link between staff shortages and quality of care was also mentioned by some of the participants.

From the above discussion, a picture is emerging as to how all of the factors and themes interlink. For instance, the current study has already established (and discussed at the beginning of this chapter) that healthcare staff gain satisfaction from helping patients, therefore, it can be concluded that if the ability to care for patients is hampered by other factors such as inadequate staffing levels and high patient demand, these will further diminish staff satisfaction. From the data analysis it can be concluded that the primary factors which influence healthcare professionals' job satisfaction are 'helping patients' and 'teamwork'. The primary factors which influence healthcare professionals job satisfaction and the quality of care they can provide are 'staff shortages' and 'time to care'. All of the key factors, 1) helping patients and 2) teamwork, 3) staff shortages, and 4) time to care have been discussed at length in this chapter as to how they influence both staff satisfaction and quality of care.

Conclusion

The three objectives of the current study were 1) to explore factors, which influence healthcare staffs' job satisfaction, 2) to investigate whether there are differing perspectives between clinical and non-clinical staff, and 3) to investigate if there is a link between staff satisfaction and quality of care. In relation to objective one, due to the range and scope of the job roles of interviewed participants, the resulting factors which participants said influenced their job satisfaction, were vast. However, despite job roles encompassing both clinical and non-clinical aspects of healthcare, distinct themes and trends did emerge and consistent factors were found across many of the participants. These included helping

patients, teamwork, social network, cognitive aspects, demand / resources and staff management.

In regards to the second research objective, one of the important findings of this study and a contributing element to the field is that the many factors, which influence healthcare staffs' job satisfaction can be categorised based on the scope of their relevancy. Some broad factors will influence all staff regardless of where they work, whilst others are specific to the individual and their job role. Furthermore, in regards to clinical and non-clinical staffs perspectives of job satisfaction and quality of care, the current study found that there are distinct factors which influence both groups, particularly, being able to help patients. From analysing the comments made by participants, it can be suggested that the main difference between clinical and non-clinical staff groups is the level of impact and the immediacy of the outcomes of the care or service provided. This phenomenon has been termed the 'impact / immediacy effect of delivered care'. For those who are in clinical roles, job satisfaction may occur when the impact of the care provided is high and can be seen immediately. In comparison, for non-clinical staff, the impact and immediacy of the care or service they provide may be less obvious (lower) but it still provides the individual with a sense of job satisfaction.

The third and final research objective for this study was to investigate if there is a link between staff satisfaction and quality of care. The findings suggest that the relationship between staff satisfaction and quality of care is reciprocal, in that staff who are satisfied in their roles are more likely to provide a higher level of quality of care, however delivering good quality of care to patients can also be a source of job satisfaction in itself. Furthermore, the factors which appeared to influence both staff satisfaction and quality of care were staff shortages and time to care.

Chapter 10: Study Contribution, Recommendations, and Limitations

Introduction

There are four principle intentions for this chapter, 1) to outline the theoretical contribution of the study, 2) to outline the impact and implication to practice, 3) to outline the limitations of the current study and 4) to make recommendations for future research. Overall, the study has enhanced conceptual understanding of job satisfaction and quality of care as individual concepts, but also as to how they influence one another - all within the context of the healthcare sector. The contribution to practice has come directly from the interviewed participants. An underlying, but unwritten objective of this thesis was to provide the healthcare staff interviewed with an opportunity to voice their opinions away from any potential restrictions imposed upon by their respective organisations. Due to time demands, this reflective opportunity is often missing from individuals' job roles. Furthermore, outlining proposals, which have arisen directly from staff working in healthcare environments, is far more valuable than any external interpretation of interviewees' comments. As with any piece of research, the study has some limitations, so these will be highlighted. Finally, the very nature of a PhD study will mean that the findings can often generate further questions and areas to investigate, so the last section of this chapter will outline these.

Theoretical Contribution

In terms of the first concept explored 'job satisfaction', the research objective was - *to explore factors, which influence healthcare professionals' job satisfaction.* The study has contributed to the job satisfaction literature in a number of ways. Firstly, it has identified several factors, which appear to influence a wide range of healthcare professionals' job

satisfaction, in particular these include, helping patients, teamwork, social network, cognitive aspects, demand and resources, and staff management. Many of these factors have arisen amongst existing findings and therefore add to this body of literature. Furthermore, the fact that some of the dimensions mentioned by participants are the same across historically older studies within healthcare, suggests that despite prolific academic work in this area, the suggestions for improvements and developments are not being successfully implemented into practice.

The second main theoretical contribution of the study in relation to job satisfaction is the recognition that the factors that influence job satisfaction can be systemised based on their scope of relevancy to staff members. Whilst this is not an entirely novel suggestion amongst the job satisfaction literature (Irvine and Evans, 1995, Siu, 2002, Cohrs et al. 2006), its specific application to healthcare staff does have a unique contribution. In terms of the factors identified by the participants, it appears that the antecedents to job satisfaction can actually be categorised into three main areas: 1) universal factors, 2) individualistic factors, and 3) job specific factors. Universal factors are likely to affect the majority of healthcare staff regardless of job role and across different organisations. Individualistic factors may affect some healthcare staff and potentially be explained by personality traits, values, norms, and expectations. These factors don't appear to be due to differences between clinical and non-clinical domains. Finally, there are job specific factors, which may be unique to the specific job roles within healthcare.

Another key objective of the research was - *to investigate whether there are differences in opinions between clinical and non-clinical staff.* Specifically, the idea was to explore whether the factors that influence healthcare staff satisfaction and the quality of care they are able to provide were the same across various clinical and non-clinical roles. This

exploration of voices across such diverse healthcare roles was another major contribution to the literature. Therefore, the findings are also substantial in their influence. The overwhelming consensus across all staff regardless of department or role type was that the primary factor influencing their job satisfaction was being able to help patients. The only difference between clinical and non-clinical staff in this area was a consequence of the nature of their job roles, specifically the fact that many non-clinical staff do not directly interact with patients regularly. The current study suggested that in situations where the outcomes of the care or service delivered is immediate, the impact this has on staffs' job satisfaction is greater than those occasions where gradual changes to a patient may occur over time. This is likely to explain the slight differences between clinical and non-clinical staffs' job satisfaction in relation to 'helping patients' as the point where the 'optimum' job satisfaction occurs may differ slightly, due to the nature of the job roles and proximity to the patients being treated. This finding was termed the 'immediacy / impact model' and is a major theoretical contribution to the literature, which may not only have relevance to healthcare settings, but other service industries too.

The final research objective for this study was **-** *to investigate the relationship between healthcare professionals' job satisfaction and quality of care.* The exploration of this relationship itself is a major contributory facet of the thesis. As already mentioned throughout previous chapters, analogous relationships between job satisfaction and performance as well as job satisfaction and service quality have been established in many industries, however, the holistic link between healthcare job satisfaction and quality of care has been largely overlooked. The data analysis and findings from the interviews suggest that these two factors do relate to each other. Specifically, it was reasoned that the relationship between staff satisfaction and quality of care is reciprocal. Staff who are satisfied and motivated are likely to deliver a much higher quality of care than those who

are tired, stressed, pressurised, and do not have support from their colleagues or managers. However, as already identified, being able to deliver good quality of care is also a crucial influencing factor of healthcare professionals' job satisfaction too. The final theoretical contribution worth highlighting is that whilst the relationship between job satisfaction and quality of care is reciprocal, there were two key factors which influenced both job satisfaction and quality of care amongst the interviewed participants, these were staff shortages and time to care. These issues were found to be important across both clinical and non-clinical staff roles, so the suggestion is that these areas should be of urgent focus for both future research and practice.

Impact and Implication for Practice

Having identified a number of key theoretical findings from the study, it is also essential to ascertain how these findings might impact practice. The first key finding is the factors which were identified as influencing healthcare professionals job satisfaction. As already stated these were helping patients, teamwork, social network, cognitive aspects, demand and resources, and staff management. One of the main issues here is that these factors are not dissimilar to existing research, in fact 'helping patients' emerges as a critical factor in much of the research. Consequently, managers must make changes to ensure that healthcare professionals get the time they need to treat and help patients adequately. This in turn will not only improve the job satisfaction levels of staff but also increase patient satisfaction.

The second key finding was that the factors which influence job satisfaction can be categorised into tiers namely universal factors, individualistic factors, and job specific factors. Furthermore, these factors may be considered more important to some staff than others, depending on personal factors as well as the specific job role they are in. Whilst

there are clearly some factors which do influence the majority of healthcare staff (helping patients) there are nuanced differences as to how these factors affect individuals job satisfaction. Due to the sheer diversity of job roles in healthcare there will be job specific factors, which may only relate to that particular role. This is significant, as existing measures of job satisfaction used in the healthcare sector often do not pick up these variations. It is therefore imperative that departments work towards developing customised job satisfaction measures and / or engage in more qualitative research, so a deeper understanding of the issues can be fully understood.

A third key finding is that as mentioned above, even despite the fact that some factors are universal across a number of healthcare roles, the way they impact the staff might be different depending on whether they are clinical or non-clinical as well as the specific job role they hold. The finding that there may be slight differences between clinical and non-clinical staff in the way being able to help patients impacts on their job satisfaction can be seen as a direct outcome of their job roles, specifically the fact that many non-clinical staff members do not regularly interact with patients. Therefore, the immediacy and impact of 'help' towards patients is both slower and less obvious. As this is such a key influencing factor, it might be worth managers examining opportunities for non-clinical staff to either interact with patients more in order to receive more rewarding outcomes and / or to ensure that patient comments are fed back to staff, particularly if this is positive. For staff who indirectly help patients but do not directly care for them, this information could significantly boost their job satisfaction and in turn the quality of care they provide, having a positive effect on this reciprocal relationship.

Finally, the finding that job satisfaction may influence the quality of care provided is of uttermost importance to practitioners. Ensuring staff are content and satisfied within their roles is likely to improve retention rates, as well as improve the standard of care that patients receive. There is no ‘quick fix’ for this and arguably some of the solutions (for example, more resources) require significant cash injections. That said, some of the issues around job satisfaction and quality of care stem from intangible aspects, such as organisational culture, the level and quality of communication, and a feeling of being valued within the workplace. Some of these areas could be improved with minimal financial implications.

Improvements to Healthcare Services

An important contribution, which the current research facilitated, was to allow healthcare staff a chance to reflect, have their say, and state their opinions in a completely confidential setting, something that does not always occur in healthcare environments. Consequently, participants were asked how they thought staff satisfaction and quality of care could be improved in their own departments and organisations. Twenty factors were identified in total and detailed comments surrounding these areas can be found in the technical appendix (Pages 302-303). However, the most frequent factors identified throughout the participants conversations were, 1) more resources, 2) feeling supported and appreciated, 3) communication and 4) training, will now be briefly summarised here in relation to practitioner recommendations.

Out of the four most frequently mentioned ways to make improvements, two were financially based and two were not. In order to achieve an increase in resources and training, the system requires more finance and / or better cash management. However, two other issues that are also extremely important to healthcare staff across the board are

not dependent on finance. The study provided evidence that if managers were to improve both communication methods and a demonstration of appreciation towards their employees (both of which are gratis) staff would have more satisfaction in their job roles. Consequently, these latter two are potentially easy and quick improvements that departmental leaders and mangers could make, that will not only improve healthcare staffs satisfaction, but also the level of care provided to patients.

More Resources

In terms of the contribution to practice, whilst funding limitations may restrict the recruitment of additional staff, it is evident that staff shortages across many healthcare domains, needs to be addressed. To some extent, the solutions lie at Governmental level, but perhaps as many participants suggested, there are potential ways improvements can be made at a departmental level too. Firstly, a better approach to understanding the current skills mix within a team is necessary, in order to ensure the ratio of junior and senior staff is adequate enough to deliver safe services. Secondly, in order to ensure job vacancies and absenteeism are not masked by staff working significantly over their allocated time and responsibilities, it might be necessary to encourage staff to adhere to their contracted hours. This recommendation will inevitably be much harder to implement. Many healthcare departments have a culture, which encourages or even expects staff to go above and beyond their job role. Furthermore, due to the caring nature of such disciplines, some staff may find it difficult to stick rigidly to their contracted hours, knowing it could have a negative impact on patients or colleagues.

Feeling Supported

Some of the comments made by interviewees revealed that even small gestures such as knowing staff members names, or occasionally saying ‘thank you’ were not always present in departments, yet if changed, would markedly improve job satisfaction and therefore the quality of care provided. A potential solution to healthcare staff feeling unsupported and appreciated is for senior management to show gratitude towards their staff. This straightforward solution does not have any financial implications, yet it could have a noteworthy effect on (arguably) the most valuable resource healthcare departments and organisations have - their workforce.

Communication

In terms of offering contributory recommendations to practice as to how communication can be improved within departments, it is near impossible to make specific suggestions due to the individualised requirements of each department or organisation. That said, some general recommendations based on the participants’ comments can be offered. Not only is it important to ensure that the communication occurs on a regular basis, but also through appropriate channels for the staff members involved. A few participants stated that their managers had unprofessional communication methods and that the non-verbal exchanges were just as important as the verbal dissemination of information. Another recommendation made by the interviewees was to ensure that there are opportunities for information to be elevated up the managerial hierarchy, as well as down. Practical proposals made here included suggestion boxes and brain storming meetings. Again, the importance of seeing suggestions actually being taken on board was also highlighted, otherwise these practices becomes futile.

Training

Training was raised as a key method in improving both healthcare job satisfaction and quality of care. There were two issues here, firstly, the availability of training and secondly, the time staff had available to attend such training. It was worrying to hear that even for roles where training is essential to both the worker and the safety of patients (such as junior doctors) that sometimes, due to poor resourcing, they do not have adequate time to attend. As already established, the fact that so many of the staff interviewed referred to their departments as having severe staff shortages, means the translation of the solution from theory to practice is extremely difficult, complex, as well as being politically charged. In order for staff to attend necessary training sessions, there needs to be more investment in human resources.

Study Limitations

The first study limitation to mention regards the literature. The researcher worked diligently to ensure as much of the literature as possible was included, however it is inevitable that some work will have been missed. The aim of the study was to include robust and peer-reviewed research only in order to add validity and credibility of the findings and conclusions.

As with all qualitative research, one of the study's limitations is the sample size. Whilst data saturation was achieved at around 20 interviews and data collection continued to 27 interviews, in order to verify previous participants accounts of the concepts, there will always be a limitation as to how the findings will generalise to other settings. Considering the diversity of roles throughout the interviewed participants, the research is extremely promising, but replicated studies are necessary to further validate the findings and links.

The thesis had ambitious and quite broad research aims. That said, the very ethos of the thesis was to initially take an exploratory and holistic approach, so in order to address this potential limitation, further research would need to be carried out. The research objectives could potentially be broken down into a more focussed approach, however the suggestion would be that this should happen after a direct replication of the current study first. The findings and contribution have significant potential, however there is a need to further explore the links addressed here.

Recommendations for further research and future publications

One of the key contributory findings of this study was that the factors which emerged in relation to job satisfaction can be systemised and in the current study, these categories have been termed 1) universal factors, 2) individualistic factors, and 3) job specific factors. Although some factors affected all participants, others only affected a small number. Ideally, the study needs to be repeated utilising differing sets of participants to see if this categorisation of factors emerges again.

Further research needs to be carried out and comparisons made between clinical and non-clinical staff. Whilst the study did start to explore this under researched aspect, as above, it needs to be further explored. In relation to the differences between clinical and non-clinical staff, the tentative theoretical proposal of the immediacy / impact model also needs to be further tested. Initially, this needs to be carried out amongst other healthcare professionals, but it could also be subsequently extended into other fields too, such as education. A finding, which was of particular interest to the researcher involved the notion of role identity and ambiguity. The difficulty of balancing clinical and non-clinical roles for managers, can often be a significant challenge. It might also be useful to determine the

level of support for staff having to transition between the types of role, as anecdotally, it appears this is another area for potential improvement.

Further research to enhance the understanding of quality of care itself, as well as how to measure it would also be beneficial. Whilst many of the existing quality of care models are reasonably well established in the literature and are arguably useful in providing healthcare departments focussed areas to establish consistent performance measures and KPIs of care, the variation of facets that came from the participants in the current study suggests that this is potentially an area that needs to be explored much more thoroughly (Stelfox and Straus, 2013). For example, one participant (SSQC004) mentioned that a particular organisation could be compliant with the CQC (Care Quality Commission) criteria, but this doesn't necessarily mean that good quality of care occurs in that department, every hour of, every day. The issue here is that current measurements provide a snapshot view and do not necessarily take into account wider influences, or the fact that quality of care may be too convoluted to be captured by measurements currently in existence (Campbell et al. 2002).

Finally, the current study has begun to explore the under-researched relationship between healthcare staff satisfaction and quality of care, therefore this needs to be duplicated on a larger scale. As the understanding of this relationship develops, it may also be beneficial to eventually produce quantitative measures to ascertain if this has generalisability across a wider number of healthcare staff. However, as already alluded to throughout this project, the subjective psychological phenomenon under investigation may make quantitative measures difficult.

In terms of future publications which may arise from this thesis. Two potential papers have already been drafted. Firstly, a paper entitled ‘An exploration of job satisfaction across healthcare professional roles: the impact and immediacy of care’. This focusses on the findings from research objective one and two. Secondly, a paper entitled, ‘The impact of job satisfaction on quality of care: exploring perceptions from clinical and non-clinical healthcare professionals in the UK’. This paper concentrates on the findings, which emerged under research objectives two and three.

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Technical Appendix – Results of Data Analysis

1. Positive factors that influence job satisfaction

During the interviews, participants were asked what they enjoy most about their job role, as well as which factors influence their job satisfaction. Eighteen factors were deemed as having a positive influence on participants job satisfaction and these have been listed based on the frequency of occurrence, in other words, how many participants mentioned that particular factor during the interview. There were fourteen factors that more than one participant referred to and an additional four factors that only one participant referred to. Quotes from the data analysis have been used to endorse each factor and are presented below.

Job Satisfaction Factor	No of Participants	Participant ID Numbers
Helping patients	27	SSQC0, SSCQ00, SSQC001, SSQC002, SSQC003, SSQC004, SSQC005, SSQC006, SSQC007, SSQC008, SSQC009, SSQC010, SSQC011, SSQC012, SSQC013, SSQC014, SSQC015, SSQC016, SSQC017, SSQC018, SSQC019, SSQC020, SSQC021, SSQC022, SSQC023, SSQC024, SSQC025
Teamwork	12	SSQC0, SSCQ00, SSQC003, SSQC005, SSQC007, SSQC009, SSQC010, SSQC012, SSQC015, SSQC020, SSQC023, SSQC024
Meeting people	8	SSQC001, SSQC002, SSQC003, SSQC005, SSQC008, SSQC019, SSQC022, SSQC024
Feeling accomplished	8	SSQC001, SSQC010, SSQC012, SSQC018, SSQC019, SSQC023, SSQC024, SSQC025
Colleagues	7	SSQC002, SSQC005, SSQC006, SSQC007, SSQC008, SSQC010, SSQC014
Feeling supported	6	SSQC0, SSQC002, SSQC003, SSQC004, SSQC010, SSQC012

Variety	6	SSQC0, SSQC001, SSQC006, SSQC013, SSQC015, SSQC022
Challenge	5	SSQC001, SSQC003, SSQC007, SSQC017, SSQC024
Learning	5	SSQC001, SSQC007, SSQC013, SSQC018, SSQC023
Responsibility	4	SSQC004, SSQC007, SSQC013, SSQC018
Pay	3	SSQC003, SSQC004, SSQC009
Work life balance	3	SSQC0, SSCQ00, SSQC004
Autonomy	3	SSQC012, SSQC014, SSQC024
Culture	2	SSQC003, SSQC004,
Career progression	1	SSQC0018
Problem solving	1	SSQC0014
Stability of job	1	SSQC006
Supervision	1	SSQC004

Helping patients

The following quotes support the theme of 'helping patients'. As this theme was mentioned by all participants' and in a frequent manner, it has been divided further into six sub-themes, namely 1) making a difference 2) positive health outcomes 3) saving / improving lives 4) building rapport / relationships 5) sense of pride and 6) caring for people.

Subtheme 1: Making a difference

***SSQC001**: I enjoy being able to make a difference.*

***SSQC002:** Actually to see that change when you know people come in are suited to the model then it's really lovely.*

***SSQC004:** I entered into this line of work to make a difference.*

***SSQC006:** It's nice to be able to help people.*

***SSQC007:** You're working with individuals that are really passionate about what they're doing as clinicians, you do see really good quality of care and obviously you've got an overarching part to play in that.*

***SSQC008:** Helping a woman have her baby and handing that baby to her and empowering her. When the labour has gone well and she's got what she wants there's nothing better.*

***SSQC010:** I mean the whole reason I became a doctor is because I enjoy kind of looking after people, so when someone is sick, when they come into hospital and they are having a really difficult time in their lives and to be able do something for them.*

***SSQC011:** I think when we actually have made a difference and you've got an improvement.*

***SSQC012:** You could start to help people to see things differently, maybe to become functional again.*

***SSQC013:** I think that just being able to put my name to something that's makes a difference for somebody.*

***SSQC016:** Trying to put the samples through and trying to get everybody's results back out there so that the Doctors can make decisions and make people better.*

***SSQC017:** It would have to be meeting a patient who might be confused, who might not be understanding what's going on, who might be suspicious about the prospects around entering a trial and making things clearer.*

***SSQC022:** The interaction with people and that you can actually make a difference sometimes.*

***SSQC024:** The best day in the office are the ones where we were working for something and something does come through, so the statistics show we actually made a positive benefit.*

Subtheme 2: Positive health outcomes

***SSQC0:** You get a lot of job satisfaction sometimes, when you get a lot of patients who've had surgery and you can see them recover very quickly.*

***SSCQ00:** The fact that you can see patients get up and get better.*

***SSCQ001:** Seeing an improvement in patients' mental well-being.*

***SSQC003:** I enjoy when the clients come in and volunteer to reduce the methadone as part of a plan they've obviously sat and thought about and planned.*

SSQC004: *Something I really enjoy about my work is getting the outcomes, when you see someone moving through into independence and you know you played a role in that by facilitating stuff.*

SSQC006: *Success rates, it's quite sad when you bring someone in and you can't fix whatever is wrong with them.*

SSQC012: *It's very rewarding to see people and to be able to follow them through, and then to discharge them.*

SSQC018: *You do have that feeling that you're actually making a huge impact on the clinical aspect, which in my eyes is really important.*

SSQC019: *I really like it when we get to see patients regularly and you get to see them improving. That's definitely the best part of the job - you see them progressively get better.*

SSQC021: *Seeing people's faces light up when you fit them with hearing aids as well. It's lovely, I've cried before. I've had patients hug me, I've had patients just being so overwhelmed that they just can't stop saying, "Thank you." That part is amazing.*

Subtheme 3: Saving / improving lives

SSCQ00: *Things that you can change, they're the good bits, when you come home and say, I saved that dudes life.*

SSQC008: *If I just make a difference to one life, if I saved her life, if that's all I do, I did a good job.*

SSQC009: *It can be chaotic but very rewarding knowing that, even at that remote distance, we are helping make people's lives better when they're having a really, really bad time but you've had a role to play in that.*

SSQC010: *To sort things out so that they can cope with their problems better and then sort of send them home to go on living their life and when you feel that you've sorted things out for somebody their problem's been improved then that is very satisfying.*

SSQC014: *It's usually when I've had to deal with a really sick patient on my own, never have to deal with it before, my colleagues aren't around to support me but I've managed to keep someone, you know, stable and alive until I could get maybe some extra help.*

SSQC015: *Yes, we're saving lives here. It doesn't feel like it when you're doing it sometimes, but yes, if you sit down and think about it, it does make a difference at the other end if we do our job well.*

SSQC019: *I find it rewarding to look after a sick patient and make them better.*

SSQC021: *I really like that because obviously, it helps with their quality of life.*

SSQC023: *I think if I make a really good connection with a family and get a good joint understanding of what the difficulties are and how to move forward, I find that really satisfying.*

Subtheme 4: Building rapport / relationships

SSQC003: *I enjoy the actual interaction with patients.*

SSQC004: *It is a privilege to hear some of their stories and they share that with me and I think that's really rewarding in itself.*

SSQC005: *I really enjoy, you get to know a lot of the families and a lot of the kids and that's really nice and you can build up quite a good relationship with people.*

SSQC008: *Building up a rapport and understanding them quickly and helping them through their labour.*

SSQC012: *I liked having the relationships with my patients.*

SSQC014: *I really enjoy the patient interaction. So I like seeing patients.*

SSQC020: *Interacting with patients. I can find that quite rewarding.*

SSQC021: *If I've had a really good fitting or a really good rapport with the patient or I've helped them when they haven't been helped before, then that will be a really good day.*

SSQC023: *I really like seeing my patients.*

Subtheme 5: Sense of pride

SSQC001: *I think that's what gives me personal satisfaction that I'm doing the best I can for my patients.*

SSQC006: *You do get a sense of pride when you've helped somebody.*

SSQC014: *I felt really proud because I managed to save someone who had a seizure.*

Subtheme 6: Caring for people

SSQC001: *My medical colleagues are in the profession because we want to, you know, we are all in it for the patients, but nothing else drives it, I don't think there's any financial incentives or work life balance incentives, I think we are driven by the efforts we put in.*

SSQC004: *Most people go in to it [healthcare] because they care; they don't necessarily do it for the money.*

SSCQ025: *I enjoy say the palliative care side of things as well, with people in their own homes.*

Teamwork

The following quotes show support for the theme of 'teamwork'. Again, as this theme was a commonly recurring theme, it has been divided further into six sub-themes, 1) looking after patients together 2) pulling together 3) multi-disciplinary teams 4) team spirit / friendship 5) learning from each other and 6) building a team.

Subtheme 1 - Looking after patients together

SSQC0: *If we're on with a really good team, you know that makes a massive difference. We look after all the patients together.*

SSQC005: *I do like the team a lot and I do think everybody works really well together and at the heart of that it is genuinely in the best interest of the patients.*

SSQC012: *I liked working as part of a team. We were a good team. We did a lot of work, we looked after each other, and we looked after the patients.*

Subtheme 2: Pulling together

SSQC009: *I really enjoyed the people I worked with, the staff were fantastic, there was a very good team spirit in sometimes tough circumstances.*

SSQC015: *As far as I'm concerned, it is the entire part of the lab. The lab would be useless if we didn't work as a team.*

SSQC020: *I think often I rely on other people a lot, if I'm having a stressful time at work you have to ask other people to help you out.*

Subtheme 3: Multi-disciplinary teams

SSQC001: *I also enjoy the kind of interface I think between mental health and physical health.*

SSQC010: *I like working as part of a team, I've got a team of people around me, some senior, some junior, a range of different professionals and when you feel like you are in a team all working together for a common aim that's very satisfying.*

SSQC023: *I really like team-working and really like interacting with other specialties because I work in a hospital environment, so I work with lots of different other specialties as well.*

Subtheme 4: Team spirit / friendship

SSCQ00: *Ultimately you're there as a working unit as long as the unit is working then that's fair enough, like you don't necessarily have to be best buddies with everybody for it to work.*

SSQC003: *The team feeling in the office is hugely important, if you have a nice feel in the office and a bit of banter and comradery then that's hugely important.*

Subtheme 5: Learning from each other

SSQC024: *I do like working in a team, if you get banter in a team, it makes your day go a bit quicker and actually learn from each other as well.*

Subtheme 6: Building a team

SSQC007: *You've got to build a team. That is enjoyable because you're trying to progress people within their own role and their own autonomy and freedom.*

Meeting people

SSQC001: *I like the fact that I get to meet so many people*

SSQC002: *I'm in this role because I like people and I think people are brilliant and amazing.*

SSQC003: *I enjoy the actual interaction with the clients.*

SSQC005: *Because the patients are either referred antenatally or at birth and they come back regularly over the years, you get to know a lot of the families and a lot of the kids and that's really nice and you can build up quite a good relationship with people.*

SSQC008: *I equally enjoy meeting somebody on the threshold of the labour ward for the first time, building up a rapport and understanding them quickly and helping them through labour.*

SSQC019: *I like being out and about driving around the city, meeting lots of people, going to different places.*

SSQC022: *That's the kind of thing I really do like because you can actually get to know people … you don't sit down very much but it has such variety and everyday you're meeting different people.*

SSQC024: *I do like working with different people and the different views you get.*

Feeling accomplished

SSQC001: *We all get good satisfaction from knowing that we are doing our best at all times.*

SSQC010: *I start the day with a whole list of jobs which need to be done and by the end of the day I feel that I can tick them off my list and feel like I've achieved a lot.*

SSQC012: *You felt like you'd done a day's work at the end of it. That's rewarding, isn't it?*

SSQC018: *When there's a lot of things to do which have to be done, like ticked off, I really feel satisfied at the end of the day if all of that things I've managed to do, I've managed to fit them within those working hours. That's really good.*

SSQC019: *If I come home and I say, "I've had a good day today." It's usually because we've had time to do all the work that we've been asked to do.*

SSQC023: *When I get it right, when it feels right, then that's satisfying because I know that I'm using the best of myself. I think that's the key thing.*

SSQC024: *The main factor is I've achieved something*

SSQC025: *I'd say pleasing as many people as possible. I mean people, staff members have all finished on time with no issues and all the patients that needed to be seen that day have been seen efficiently and people come back with positive remarks rather than negative.*

Colleagues

SSQC002: *My colleagues are great, I do love them and they're really helpful to have around.*

SSQC005: *I do genuinely like the people I work with so that is really good.*

SSQC006: *The theatre that you're in and anaesthetist you have changes daily and that can have a huge impact on how happy you go home at the end of the day.*

SSQC007: *I've got a huge cohort of staff; somewhere in the region of 500 staff will report to me, so the day to day engagement with those staff is great.*

SSQC008: *If you need somebody to support you in your decisions, to chew things over with, there's always somebody there.*

SSQC010: *You build up quite a strong bond with the people around you.*

SSQC014: *I like seeing me colleagues.*

Feeling supported

SSQC0: *Most of the sisters that are on are really supportive.*

SSQC002: *It's a good bunch of people and they're hugely supportive.*

SSQC003: *Just feel that someone's taking seriously what you said and I think that hugely affects how you feel about your job.*

SSQC004: *I feel like I've got a really good relationship with my line manager, she's approachable, she asks me about the factors that are influencing on me. I feel like I could talk to her about things.*

SSQC010: *So I think feeling well supported is really important, I'm very lucky because my consultants are all very approachable.*

SSQC012: *Also I was very supported where I worked. There was always assistance. I didn't ever feel that I was left without clinical support and that was really important.*

Variety

SSQC0: *So I really enjoy it, every day is very different.*

SSQC001: *I really enjoy the variety of the work, so no one person is the same.*

SSQC006: *It's really interesting seeing all the operations.*

SSQC013: *If you do what you're meant to do which is rotate through the different areas, then you get variation. That in itself should give you some level of job satisfaction, because you're maintaining your competencies across the different areas.*

SSQC015: *Variety is good. Variety is the spice of life.*

SSQC022: *I think the variety of the job as well. Nursing is never boring and anyone who says that they're bored in their nursing job should just go and find another job.*

Challenge

SSQC001: *I think I enjoy the challenge of achieving wellness for someone.*

SSQC003: *The job itself, if it interesting, bit challenging, but not too challenging.*

SSQC007: *Different service lines can bring different challenges so there is always kind of exciting things on the horizon.*

SSQC017: *When you do something that's difficult and that turns out successful, that's quite satisfying.*

SSQC024: *I like overcoming challenges as well, so it's not really like an easy job where it gets up and done it tends to be like something that's passed back and trying to work out if it can be progressed to the next stage.*

Learning

SSQC001: *I enjoy the academic side of the job.*

SSQC007: *It's quite nice to learn from other healthcare providers and bring that best practice back and try and implement that within a service.*

SSQC013: *I've been given the opportunity to work with the new kit; it's been a real, quite a nice boost, because it stretches your mind learning new things.*

SQC018: *I enjoy some lectures which are provided externally or internally as well.*

SSQC023: *I like attending teaching sessions and teaching myself.*

Responsibility

SSQC004: *I obviously enjoy the training side of it loads, I think that's really important to develop staff members and also to give service managers the benefit of my knowledge of running services.*

SSC007: *It's nice to take responsibility for a service line, what's difficult sometimes is I guess the influence that you can have within the business direction within a hospital.*

SSQC013: *I enjoy having the responsibility, it's really significant. Especially when I used to do night shifts and you'd be the only one there.*

SSQC018: *I've really enjoyed working on call, I like to work independently and it gives me this extra satisfaction, that in a way I've got that power to do what needs to be done, and it's really responsible.*

Pay

SSQC003: *The usual, pay, feeling like you're busy and earning a reasonable amount of money for what you're doing.*

SSQC004: *Obviously salary I'll be honest with you.*

SSQC009: *I enjoyed the pay, for an unskilled job it paid well, although we have to put in the hours for that.*

Work life balance

SSQC0: *Because I work part time, I think that helps as well with the work life balance.*

SSCQ00: *Work life balance, I've reduced my hours and now it's better.*

SSQC004: *The other things that are factors to me is around work life balance and about how the organisation accepts that.*

Autonomy

SSQC012: *I liked the degree of autonomy that I had. I liked being able to manage patients from start to finish myself.*

SSQC014: *I get to sort of manage my time; I get to be really flexible.*

SSQC024: *The thing that I really enjoy is it's quite autonomous.*

Culture

SSQC003: *The department issues can be dealt with by the department regarding culture and the atmosphere at work, so encouraging pleasantness in the office. Feeling comfortable being who you are in the office is what I think is quite important.*

SSQC004: *It's about having a culture of transparency and honesty.*

Career progression

SSQC018: *I enjoy the progression of my career and the training, which is really important for me.*

Problem solving

SSQC014: *The other really important thing I like about the both the research and clinical side of things is that I get to work out what's wrong, what's the root cause, of what happened.*

Stability of job

SSQC006: *It's nice to have a job that I know is always going to be there to have that stability of knowing that I'll always have a job.*

Supervision

SSQC004: *You know I think what's really; really important to me is constructive feedback.*

2. Negative factors that influence job satisfaction

During the interviews, participants were also asked what they do not enjoy about their job or negative factors. There were twenty-one factors altogether and these have again been listed based on the frequency of occurrence, in other words, how many participants mentioned that particular factor during the interview. There were sixteen different factors that more than one participant referred to and an additional five factors that only one participant referred to. Quotes from the data analysis have been used to endorse each factor and are presented below.

Job Satisfaction Factor	No of Participants	Participant ID Numbers
Time to care	9	SSQC0, SSCQ00, SSQC002, SSQC008, SSQC010, SSQC0012, SSQC0014, SSQC0020, SSQC025
Staff shortage	8	SSCQ00, SSQC008, SSQC0011, SSQC0015, SSQC0020, SSQC0021, SSQC0022, SSQC0023
Lack of support / recognition	7	SSCQ00, SSQC002, SSQC006, SSQC009, SSQC0010, SSQC0011, SSQC0013
Staff management	7	SSQC002, SSQC003, SSQC006, SSQC008, SSQC0009, SSQC0019, SSQC0020
Increased demand / complexity	6	SSQC002, SSQC006, SSQC007, SSQC008, SSQC012, SSQC0022
Paperwork	6	SSQC0, SSQC008, SSQC010, SSQC011, SSQC016, SSQC0022
Lack of decision making	5	SSQC002, SSQC003, SSQC007, SSQC008, SSQC010
Lack of funding / budget	5	SSQC001, SSQC003, SSQC007, SSQC013, SSQC017
Politics	5	SSQC008, SSQC010, SSQC013, SSQC017, SSQC019

Communication	3	SSQC002, SSQC003, SSQC007
Pressure / stress	3	SSQC0, SSQC0014, SSQC0020
Managing people	3	SSQC005, SSQC007, SSQC0025
Working beyond role	3	SSQC001, SSQC0014, SSQC0015
Junior doctors contract	2	SSQC001, SSQC010
Work life balance	2	SSQC001, SSQC014
Conflicting priorities	2	SSQC004, SSQC007
Monotony	1	SSQC011
Environment	1	SSQC017
Workload	1	SSQC018
Expectations of patient	1	SSQC008
Delivering bad news	1	SSQC0
Long hours	1	SSQC001

Time to care

SSQC0: *You don't really get a lot of time to talk with relatives or patients.*

SSCQ00: *You don't have a lot of time to care for patients.*

SSQC002: *I think sometimes you know I've rushed people or I've not been with them the way I want to.*

SSQC008: *Because we haven't got the time to sit with them and spend with them and empower them.*

SSQC010: *Quite often I feel like I'm so busy that I can't do as good a job for people that I would like to.*

SSQC012: *The pressure on time. The fact that you couldn't necessarily give somebody the attention that they needed …Actually, I don't mind the complexity, I don't mind unpicking things, but you've got to have time to do it. Otherwise, it doesn't work, particularly patients with mental health issues.*

SSQC014: *I always feel I don't do my complete best because I've got other pressures, other patients to see. So it means I can't do as good a job as I'd like to do or be as thorough as I'd like to be.*

SSQC020: *Often when there's just been too much to do and you come home thinking that you've given people bad care and you haven't done the best you can do. Usually not because I've necessarily done the wrong thing, but it's usually because I haven't had time to do things properly or I haven't been able to get the help I need from someone else.*

SSQC025: *Yes and from patient feedback that I've had as well. When the nurse goes in and they are just doing a task and then leaving they are less satisfied. When the nurse goes in and give a patient a full holistic assessment and its thorough, has time to spend they have a more positive outcome. So I definitely think there's a link that is visible to patients as well as staff.*

Staff shortage

SSCQ00: *What don't I like, is the fact that we haven't got any staff. It's very bottom heavy so lots of junior staff so that puts the patient at risk.*

SSQC008: *We haven't got the time and resources to properly learn any more.*

SSQC011: *I used to have admin support. So I'm now doing all those roles and you think…it's quite soul destroying because we're told accreditation and quality is key and yet there's less and less resource going into it.*

SSQC015: *We're short staffed on the weekends as well so they always ask for volunteers to work more weekends.*

SSQC020: *Yes, definitely. I think lack of time and lack of resources especially anyone working in the NHS and healthcare is probably the key thing that means that we have a bad day, because we can't do our job as well as we would like to do.*

SSQC021: *We do have stress and strain on numbers, which is putting a lot of stress on the department.*

SSQC022: *They've got absolutely no doctors to look after them. I feel that a lot of the patients are getting a short straw because there are no doctors, we're very, very short of doctor.*

SSQC023: *When I've had worse days it's really been around feeling overwhelmed, too many patients, not enough time, too many demands, not enough time, not enough staff.*

Lack of support / recognition

SSCQ00: *No recognition, none at all.*

SSQC002: *I don't feel very supported, I don't feel very appreciated at all. It's really upsetting when I think about it because the job that we do is emotionally intense. Any experience you've built up over the years isn't really acknowledged.*

SSQC006: *There's nobody actually there standing up for the staff and that should be the manager's responsibility or the person in charge's responsibility. So they just kind of feel a bit left out in the wilderness to just deal with what gets thrown at them. I mean even just as simple as them saying thank you to the staff at the end of the day makes people feel better*

SSQC009: *I think staff feel undervalued, that seems to be across the national health service at the minute and it's really coming from government level down. I don't recall ever having an email saying you worked really well, you pulled it out of a hole this month, thank you, so that's just the sort of stuff that makes you feel a bit valued and it doesn't take a lot.*

SSQC010: *It doesn't really take much at all to make you feel that it's worthwhile but it makes such a difference when somebody says, that's a good job and thank you, and it's a bit depressing how infrequently that happens.*

SSQC011: *The only time you really hear any sort of feedback is when something's gone wrong or a mess so you're being reactive, rather than proactive. I mean one of our very, very senior managers I once said to him, "Why don't you thank them for that day of work?" Because that was really good and his attitude was "They'll know if I'm not happy".*

SSQC013: *I think that a lot of us get frustrated because as a profession, people don't really know about us and I think they think the doctors take the samples and then go off and do something with it and come back Yes, I think a lot of people feel like we're not recognised as an important part of the process but without us, really, they would just guess.*

Staff management

SSQC002: *We are treated like children and therefore I think it brings out a really childish like reaction in me. The stress that people are under is kind of individualised*

SSQC003: *There's no concern about the confidence of the practitioner feeling safe and secure in a situation. I don't feel that the managers are particularly interested in what the front line staff have got to say.*

SSQC006: *I personally don't really get annoyed by a huge amount, but there's a lot of people I know who get annoyed with the politics of the place and the management*

SSQC008: *The bureaucracy of the management structure, the politics of the management structure not just locally but stretching all the way up to Westminster.*

SSQC009: *As awful as it sounds I felt that management were quite difficult, quite disruptive, and at times destructive. I do try and be a little bit aware that the managers are under pressure themselves; they have people above them putting pressure on.*

SSQC019: *Other things I don't like we have some management that are needlessly picking on people sometimes. Yeah, that's not very nice.*

SSQC022: *I do have a bit of a problem with the hierarchy. I think there are far too many at the top dictating this that and the other and maybe they actually need to come onto the ward and do a bit of work. We see what we're doing because sometimes I think their expectations are unrealistic.*

Increased demand / complexity

SSQC002: *I don't think that they've reconsidered that model because actually we are seeing quite complex people now.*

SSQC006: *The only thing that is slightly frustrating at the moment in the hospital I'm in is the bed situation. We go to theatres at 8 o'clock in the morning and we can't start our cases until 10-11 o'clock because they can't let us know whether there is a bed available, so we're all just sat there thinking you're paying us to be here for nothing and that can get quite frustrating.*

SSQC007: *The operational stuff is hard, it's nobody's fault, and it's just in terms of the demand at the moment. Healthcare is becoming more complicated, people are living longer, so it's how the system copes with that and at the moment it feels like it's really bulging, so that's very difficult on a day to day. We've probably seen a 10% rise year-on-year, for the last few years and that becomes particularly challenging.*

SSQC008: *Sometimes you will have eight women in labour and then three days will go past and nobody will have a baby, so it's a very ebb and flow kind of service, you can't predict it. As a society we're a bit more sedentary than we used to be, we don't eat as well as we used to and that has a knock-on effect to the women's health.*

SSQC012: *The increase in the number of patients, who had serious mental health issues, for me, was overwhelming. And I actually didn't like what it was making me feel like. Because when you've a third suicidal patient in the space of an afternoon, it's not right.*

SSQC022: *At the moment it's incredibly challenging. The ward I work on we should be women's health so gynaecology and breast really and early pregnancy. We're full up with medical patients because there's nowhere in the hospital for the medical patients to go, because all the hospitals are chock-a-block full of medical patients.*

Paperwork

SSQC0: *All the paperwork that we do, we get snowed under with that.*

SSQC008: *So the documentation is becoming more and more onerous, for example, when I deliver a baby I have to write the baby's weight down in 11 or 12 different places. Because I am attending to the paperwork much more than I'm attending to the women which comes up a lot in patient satisfaction surveys.*

SSQC0010: *It's more difficult than it needs to be to accomplish things, so lots of completed forms to fill in or lots of phone calls to make for something that ought to be quite easy to arrange and sometimes you feel like things are quite unnecessary.*

SSQC0011: *It's a waste of time admin, your chasing people and typing, you're far better off being used in a proactive rather than a reactive role.*

SSQC016: *The bits that I don't like are the personnel side, the paperwork and pointless, pointless episodes of paperwork.*

SSQC022: *The biggest chore is the amount of paperwork we have to do**,** there's too much of it.*

Lack of decision making

SSQC002: *No I think that's what it comes down to, there is no decision-making for us, and we're not really included. A lot of it was you just have to change this and there was no say in it, but that was really hard and anxiety provoking for us as practitioners.*

SSQC003: *Instead of letting the front line staff have an opportunity to discuss how they think they could get to those budgets and targets, they just come in and tell you we're doing this.*

SSQC007: *As much as we talk about autonomy in roles, quite often it's top down, rather than a bottom up, as much as the culture is kind of supposedly bottom up.*

SSQC008: *We weren't engaged in the process at all, we were just thrown into it. I mean in our trust that's what happens, you come in, you make a massive change and you pick up the pieces afterwards instead of properly planning.*

SSQC010: *It was never can we discuss this with you, just you will be doing this.*

Lack of funding / budget

SSQC001: *I dislike the lack of funding*

SSQC003: *The way the service has been changed recently to allow budgetary cuts.*

SSQC007: *At the moment with the financial challenges, we are really feeling them in healthcare so that's the difficulty. I think the financial challenge is huge at the moment, we are not talking a couple of hundred thousand, we are talking millions and tens of millions in terms of savings that the trust needs to make every year. It is just the reality of healthcare so we can have a £20 million budget and get asked to save 10% of that year on year, yet we've got more patients coming in year-on-year.*

SSQC013: *There's a constant lack of money, everything gets blamed on lack of money.*

SSQC017: *Worries about funding streams, which can threaten jobs and certainly does in nurse research work.*

Politics

SSQC008: *In my workplace there is definitely a culture of bullying.*

SSQC010: *I see it in the nursing staff, their leadership is quite negative, so for example there are people who are told off in the middle of the ward, nurses who are kind of pulled up on things right in the middle of the ward, in front of patients in front of other staff, you can imagine how that makes you feel, it's just quite a punitive atmosphere.*

SSQC013: *It's just human nature to have a moan about different people. I think sometimes when that gets a bit over bearing, if you've got one person who's particularly negative all the time, it can bring the team down.*

SSQC017: *Time wasted on local politics, if you like, within the hospital somebody is being obstructive and it's not helpful.*

SSQC019: *I generally don't like when we have politics getting involved.*

Communication

SSQC002: *Communication in my opinion is appalling unfortunately. One day we had three back-to-back really badly worded emails saying that we weren't doing this, and we weren't doing that, and we weren't meeting this target, and could people do more work. We're all open to change; it's just if it was communicated in a more supportive way.*

SSQC003: *There is no discussion point.*

SSQC007: *It influences you day-to-day, how you feel about the system; it's very difficult to kind of talk that through sometimes with your teams.*

Pressure / stress

SSQC0: *There is a lot of pressure. I think the long hours are quite difficult so long days and nights and that puts a strain on all of us I think.*

SSQC014: *I don't think, like the pressure. I think that I would enjoy it a lot more if I had maybe half the amount of work I have to do … I have to perform really well. That's a lot of pressure whereas other people they've not got that pressure they can walk into a job and not worry about it.*

SSQC020: *It varies; the on calls are usually very stressful. It's often very busy you're getting calls from lots of different people often multiple bleeps at the same time trying to respond to different things. I think the thing I like least is probably the stress particularly when you're trying to make difficult decisions either, whether that's how you manage a patient or often it's, the consequences if you make the wrong decision are pretty big, so actually its very stressful having to make those decisions particularly when you don't have time to necessarily think over them and you've got lots of other pressures as well.*

Managing people

SSQC005: *So I think I've never really wanted to go into staff management, but that's just part of the job and I kind of ended up just doing this job when the last person left because I was the assistant. I'm quite an easy-going, laid back person and I don't think I've got the sort of authority side of staff management down very well. I don't like anything to do with confrontation.*

SSQC007: *Being so stretched and pressurised within a system, it is difficult to keep buoyant sometimes, and keep your team buoyant. I see a full emergency department, I see tired nurses, I see tired consultants, I see them really stretched and the balance for me is to try to be the cheery directorate manager, plus the manager that goes to go round and gees them up.*

SSQC025: *I don't enjoy the people management so much within the team that can be difficult. I'm a bit of middle point really so people will bring their problems to me and I can't make any changes without running anything past the team manager and sometimes when that's not coming directly from the staff nurse themselves. There's a lot of changes and yes, that's just something I find difficult to manage within that key management section.*

Working beyond role

SSCQ00: *You're doing senior roles at say a band 7 or 8, you're not getting paid.*

SSQC014: *So they're the difficult things, and not getting paid for the hours that you do. So in one job I worked out that I got paid for 56 of the 180 hours that I did and that was really disheartening I think.*

SSQC015: *When you do the out-of-hours work and you look at your payslip, it just doesn't feel worth it at all.*

Junior doctors contract

SSQC001: *I dislike the current worry about the junior doctors' contract.*

SSQC010: *Wider issues to do with the NHS, there is a new junior doctor's contract that is being proposed at the moment, which has created quite a lot of personal unhappiness. All of my colleagues are quite unhappy about it. When you feel like you're working for a government funded system that doesn't necessarily appreciate how hard you work, that is quite demoralising. It's one thing having a consultant that doesn't appreciate you, it's like the next level up when you feel like your ultimate boss, the secretary of state really doesn't appreciate you and again it's that powerlessness of feeling what more can I do, I know this isn't fair and it's not ultimately going to result in good patient outcomes either. It's not a good thing for me or my patients and yet there's not very much you can do about it.*

Work life balance

SSQC001: *I dislike the balance, the poor work life balance.*

SSQC014: *Then I guess the other thing is I don't like coming home late all the time, it puts pressure on my relationships, especially if I want to see family. I don't see my family as much.*

Conflicting priorities

SSQC004: *The balance between quality and business because often you know if you want more quality it involves additional costs*

SSQC007: *So I think the kind of firefighting nature of the role is difficult, certainly conflicting priorities so they can change.*

Monotony

SSQC011: *What I don't enjoy is say the drudge, so doing the same thing, chasing people, reminding people, it's not that rewarding.*

Environment

SSQC017: *In clinic, there's often very little space and you're having to try and manage things in places or areas which aren't necessarily appropriate for what you're trying to do.*

Workload

SSQC018: *Well, I know it's really simple and just really basic and might have sound silly but I don't like to be bored at work. If there's no workload, and it can happen, of course we all say we're so busy, but there are days or hours when there is no workload at all.*

Expectations of patients

SSQC008: *The women we are looking after sometimes their expectations are massive and they want everything to be perfect.*

Long hours

SSQC001: *I think the long hours are quite difficult so long days and nights and that puts a strain on all of us I think.*

3. Positive factors that influence quality of care

In addition to questions on job satisfaction, participants were also asked about the quality of care that is provided. General conversations emerged regarding the factors that affect the level of care that staff are able to provide. From this, the researcher was able to determine the factors that the participants felt had either positive or negative impacts on the level of care (or service) provided. The factors shown below were shown to have a positive influence on quality of care. There were three main factors that more than one participant referred to and two additional factors that only one participant referred to. Quotes from the data analysis have been used to endorse each factor and are presented below.

Positive Quality of Care Factors	**No of Participants**	**Participant ID Numbers**
Communication	4	SSQC003, SSCQ005, SSQC012, SSQC018
Team support	4	SSQC0, SSQC001, SSQC003, SSQC012,
Staff levels	4	SSCQ005, SSCQ006, SSQC017, SSQC018
Funding	1	SSCQ005
Decision making	1	SSQC012

Communication

SSQC003: *I think that [referring to team meetings] in itself enables a better service on an individual level if you're able to kind of off load and discuss and review and analyse your own conduct, I think you must be able to provide a better service*

SSCQ005: *We do have social events things like that, so I think that does help team morale and regular sort of team meetings, there is good communication.*

SSQC012: *Yes, we always had space for that. You couldn't do it without that … it was always possible to discuss with someone else even if it wasn't necessary on the premises but there was always the opportunity to phone somebody or to speak to somebody.*

SSQC018: *There's communication, there's a lot of like staff meetings…there's a lot of like boards on the sides to make a comment whenever something comes to your head and then you have to write it down otherwise you forget about it. It is there. Then, for example, once, weekly we talk about it. We just talk about it before it gets too late to keep things updated pretty much on a daily basis.*

Team support

SSQC0: *It's always helpful to have a supportive team.*

SSQC001: *We're heading towards joint or multi-disciplinary assessment rather than individual assessment and it just works a lot better, it's more efficient, you've kind of got the ability to discuss. You know it's a team effort, so working in a team is vital in providing excellent healthcare.*

SSQC003: *I think that in itself enables a better service on an individual level if you're able to kind of off load and discuss and review and analyse your own conduct, I think you must be able to provide a better service.*

SSCQ012: *I was fortunate enough to have a team of people all of whom are really good at their jobs, and that was everybody. It didn't make any difference who it was, we had a very loose hierarchy as well and I think that helped.*

Staff levels

SSQC005: *Well it's well-staffed and the staff that we have got are genuinely very caring people who do the best that they can for the patients and I do genuinely feel like the whole team is all about that.*

SSQC006: *I think our quality of care is quite high because we're quite lucky in that we can only concentrate on one patient at a time, so they have all our attention.*

SSQC017: *Because haematology is perhaps slightly rarer than other types of cancer, we tend to know our patients quite well because there's not that many of them and so the consultants can have quite a personal relationship with the patients that they look after. We've got seven consultants, and I think patients do really feel quite well cared for.*

SSQC018: *In the place where I'm right now, definitely I can say the quality is better. Maybe the workload is a little bit less; maybe we're not as short staffed as I was in the previous lab.*

Funding

SSQC005: *We are really lucky in that we are very well funded.*

Decision making

SSCQ012: *I don't think people felt excluded, it was top down but with a light touch and I think it meant that we were able to produce phenomenal amounts of really good care in what was a very difficult environment with increasing demand and a reducing budget.*

4. Negative factors that influence quality of care

Although the participants highlighted factors that had a positive influence on quality of care, there were also negative factors which arose. Six key issues were identified from the participants' dialogue, and four additional factors were mentioned by a single participant. Quotes from the data analysis have been used to endorse each factor and are also presented below.

Negative Quality of Care Factors	No of Participants	Participant ID Numbers
Staff shortage	11	SSQC0, SSCQ00, SSQC002, SSQC006, SSQC007, SSQC008, SSQC014, SSQC019, SSQC021, SSQC022, SSQC023
Time to care	6	SSQC002, SSQC010, SSQC014, SSQC017, SSQC023, SSQC025
Stress	3	SSQC002, SSQC013, SSQC014
Tiredness	3	SSQC001, SSQC014, SSQC020
Other departments	2	SSQC017, SSQC022
Leadership	2	SSQC004, SSQC010
Equipment issues	1	SSQC006
Decision making	1	SSQC03
Business outcomes	1	SSQC004
Feeling undervalued	1	SSQC009

<u>Staff shortage</u>

SSQC0: *Staff shortage, I think that's a major issue within nursing actually. It can effect quality again if the patients deteriorating and it depends on acuity.*

SSCQ00: *There's certain skills mix issues you can't provide that care, you've got to look after the most poorly and prioritise your care.*

SSQC002: *Our resources seem to be decreasing because a lack of satisfaction I think and stress levels.*

SSQC006: *It is a lot more difficult up on the wards where they are obviously just too stretched to be able to give the care to everybody all of the time.*

SSCQ007: *If you look at the consultants, they're an amazing bunch, I think the senior nurses are excellent, the nursing team is excellent, it's just pure numbers and volume, we've probably seen a 10% rise year-on-year for the last few years and that becomes particularly challenging.*

SSQC008: *One of things that haven't happened recently because of our lowered staffing is that junior colleagues don't get to work alongside their more senior colleagues, so they don't observe good practice.*

SSQC014: *I'm too busy or there's a group of us on nights we're too busy to see middle grade sick people, we have to see the sickest and things like that, so people miss out. Sometimes if people are sick, which happens, most people-- we'll do our best to cover everyone, but if you don't have the members of staff, it is a nightmare.*

SSQC019: *There's been a lot of people leave recently there's been the high turn over the last couple years so the overall abilities of our staff to look after the patients recently has gone down a bit. A lot of people don't want to work for a private provider and so are leaving. We've had 12 people leave in the last month.*

SSQC021: *Unfortunately, sometimes they're [referring to patients] not seen as quickly as we would like due to the limited staff.*

SSQC022: *Firstly it would have to be enough staff. You cannot provide good care if you don't have enough staff to provide it.*

SSQC023: *I think there's definitely the human resources. I think in my field that's more important than the actual technical resources. We can pretty much, well apart from specialised treatment, for example, we might have a team with enough nurses but not enough psychologists. We can't really deliver more specialist treatments. So staff mix is an issue.*

<u>Demand / workload</u>

SSQC002: *I feel like there's possibly more risk issues coming through.*

SSQC010: *I think the biggest things that influence my own quality of care are about workload.*

SSQC014: *I think it's a really, really good hospital but what lets us down is that we're too busy, we weren't built to work at double capacity, we never were, so where we fall down is not the patients who are very, very, very ill, but those that are just borderline I'm just not able to see them because they're so low down on my list of priorities, I'm just never going to get there. But the really sick patients get looked after very well.*

SSQC017: *The real obvious one is being busy. So you've got to prioritise; you can't always spend as long with people as they would like you to.*

SSQC023: *I think the overriding thing is about supply and demand really. Probably, everyone's aware that demand has increased massively, and the supply in terms of staffing has decreased massively. Well, that's certainly how it feels, when you're working in a service where posts get frozen not my current one, but previous post get frozen. There's someone goes on sick leave and maternity leave, they're not covered etc. It can be extremely frustrating.*

SSQC025: *On the days particularly where we are above our capacity level really and seeing people that we don't really have the capacity to see but we are still offering our care. It becomes a little bit task-orientated rather than holistic, then I think which could be argued perhaps isn't as ideal as being able to holistically assess that patient and having the full amount of time that you require for those tasks. Within the community, the difficulty for us as district nurses is that we don't have a capacity where we say that's enough, we can't take anybody else ….we keep going and increasing our care slot and so yes, it's definitely supply and demand.*

Stress

SSQC002: *I do notice more frustration levels creeping in and that's just to do with stress.*

SSQC013: *It looks like things have improved and there are measures in place to try and limit the number of mistakes that are made but it probably boils down to stress that's on the staff on the ward and lack of staff.*

SSQC010: *If I'm working with a colleague who I don't get along with and that's happened before and that's impacted on the quality of care I've given to patients because I've been very stressed around them and I've found myself making a lot of mistakes not thinking in sort of a normal, logical manner, which is so important.*

SSQC014: *I guess stresses, so if I've got something else stressing me … if I've got to do another course and I've spent all night staying up trying to revise and I'm tired the next day, thinking about it, that can be stressful.*

Tiredness

SSQC001: *You worry that you're not in the best position to give the best care because you're tired, you're stretched.*

SSQC014: *I guess on a longer term I remember doing a string of 12 days and I was leaving late every single day by hours and at the end of that I don't think I made any mistakes, but actually in that job I think I made mistakes, because I was so tired and stressed and stuff.*

SSQC020: *I know I'm probably not at my best because I know when I drive home after that shift it's always a bit hairy and I'm tired and I'm grumpy. I'm sure that does influence on the care I gave and my interactions with other staff. I think that's-- the care I give is probably mostly influenced by either having too much to do or being tired at the end of a long shift. Obviously, you try and not let it effect to the care you give, but ultimately I'm sure it does.*

Other departments

SSQC017: *It would be nice if the whole system worked as well as our little bit of it….places like pharmacy and places like radiology services have an impact on our patient's experience which is completely out of our control.*

SSQC022: *You asked them to move, because a patient is in the wrong place and they need much more specialist care than they can be given, and their attitude is, "We don't care really." That's a classic example of where the quality of care being delivered to that patient is actually impinged on.*

Leadership

SSQC004: *If you have an autocratic manager it does have an adverse effect on quality.*

SSQC010: *Partly the leadership on the ward. I suppose in that sense it compromises the level of quality of care that I can give because I can't rely on other people to do their bit.*

Equipment issues

SSQC006: *Equipment failures or in the morning sometimes we are running around trying to find the equipment we need and it's here there and everywhere and it can be quite frustrating because you're not starting the day off on the right foot your kind of playing catch-up from the very beginning. Occasionally you will have someone come into your anaesthetic room and take something and you turnaround to use it and it's not there that can be quite frustrating.*

Decision making

SSQC003: *I think there's a whole chunk of interaction between frontline staff and decision makers and that definitely effects service provision.*

Business outcomes

SSQC004: *Managers aren't motivated by meaningful outcomes to the people they are supporting they're motivated about their bonus getting all the right amount of QPIs and KPIs in place. Those reports are published to parents, social workers and that report may well be accurate and factual, but actually is that going to motivate the staff to improve if they get a report that just damns them.*

Feeling undervalued

SSQC009: *I think staff feel undervalued that seems to be across the NHS at the minute and it's really coming down from government level down.*

5. Level of care provided

Participants were asked to talk about and describe the current level of care provided by both themselves as individuals, and by their department or organisation as a whole.

Individual level of care

At an individual level, all participants who were asked the question 'How do you feel about the level of care you provide?' stated that they were content with the level of care they are able to give. Many of the healthcare staff interviewed felt that they offer the best possible care they can, regardless of other factors.

Departmental level of care

Although at the individual level all participants were positive about the level of care they provided, at the departmental and organisational level, the opinions were more varied, however for the purpose of analysis they have been divided into generally positive or negative comments. Quotes from the data analysis have been used to endorse each area and are presented below.

Level of care provided	No of Participants	Participant ID Numbers
Individual care positive	13	SSQC0, SSCQ00, SSQC001, SSQC002, SSQC008, SSQC009, SSQC010, SSQC013, SSQC014, SSQC015, SSQC016, SSQC019, SSQC020
Organisational care positive	10	SSQC005, SSCQ007, SSCQ009, SSQC011, SSQC014, SSQC015, SSQC017, SSQC021, SSQC022, SSQC024
Organisational care negative	6	SSQC0, SSQC001, SSQC003, SSQC004, SSQC010, SSQC013
Goodwill	9	SQC006, SSQC011, SSQC012, SSQC013, SSQC013, SSQC019, SSQC020, SSQC020, SSQC023, SSQC024, SSQC025

Individual level of care

SSQC0: *So I'm fairly happy with the level of care I provide.*

SSCQ00: *Most of the time I feel that I can provide optimal care but when there's certain staff shortages, you can't provide that care.*

SSQC001: *I think that on an individual level I feel that the level of care I provide is the best that I can.*

SSQC002: *Well I'm doing the best I can do, I really do believe that.*

SSQC008: *Personally I will give everything I possibly can to the women and if I'm lucky enough to be working on a day where we don't have a great demand on the service then that's fine they can have everything and anything that they need.*

SSQC009: *I've always personally tried to do the best no matter what; even if I'm having a bad time I will try and do my best.*

SSQC010: *I feel like my current role I've got time to do things properly so I have got time to talk to people properly, to sort out all the loose ends to make sure I'm not missing things. Whereas I've had previous jobs before that I've had such a heavy workload that I haven't felt happy with the quality of care that I'm giving.*

SSQC013: *So, as far as we are concerned in the lab, I do everything I can to make sure the quality of the service is as high as possible.*

SSQC014: *Well, I think it could always be improved, but I give the best care that I could possibly supply with the knowledge that I have. Most Doctors sort of don't leave any stone unturned, they really go for it.*

SSQC015: *I think I do all right. I try my best. I'm lucky in the sense of, this is a job that I've always wanted to go in the direction of. I've always wanted to work in pathology. It's a job that I find interesting and it's a job that I'm not just doing for the money, which makes me incredibly lucky in some ways.*

SSQC016: *I go in and I literally don't stop. From the time that I get there, I can honestly say, I push myself. You know I'm missing my tea breaks, I'm going home late, I'm digging deep to get them. But I'm happy with that. I want to do what needs doing.*

SSQC019: *For myself, I do my job to the best of my ability with the experience of my job, I know what's expected with me and what care I can provide and I do that as well as I can.*

SSQC020: *I hope that generally I give a good standard of care. I know full well, that at the end of a shift-- at the end of a sort of 13 hour long night shift, I'm sure I'm probably not giving as good care as I ought to do.*

Departmental level of care - positive

SSQC005: *I'm definitely happy with the level of service that we provide, I think that is one of the strong points. Our service is sort of specially commissioned, so I do think we are particularly well resourced, we are really lucky in that respect that we are able to provide a good service.*

SSCQ007: *I think actually the quality of care provided by the clinicians and the nursing staff is excellent. So you know when they're with the patients, you'd put their life in their hands, they are really, really good.*

SSCQ009: *I think by and large we provided a very good service; it was an incredibly busy place.*

SSQC011: *I think pathology as a whole is very good. It's virtually seamless for most of the work we do.*

SSQC014: *Well, actually I think it's extremely high, we have some very talented doctors and I really enjoy learning from them every single day. The nurses work really well together, in the department I work in and I've just seen how they can help each other and build each other up. And recently, I've been on a medical course and it's assessed but we have some of the nurses form the ward come and join us and learn with us and do some of the stuff with us and I think that breaks our barriers.*

SSQC015: *The lab in general, I think we do pretty well considering the limited funds and red tape.*

SSQC017: *Yes. Department wise, I think yes, the team on the wards, I've never heard anything but praise from patients about how they care they've had on the inpatient ward at the hospital where I work most of the time.*

SSQC021: *Well, give our department its dues, it has been told that we provide really good patient care. Patients are really well looked after ….compared to some other places that I've worked, I would rather work with this bunch of people because they actually know their stuff and they do what's best for the patient.*

SSQC022: *Generally speaking the ward that I work on talking personally on my ward, it's one of the better wards in the hospital and it's got an extremely good reputation.*

SSQC024: *I think it's quite a high level standard of care. Everything we try and do is evidence based.*

Departmental level of care - negative

SSQC0: *There's issues regarding resources, you know maybe we haven't quite got enough.*

SSQC001: *So you are imposed I think by the greater structure of the organisation.*

SSQC003: *We end up losing the trust of the service users because everything's changing all the time …people are leaving left right and centre, there is no consistency, so I can't see that's providing a good quality of service to people.*

SSQC004: *Often if you want more quality, it involves additional costs.*

SSQC010: *I'm not very happy with the level of care they get. It's a ward which I don't think it's particularly well managed.*

SSQC013: *You feel let down by the bigger team when you find out that somebody's been, a sample has been mislabelled or something. That really worries me, that, that can happen.*

Goodwill

SSQC006: *It relies a lot on guilting staff into staying because the last thing you're going to do is go and leave that patient on the, on the operating table or refuse to do a patient that has been waiting a year for it, so the kind of, they use guilt a lot to make people do things which obviously, it gets to a point where you just become angry because you are taken advantage of.*

SSQC011: *Because it is about goodwill because the only way you're going to give that extra, is if you happy in the place.*

SSQC012: *That was, it was expected, that sort of goodwill and it was delivered. You didn't work a certain number of hours. You just worked, you know? You worked until somebody came and said, "We're shutting the building up now". But nobody expected you to work it, you just did it and yes, it was goodwill, and it's for the patients. I do think you possibly, you can only do it for so long, but that's not just NHS, is it?*

SSQC013: *It's the goodwill at the end of the day. When people do take mick, it can have a negative effect on you. But the system, if you cope for long enough, they then do turn around and say, "Well, you've had that vacancy for that long. Do you really need somebody?" That is very wrong because you don't see the level that people are being pushed to in that period of time; whether it's down to goodwill, or just whatever.*

SSQC014: *The healthcare assistants in the orthopaedic clinics, in the clinics I know lots of them stay very, very late and I always think oh, it's the Doctors who leave really, late, but they stay really late because the transfer hasn't come and they don't get paid if they've left late, but they couldn't just leave the patients in a clinic on their own, so they stay late all the time.*

SSQC019: *We frequently get asked by our management to do things that we're not necessarily supposed to. In our cases we physically lift and carry patients using the manual handling equipment we've got. And we'll find a patient that we're not sure if we're able to safely carry between say two of us. And we'll ring up and ask for some assistance and they say, "Oh, well you have to do it yourselves. Or you'll be sat there waiting for an hour for another crew." So you might be pushing the boundaries of what really you should be doing in that respect. In addition to that, say we're on a 10 hour shift, we might have planned patients and due to the traffic conditions and distances involved, we'll know that we're not able to get those patients done within our shift. And a lot of the time, they'll expect you to go over even though you know that the work that you're being asked to do will take you past your finish time and it's not an emergency situation or anything like that. They expect you to do more work than you're employed to do in a time sense.*

SSQC020: *I think that's very true, so most of the doctors and nursing staff that are on my ward, we all go in about half an hour to an hour early in the morning. We're always there an hour late in the evening. It's just expected that you're going to stay to finish off your job and if there's a sick patient you stay and of course we would, we're human beings and we're not going to walk out when someone is unwell.*

SSQC020: *Actually, I think it's often abused not by individuals, people you work with necessarily, but I think often from a government side of things. It's just; they rely on lots of goodwill off staff. And actually I think if we all left on time and didn't stay to do the extra things*

and they'd probably find that things would fall apart. There's just not enough doctors, nurses and other healthcare professionals to provide the care that we need.

SSQC023: *As you know, people say that healthcare depend on goodwill. I think that it's been working like that for many, many years since I was a medical student back in the '80s. And it's the same with all public services and people will, and they do, but ultimately, it's not actually good for anyone because those staff actually do get-- it's not sustainable at the point.*

SSQC024: *I definitely believe within the NHS, and especially within my team, a lot of the things are generated on goodwill, wanting to do a good job and going above and beyond. A lot of people on the team work a lot of extra hours. I've just done some PDRs with a couple of people and one of the clinical auditors you can see, he used to punch it, he said he was in at seven o'clock and never left until 20 o'clock.*

SSQC025: *There is an expectation that until all tasks are finished you keep going, you go above your required time as they say, and one of the things I've tried to do is relay that back to higher management but it is an expectation really to provide that care and often myself and other staff members don't want to see the patients go without so we do it anyway.*

6. Dimensions of quality of care

Chapter 3 extensively reviewed numerous existing studies, which have looked at quality of care and the various dimensions, which have emerged throughout these works. As mentioned previously in this thesis, despite attempts to measure 'quality of care' the concept itself is very subjective and therefore treated as such for the purpose of this study. Consequently, it was considered important to ask the participants who work in healthcare what they think quality of care actually encompasses. Their responses are summarised in this section of the results and quotes have been used to support each factor.

Dimensions of Care	No of Participants	Participant ID Numbers
Patient focus	7	SSQC002, SSQC004, SSQC008, SSCQ009, SSQC017, SSQC020, SSQC025
Efficient / effective	4	SSQC002, SSQC004, SSCQ007, SSQC022
Empathy / understanding	1	SSQC002
Environment and resources	1	SSQC008
Signs and symptoms	1	SSQC008
Safe outcomes	1	SSQC012
Atmosphere	1	SSQC004
Science and art	1	SSQC023

<u>Patient focus</u>

SSQC002: *As a therapist you know you kind of have to be there with the patient and if you are there with them, that's the best kind of quality of care that you can give.*

SSQC004: *It's about an ethos within a staff team of person centeredness. So actually the people that you support are at the centre of everything you do.*

SSQC008: *So we need to give the women time, to listen, and to give them evidence-based information so they can make their choices.*

SSCQ009: *I think if I had to sum it up in one phrase it would be always having an eye on what you're doing. You're providing a service to patients who are ultimately customers; they have paid for this through their taxes and have a right to expect a good high quality service.*

SSQC017: *You have to be there, you have to pay attention to them, and you have to listen to them. You have to address their particular personal concerns. … You've really got to engage with people.*

SSQC020: *That's a difficult one. I think that really varies on your patient because actually what is good quality of care for one patient may not be for another patient. Some patients are very happy to come in, have their investigation done and go home but actually for a lot of patients particularly, the elderly, you realise that it's not necessarily about making their pain better, but a lot of it is about, because they're lonely maybe and they want to talk to someone and they want interaction with other people. So actually I think quality of care really varies depending on who your patient is. Maybe making the right diagnosis is good care or it may be just having time to speak to that patient, means that you've provided good quality of care.*

SSQC025: *To give our patient what they need, when they need it.*

Efficient / effective

SSQC002: *Listening and not judging and being able to follow up on their care and call in extra services if needs be and you have to be able to do that efficiently and effectively.*

SQC004: *I actually really like the new CQC framework for inspection, you know, is the service safe, is it effective, is it well led, is it responsive, and is it caring.*

SSCQ007: *In an ideal world people would come in, they'd be seen in four hours, they'd flow through the hospital beautifully, that just isn't the case at the moment and that's the reality up and down the country.*

SSCQ007: *Patients want to come in, be seen quickly, get treated and go home. It can be as complex as you want, if you add on top of that, you know they're understood, you communicate well with them, they are treated with respect and it needs to be responsive clearly.*

SSQC022: *Good quality of care is seen, diagnosed, treated, all within a timely manner.*

Empathy / understanding

SSQC002: *Being empathic and non-judgemental.*

Environment and resources

SSQC008: *We need to maintain that wellness, so they need to eat well, they need to have access to simple things like water and drinks and food when they want it and that is a fundamental. The environment is really key in all good healthcare, I know we've got to keep it clean I know we've got to be able to clean it, but we need to make it more friendly.*

Signs and symptoms

SSQC008: *Good healthcare is about spotting when things are going to go wrong. Being aware what signs and symptoms might mean in the longer term.*

Safe outcomes

SSQC012: *I think I would say it was safe outcomes, using evidence-based practice but not being a slave to evidence-based practice. Patient feedback, and maybe a degree of supervision of our work.*

Atmosphere

SSQC004: *If people are giving people eye contact, if they're smiling, there's a vibe, a positive vibe in the house, if people are laughing if there's music playing, just little things.*

Science and art

SSQC023: *It's sort of summed up in giving the care that you would like to receive in a way, or that you'd like friends and family to receive. That consists of up to date evidence-based treatments and diagnostics, along with compassionate care and also wisdom as well to know when there's enough investigation, maybe it's time to stop. Just a combination of science and art if you like, or science and human factors I think.*

7. Relationships between staff satisfaction and quality of care

In addition to looking at staff satisfaction and quality of care as individual constructs, participants were also asked to consider how they might interrelate. Interviewees were asked to deliberate whether staff satisfaction influences the quality of care provided as well as whether the level of care provided influences staff satisfaction. Twenty-four participants felt there is a relationship between staff satisfaction and quality of care; however the responses were split as to whether they referred to this relationship in a positive or negative way. Fifteen participants referred to the fact that the relationship also works the other way around too, so being able to provide high quality of care impacts job satisfaction. The results are summarised in the table below and again, quotes from the data analysis have been used to support each direction of the relationship.

Relationship	No of Participants	Participant ID Numbers
Staff satisfaction influences quality of care		
Positive relationship	12	SSQC003, SSQC004, SSQC012, SSQC013, SSQC016, SSQC018, SSQC019, SSQC020, SSQC021, SSQC022, SSQC023, SSQC025
Negative relationship	12	*SSQC003, SSCQ008, SSCQ009, SSQC010, SSQC011, SSQC013, SSQC014, SSQC015, SSQC016, SSQC017, SSQC018, SSQC024*
No relationship	3	SSCQ00, SSQC019, SSQC022
Breaking point	9	SSQC001, SSQC003, SSCQ007, SSQC008, SSQC012, SSQC013, SSQC014, SSQC023, SSQC024
Quality of care influences staff satisfaction		
Positive relationship	11	SSQC0, SSCQ00, SSQC001, SSQC003, SSQC004, SSQC005, SSCQ006, SSCQ008, SSCQ009, SSQC013, SSQC023
Negative relationship	4	SSCQ006, SSCQ007, SSCQ010, SSQC017

Does staff satisfaction influence quality of care? - Positive relationship

SSQC003: *If you're satisfied you come in with a better frame of mind, if you're satisfied your service provision is better.*

SSQC004: *I think there's definitely a direct link between staff motivation and quality.*

SSQC012: *In the place that I was working, if you weren't happy with or didn't get job satisfaction, you couldn't do it. It wasn't possible because it was so demanding that you had-- there had to be some reward for doing it, internal reward.*

SSQC013: *I think the more positive people are, the happier people are; the better they work and the better quality work you get out of them.*

SSQC016: *Yes. I think so. I'm happy in my job. I think I dig deep and I get it done.*

SSQC018: *The more satisfied the staff is, I think will deliver better service.*

SSQC019: *I think it does impact it to a degree because perhaps we're….If we were happy and not worried about things, we perhaps might be more worried when we're late for things…. we might not take the extra minute on break because we know what they need and we'd try to be a bit more productive.*

SSQC020: *Yes, I'm sure it does. I know days when I'm not tired, I've got good support around me. I'm not being pulled in too many directions. I usually have longer for my patients. I probably do things to a better standard. I'm sure it does; yes definitely impact on the care we provide.*

SSQC021: *Obviously it helps, because if you're in a good mood and you're not rushed with time then obviously you can give a little bit more.*

SSQC022: *I think if you're working in a happy culture where there isn't criticism and blame, then you're going to be more able to function better and be more helpful to patients.*

SSQC023: *I suppose if we're more satisfied and happy in our work, and that can be to do with culture, it could be to do with good flexible working hours, where we can actually have a balance. We've got enough staff so we can get home on time and all the rest of it. I think if we've got that, then we're going to be just happier, less stressed human beings that can therefore be more compassionate and be better at our art really in looking after people, yes.*

SSQC025: *I definitely think that job satisfaction improves the quality of care and vice-versa actually. If you're happy in your role, you are able to provide that quality of care because you're not thinking about the other issues.*

Does staff satisfaction influence quality of care? - Negative relationship

SSQC003: *Then your satisfaction goes down and therefore service provision goes down.*

SSCQ008: *I think I would be lying if I didn't say that at times, because I feel under pressure, sometimes I might not give as good a job as I'd like to. When you're under pressure, when things are going wrong or when things are just busy I think that the quality of care does go down and I think if you're under long-term stress then that's got to come out.*

SSCQ009: *I understand that people get fed up and maybe do let their quality of their work suffer and the care that they give maybe suffers as well.*

SSQC010: *If you're doing a lot of shift work if you're working long hours, it can be quite difficult to focus and be as cheery as you would otherwise might be. I mean if you're demoralised for whatever reason, it just means you don't give as much to your job.*

SSQC011: *Yes, I do think so. I think, particularly for me, if I'm tired that does influence how I behave. I mean, we all revert to the bare minimum when we're really upset about something or depressed about something.*

SSQC013: *Yes, I think people can be distracted if they're not happy. Or they have something playing on their mind. I think anybody's capable of being distracted in some way, shape, or form. And if someone's not a hundred percent happy it's bound to have an effect in some way.*

SSQC014: *So I think, we were so stressed that things can get missed, or not done inappropriately and not necessarily putting people's lives at risk but mistakes can be made. I think if people aren't able to cope then the level of care is quite poor.*

SSQC015: *If I'm grumpy and really don't want to be there then there's a chance that I might not be paying quite as much attention.*

SSQC016: *I know there are people that are unhappy in there so therefore, they don't bother. They don't do the extra mile. They don't do the next part of that samples journey, they're just like, "Someone else can do it", and they don't. That's very frustrating from my point of view.*

SSQC017: *I should think a demotivated work staff; workforce would find it quite hard to deliver care to the standard that they would like to deliver to. If there aren't enough of you, it's impossible, but that's not to say that demotivated staff can't give good care. They can, but it just makes it harder.*

SSQC018: *Yes, I do agree with that. Because if the staff is frustrated for some reason that can definitely affect the quality of care.*

SSQC024: *Yes. It absolutely does. I think they're both aligned. If people aren't satisfied in their work, they're probably not going to go and follow the policies to the letter or want to understand why that's the case or even go above and beyond to do that bit of extra work.*

Does staff satisfaction influence quality of care? - No relationship

SSCQ00: *Because I should be giving the same standard of care regardless of whether I'm feeling good mood, bad mood.*

SSQC019: *I wouldn't say it affects the way I treat the patients themselves when they're there… you deliver the care to the patient as best and then try to put everything else to one side.*

SSQC022: *I wouldn't say just because I'm having a bad day, I would take that out on a patient.*

Breaking point

SSQC001: *I see in healthcare time and time again, people burning out and levels of stress it has such a massive impact on your ability.*

SSQC003: *I think that can happen quite easily in the caring profession I think you can get too stuck in and it's hard to step back a bit.*

SSCQ007: *The challenges you've got, that can be very, very wearing to your own well-being really in terms of cancelling those patients going down talking to them, cancelling them not once not twice but three times and that's a really difficult challenge.*

SSQC008: *I will be clear with you the changes that have happened in our trust and to my role over the last two years has led me now to be on long-term sick through stress and anxiety.*

SSQC008: *I love my job, but we come home sometimes and we think oh my god, I can't do this anymore and I clearly think if you get worn down and worn down eventually something's going to break. People are going to snap, they're going to bite people's heads off, they're not going to be able to answer bells and when they've answered the fifth bell in the last five minutes for somebody who just needs you to turn the light off or something, it can be so frustrating.*

SSQC012: *There is a breaking point. I think there's a breaking point for everybody and sometimes you can change the role that you're doing. One of my colleagues moved more to a*

strategic role rather than seeing patients. For me, I saw a job elsewhere and thought, "Well, I'll take this opportunity", because I couldn't have done it for much longer and it wasn't about quality, there comes a point when you can't offer the safe work, safe quality and then you stop.

SSQC013: *I didn't realise how bad that person was and how much they were taking on to their detriment. We were joking about her hopping around, needing the loo, and she'd been doing that all the time to the point where she was shaking— If you're that short staffed that you feel that you can't go to the loo, that's bad.*

SSQC013: *They burn out, yes. People don't like to say no, and I think people are shocked when someone turns round and says no, I'm not doing it. I know a friend who's been off with burnout and she's making sure that they don't put too much on her, but she knows she has to say now.*

SSQC013: *People are knackered because there's so much work to do for so few people. And we're covering people who've been signed off for, well the ones I do know about for burnout and I can assume that it's similar for the ones that I obviously don't know about.*

SSQC014: *But there are breaking points and I know, well actually I know lots of people who have moved out of a specialty and chosen a different career path because they've found it too stressful and I think there is always that option available to me and I know that so.*

SSQC023: *Simply, if you don't have enough staff to meet the need that you've been requested or demanded to meet, then you have this terrible feeling of responsibility, without power, which is a sure-fire way of getting burned and depressed.*

SSQC023: *I've chosen to be under-employed rather than to take those jobs because I really don't want to do a job which is not doable. Because otherwise, I'll feel like I'm setting myself up for burnout, depression, and ill health because I'll end up-- because like most NHS worker, I'm passionate about what I do, and I'm passionate about being committed to giving a good service to patients. What I've done previously… I just worked really long hours and neglected my own physical health and social life in order to try to meet the needs of others. I realised that that actually is ultimately not good for anyone. Now, I just won't do a job that's not doable.*

SSQC024: *I think its fine in parts, but when it becomes a part of the norm; then people tend to expect it. When you don't do it, it's like you're not performing. I think it happens, and it's not like a pressure off anyone. I think it's just because people want to do a good job for the good outcomes, but it gets to a point where I think it does become unhealthy.*

SSQC024: *I actually ended up getting really ill, ended up being in hospital. I think genuinely, I was completely wiped out. When I was off, I was like, this isn't done. This isn't done. All the things were extra to what I probably should have been doing. I've become acutely aware of your own health effects and pushing it at work. Now I'm trying to strike the balance.*

<u>Does quality of care influence staff satisfaction? - Positive relationship</u>

SSQC0: *Yes, I would say that's one of the most important things to me yes. If a patient turned around to me or my colleague and said the quality of care is poor I wouldn't necessarily blame myself and obviously I would look at what care I'd provided but yes, it is very, very important.*

SSCQ00: *If I care for my patients well then I come home feeling that I did that well, I feel happy, job satisfaction, yes. That's the essence of the job, if I can't look after somebody and give them the best quality of care there's no point being there.*

SSQC001: *I think that's what gives me personal satisfaction that I'm doing the best I can for my patients.*

SSQC003: *If you feel like you're giving a good service and interacting well with service users then job satisfaction is really high.*

SSQC004: *I would say that there is a direct link between quality and satisfaction*

SSQC005: *Yeah I think that's probably the highest factor in job satisfaction for me personally, is that the service provided is a good one; I think that's really important.*

SSCQ006: *I mean when you've done something successfully you feel good about it, but it's a bit like driving you just go into autopilot you don't even think about it.*

SSCQ008: *When I feel able to give the care that I want, I feel very satisfied with my job. So when I've been able to give really good care, when I've really made a difference, that's I'm happiest in my job.*

SSCQ009: *Doing the job well makes you feel better about yourself.*

SSQC013: *Yes, if I feel like I've made a difference more than usual. You do feel like you've done your job and you've done a good job because you've noticed that it wasn't right. So Yes, I think it does impact*.

SSQC023: *We're happiest and most satisfied with our jobs when we can deliver a good service. Because I actually that's what most people want, well nearly everyone wants to do. They want to deliver a service they can be proud of, that they'd be happy for family and friends to have, and that's very satisfying.*

Does quality of care influence staff satisfaction? - Negative relationship

SSCQ006: *Like with most things you're more affected when something doesn't go right and you go home feeling a bit deflated.*

SSCQ007: *The kind of challenges you've got and that can be very, very wearing to your own well-being really in terms of cancelling those patients, going down talking to them, cancelling them not once, not twice, but three times and that's a really difficult challenge.*

SSCQ010: *I think if I feel I can't give good quality of care to patients then my job itself is less satisfying because I get a lot of my satisfaction from the feeling that I've sorted things out properly for people. If I feel like things haven't gone well and you haven't done things as well as you could have done, it's not a good feeling and it's quite frustrating.*

SSQC017: *Yes, I think they probably do. Certainly, if you can't deliver care to the standard that you think it should be delivered; your job satisfaction goes down.*

8. Areas for improvement

An important aspect of this research was to allow healthcare staff a chance to reflect, have their say, and state their opinions in a completely confidential setting, something which does not often occur in some healthcare environments. As part of this approach participants were asked how they thought staff satisfaction and quality of care could be improved in their departments and organisations. Ten factors were mentioned by more than one participant as being important to improving staff satisfaction and quality of care, with an additional seven, being mentioned by a single participant. Quotes from the data analysis have been used to endorse each factor and are presented below.

Areas for improvement	No of Participants	Participant ID Numbers
More resources	11	SSCQ001, SSCQ007, SSCQ008, SSQC010, SSQC013, SSQC014, SSQC019, SSQC020, SSQC021, SSQC023, SSQC025
Feeling supported and appreciated	9	SSCQ001, SSCQ002. SSCQ006, SSCQ007, SSQC009, SSQC010, SSQC011, SSQC014, SSQC019
Communication	8	SSQC0, SSCQ001, SSCQ002, SSCQ006, SSCQ007, SSCQ009, SSQC016, SSQC016, SSQC024
Training	8	SSQC0, SSCQ00, SSCQ003, SSCQ004, SSQC010, SSQC014, SSQC018, SSQC025
Staff involvement / decision making	7	SSCQ001, SSCQ002, SSCQ003, SSCQ004, SSCQ008, SSQC010, SSQC010, SSQC016
Better leadership / management	7	SSCQ001, SSCQ007, SSCQ009, SSCQ010, SSCQ011, SSCQ018, SSCQ024

Meetings	5	SSQC0, SSCQ001, SSCQ003, SSCQ005, SSCQ009
Working conditions	5	SSCQ001, SSCQ007, SSCQ008, SSCQ009, SSQC010
Supervision / feedback	4	SSQC0, SSCQ001, SSCQ002, SSCQ004
Improved technology	4	SSCQ007, SSCQ008, SSQC013, SSQC016
Culture	3	SSCQ003, SSCQ004, SSCQ008
More time to care	3	SSQC0, SSQC012, SSQC020
Funding	2	SSCQ001, SSQC017
Team building	2	SSQC021, SSQC025
Amenities / perks	2	SSCQ00, SSQC015
External services	1	SSQC022
Paperwork	1	SSQC025
Best practice	1	SSCQ007
Skills mix	1	SSCQ00
Self-care	1	SSCQ007

<u>More resources</u>

SSCQ001: *We need more bodies on the ground, we need more beds, we need more provision; we need more service.*

SSCQ007: *If you ask me would we need more resources just on the grounds, yes probably.*

SSCQ008: *We could really do the ward clerk, somebody to answer the telephone; we don't have a ward clerk all the time, somebody to do our discharges*

SSQC010: *Having a smooth administration system that works and good secretarial support is very important for my particular job. I think sometimes those things are cut because it's an easy target and that ends up having quite a big impact.*

SSQC013: *I think the staffing at the end of the day improve the quality as because they aren't as rushed and they can take the time to focus on one dedicated thing rather than having to split yourself between several tasks.*

SSQC014: *Equally, if there was more staff to patient ratios, no-one really cares, there could be any number of patients to one Doctor, it's like no-one cares about that.*

SSQC019: *Our vehicles are currently falling to pieces …we've got 8 vehicles off the road at the moment waiting for repairs and a couple years ago when we were in the middle of the contract, that wouldn't have happened, they would have been repaired and back out on the road fairly quickly.*

SSQC020: *I think I'm sure everybody's probably said this to you. Having just more staff would improve things. I think everyone's stretched.*

SSQC021: *This is something that we're currently discussing. One of them is trying to obviously get more staff in, which is really difficult.*

SSQC023: *I mean it's an obvious thing really. Staffing and getting that right staff and the right staff mix and the right numbers of staff really, so that it creates a job that's doable.*

SSQC025: *And the biggest one, if I were to talk generally is that we could do with perhaps another full-time staff member because we run with a lot of part-time staff which is difficult.*

Feeling supported and appreciated

SSCQ001: *It's that feeling of massively being more relaxed and supported and heard and validated.*

SSCQ002: *I guess just to feel a bit more welcoming maybe that would be nice*

SSCQ006: *I would say just staff feeling listened to by their superiors is in some of the departments not very good.*

SSCQ007: *So that's when I think you have to look at on the day-to-day side and the simple quick wins, how can you support the staff, what can you do for them.*

SSQC009: *I don't recall ever having an email saying you know you worked really well, you pulled it out of a hole this month, thank you.*

SSQC010: *I think it's always important to feel supported by your immediate seniors and I've been in previous departments where I felt like the people I was working for just didn't appreciate me at all and sometimes it's just simple things like knowing your name or just appreciating the fact that you've obviously done your best for somebody. It's quite demoralising when you've worked and they just aren't appreciating all the effort you've put in.*

SSQC011: *To actually praise, and actually the other part of that is to be visible when things go wrong.*

SSQC014: *I think just a simple, thank you for staying hours late, I think that's really important.*

SSQC019: *I think I'd be more satisfied if I did get some thanks for when I do go over and above what we're supposed to be doing. For instance, "Oh yesterday you were half an hour late back, cheers for doing that, it really helped us out". That sort of thing. That would have an immediate positive effect on just about everything.*

SSQC010: *It's really simple things like my consultant makes a point of every now and again, he buys us all coffee and a tiny thing like that just makes you feel so appreciated.*

Communication

SSQC0: *Communication I would say is the key, yes people seem a bit too busy to communicate with you really.*

SSCQ001: *Full team meetings a little more often*

SSCQ002: *First and foremost probably communication, when you're in a room with therapists let alone just human beings there is a way to communicate.*

SSCQ006: *I mean you have briefs in the morning where you all introduce yourselves and talk about the patient and you talk about if you have any issues, if you're feeling unwell or any personal things that might affect like your performance that day and then in the evening after you finish you have a debrief and talk about what was good, what was bad and how it all went.*

SSCQ007: *Try and communicate as much as we can in terms of what's happening, keeping them engaged. We're reasonably good at communicating within the department but you know it can always be improved.*

SSCQ009: *Communicate more rather than handing out diktats, communicate, ask people questions, you know a monthly email just for feedback would be nice.*

SSQC016: *I think communication is the key. I think they need to ask the people who run it more.*

SSQC024: *Yes. One of the things that always comes up in our staff satisfaction surveys is communication, which comes up sometimes too much, too little.*

Training

SSQC0: *I was thinking study days, this is linked to resources; a lot of the time, the ward or the hospital can't really afford to you know put you on various study days*

SSCQ00: *Better training, more training, being allowed to go for training.*

SSCQ003: *Training on a reasonably regular basis to keep up with governmental changes, NHS changes, organisational changes within the NHS and department changes, plus your own qualification. So it's hugely important that that's a continual thing, but again because everybody is under pressure that sort of gets pushed to one side quite quickly, which then affects job satisfaction because you don't feel safe and secure in what you are doing.*

SSCQ004: *There have been things I've done in the past, like little exercises to really get staff to take a step back and understand that empathy side of things.*

SSQC010: *You were supposed to go to 70% of teaching sessions and I think I probably went to 5% because I could just never ever get away from the job.*

SSQC014: *I think quality of training is really important too … if people can't get into theatres to do their training to become surgeons, that's really important, if you literally can't get trained to do your job that's a huge issue.*

SSQC018: *Definitely, the training, more lectures, more of passing knowledge from higher band staff to lower band staff so they do know what they're doing.*

SSQC025: *Training, that's a big thing as well. If we could access more efficient and trust-wide training that would improve things, you know standardised care which is always helpful.*

Staff involvement / decision making

SSCQ001: *Involvement of staff at all times.*

SSCQ002: *Talking it through and asking for opinions or involving us in the decision-making.*

SSCQ003: *Allow people to feel comfortable to discuss day-to-day issues, good and bad, because there might be good things that come up and bad things that come up and think that then information could be fed back up the chain.*

SSCQ004: *In services in the past that I've worked with I've introduced an anonymised suggestion box which generally works quite well, as long as they are positive and constructive and that people are using them in the right way.*

SSCQ008: *We could do with being listened to about how best to run the work from a personal point of view.*

SSQC010: *In some hospitals there are mechanisms where you can raise your good ideas or report things that aren't working very well and that feels really positive. You feel like you can contribute and share what you're experiencing and then in other hospitals there's no real formal channel of reporting so you might have a great idea about how the hospital could improve and there's no-one to tell, so you just sit on it.*

SSQC010: *Quite often things just happen and you didn't know they were going to happen and you have no control over them. For example my patients recently moved from one ward to another and we didn't know it was going to happen; one day someone just said okay we are moving wards.*

SSQC016: *They've brought all these new machines in, they changed over, they didn't take anybody with them from reception. At one point, it wasn't even as if reception were going to matter. So we were very undervalued in the whole process.*

Better leadership / management

SSCQ001: *People in senior positions, if they are lacking in personality and experience, there can be a lack of leadership at times which can result in a breakdown of a team.*

SSCQ007: *So sometimes they look to you for that help and that's what you need to provide really you just need to be there visible and helping.*

SSCQ009: *Just try to humanise the staff a bit more, you know don't treat them as a number and then on the whole they will do the job, because the staff mostly realise that the managers work under stress themselves.*

SSCQ010: *So in some hospitals the senior managers are quite visible and you've got opportunities to meet them.*

SSCQ011: *He [referring to a previous manager] used to walk through the lab no matter what. No matter what his day had been like, he walked through the lab and listened to other people. And that was just so positive.*

SSCQ018: *Staff management, I think in my eyes that's really important thing. How everything is managed, organised, prioritised. How actually the lab is led by someone. If the leader is good then everyone follow him and things are getting better.*

SSCQ024: *Departmentally, I think there's just some weaker managers and leaders. Recently, shifting into a new office, there's been some quite old school leadership and management style.*

Meetings

SSQC0: *We do have ward meetings every month or so, but not everyone can go to them, maybe more of them.*

SSCQ001: *Full team meetings a little more often.*

SSCQ003: *Resume team meetings.*

SSCQ005: *We have regularly sort of clinical lead meetings, so I think that side of it is good and I think that's probably the best thing to keep going is that everybody just sort of have, have the chance to communicate with the rest of the wider team and that they get chance to be heard if they've got opinions or problems that sort of need dealing with or escalating up to the sort of the Network Manager.*

SSCQ009: *Call a meeting with groups of staff just to find out what their concerns are, because they tend to not really happen.*

Working conditions

SSCQ001: *We need better working conditions, so shorter days, more staff.*

SSCQ007: *So you know it's being visible, it's asking questions, it's as simple as making them a cup of tea, you know it's the softer side of stuff really. Doing that kind of supportive stuff, can I sit at the desk for 10 minutes and give you a break, you know go outside.*

SSCQ008: *The staff also need to be comfortable, you can't expect somebody to work for 13 hours and not have a proper break, not be able to have a cup of coffee, not be able to sit and eat their dinner; you won't get the best out of them. That care isn't going to be as good if you're not hydrated and nourished.*

SSCQ009: *I mean some simple little things like the room that we were in didn't have proper desks, proper computer terminals, ergonomically it was awful and it actually took me to have spinal surgery before they decided to get us a proper chair to sit on.*

SSQC010: *If you're working night shifts and you find out that you haven't even got anywhere to heat up food or you can't buy food overnight; just practicalities, just looking after you as a human being.*

Supervision / feedback

SSQC0: *A lot of the time you don't know how you're doing… just a little bit more feedback I would say.*

SSCQ001: *Encouragement of supervision.*

SSCQ002: *I think more supervision needs to be given.*

SSCQ004: *It's about their [managers] leadership skills, quality of supervision so looking at the training and supervision.*

Improved technology

SSCQ007: *The use of technology, how we draw up a strategy for that, fund it, how we link in to the community because as much as we can come up with a system it's how we pay for it and at the moment a lot of the gain as much as we're talking about quality of care we're really hampered by financial constrictions.*

SSCQ008: *Better technology would absolutely solve a lot of the problems that I have doing my job. I spend so much time chasing my tail because I haven't got a good information system. If the health visitors, midwives, safeguarding officers and doctors all used the same system it would be fine, but everybody's got a different system.*

SSQC013: *I think the changes they've made already by changing the company that provide the equipment, is going to be massive. There's a lot less maintenance with the new machines and there's far better help systems built into the machine.*

SSQC016: *It's lots of little things in the IT system that could improve the quality of care. I think the IT system needs looking at.*

Culture

SSCQ003: *The department issues can be dealt with by the department regarding culture and the atmosphere at work, so encouraging pleasantness in the office.*

SSCQ004: *I think actually there's something there about having fun in the workplace and enjoying work and people staying motivated to want to come to work by, by creating a culture that yes, is outcome focused but it's not an oppressive culture.*

SSCQ008: *I've tried to escalate the concerns in the workplace and the culture, the bullying culture but because I've done that, I have then been targeted as a troublemaker so it's very difficult to do that.*

More time

SSQC0: *Spend more time with individuals.*

SSQC012: *I actually think the only thing that would've improved the satisfaction would have been more time. We needed to be able to spend more time with patients.*

SSQC020: *Ultimately a lot of these things come down to people having time to do things properly.*

Funding

SSCQ001: *I mean it comes down to funding.*

SSQC017: *Certainly a little bit more security around funding would be good.*

Team building

SSQC021: *Another thing they're thinking of doing is more team building things like-- because at the moment, because our department is so big, we're kind of split-- it's like paediatrics and adults and we don't want that, we want people to gel a little bit better.*

SSQC025: *Team building. I think it improves the quality of care because if you've got a team that works well together then the outcomes are always more positive so I think that's something we could look at that would probably improve the quality of care that we're giving as well.*

Amenities / perks

SSCQ00: *Allow staff parking. Maybe discounts for meals and things.*

SSQC015: *Perhaps better incentives for working on call.*

External services

SSQC022: *It comes back to we've got to improve social care, really. In the hospital yesterday, there were a hundred patients in the hospital that were bed-blocking. That's a horrible word, but they should have been back in the community.*

Paperwork

SSQC025: *Improving our paperwork would make things run smoother perhaps you know if care plans are completed effectively that would help with day-to-day tasks.*

Best practice

SSCQ007: *Quite often as an organisation we'll do things the way we've always done them and it's quite nice to learn from other healthcare providers and bring that best practice back and try and implement that within a service.*

Improve skills mix

SSCQ00: *Employ senior staff, it's completely bottom heavy.*

Self-care

SSCQ007: *Moving to the future around more self-care and how we engage patients in that.*

10. Serendipitous themes

Although key themes and factors emerged via the questions from the semi-structured interviews, on occasions conversations deviated off these topics, however, this was encouraged as part of the exploratory nature of this study. Four additional themes were deemed important and relevant to the areas of job satisfaction and quality of care and have therefore been included here.

Additional Themes	No of Participants	Participant ID Numbers
Media portrayal	5	SSQC0, SSQC006, SSQC008, SSQC019, SSQC023
Resistance to change	2	SSQC011, SSQC006
Importance of caring for the carers	2	SSQC022, SSQC023
Whistleblowing	2	SSQC008, SSQC023

<u>Media portrayal</u>

SSQC0: *No just that nurses I think, we get pressurised I think and often with the media we get portrayed quite badly you know, a lot of reports come out and obviously quality is quite poor but I think that is due to staff shortages, I don't think it's anything to do with the nurses attitude, generally not to do with their skills, it's just time issues and staff shortages which I don't think is very fair.*

SSQC006: *I think, I don't know if this is relevant at all I think there's a lot of scaremongering with media because obviously we see hundreds and hundreds of patients and almost every single one of them praises us when they're in there, so where all these negative feelings towards health care in general come from is, like I don't know, I just feel like it's unfair and that can kind of just bring you down as well as you feel like you're fighting a losing battle.*

SSQC008: *I still take great offence at the way that the staff at mid Staffs were vilified, you know the nurses were terrible and they wouldn't give people drinks, well how many nurses were there*

on that ward and did they have anybody to help give drinks out and who is to blame for that, it's about the root cause. I don't believe any of those nurses went out of their way to be mean, but I think after you get worn down and worn down, I have sympathy with them.

SSQC019: *We're often getting told things like that we're risk of privatisation and when you have the big news stories about how badly the ambulance service is performing and things like -- when you get a negative media image.*

SSQC023: *Other situations I know of in a previous Trust where there's been a lack of support for clinicians involved. So, when media attention is turned on them and tried to vilify an individual or department or so on, there hasn't been adequate support in terms of standing up strongly for those people really.*

Resistance to change

SSQC006: *Speaking to some other people there was some reluctance at first because they were like oh what's the point and they really had to enforce it in some theatres, but now it's generally just a part of what we do.*
SSQC011: *They get used to it. This is the way it's always done; there's always been a 7 day back log. But once they've achieved maintaining a 7 day backlog they'll never look at improving it.*

SSQC011: *There's quite a lot of, well this has got to happen now and it can be a chore, but you might need a pressure to change, but if you're given more of a warning and involvement, then you can move things through, rather than this this has got to be done now.*

Importance of caring for the carers

SSQC022: *When I first started, I missed it a lot. Sometimes I didn't get a break at all. Probably nine times out of 10, I take it now and I take it because I know I am not young any longer and I need my break. I need to sit down. I need to have a drink. I need to have something to eat and I need to regroup and rethink. Some of the younger ones, I'm always pushing them to go off to break and they say "I've got too much to do." And I say, "You'll work better if you just have a chance to sit down." Even if you take a small break, you come back and you can refocus and you're better for it and that's just something over the years that I've worked out.*

SSQC023: *I've personally—I've actually taken a couple of career breaks, specifically to learn to look after myself. In my 40s, I've come to the conclusion I've got to heal the healer, as it were, I got to start really learning how to treat myself as well as I treat others. That really paid off. It's been really, really useful.*

SSQC023: *"Oh she's very rigid. She gets away from work at 5 o'clock every night" [laughs]. Actually it was really inspiring, I thought, "Well, isn't that amazing that I'd never come across that before and possibly not since" that people actually going home on time, it almost seems like wrong, some might be naughty or uncaring about it, "How can you go home on time?".*

SSQC023: *As senior staff, if we're mature enough to actually realise that we need to look after ourselves, and we can model that.*

Whistleblowing

SSQC008: *We have our Datex system, we have problems going on I have had, you know I've tried to escalate the concerns in the workplace and the culture, the bullying culture but because I've done that, I have then been targeted as a troublemaker so it's very difficult to do that.*

SSQC023: *Even in my current organisation I come across-- The other day someone was telling me the story of how some nurses had whistle blown and then nothing was done about it, and they were told that it's very difficult to get rid of doctors and they didn't want any public-- They didn't want anything going into the press or any public knowledge about this [laughs] And this was in terms of risk of their -- The concerns were the risk to patients and patients safety. That sort of situation is very demoralising.*

General Appendices

Appendix 1: Examples of Quality Indicators in the NHS

NICE Quality Standards

The NICE quality standards aim to measure the quality of service received from the patient perspective and includes three elements: effective, safe, and cost effective care (NICE, 2018). In total there are currently 148 quality standards. The aim of the quality framework is to ensure service providers are adhering to agreed standards, which in turn are regulated by the CQC (NICE, 2018). The standards enables healthcare providers to demonstrate whether they are conforming, which also gives patients the relevant information for them to make informed choices regarding the whereabouts of their care.

NHS England Quality Indicators

The quality indicators used by NHS England can be grouped in to twenty-five main areas, these can be seen in Table A. Within each area, specific measures are used to capture the performance of each discipline or service. For example ambulance indicators include measures of response times and clinical outcomes; whereas the NHS Staff Survey consists of a 32 item survey.

Table A: Areas of statistical data collected by NHS England.

A&E Waiting Times	Child Immunisation	Diagnostic Waiting Times	Integrated Performance Measures	NHS Staff Survey
Ambulance Indicators	Critical care Bed Capacity	Direct Access Audiology	Maternity and Breastfeeding	Overall Patient Experience Scores
Bed Availability	Delayed transfers of Care	Friends and Family Test	Mental Health	Patient Reported Outcome Measures
Cancelled Elective Operations	Dementia Assessment Referral	GP Patient Survey	Mixed-Sex Accommodation	Venous Thromboembolism Risk
Cancer Waiting Times	Diagnostic Imaging	Hospital Activity	National Maternity Survey	Winter Pressure Reports

NHS Information Centre

The NHS Information Centre is a Non-Departmental Public Body and is the main authoritative source of health and social care information in England (Health and Social Care Information Centre Annual Report, 2014). The main aim of the corporation is to collect, analyse and present national health and social care data. Data collection is normally initiated by the Secretary of State or NHS England. The corporation has created a library of indicators that are used to measure the quality of healthcare services provided to the general public (Health and Social Care Information Centre Annual Report, 2014). The NHS Information Centre collects data from fourteen main areas, which can be seen in Table B.

Table B: Areas of quality indicators collected by the NHS Information Centre

Cancer	Long Term Conditions	Patient Experience	Revisions
Cardiovascular	Mental Health	Patient Outcomes	Timeliness of Care
Children / Family	Mortality	Patient Safety	
Healthcare Infections	Patient Environment	Re-admissions	

NHS Outcomes Framework

The aim of the NHS Outcome Framework (Table C) is to provide a national overview of the NHS performance. Another reason for the framework is to provide a connection between the Secretary of State and the NHS Commissioning Board for the effective spend of the NHS budget. It also aims to act as a catalyst to drive improvements in quality. The five domains of the framework include 1) Preventing people from dying prematurely, 2) Enhancing quality of life for people with long term conditions, 3) Helping people to recover from episodes of ill health or following injury, 4) Ensuring that people have a positive experience of care and 5) Treating and caring for people in a safe environment and protecting them

from avoidable harm.

Table C: Indicators of Quality Care – NHS Outcomes Framework

Indicator Category	**Indicators per Category**
Cancer	56
Cardiovascular	60
Children, Family and Maternity	9
Healthcare Associated Infections	34
Long Term Conditions	33
Mental Health	17
Mortality	69
Patient Environment	32
Patient Experience	58
Patient Reported Outcome Measures	4
Patient Safety	39
Readmissions	30
Revisions	17
Timeliness of Care	7

Appendix 2: Semi-Structured Interview Schedule

Theme / Topic	Main Question
Introduction (5 minutes)	**Q1. Age? Role? Pay Band? Which department / area? Hospital?** **Q2. How long have you worked in the healthcare?**
Satisfaction (10-15 minutes)	**Q3. Tell me a bit about your job and in particular what you like and dislike about it?** **Q4. What parts of your job influence your overall satisfaction?**
Quality of Care (10-15 minutes)	**Q5. How do you feel about the level of care (service) you provide to patients?** **Q6. How does the level of care (service) you provide to patients relate to your job satisfaction?**
Improvements (10-15 minutes)	**Q7. How could your department or organisation improve staff satisfaction?** **Q8. If you were in charge of your department, what would you change to improve your overall job satisfaction?**
Ranking of Factors from the Literature (10-15 minutes)	**Previous research has shown that some of the following factors may be important to staff satisfaction.** **I am going to ask you to rank these factors in order of importance.** **Q9. How important are each of these factors to your overall job satisfaction?** *Access to training* *Working in a team* *The job itself* *Your health and well being* *Staff management* *Being able to deliver quality of care* *Interaction with colleagues* *Interaction with managers* *The organisation itself* *Staff turnover*

	Hospital environment **Q10. Why have you ranked them in this particular order?** **Q11. Are there any other factors that you think are important to your job satisfaction that are not on this list?** **If so please specify what they are.**
Survey Questions / Closing **(10-15 minutes)**	**Q12. Have you ever completed the annual NHS staff survey?** **IF YES:** **Q13. What was your overall opinion of it?** **Q14. Did you complete it all?** **IF NO:** **Q15. In general, what do you think makes a good survey?** **Q16. What would make you want to complete a survey on job satisfaction?** **Q17. Is there anything else you would like to add regarding the topics we have discussed today?**

Appendix 3: Participant Information Sheet

Participant Information Sheet - Interviews

Study Title

How does staff satisfaction influence quality of care in healthcare environments?

Researcher Information

Moya Lerigo-Jones (Doctoral Teaching Assistant)
518 Cookworthy Building
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What are the aims and objectives of this study? The aim of this study is to understand the factors that influence *Healthcare Staff Satisfaction* and *Quality of Care* and explore these relationships in depth. The interviews will examine a number of factors that previous research has suggested are important to staff satisfaction. However, the interview will provide an opportunity for you to discuss any other factors, which you think are also important. You will be asked a couple of questions on both job satisfaction and quality of care. You will also be asked to think of possible ways to improve staff satisfaction and quality of care in your own departments. Open-ended questions have been used to allow your own, honest opinion to be given in a completely confidential setting.

Why have I been selected to participate? This study requires participants who have worked in a healthcare setting for a minimum of 12 months and are over the age of 18 years old. Participants have been selected to represent both clinical and non-clinical staff. The sample aims to capture a 'typical' healthcare worker, whilst also representing a wide range of staff in terms of age, tenure, background and pay grades.

Do I have to take part? Involvement in this study is completely voluntary; therefore participants have the right to withdraw at any time. If you have completed an interview but later decide you do not want your data to be included, you can contact the researcher using the information provided above. If you decide at any time to withdraw from the study, all forms of your data will be destroyed.

What are the potential risks involved in taking part in this research? There are no potential risks within this study. The interviews will be held in a comfortable environment.

What are the potential benefits involved in taking part in this research? You will be given the chance to talk about your current job in a setting that is removed from the actual location. You will be asked to consider the factors that you think are important to an individual's job satisfaction. Potentially, the information you provide will allow the development of an improved monitoring system of staff satisfaction and well-being. Furthermore, this information will help to establish ways of linking staff satisfaction to quality of care in order to improve the overall patient experience.

Will the information I provide be kept confidential? All data will be treated confidentially and no personal information will be collected. Full anonymity will also be assured throughout the research. Any recorded information will be safeguarded by encrypted and password protected devices under the Data Protection Act (1998).

What will happen to the information I provide? It is possible that publications may arise from this study in the form of academic journal articles or conference papers. However, you will receive a randomly selected participant identification number and only these will be used in any publications. Names, addresses or any other identifiable personal data will NOT be collected; therefore total anonymity can be assured. Any participants wanting to be informed of the results will have the opportunity to leave their email address on the accompanying consent form.

Which ethical policies does this study adhere to? The study conforms to the Data Protection Act (1998), Freedom of Information Act (2000) and has been approved by the University of Plymouth Ethics Committee.

Appendix 4: Blank Participant Consent Form

Consent Form - Interviews

Study Title

How does staff satisfaction influence quality of care in healthcare environments?

Researcher Information

Moya Lerigo-Jones (Doctoral Teaching Assistant)
518 Cookworthy Building
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Please read the following statements carefully and place a tick in the corresponding boxes if you agree to the terms.

I can confirm that I have read and understood the corresponding participant information sheet for the above study and have had the opportunity to ask any questions.	
I understand that my participation in this study is voluntary and I have the right to withdraw from the above study at any time, without any explanation.	
I agree to take part in an interview for the above study.	
I agree to this interview being audio recorded.	
I agree to anonymised quotes being used in future published work.	

Date: _____

Unique Participant Identification Number: _____

Participant Signature: _____

Researcher Signature: _____

Email address (only complete if you want to be notified of the research results)

University Ethical Approval Number: FREC1516.04