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Dissertation Title: Exploring the Lived Experiences of Lung Cancer Patients Attending a Nurse-Led Follow-Up Clinic: A Qualitative Study

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Declaration

I hereby declare that this thesis is my own work and effort and that it is has not been submitted elsewhere for any award. Where other sources of information have been used, they have been acknowledged.

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Acronyms and Abbreviations

ASCO - American Society of Clinical Oncology

CASP- Critical Appraisal Skills Programme

CNS - Clinical Nurse Specialist

CT Scan - Computed Tomography

ESMO - European Society for Medical Oncology

NCCN - National Comprehensive Cancer Network

NICE - National Institute for Health and Care Excellence

NSCLC- Non-small cell lung cancer

PET Scan - A Positron Emission Tomography Scan

PICO - Patient/Population, Intervention, Comparison/Control, and Outcome

RCN – Royal Collage of Nursing

RCT's – Randomised Controlled Trails SPLC - Second Primary Lung Cancers

UK – United Kingdom

Abstract

Background: Lung cancer remains a leading cause of cancer-related mortality in the United Kingdom, creating a growing demand for effective, sustainable follow-up services. Nurse-led clinics have emerged as an increasingly prominent model for delivering post-treatment surveillance, yet little is known about how patients experience this form of care over the five-year survivorship period. This study aimed to explore the lived experiences and perceptions of individuals attending a nurse-led lung cancer follow-up clinic.

Sample and Setting: Participants were adults who had undergone curative-intent, lung cancer treatment and were within the five-year follow-up period at a nurse-led clinic. Purposive sampling was used to capture a range of experiences across treatment backgrounds and follow-up stages.

Data Collection and Analysis: Guided by an interpretivist paradigm and adopting an inductive qualitative design, semi-structured interviews were conducted to generate rich, in-depth accounts of participants' experiences. A phenomenological methodology enabled exploration of how participants perceived and made meaning of their follow-up care. Data were analysed using Braun and Clarke's (2006) six-phase thematic analysis, supporting the identification of patterns of meaning grounded in participants' lived experiences.

Findings: Five themes were identified: navigating the treatment journey, emotional response, communication and information, feeling supported, and continuity of care. Participants described nurse-led care as providing clear and reassuring communication, offering valued continuity with familiar

clinicians, and ensuring accessible support through responsive contact routes. Holistic care that addressed emotional, practical, and psychological needs was central to participants' sense of safety, confidence, and wellbeing throughout survivorship. Overall, the findings suggest that nurse-led clinics offer a unique relational and integrative model of care that extends beyond clinical surveillance alone.

Conclusion: The study demonstrates that nurse-led lung cancer follow-up delivers highly valued, person-centred care that meets both clinical and holistic needs. It addresses the research question by illustrating how communication, continuity, accessibility, and holistic support shape patient experience. The findings support further investment in advanced nursing roles and highlight opportunities for future research to refine and strengthen survivorship pathways.

Chapter 1: Introduction and Background

1.1 Introduction

The aim of this dissertation is to critically examine how nurse-led lung cancer follow-up clinics explore patients lived experiences, with particular attention to the aspects of communication, continuity, accessibility, and holistic support that influence perceived quality of care. This chapter introduces the background, context, and rationale for the study. It defines key concepts, outlines the research problem, and presents the research aim, objectives and questions. It concludes with an overview of the structure of the dissertation.

1.2 Background Context

Lung cancer remains one of the leading causes of cancer-related morbidity and mortality in the United Kingdom (UK), with approximately 49,200 new diagnoses and 35,000 deaths recorded annually (Cancer Research UK, 2024; UK National Screening Committee, 2022). Despite advances in screening, diagnosis, and treatment, long-term survival remains poor compared with other malignancies, emphasising the need for effective post-treatment surveillance and support strategies.

Following curative intent therapy for lung cancer whether surgical resection, radiotherapy, or multimodal treatment patients require structured surveillance to monitor for disease recurrence, second primary lung cancers (SPLCs), and treatment related complications (Colice *et al*., 2003; Colt *et al*., 2013; Rubins *et al*., 2007). Most recurrences occur within the first two to four years, although approximately ten percent present after five years,

highlighting the importance of extended follow-up (Colice *et al*., 2003; Stirling *et al.,* 2021).

Multiple international guidelines, including those from the American Society of Clinical Oncology (ASCO, 2021), the National Comprehensive Cancer Network (NCCN, 2025), the European Society for Medical Oncology (ESMO, 2023), and the National Institute for Health and Care Excellence (NICE, 2020), recommend routine surveillance for at least five years following curative-intent treatment. ASCO (2021) and NCCN (2025) advocate for chest computed tomography (CT) imaging every three to six months for the first two years and annually thereafter to detect recurrence and second primary lung cancers (SPLCs), (Schneider *et al*., 2020; NCCN, 2025; ESMO, 2023; NICE, 2024; ASCO, 2021).

Structured follow-up visits are advised to ensure early detection and timely management of recurrence and late treatment related toxicities (NICE, 2024). This systematic surveillance is crucial for improving survival outcomes, maintaining quality of life, and facilitating the management of ongoing physical and psychosocial issues (World Health Organization (WHO), 2017; Zebrack, 2024).

1.3 Research Problem

Increasing numbers of lung cancer survivors, combined with rising patient complexity, have placed growing pressure on consultant-led outpatient services, rendering traditional follow-up models increasingly unsustainable (Thomas, 2023). In response, nurse-led follow-up clinics have emerged as a clinically and operationally effective model for delivering flexible, patient-centred, and cost-efficient care that aligns with evidence-based surveillance schedules. These clinics offer holistic assessment, timely symptom

management, psychosocial support, and continuity of care, particularly during the critical five-year post treatment period (De Leeuw and Larsson, 2013).

National strategies, such as the NHS Long Term Plan (2019), advocate for the expansion of advanced nursing roles to improve accessibility, continuity, and quality of care while reducing strain on acute and consultant-led services. In alignment with these priorities, local healthcare initiatives have introduced nurse-led lung cancer follow-up clinics designed to provide structured, protocol driven care that addresses patients' clinical, emotional, and supportive needs

Despite the increasing implementation of nurse-led clinics, there remains minimal research exploring patients lived experiences and perceptions of these services, particularly within local contexts. Locally, rising numbers of lung cancer survivors and growing demands on respiratory and oncology consultant-led outpatient services have made the expansion of nurse-led follow-up clinics both a clinical and operational necessity (National Disease Registration Service, 2020). These clinics offer a more flexible, patient-centred, and cost-effective model of care that can ensure sustainability while providing holistic assessment, psychosocial support, and timely management during the five-year post-treatment period (Moore., *et al* 2006). Understanding patient perspectives is therefore critical for evaluating service effectiveness, guiding quality improvement, and ensuring that these models truly meet the needs of those they serve.

1.4 Purpose of the study

The sustainability of lung cancer follow-up care depends not only on formal process of the clinic, but also on ensuring that patient's needs are met

holistically and compassionately. Exploring patients lived experiences can provide valuable insight into how nurse-led clinics influence satisfaction, engagement, and quality of care, thereby informing evidence-based service development and policy (Jakimowicz, 2012; Pu, Malik and Murray, 2024).

The clinical nurse specialist (CNS) is central to the delivery of nurse-led follow-up. A CNS is an experienced nurse with enhanced clinical knowledge, assessment skills and expertise within a defined speciality, enabling them to provide high-quality support, education and care coordination for patients and their families (NICE, 2019). Their scope of practice allows them to deliver an effective and holistic service, addressing physical, emotional and psychosocial needs throughout the cancer pathway (Ulit *et al.,* 2020).

Currently, there is a lack of research exploring how lung cancer patients experience their care within this setting. This project seeks to fill that gap by using qualitative interviews to gather insights from individuals who attend nurse-led follow-up clinics. The knowledge gained is intended to support evidence-based practice and guide future improvements in service provision.

1.5 Significance of the study

Understanding how patients experience their care is vital to ensuring that follow-up services remain effective, high quality, and sustainable. This study is particularly important for many reasons. Lung cancer affects a large population, and gaps in follow-up care, such as missed signs of recurrence, untreated symptoms, or unrecognised emotional concerns can have significant consequences for patients' wellbeing (Zebrack, 2024). Furthermore, both national and international guidance highlights the value

of structured follow-up pathways and supports the development of enhanced nursing roles to enhance continuity and improve access to care. At a local level, rising cancer incidence and increasing pressure on consultant led clinics highlight the need for nurse-led models of follow-up as a practical and sustainable way to meet growing demand (National Disease Registration Service, 2020) (Appendix I).

Limited qualitative evidence exists on how patients experience these clinics, particularly concerning communication, continuity and holistic support. By examining the lived experiences of individuals attending nurse-led lung cancer follow-up, this study contributes valuable insights that can inform service refinement, enhance patient-centred care and support future policy development.

1.6 Research Question

The formulation of a well-defined research question is essential for rigorous evidence-based inquiry (Hosseini *et al*., 2024). Structured frameworks such as PICO, PICo, and SPIDER serve as methodological tools that facilitate the systematic development of research questions aligned with the underlying research paradigm be it quantitative, qualitative, or mixed methods in nature (Cooke, Smith, and Booth, 2012). The selection of an appropriate framework is dependent upon the epistemological stance of the study and the specific objectives of the research question (Hosseini *et al*., 2024). The SPIDER framework was specifically designed for qualitative research and priorities elements central to interpretivist inquiry, such as individual experiences, perceptions, and contextual understanding (Hosseini *et al.,* 2024). The SPIDER framework (Table 1.1) provided a structure approach to guide the focus of the research question towards understanding meaning

rather than measuring variables, ensuring consistency between the philosophical foundations and practical execution of the study (Cooke, Smith, and Booth, 2012).

Table 1.1 SPIDER Framework

SPIDER component	Application
Sample	Patients who have completed primary treatment for lung cancer and are currently participating in nurse-led follow-up care
Phenomenon of Interest	The lived experiences of patients engaging in nurse-led follow-up
Design	A qualitative methodology incorporating semi-structured interviews
Evaluation	Experience and perception
Research Type	Exploratory research focusing on patients' subjective experiences

The question posed therefore is:

What are the lived experiences and perceptions of lung cancer patients regarding follow-up care in a nurse-led clinic during the five-year follow up period?

1.7 Research aim and objectives

Setting aims and objectives is essential in research because they provide a clear purpose, direction and structure for the study Denicolo and Becker (2016). The research aim expresses the overall intention of the project, while the objectives break this down into specific, manageable steps (Doody and Bailey, 2023). Together, they help maintain focus, guide the choice of appropriate research methods, and ensure that the study is coherent and achievable (Doody and Bailey, 2023). Well defined aims and objectives also make the researcher's intentions clear to readers and supervisors, support the justification of the study's relevance, and form the basis for analysing and interpreting findings (Research Prospect, 2025).

1.7.1 Research Aim

To explore and critically evaluate the lived experiences and perceptions of individuals receiving follow-up in the lung cancer nurse-led clinic.

1.7.2 Research Objectives

1. To explore lung cancer patients' experiences of follow-up care within a nurse-led clinic over the five-year follow-up period.
2. To identify key aspects of care (communication, continuity, accessibility, and holistic support) that influence patients' satisfaction.
3. To explore how patients describe their communication, continuity, accessibility, and holistic support experiences.
4. To evaluate the extent to which the nurse-led clinic meets patients' ongoing needs.
5. To generate evidence-based recommendations for enhancing the delivery and quality of nurse-led follow-up services for lung cancer patients.

1.8 Structure of Dissertation

Chapter 1 introduces the background to the study and outlines the rationale that supports the research. This is followed by Chapter 2, where existing literature relating to nurse-led follow-up and patient experience is critically reviewed to establish the current evidence base and identify gaps that the study seeks to address.

Chapter 3 then describes the methodological framework and the specific methods employed in the primary research, providing a clear justification for the chosen approach. Building on this, Chapter 4 presents the analysis

and interpretation of the research findings, drawing on thematic analysis to explore the key patterns that emerge from the data.

Finally, Chapter 5 brings together the insights from the earlier chapters to offer a discussion of the findings and develop recommendations grounded in evidence-based practice, with a particular focus on supporting holistic, patient-centred care.

This chapter has introduced the context, significance and rationale for exploring patients lived experiences of nurse-led lung cancer follow-up care. It has outlined the clinical and policy drivers supporting the development of nurse-led models, highlighted the gaps in current knowledge, and presented the research aim, objectives and question guiding this study. By establishing the importance of communication, continuity, accessibility and holistic support within follow up care, this chapter provides the background for examining existing evidence related to these themes. The next chapter critically reviews the literature on nurse-led follow-up and patient experience to situate the study within the existing evidence base and further justify the need for this research.

Chapter 2: Literature review

2.1 Introduction

This chapter presents a structured and critical review of the literature exploring patient reported experiences of nurse led follow up clinic for lung cancer. Existing evidence is identified and appraised to inform the rationale and relevance of the research question.

2.2 Search Strategy

A structured and comprehensive search was undertaken to identify studies exploring patient reported experiences of nurse-led follow-up in lung cancer care (Table 2.1). Searches were carried out across MEDLINE, CINAHL Complete and MAG Online, which were selected for their recognised relevance to nursing, oncology and healthcare services research (Oermann *et al*, 2020). These databases offer broad international coverage of peer reviewed healthcare literature, making them well suited to capturing evidence on advanced practice roles, patient experience and cancer follow-up care. Collectively, these databases facilitate access to high quality, peer reviewed studies essential for evidence-based practice (Wright, Golder and Lewis-Light., 2015).

The search strategy aligned with Royal College of Nursing (RCN) (2025) best practice guidance by defining a clear research question, identifying key concepts and using structured frameworks such as SPIDER to appropriately frame the qualitative focus of the review. Multiple discipline relevant databases were included to minimise database bias and enhance the comprehensiveness and quality of retrieved evidence, consistent with RCN (2025) recommendations to avoid reliance on a single source. The approach

was also informed by PRISMA principles to ensure transparency and methodological rigour (Page *et al*., 2021).

Key search terms were developed by returning to the research question to identify key concepts and expanding these using keywords, synonyms, and Medical Subject Headings (MeSH) to ensure sensitivity and specificity. Including synonyms ensured full coverage of relevant terminology and minimised the risk of missing eligible studies, as variations in natural language can otherwise obscure important evidence (Schotter, 2013). This strengthened both the precision and comprehensiveness of the search. Boolean operators (AND/OR) and truncation were applied to combine key concepts relating to lung cancer, nurse-led services, and patient experience. Filters were applied for English language, peer-reviewed articles, and publication date. Initially the date range was restricted to 2015–2025, but due to a scarcity of current research specifically addressing nurse-led lung cancer follow-up, the range was expanded to 2000–2025. Although older studies were included, they remain relevant because they provide valuable insights into the development of nurse-led models in oncology care (Boote and Beile, 2005).

Table 2.1 Literature search strategy and results

Database	Search terms	Limits applied	Number of Hits	Number of relevant articles
MEDLINE	("lung cancer patients" OR "lung neoplasm patients") AND ("nurse-led clinic" OR "nurse-managed care" OR "nurse-led service") AND ("patient experience" OR	English; peer-reviewed; 2000–2025	306	2

	"patient satisfaction" OR "quality of care")			
CINAHL Complete	AS ABOVE	English; peer-reviewed; 2000–2025	307	4
MAG Online	AS ABOVE	English; peer-reviewed; 2000–2025	96	0
Total			**6**	**6**

Clearly defining the inclusion and exclusion criteria (Table 2.2) ensured the search strategy remained focused and methodologically rigorous and is a critical step in designing high-quality research studies (Patino and Ferreira, 2018). Inclusion criteria identify the key characteristics of the target population necessary to answer the research question, including demographic, clinical, and geographic features, while exclusion criteria identify characteristics that may interfere with the study's success or increase participants' risk of an adverse outcome (Connelly, 2020). Exclusion criteria are important because they provide clear boundaries for removing irrelevant or low-quality studies, ensuring that the review remains focused, systematic, and methodologically rigorous (Connelly, 2020).

Table 2.2 Inclusion and exclusion criteria

Criteria	Inclusion	Exclusion	Justification
Population	Lung cancer patients at any stage of care	Other cancer populations	Direct relevance to research question
Intervention	Nurse-led follow-up services	Physician-led follow-up only	Focus on nursing role
Study design	Qualitative studies	Quantitative studies without patient perspective	Exploration of lived experience
Outcomes	Patient-reported experiences	Clinical outcomes only	Alignment with patient-centred aims
Language	English	Non-English	Feasibility and accuracy, time

			constraints, finances
Publication date	2000–2025	Pre-2000	Ensures relevance while capturing early evidence

2.3 Study Selection

Following the database search, all studies were reviewed and the removal of duplicates through manual screening, titles and abstracts were assessed for relevance, followed by full text appraisal against the inclusion and exclusion criteria. A total of six articles met criteria and were retrieved and reviewed fully. The study selection process was documented using the PRISMA (2020) flow diagram (Appendix II), PRISMA helps illustrates the identification, screening, and eligibly, this helps to ensures transparency and methodological rigour (Page *et al.,* 2021). No eligible studies were identified through MAG Online.

2.4 Literature Review

Six studies were retrieved for critical appraisal. The Critical Appraisal Skills Programme (CASP, 2024) checklist was used to guide the appraisal process and to support the structure of the literature review (Appendix III: CASP Table). CASP enabled a systematic assessment of the methodological quality, rigour and relevance of the included studies. It is a widely recognised appraisal tool in healthcare research, endorsed by organisations such as NICE (2023), and provides a structured framework for judging study validity, trustworthiness and the robustness of findings (Long, French and Brooks, 2020). Although CASP offers a comprehensive framework, a noted limitation is its emphasis on methodological aspects rather than on the credibility and interpretation of the findings, which may be influenced by researcher bias (Smith and Noble, 2025). Despite this CASP (2024)

remains an established and widely accepted tool for appraising healthcare literature, particularly within clinical research and student dissertations.

Moore *et al* (2006) conducted a multi-method qualitative study exploring the development and delivery of a nurse specialist led follow-up model for lung cancer services in the UK. Although the study primarily focuses on nurses' experiences of implementing the model rather than directly examining patient perspectives it offers valuable early insights into concepts that continue to support nurse-led practice, such as continuity, relational care, and the emotional labour involved in follow-up. As Boote and Beile (2005) emphasise, older literature remains important where evidence is limited or when examining the evolution of emerging roles. Similarly, Greenhalgh *et al.* (2004) argue that foundational studies can illuminate historical context, inform current service design, and highlight gaps that persist in more recent research. In this way, Moore *et al.* (2006) contributes meaningfully to the current research question by demonstrating how early nurse-led models were shaped and how they laid the groundwork for patient-centred follow-up pathways used today.

The methodological strengths of Moore *et al*.'s (2006) work include its multi-method design and transparent description of data collection and analysis, allowing for triangulation that enhances credibility. The findings are also clearly illustrated and provide depth regarding professional roles, communication, and boundary negotiation within nurse-led care. However, the study provides limited detail on sampling and recruitment, which restricts the ability to judge transferability and introduces potential selection bias. A lack of transparency in sampling procedures makes it difficult to evaluate such bias, as clear articulation of sampling strategies is

central to qualitative rigour (Patton, 2015). Also, the study focuses on nurse experience rather than direct patient accounts limits its value for understanding patient perspectives. The study does report that patients valued nurse specialists' expertise and continuity, particularly in relation to emotional reassurance and communication during follow-up (Moore *et al. 2026)*.

Despite its age and limitations, Moore *et al.* (2006) offers important early insights into the emotional demands placed on nurse specialists and highlights aspects of continuity and relational care that patients appreciate. This helps contextualise why patient perspectives of nurse-led follow-up remain an essential area for research, particularly within lung cancer where supportive needs are complex and ongoing.

Pearce and Breen (2018) conducted a service evaluation of advanced clinical practice (ACP) and nurse-led clinics in the UK. They reported several benefits, including greater efficiency, improved access, and increased practitioner autonomy. Patients also expressed confidence in ACPs ability to manage complex issues, reflecting wider evidence of timely and holistic care delivered by advanced practitioners.

A key strength of this evaluation is its clinical relevance, as it reflects the realities of everyday clinical practice rather than controlled research settings. The evaluation also showed that ACPs made rapid, independent clinical decisions and that patient's trusted nurse-led model, offering useful insight into the acceptability of advanced practice roles. These observations align with the Nursing and Midwifery Council's expectations for advanced levels of practice, outlined in its 2024 principles, which highlight autonomy,

complex decision-making, and high-quality, patient-centred care (NMC, 2024).

The evaluation lacks methodological detail, limited information on sampling, data collection, and analysis makes it difficult to assess credibility or transferability, and transparency in sampling which is essential for qualitative rigour (Patton, 2015). As the evaluation was conducted within the same organisation delivering the service, there is potential for researcher or institutional bias, as insider evaluations may be influenced by loyalty to the service or reluctance to report negative outcomes (Polit and Beck, 2017). The study does not use a clear theoretical or evaluative framework, which limits understanding of how and why the model works, as frameworks such as realist evaluation strengthen explanatory depth (Pu, X., Malik, G. and Murray, C., 2024). Service evaluations are also highly context specific, meaning findings cannot be generalised, and nursing interventions may operate differently across settings (Howe *et al*., 2025). The patient voice was only briefly explored, limiting insight into personalised care or shared decision-making.

Despite these limitations, the evaluation offers useful insight into how nurse-led clinics operate in practice. It demonstrates that ACPs can work autonomously, streamline patient pathways, and deliver accessible, holistic follow-up care. The reported patient trust in ACP expertise is particularly important, as trust supports the acceptability of nurse-led models and supports the wider case for advanced practice in cancer follow-up. Overall, Pearce and Breen's (2018) evaluation remains relevant to the research question because it highlights patient trust, acceptability, and experiences within nurse-led and advanced practice clinics factors central to understanding patient perspectives of nurse-led follow-up in lung cancer.

McPhillips *et al.* (2015) conducted a study describing the role of lung cancer nurse specialists (CNSs) across the UK and USA. Their work highlights the value of personalised and flexible follow-up, including telephone reviews and home visits, and identifies continuity and collaborative decision-making as key contributors to patient trust and engagement (McPhillips *et al.,* 2015). These findings support the effectiveness of nurse specialist-led follow-up within lung cancer pathways. More recent evidence also demonstrates that oncology CNS involvement is associated with improved patient outcomes, including reduced non-acute hospitalisations among lung cancer patients and enhanced quality of life, further reinforcing the essential role of CNSs in modern cancer care (Alruwaili *et al*., 2023).

A key strength of the paper is that it provides a clear and detailed account of what lung cancer CNSs do in routine clinical practice. The authors outline how CNSs deliver holistic care, provide emotional and informational support, and guide patients through complex treatment decisions (McPhillips *et al.,* 2015). Another strength is the comparison of UK and US practice, offering a broader perspective and demonstrating how similar specialist nursing roles function across different healthcare systems. International comparisons such as these can enhance relevance by showing how roles translate across contexts and are recognised as valuable for understanding variation in nursing practice despite being relatively underused (Suhonen, Saarikoski and Leino-Kilpi, 2009).

Limitations it is primarily descriptive and does not involve primary data collection, formal evaluation, or systematic appraisal processes. This reduces the extent to which the effectiveness of CNS-led follow-up can be judged confidently. Descriptive approaches are inherently limited because they provide only a static account of current practice and do not establish

causation or determine effectiveness, making them less reliable for drawing firm evaluative conclusions (Grimes, and Schulz, 2024). The findings are also based only on UK and US examples, making them context-specific and potentially less transferable to other healthcare settings. UK based nursing research has traditionally prioritised English-speaking contexts, a methodological choice often justified by challenges associated with translation, interpretation, and data reliability (Pilegaard, 1997). While international comparative research offers significant potential to deepen insight into nursing practice across diverse healthcare systems and to expose both strengths and gaps in care delivery, such studies remain underrepresented in the literature, despite their recognised contribution to advancing nursing knowledge (Suhonen et al., 2009).

Despite these limitations, the paper contributes meaningfully by clarifying the roles and responsibilities of lung cancer CNSs and illustrating how these roles support continuity, patient understanding, and coordinated care. Overall, McPhillips *et al*. (2015) is relevant to this research question because it highlights aspects of CNS-led follow-up that matter to patients including continuity, personalised support, and clear communication all of which are central to understanding patient perspectives of nurse-led follow-up in lung cancer.

Williamson, Collinson and Withers (2007) explored patient experiences of a nurse-led lung cancer follow-up clinic, identifying several aspects that patients valued. Continuity of care was a central theme, with patients emphasising the reassurance and trust that came from seeing the same nurse at each visit. This finding aligns with recent UK audit data, which show persistent variation in lung cancer service provision and highlight the importance of consistent, coordinated support throughout the pathway

(National Lung Cancer Audit, 2024). The authors also reported that patients appreciated personalised attention, with the nurse-led model enabling consultations to be tailored to individual needs. This is supported by wider evidence showing that personalised, coordinated care is essential in pathways where service variation remains a challenge (National Lung Cancer Audit, 2024).

The study demonstrated the significance of emotional support in nurse-led follow-up. Patients described the CNS role as pivotal in reducing anxiety associated with diagnosis and ongoing review. Tod *et al.* (2015) similarly found that lung cancer nurse specialists provide crucial psychological and emotional support throughout the patient journey. Effective communication also emerged as a key theme; patients valued clear explanations and guidance about treatment plans. This is consistent with evidence that timely, face-to-face communication enhances patient involvement, shared decision making, and confidence in care (Clayton, K., Fox, J., and McNamara, A., 2026).

A strength of the study is its direct patient-centred focus, offering authentic insight into what patients value in nurse-led follow-up. Qualitative accounts of this type are particularly useful in shaping service development, as they highlight what is meaningful from the patient perspective (NICE, 2020). The evaluation was also carried out within routine clinical practice, increasing its clinical relevance and immediate applicability for improving local cancer services (NICE, 2020). Given that nurse-led lung cancer follow-up was still emerging at the time, early evaluations such as this are valuable for assessing whether new models are acceptable and workable for patients (Richardson *et al.,* 2001).

Limitations, although described as an audit, the design is more accurately a service evaluation, as it gathered patient views without measuring the service against explicit standards which is a key requirement for clinical audit (NICE, 2020). The small, single-site sample limits transferability, which is a known constraint of local qualitative studies (Marshall and Rossman, 2016). Methodological detail is limited, with little information on how data were analysed or how rigour was ensured, reducing transparency (Tong, Sainsbury and Craig, 2007). Collecting feedback in the clinical environment also introduces the possibility of social desirability bias, where patients may feel reluctant to report negative experiences. (Badejo *et al*, 2022).

Overall, the study contributes valuable patient-centred insight into nurse-led lung cancer follow-up. It highlights continuity, personalised care, emotional support, and communication key elements that directly inform understanding of patient perspectives and strengthen the evidence base for nurse-led models within lung cancer pathways.

Stewart *et al.* (2021) conducted a retrospective cohort study using data from the English National Lung Cancer Audit to examine whether cancer nurse specialist (CNS) working practices were associated with clinical outcomes. The analysis included 108,115 adults with non-small cell lung cancer (NSCLC) diagnosed 2007–2011, with outcomes assessed from 30 days to 12 months post-diagnosis. Using adjusted Cox models, the study found that CNS assessment was linked with lower mortality in patients receiving radiotherapy or surgery (Stewart *et al,* 2021). In the radiotherapy subgroup, greater CNS confidence within MDTs was associated with reduced mortality and fewer unplanned cancer related admissions (Stewart *et al*,

2021). These findings show associations rather than causation, which is expected in a retrospective observational study (Stewart *et al*, 2021).

Overall, the study's large national dataset, robust statistical methods, and clinically meaningful associations are key strengths, while limitations relate mainly to its retrospective observational design, self-reported CNS practice data, and potential unmeasured confounding, meaning findings indicate associations rather than causal effects (Stewart *et al.,* 2021).

Although Stewart *et al*. (2021) focus on clinical outcomes rather than lived experience, their findings demonstrate that CNS involvement is associated with improved mortality and reduced unplanned admissions, reinforcing the importance of CNS roles and providing a strong foundation for exploring how patients experience nurse-led lung cancer follow-up care.

Htay and Whitehead (2021) conducted a systematic review evaluating the effectiveness of advanced nurse practitioners (ANPs) compared with physician-led or usual care models. The review followed PRISMA guidelines and used an extensive search strategy across major databases including MEDLINE, EMBASE, CINAHL and the Cochrane registers. Thirteen randomised controlled trials (RCT's) published over the previous 20 years were included, involving adult and paediatric populations across primary and acute care settings. The authors used structured appraisal methods, including risk of bias tools and the GRADE framework, to assess the quality and certainty of the evidence.

A key strength of the review is the breadth of evidence examined. The inclusion of multiple RCTs across diverse settings provides a broad picture of how ANP-led care impacts patient centred outcomes such as satisfaction, communication, and involvement in decision-making. Several trials also

reported potential benefits such as reduced waiting times and improved service efficiency, offering useful insight into the wider value of nurse-led models in healthcare.

Limitations, the included RCTs varied considerably in design, setting, ANP roles, and outcome measures, resulting in substantial heterogeneity. Due to these differences, the authors were unable to conduct a meta-analysis and instead presented a narrative synthesis, which limits the ability to draw firm conclusions (Htay and Whitehead, 2021). The study quality was inconsistent, with several trials rated as low or moderate quality, weakening the overall strength of the evidence. Restricting inclusion to English language RCTs may have excluded relevant international work, introducing language and publication bias. These issues reduce confidence in the generalisability of the findings (Polit and Beck, 2017).

Htay and Whitehead's (2021) review provides a useful overview of the potential benefits of advanced practice roles and supports the importance of skilled nursing input within follow-up and ongoing care. However, the limited qualitative focus and heterogeneity of included studies highlight the need for further research exploring how patients experience nurse-led follow-up. This gap strengthens the rationale for studies examining patient perspectives of nurse-led lung cancer follow-up, where evidence remains sparse and patient needs are often complex.

Despite these limitations, the review contributes valuable evidence demonstrating that ANP-led models can deliver positive patient facing outcomes and may offer an effective alternative to traditional medical-led care. The review also highlights important gaps, including limited exploration of long-term psychosocial outcomes, organisational influences,

and the mechanisms through which nurse-led services achieve their impact. Few trials examined patient experiences in depth, relying largely on satisfaction measures rather than qualitative accounts (Htay and Whitehead, 2021).

2.5 Conclusion

This review identified a developing but mixed evidence base on nurse-led follow-up in lung cancer. The six included studies varied widely in design, focus, and outcomes, which limits how easily they can be compared. Only two studies explored patient experience directly, while three focused mainly on staff roles, service delivery, or descriptions of nurse-led practice, rather than on how patients experienced follow-up. One study examined clinical outcomes, not patient perspectives, and the systematic review considered ANP effectiveness broadly but offered limited insight into lived experience. Although some papers reported elements valued by patients such as continuity, reassurance, communication, and trust these insights were often brief and not explored in depth. Most studies did not collect detailed qualitative accounts, and patient-reported experience measures tended to be descriptive rather than exploring psychosocial needs, preferences, or decision-making.

Overall, the evidence does not provide a clear understanding of how patients experience nurse-led follow-up in lung cancer. The review highlights a significant gap, the lack of robust, in-depth qualitative research focusing on patient experience. This gap forms the rationale for the present study. The next chapter outlines the research design developed to address this need.

Chapter 3: Research Design

3.1 Introduction

Having introduced the focus of the research, developed a research question and explored the literature, this chapter outlines and justifies the research approach adopted to explore the lived experiences and perceptions of individuals receiving follow-up care in a lung cancer nurse-led clinic. Initially the theoretical and philosophical foundations supporting the study will be presented, before detailing the methodological approach, data collection methods, data analysis and recruitment, followed by the final section considering ethical issues within the design are addressed. Each section critically explains the rationale for the decisions made, demonstrating alignment between the interpretivist paradigm, phenomenological methodology, and the research aims and objectives. The overarching aim of this study is to explore and critically evaluate the lived experiences and perceptions of individuals receiving follow-up care in a lung cancer nurse-led clinic. The aim is addressed by the following objectives:

1. To explore lung cancer patients' experiences of follow-up care within a nurse-led clinic over the five-year follow-up period.
2. To identify key aspects of care (communication, continuity, accessibility, and holistic support) that influence patients' satisfaction.
3. To explore how patients describe their communication, continuity, accessibility, and holistic support experiences.
4. To evaluate the extent to which the nurse-led clinic meets patients' ongoing needs.

5. To generate evidence-based recommendations for enhancing the delivery and quality of nurse-led follow-up services for lung cancer patients.

3.2 Philosophical basis

As the study aims to explore and critically evaluate the lived experiences and perceptions of individuals receiving follow-up in the lung cancer nurse led clinic, this research aim positions the research within the interpretivist paradigm. Interpretivism is recognising that reality is socially constructed and best understood through the meanings individuals assign to their experiences (Schwandt, 1994; Lincoln, Lynham and Guba, 2011; Denzin and Lincoln, 2018). This perspective prioritises patient voice and background understanding, and acknowledging that perceptions of care quality, emotional support, and satisfaction shaped by personal, relational, and situational factors (Creswell and Creswell, 2018).

The interpretivist philosophy is not fixed but is instead shaped by individuals' unique experiences and social contexts (Ma and Ma, 2022). Therefore, patients' perceptions of care and support may differ, and each viewpoint provides valuable insight into the overall experience of follow-up care (Ma and Ma, 2022). In contrast, positivism would aim to quantify experiences and identify patterns, potentially overlooking the subjective and interpersonal nature of care interaction (Ma, and Ma, 2022). Denzin and Lincoln, (2018) describe interpretivism as a philosophical framework that values depth over breadth, prioritising individual voice and the contextual understanding of care quality, emotional support, and patient satisfaction. This aim of this research seeks to explore and critically evaluate the lived experiences and perceptions of individuals receiving

follow-up care in a lung cancer nurse-led clinic and fits within the philosophy of interpretivism.

3.3 Methodology

The research methodology that best aligns with an interpretivist paradigm is qualitative research. A qualitative approach is appropriate as it enables an in-depth exploration of individual experiences, communication, emotional support, continuity of care, and satisfaction dimensions that quantitative methods may not adequately capture. Quantitative research is typically deductive and objective, focusing on hypothesis testing and measurement rather than exploring the subjective meanings individuals assign to their experiences (Ali, Al Hatef and Alamri, 2024; Silverman, 2016). In contrast, this study adopts an inductive qualitative approach, allowing understanding and insight to emerge from participants' accounts rather than being imposed through predetermined categories, consistent with interpretivist qualitative inquiry (Creswell and Poth, 2018; Braun and Clarke, 2021).

Answering the research question requires an in-depth understanding of patients' lived experiences; therefore, a qualitative methodology is most appropriate, specifically phenomenology (Creswell and Poth, 2018; Moustakas, 1994). Phenomenology seeks to explore and describe how individuals perceive and make sense of their experiences, emphasising the meanings those experiences hold for participants rather than attempting to generalise findings to a larger population (Frechette et al., 2020).

In the context of healthcare research, phenomenology allows researchers to gain rich, in-depth insights into patients' subjective experiences within a specific context, (Creswell and Poth, 2018). This aligns with exploring the lived experiences of a patient follow-up care in a nurse-led lung cancer clinic. By adopting a phenomenological approach, this study design could prioritise the voices of patients and capture the nuances of their experiences, including perceptions of care quality, communication, continuity, accessibility, and holistic support (Frechette *et al.,* 2020). Phenomenology sits within interpretivist philosophy, as it recognises that reality is socially constructed and experienced differently by everyone (Frechette *et al*., 2020). This approach can enable the researcher to not only describe what patients experience but also understand how they interpret and make meaning of these experiences.

3.4 Data Collection Methods

Semi-structured interviews are well aligned with phenomenology as they allow flexibility for participants to describe their experiences in their own words while enabling probing of emerging themes (Mealer and Jones, 2014; DiCicco-Bloom and Crabtree., 2006). Having semi-structured open-ended interviews allowed participants to describe their experiences in their own words. In contrast, quantitative designs using closed questions, while useful for quick data collection can limit respondents' answers due to predefined options such as yes or no, multiple choice, or rating scales. These can be limiting in qualitative research because they do not allow participants to fully describe their feelings, reasoning, or experiences (Siedlecki, 2022; Williams and Allen, 2022). Semi-structured interviews, provide deeper and more detailed insights, which is especially important when exploring

complex experiences such as patient care in healthcare and utilised within this dissertation (Eppich, Gormley and Teunissen, 2019).

This project involved gathering detailed, potentially sensitive information where trust, rapport, and non-verbal communication are important. Face-to-face and telephone interviews each offer distinct advantages and disadvantages, but their suitability depends on the depth and sensitivity of the information required (Rahman, 2023). Telephone interviews can be efficient, cost-effective, and convenient making them valuable for screening or when reaching isolated participants (Musselwhite *et al*., 2007; Saarijärvi and Bratt, 2021). However, they lack visual cues and can make it harder to judge engagement or emotional responses (Welles, Sun and Miller, 2022). Therefore, face to face interviews were planned. Welles, Sun and Miller (2022) highlight that face-to-face interviews allow researchers to observe body language, monitor distress, and build stronger rapport, which supports richer and more nuanced data collection.

Interviews were arranged at a convenient time for the participants and conducted in a private room within the outpatient's department to ensure confidentiality and participant comfort. The careful selection of location is important in qualitative research, as participants need to feel safe, at ease, and free from interruptions, particularly when discussing sensitive topics (Elmir *et al*., 2011). Although interviews conducted in participants' homes can provide insight into private aspects of their lives and allow a greater sense of control (Dickson-Swift *et al*., 2007), practical considerations such as minimising distractions and maintaining confidentiality must also be addressed (Porter, 2014). By arranging interviews in a private clinical setting at a mutually convenient time, this study balanced both ethical and

practical considerations, adopting an environment suitable for open and honest discussions (Dempsey *et al.,* 2016).

Interviews can vary in length depending on the context, and it is important that participants do not feel time pressured or distracted and that rapport is established (Public Health England, 2021). Overly brief interviews risk generating superficial insights, whereas longer sessions may facilitate richer and more nuanced data (Chand, 2025). For this reason, interviews were scheduled to last 45–60 minutes. This duration was selected to balance the need for sufficient depth of information with consideration for participants' time and attention span, helping to reduce fatigue and support thoughtful, detailed responses (Chand., 2025).

The interviews were audio-recorded with informed consent, allowing accurate data capture while enabling active listening and rapport building (Lavee and Itzchakov, 2023; Jimarkon, Louw and Watson, 2018). Recording ensures that no details are lost during transcription, which supports rigorous analysis and enhances reliability (MacLean, Meyer and Estable, 2004). Importantly, it also allows the interviewer to focus on the conversation rather than note taking, encouraging a natural dialogue and deeper engagement with participants (Muswazi and Nhamo, 2013). Active listening contributes to building trust and rapport, which can encourage participants to share more openly and authentically, improving the richness and credibility of the data (Lavee and Itzchakov, 2023). By clearly communicating the expected duration and purpose of the recording, participants are empowered to provide informed consent and feel respected throughout the research process. The combination of careful time management, consent procedures, and rapport building ultimately strengthens both the ethical integrity and the quality of the collected data.

3.4.1 Sampling

A purposive sampling strategy was used to recruit six participants who met the inclusion criteria (Table 3.3.3). This range is appropriate within an interpretivist qualitative study, where the goal is to develop an in-depth understanding of participants' subjective experiences rather than to achieve empirical generalisability (Ma and Ma, 2022). Interpretivist research values the interpretive depth, nuance and lived meaning within individual accounts; therefore, smaller, information rich samples are often more suitable than larger ones that sacrifice depth for breadth. Traditionally, data saturation is considered the point where no new themes emerge and can indicate that the sample size is adequate (Guest, Bunce and Johnson, 2006; LaDonna, Artino and Balmer, 2021). However, Braun and Clarke (2021) challenge the concept of data saturation, arguing that any decision to stop data collection is a judgement based on whether sufficient data has been collected to answer the research question. Taken together, this suggests that rather than strictly aiming for data saturation, interpretivist research benefits from focusing on whether the data collected provides meaningful and nuanced insights into the phenomenon under study (Braun and Clarke, 2021).

Table 3.1 Patient Inclusion and Exclusion Criteria

Criteria Type	Description
Inclusion Criteria	- Adults (18+) with a confirmed lung cancer diagnosis - Completion of primary treatment (surgery or radiotherapy) - Attendance in the nurse-led clinic for at least three months
Exclusion Criteria	- Patients receiving palliative care - Patients with significant cognitive impairment

According to Patino and Ferreira (2018), the establishment of clearly defined inclusion and exclusion criteria plays a crucial role in ensuring methodological rigour, supporting reproducibility, and reducing the risk of harm while safeguarding vulnerable participant populations.
Researchers must be able to justify all criteria applied, and unless the purpose of the study specifically warrants the exclusion of a group, the research population should be as diverse as possible (Connelly, 2020). Furthermore, establishing these criteria systematically ensures ethical and methodological rigor in primary research and provides a transparent framework for participant selection.

3.4.2 Recruitment Strategy

Purposive sampling was used for recruiting participants; it is a sampling technique where researchers select participants based on specific characteristics, experiences, or knowledge relevant to the aims of a study (Stratton, 2024). This method is commonly used in qualitative research, where the depth and value of data are prioritised over broad coverage (Palinkas *et al.*, 2015). By intentionally including individuals who can provide meaningful insights, purposive sampling supports highly targeted and purposeful data collection aligned with the research objectives. An advantage of purposive sampling is its ability to generate relevant and specific data, as researchers can focus on participants most likely to contribute valuable information (Stratton, 2024). However, a disadvantage of this participant selection approach is that it can introduce research bias particularly selection bias, which may affect the findings. Furthermore, because the sample is not randomly selected, the results are not statistically generalisable to the wider population (Palinkas *et al.*, 2015; Stratton, 2024).

Because potential participants were patients from the clinic where I work as a CNS, I implemented several safeguards to minimise power imbalance. I did not discuss the study during consultations, as clinician-led recruitment can increase coercive pressure *(*Barton *et al., 2016)*. Recruitment occurred through a gatekeeper approach, an administrative colleague handed out the Participant Information Sheet (PIS) (Appendix IV), enabling patients to self-refer if interested (Adams, M., Caffrey, L. and McKevitt, C. 2015). This avoids direct clinician influence and promotes voluntary participation *(*Barton *et al., 2016)*. A cooling-off period was provided so patients could review the information and make an informed decision without pressure *(*Barton *et al., 2016)*. My insider position offered contextual understanding but also raised risks of bias (Greene, 2014). To address this, I kept a reflexive journal and engaged in regular supervision and peer debriefing to examine how my role might influence data collection and interpretation *(*Guillemin *et al., 2017)*. Reflexivity is an important safeguard when clinicians conduct research within their own clinical environment. Clear boundaries were maintained between clinical care and research activity throughout.

Participants were purposively recruited from the lung cancer nurse-led follow-up clinic. The clinic nurse identified potential participants who met the inclusion criteria (Table 3.1) and provided them with an initial invitation to participate, including the Participant Information Sheet (Appendix IV). Participants were given the opportunity to ask any questions and were given time to consider consenting to take part. Once the participant was happy to take part, they were asked to sign a consent form and reminded of their right to withdraw if they change their mind (Appendix V: Consent

form). A written consent form was used to ensure informed, voluntary participation in line with ethical research standards.

3.5 Data Management Plan

A comprehensive Data Management Plan (DMP) was developed to ensure the ethical governance, confidentiality, and legal compliance of all research data throughout the study lifecycle. The DMP outlined procedures for secure data collection, transfer, storage, access control, retention, and deletion, in line with the Data Protection (Jersey) Law 2018 and UK-aligned best practice (UK Data Service, 2025). Interviews were conducted using Microsoft Teams, an HCJ-approved platform selected for its robust security features and compliance with institutional requirements (Coggins, 2025). Audio recordings were subsequently transcribed by the lead researcher to maintain accuracy and preserve the integrity of participant's responses, supporting rigorous qualitative analysis (Eftekhari, 2024). Full technical details of data handling including encrypted storage, secure transfer protocols, and scheduled data destruction are provided in (Appendix VI: Data Management Plan).

Recordings and transcriptions were securely transferred to a password protected computer for analysis and storage, after which the original files on Microsoft Teams were permanently deleted. At the end of the designated retention period, all data will be securely destroyed, digital files will be permanently deleted, and any physical copies will be shredded in accordance with HCJ data disposal procedures. Data will be retained in compliance with Data Protection (Jersey) Law 2018, which requires that research data be kept only as long as necessary. For the purposes of this

study, data will typically be retained for ten years following its last use, usually after the completion of the dissertation.

During transcription, all identifying information, such as participants' names, addresses, or clinic locations, were removed or replaced with pseudonyms. NHS Digital (2023) explains that data must be anonymised or with pseudonyms when used beyond individual care, any quotations included in the dissertation or in future publications will be anonymised to minimise the risk of participants being identified. Additionally, contextual details that could indirectly reveal participants' identities, such as specific medical circumstances, are generalised or omitted (NHS Digital, 2023; Appendix VI and Appendix VII: Risk Assessment).

3.6 Data Analysis

Data was analysed using Braun and Clarke's (2006) six-phase framework for thematic analysis, this approach was chosen because it provides a systematic and rigorous approach to identifying, analysing, and interpreting patterns within qualitative data (Figure 3.1). This method allows for both inductive and interpretative engagement with participants' narratives, ensuring that themes are grounded in the data while reflecting the broader contextual meanings. The approach is consistent with the study's phenomenological and interpretivist orientation, as it prioritises understanding participants lived experiences and the meanings they attribute to nurse-led follow-up care within their natural contexts. The emphasis on repeated reading, coding, and theme development, supports careful, logical, and precise thinking and ensures that themes emerge directly from the data rather than imposed by pre-existing assumptions Braun and Clarke's (2006).

However, the approach is also inherently interpretive, and therefore vulnerable to researcher bias. As coding was conducted manually and, by a single researcher, with support from academic supervision, it is recognised that the analysis risks reflecting the researcher's own experiences and therefore to mitigate this, a reflexive diary was kept throughout the process. Reflexive journal or documenting analytic decisions have been suggested as strategies to minimise the risk of unconscious bias (Jamieson, Govaart., and Pownall, 2023). This approach is time intensive, which may limit the depth of analysis in studies with larger datasets (Saldaña, 2021), further justifying the need for smaller sample sizes in qualitative research. Despite these limitations, the inclusion of coding examples, theme development tables, and extracts enhances transparency and trustworthiness (Braun and Clarke, 2006), thus enabling following the analytic trail from raw data to final themes.

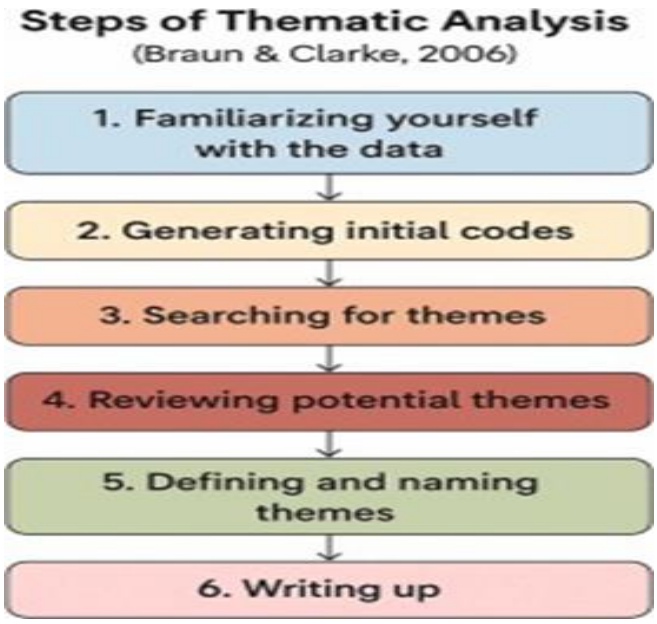

Figure 3.1 Braun and Clarke (2006)

3.7 Quality Assurance and Ethical issues

Ethical considerations are integral to all research, regardless of topic, design, or method (Creswell and Creswell, 2018). As per the requirements for research involving participants, an ethical review process was followed and ethical favourable opinion was secured, to ensure protection of participant rights (WHO, 2025). The ethical review process has been documented to reinforce the study's credibility and integrity (WHO, 2025). A scientific review and approval from RGU School of Health Ethics Review Panel was sought (Appendix IX, X) Furthermore, an application for research ethics review was submitted to the Jersey Health Research Ethics Committee for approval (Appendix XI).

This study adhered to established principles of ethical research, including autonomy, beneficence, non-maleficence, and justice (WHO, 2025). Autonomy was upheld through the provision of fully informed, voluntary consent. Each participant received a detailed information sheet outlining the study's purpose, procedures, potential risks, and anticipated benefits (Appendix IV). All participants were given the opportunity to ask questions before providing written consent (Appendix V). Participants were also informed of their right to withdraw at any stage without explanation, a point reiterated both verbally and in writing.

Beneficence and non-maleficence were central considerations throughout the study. Efforts were made to maximise potential benefits while minimising risks associated with participation. Measures to protect confidentiality and privacy included anonymising all data and securely storing interview transcripts and recordings Data Protection (Jersey) Law 2018. A formal risk assessment and data management plan were developed

to guide ethical conduct (Appendix VII). Participants discussing sensitive experiences related to lung cancer and follow-up care were provided with access to psychological support, and referral pathways to professional services were clearly outlined in the participant information sheet and risk assessment (Appendix IV). Additionally, to minimise any potential reputational risk to the service, it was made clear that the research was conducted in the role of an MSc student under the supervision of an experienced researcher, with prior permission to access the site and recruit participants granted (Appendix VII). Findings will be shared with the clinical team upon completion of the dissertation.

Justice guided the recruitment process, ensuring equitable and fair selection of participants. All patients meeting the inclusion criteria were invited to participate, and recruitment was initially limited to six participants, with further participants included as necessary to ensure sufficient data to address the research question (Braun and Clarke, 2021). By explicitly addressing each ethical principle, the study sought to safeguard participants' rights, wellbeing, and dignity while ensuring that the research was conducted rigorously and responsibly (AVAC, 2025).

3.8 Conclusion

This chapter has outlined the philosophical, methodological, and ethical foundations that support this study. By adopting an interpretivist paradigm an inductive qualitative approach, and phenomenological methodology, the chapter has demonstrated how the research approach is aligned with the aim of exploring and critically evaluating the lived experiences of individuals receiving follow-up care in a lung cancer nurse-led clinic. The rationale for the qualitative design, use of semi-structured interviews, purposive

sampling strategy, and thematic analysis has been explained, showing how each methodological choice supports the exploration of subjective meaning, depth of experience, and patient perspectives. Furthermore, the ethical considerations, data management procedures, and safeguards implemented throughout the study highlights the trustworthiness, and commitment to protecting participant wellbeing.

Having established the research design and justified the methods used to generate and analyse the data, the dissertation now moves to present the findings of the study and presents the results of the thematic analysis.

Chapter 4: Findings Chapter

4.1 Introduction

This chapter presents the findings, from the interviews which explored patient experiences of nurse led follow-up after lung cancer treatment. Data were analysed using Braun and Clarke's (2006) six phase approach to thematic analysis outlined in Chapter 3 (Figure 3.1). The findings are organised thematically, with direct quotations included to express the participants lived experiences while maintaining focus on answering the research question. The chapter will begin with an overview of the participants, the process of coding, identifying potential themes and then finalising the named themes will be formulated and finally the analytical narrative will be presented.

4.2 Overview of participants

A total of six participants were recruited and participated in semi-structured interviews, each offering valuable and detailed accounts of their cancer journey and their interactions with the nurse-led follow-up clinic. The participants included individuals treated for lung cancer who completed surgery or radiotherapy and afterwards attended the nurse-led clinic as part of their five years follow up surveillance and care. To protect anonymity, all participants were assigned the pseudonyms participant 1–6.

4.3 Generating the Initial Codes and Searching for Themes

All interviews were audio recorded and transcribed. Transcripts were read and re-read multiple times to gain full familiarisation with the data. During this process initial thoughts, patterns and potential meanings were noted through highlighting and underlining key sections of the transcript (Braun

and Clarke, 2006). Initial codes were generated systematically across all transcripts (Appendix XII).

Having determined the codes, the next step was to collate these into potential themes. Codes were examined for similarities and patterns. For example, codes relating to symptoms, diagnosis, scans, and procedures were group together to form a broader potential theme related to navigating the diagnostic process (Braun and Clarke, 2006). During this process, themes were refined, combined, or removed to reach the final named themes (Table 4.1) (Braun and Clarke, 2006). Each theme was clearly defined and named to capture its core meaning. The final themes reflect my interpretation of participants experienced and navigated their cancer journey (Braun and Clarke, 2006).

Table 4.1 Table of Themes

Initial Broad Codes	Review of Themes	Final Named Themes
Symptoms/Diagnosis/Cough/Smoking Procedures/ investigations/ Biopsy/Surgery/ Scans – Chest-Xray, CT Scan, PET Scan/ Blood tests, ECG, Heart check, breathing test Diagnosis Off island/travel Nurse, Kindness/Wonderful/Very welcoming/Lovely/Like a friend/ helpful/amazing Patience, not medical terms, Communication / providing information / listening/ explained everything/Explanation/ Describes everything/ point of contact/Telephone contact/Gave me all the details point of contact/ Tells me what's going on consistent at ease Radiotherapy Clinic Always been there Scary, Frightening Hated nervous Very claustrophobic Follow up 5 years Complete shock Relaxed me Organised Updating Overwhelmed Frustrated Referral breathless Referral social worker	Diagnostic process Treatment journey Managing off island treatment/travel Staff support/personal qualities of staff Ongoing follow up and monitoring Emotional experiences/ Emotional response to diagnosis/Emotional responses to investigations Communication/keeping patients informed	1. Navigating the treatment journey 2. Emotional response 3. Communication and information 4. Feeling supported 5. Continuity of care

4.4 Narrative write-up of themes

The final stage of Braun and Clarke's (2006) framework involves producing the written report, in which the themes were analysed and illustrated using participant's quotations to answer the research question.

4.4.1 Navigating the Treatment Journey

All participants discussed how they were navigating their personal treatment journey. This theme highlights the participants experiences of their cancer journey from initial symptoms through diagnosis, treatment and long term follow up. It includes multiple investigations, referrals, and treatment pathways, over an extended period of time and in some cases requiring off island travel for specialist services.

Participant one discussed how they had been talked though what to expect and how this made them feel secure and safe.

> "You talked me through travel, surgery what to expect so much panic and just knowing what was going on it was so nice to feel secure and safe and how well organised things." **(P1)**

Participant two knew they were going to be told it was cancer, and this gave some sense of what they journey was going to go.

> "In the back of my mind, I think I already knew, because you said likely cancer." **(P2)**

Participant four talked about the options they were given to be able to navigate their journey.

> "I was advised there were three things I could do, I could wait until it was my time, or to go to Southampton or I could go private special blood test. CNS arranged an appointment with the consultant

oncologist, took my bloods and sent for a special test find the DNA." **(P4)**

For participant five, knowing the journey was not a comfort as they experienced a sense of upset at their perception of wasting people's time.

> "I went to Southampton for PET scan, which unfortunately I'm very claustrophobic and I just couldn't go through with it. I felt terrible because I've just wasted a lot of people time." **(P5)**

However, participant six had a more positive experience on their personal journey.

> "I had a CT scan, and then a CT-guided biopsy. You talked me through the whole procedure, so I understood exactly what to expect. You organised all my blood tests, breathing tests, ECG, and even an echo before I'd even wrapped my head around what was happening." **(P6)**

These quotes highlight how participants experienced ongoing support while navigating their treatment journey, particularly during periods of uncertainty. This reflects some understanding of their journey as a continuous process rather than a series of separate events.

4.4.2 Emotional Responses

Emotional response came through as a theme, highlighting the emotional and psychological experiences participants experience in relation to the investigations, diagnosis and invasive or unfamiliar procedures. Feelings of anxiety, fear, and uncertainty, which were prominent in most participants.

Participant one talked about the panic of uncertainty and how having someone talk through the practicalities of travel and surgery went some way to helping them 'feel secure and safe'.

> "Talked me through travel, surgery what to expect so much panic and just knowing what was going on it was so nice to feel secure and safe and how well organised things, always kind, smiling, positive." (**P1)**

Participant three described continuing feelings of fear despite having information about the procedure.

> "CT Biopsy which I hated, I hated, but you did tell me all about the procedure still horrible. It was scary I couldn't breather something went wrong really frightening." **(P3)**

Participant six describes feeling scared when required to travel off island and the importance of not being alone.

> "I then needed a PET scan off-island. It was a long day and I was scared, but you arranged for my friend to travel with me. That meant everything. I didn't want to be alone." **(P6)**

These quotes highlight participants' emotional responses to uncertainty.

4.4.3 Communication and Information

This theme highlights the importance participants placed on receiving clear, timely and understandable information throughout their cancer journey. Effective communication helped participants feel informed, reassured and better to navigate their care.

Participant two appreciated the information being delivered in a manageable way.

> "You always seem to explain it to me; you will decipher for me." **(P2)**

Participant three described being told what each stage of their care would involve. They also related their appreciation of the supportive manner in which the information was provided

> "Just way you describe everything to me and tell me what's going on and let me understand, explain to me, my next stage will be, what's going to go on from there, the CNS was absolutely fantastic, very kind, very welcoming, she relaxed me. She made me feel relaxed with how she approached things, I was given all the details that I needed." (**P3)**

Participant five described being able to contact the nurse if they required clarification.

> "Nurse always there for me, if I need to talk, I could phone, if I was worried about anything. Very kind." **(P5)**

Participant six referred to the clear communication and explanation of information at an appropriate level of understanding avoiding medical jargon.

> "You always explained things clearly and never rushed me." **(P6)**

> "You explained both chemotherapy and surgery so well. Your knowledge made me feel like I was in safe hands." **(P6)**

> "You explained everything at my level of understanding not all the medical terms simple language, and that made the whole journey far less frightening." **(P6)**

These examples demonstrate how participants described communication as part of their follow up experience.

4.4.4 Feeling Supported

This theme highlights the importance of feeling emotionally and practically supported throughout their lung cancer journey. Participants talked about how the supportive, therapeutic relationships with the CNS played a key role in shaping their overall experience of care.

Participant one described how meaningful it was to feel heard and not rushed during the consultation.

> "You were somebody was there for me, never felt like you were trying to push me out the door, You listened to everything I needed to say, They were really supportive and helpful with any questions that I had , I felt listened to even when I was anxious, the nurse put me at ease, which was really lovely." **(P1)**

Participant two described follow up contact and knowing that someone was checking in on their wellbeing.

> "You were always kind to me, phoning checking up on me." (**P2)**

Participant three referred to being able to make contact with the CNS when needed.

> "If we just phone and ask for you, you always phone us back, always just get us in to see you if I have any worries or concerns." **(P3)**

Participant five shared a similar experience of the CNS being consistently available for support.

> "Nurse always there for me, if I need to talk, I could phone, if I was worried about anything. Very kind." **(P5)**

Participant six felt the value of reassurance when they were panicking.

> "You reassured me when I panicked or started imagining the worst." **(P6)**

These quotes demonstrate that participants experienced support as both emotional and relational. The availability of support helped participants manage the anxiety and fear associated with investigations and treatment. This suggests that having support available helped participants cope with the anxiety and fear surrounding their investigations and treatment.

4.4.5 Continuity of Care

This theme highlights the importance participants placed on having continuity of care and access to consistent, reliable point of contact throughout their lung cancer journey. Having a familiar CNS enhanced feelings of reassurance, trust, and confidence in the care process.

Participant three described the reassurance gained from knowing they could reach the CNS when concerns arose,

> "If we just phone and ask for you, you always phone us back, always just get us in to see you if I have any worries or concerns." **(P3)**

Participant five shared a similar experience of consistent availability and emotional support.

> "Nurse always there for me, if I need to talk, I could phone, if I was worried about anything. Very kind." **(P5)**

Participant two referred to the importance of ongoing follow up contact and support.

> "You were always kind to me, phoning checking up on me." **(P2)**

Participants five and six expressed expectation for ongoing follow up and their feelings of comfort and familiarity

> "Follow up the next five years? I'm going to see a nurse that I can talk to just as I would to my own friends." **(P5)**

> "Generally, thank you for everything. I really hope my follow-up continues with you." **(P6)**

These quotes highlight the importance of continuity and having a reliable point of contact. Consistent availability helped build trust and provided reassurance, particularly during periods of uncertainty. Continuity supported participants' feelings of support and reduced emotional distress, demonstrating how this theme overlaps with both emotional responses and feeling supported.

This chapter has presented the findings from the analysis of the interview transcripts. Five key themes were identified that capturing both the practical and emotional aspects of participants' experiences across their cancer journey. Clear communication, continuity of care and support

emerged as key themes. The next chapter will discuss these findings in the relation to existing literature and answering the research question, their significance to practice and the wider implications for nurse led follow clinics will be considered.

Chapter 5: Discussion Chapter

5.1 Introduction

This chapter critically discusses the findings in relation to existing literature regarding nurse-led follow-up in lung cancer care. The aim of this research study was to explore and critically evaluate the lived experiences and perceptions of individuals receiving follow-up in a lung cancer nurse-led clinic. Five key themes were identified: navigating the treatment journey, emotional responses, communication, and information, feeling supported, and continuity of care. The themes were closely interconnected, reflecting the complex and multifaceted nature of participants' experiences, in which emotional, informational, and relational elements continuously interacted. This interconnectedness reflects the nature of qualitative inquiry, where patterns of experience are understood as overlapping and mutually reinforcing (Braun and Clarke, 2006). This discussion draws together these findings and considers implications for nursing practice, service development, and future research.

5.2 Interpretation of Findings

5.2.1 Navigating the Treatment Journey

Participants described their cancer experience as a continuous journey requiring active navigation, rather than a series of isolated appointments. They described planning appointments, organising off-island travel, coordinating investigations, and relying on family support. Similar to findings reported in personalised follow-up research, patients valued flexible and responsive models of care that reduced fragmentation and

helped them move through complex pathways (McPhillips *et al.,* 2015; Moore, 2006).

Participants explained that being prepared for upcoming procedures helped reduce uncertainty. Feelings of guilt when unable to complete tests introduced an under acknowledged emotional burden to navigation. This adds nuance to current literature, which highlights how travel distance and logistical barriers negatively affect access to diagnosis, treatment uptake, and quality of life (Ambroggi *et al.,* 2015). Qualitative work shows that time pressures, competing responsibilities, and logistical coordination impose significant burden on patients undergoing cancer treatment (Dona *et al*., 2024). This study therefore suggests that nurse-led follow-up contributes not only to coordination but also to patients' psychological safety by helping them anticipate and manage logistical and emotional demands.

5.2.2 Emotional Responses

Emotional distress was a clear theme. Participants described ongoing fear, panic, claustrophobia, and uncertainty, even years after treatment. Although previous research found that nurse-led models can enhance satisfaction (Williamson *et al.,* 2007; Htay and Whitehead, 2021), the present study demonstrates that strong emotional responses remain a significant component of survivorship.

Other studies show that nurse-led follow-up can create safe spaces for raising psychological concerns (Cox *et al.,* 2008) and that nurse-led care can improve emotional functioning (Ngu *et al*., 2020). However, persistent fear and distress in this study highlight the need for routine psychosocial attention within follow-up. Emotional responses should therefore be

understood as a main component of survivorship rather than a residual issue.

5.2.3 Communication and Information

Clear, accessible communication strongly influenced positive experiences. Participants valued explanations free from jargon, time to ask questions, and a relational communication style that was perceived as reassuring. The nurse-led setting provided a space where information was not only given but actively interpreted and translated into meaningful terms something highlighted in reviews highlighting enhanced communication within nurse-led models (Htay and Whitehead, 2021). These findings are seen in studies showing that telephone-based nurse-led follow-up can support personalisation, understanding, and continuity (Williamson, Chalmers and Beaver, 2015). Participants in this study described communication as intertwined with emotional support, suggesting that clarity, tone, and relational familiarity are integral aspects of effective follow-up communication.

5.2.4 Feeling Supported

Participants described feeling supported practically, emotionally, and relationally. They valued being listened to, not feeling rushed, and having reliable access to their nurse between appointments. These findings reflect earlier work which identified emotional reassurance as a central component of specialist nursing roles (Moore, 2006). Some participants expressed strong preference for continued follow-up with the same nurse, indicating the depth of relational connection. While continuity can enhance trust, it may also create dependency if not managed with appropriate transition planning. The literature recognises continuity and emotional reassurance as

key benefits of nurse-led models (Williamson, Chalmers and Beaver, 2015; Cox *et al*., 2008). This study adds that relational support is experienced as an essential part of follow-up, not an optional supplement.

5.2.5 Continuity of Care

Continuity of care was strongly associated with reassurance, familiarity, and trust. Participants described their nurse as a consistent point of contact, which helped reduce anticipatory anxiety and increased confidence in surveillance processes. These findings complement evidence showing that CNS involvement is associated with improved quality indicators in lung cancer care (Stewart *et al*., 2021). Continuity appears to be protective against anxiety and uncertainty in a pressured healthcare environment. The study therefore supports continuity as a foundational component of effective nurse-led follow-up.

5.3 Reflexivity and Researcher Positionality

As an insider researcher, I held pre-existing clinical relationships with participants. This positionality brought advantages such as rapport and contextual knowledge but also potential challenges, including power imbalances and the risk of influencing responses. Reflexive strategies were employed to manage these dynamics, including journaling, supervision, and deliberate separation of clinical and research roles. These practices align with discussions of insider outsider positioning and the need to recognise and manage subjectivity within qualitative inquiry (Berger, 2015; Dwyer and Buckle, 2009).

5.4 Limitations

The qualitative design provided in-depth insight into patients lived experiences; however, findings are specific to a single service context and may not reflect experiences in other settings. Qualitative studies aim for depth rather than generalisation, and transferability depends on the reader's judgement of contextual similarity (Marshall and Rossman, 2016). Insider researcher positioning may also have shaped participant responses and interpretation. Although reflexive strategies were used, subjectivity is understood as inherent to qualitative research rather than a flaw (Braun and Clarke, 2006). These limitations do not detract from the value of the study but highlight the importance of context.

5.5 Implications for Practice

Based on the findings:

1. Structured preparation should be enhanced to support patients navigating complex logistics.
2. Routine psychosocial assessment should be integrated into follow-up, acknowledging ongoing emotional responses.
3. Accessible educational materials should be developed to support understanding and engagement.
4. Relational continuity should be prioritised, with planned transitions to avoid dependency.
5. Communication and emotional-support training should be embedded in CNS and ACP development.

The study addressed the research question by showing how participants experience and evaluate nurse-led follow-up across emotional, practical, and relational domains.

5.6 Conclusion

This chapter has discussed the findings in relation to wider literature, demonstrating that nurse-led follow-up supports patients by providing coordination, emotional reassurance, clear communication, and continuity. The research question has been addressed, and limitations and positional influences acknowledged. The next chapter will present overall conclusions and recommendations for practice.

Chapter 6: Conclusion and Recommendations

6.1 Introduction

This chapter brings together the key findings of the study, evaluates their significance in the context of existing evidence, and presents recommendations for practice, policy, and future research. The chapter concludes by reflecting on the research question and the contribution of the study to the field of nurse-led lung cancer follow up care.

6.2 Summary of Key Findings

This research explored the lived experiences and perceptions of individuals attending a nurse-led lung cancer follow up clinic during the five years follow up. The research was guided by an interpretivist paradigm, and adopted an inductive qualitative approach supported by a phenomenological methodology design was adopted. Semi-structured interviews were conducted to gather in depth accounts of participants' experiences. While previous research has established that nurse-led follow-up is feasible, acceptable, and cost-effective (Moore *et al*., 2006; McPhillips *et al.*, 2015; Williamson *et al*., 2007; Htay and Whitehead, 2021). Limited work has explored how patients experience this care over time and what it means to them on an emotional, relational, and practical level (Pearce and Breen, 2018; Stewart *et al*., 2021).

Five themes were identified: navigating the treatment journey, emotional responses, communication, and information, feeling supported, and continuity of care offering an understanding of how communication, continuity, accessibility, and holistic support shape perceptions of quality and safety in lung cancer follow up care.

The study highlighted the importance of holistic support, with the nurse-led clinic described as a space where the emotional, practical, and clinical management were integrated. The unique contribution of this research lies in its focus on the human dimensions of care, demonstrating that patients do not simply value clinical expertise, but deeply appreciate the compassion, personal connection, and sense of being recognised as individuals within nurse-led survivorship services. It offers a relational, person-centred experience that supports long-term adjustment and helps patients feel safe, informed, and emotionally contained throughout cancer journey.

6.3 Recommendations

The findings highlight several opportunities to strengthen lung cancer follow up services and guide future service development. Based on the findings, recommendations have been made.

1. Establishing a standardised communication framework for results discussions and follow up appointments would help reduce variability between clinicians and ensure that essential information is conveyed consistently. Providing patients with written or digital summaries after appointments can support understanding and alleviate anxiety, particularly at moments of high cognitive and emotional load. These summaries should incorporate key results, treatment changes, next steps, and signposting to reliable resources. The use of visual aids such as simplified diagrams of procedures, investigations, or treatment pathways may further support comprehension, especially for individuals experiencing distress or low health literacy.

2. Improving continuity of care is also essential. A named nurse or micro team model would allow patients to build sustained relationships with a familiar clinician, enhancing trust, emotional safety, and clinical accuracy. Such relational continuity is particularly valuable as patients navigate complex diagnostic and treatment pathways. Continuity can be further supported by optimising scheduling systems so that patients are routinely booked with their usual health provider wherever possible. Linking patients to a preferred clinician, identifying those who would most benefit from continuity, and reducing unnecessary fragmentation in follow up processes may help deliver a clearer experience and reduce repeated explanations. These measures collectively promote therapeutic rapport, improve patient satisfaction, and support a more efficient clinical encounter.

3. Maintaining dedicated advice lines or digital communication platforms with clear triage expectations would support accessibility and ensure patients know how and when they will receive support. Flexible appointment formats including face-to-face, telephone, or video consultations should be offered based on clinical need and patient preference. This can improve access, reduce travel burdens, and preserve patient autonomy.

4. Embedding routine needs screening into follow up appointments, using validated tools such as Holistic Needs Assessments or distress screening instruments, would support early identification of needs. Integrating the findings of these assessments into multidisciplinary communication and care planning can help ensure that support is proactive rather than reactive. Strengthening referral pathways to psycho oncology, pulmonary rehabilitation, welfare services, and community organisations is also essential. Clear routes of access, shared service, and reliable feedback

would facilitate timely support and reduce the likelihood of emotional or practical issues escalating.

5. The sustainability of these improvements depends on investment in the workforce. The nurse requires protected time for professional development in communication, survivorship, and psychological assessment to ensure they can meet the complex needs of lung cancer patients.

6. Supervisory structures, reflective practice spaces, and access to specialist mentorship can further enhance capability and reduce burnout. Alongside this, monitoring caseloads systematically is essential to preserve time for relational work, which is a core component of high-quality cancer care.

7. Tracking workload complexity, identifying pressure points, and enabling responsive workforce planning will help maintain safe, equitable caseloads and protect the quality of patient support.

8. Further research adopting a longitudinal design could explore if positive experiences were sustained or if patient experiences and perception changed over time following multiple visits.

9. Further research adopting a comparative design, exploring experiences in doctor or GP led clinics could help to determine if the findings are unique to nurse-led in general.

6.4 Conclusion

To answer the research question, nurse-led clinics played a vital role in shaping participants' sense of safety, confidence, and wellbeing throughout the cancer journey. Using the patient voice, the emotional, practical, and

clinical needs of the participants was identified. The lived experiences of patients in nurse-led clinics are characterised by trust, relational continuity, accessible support, and holistic care**.** These insights offer valuable direction for future service development and highlight the importance of maintaining the relational strengths that make nurse-led models so highly valued.

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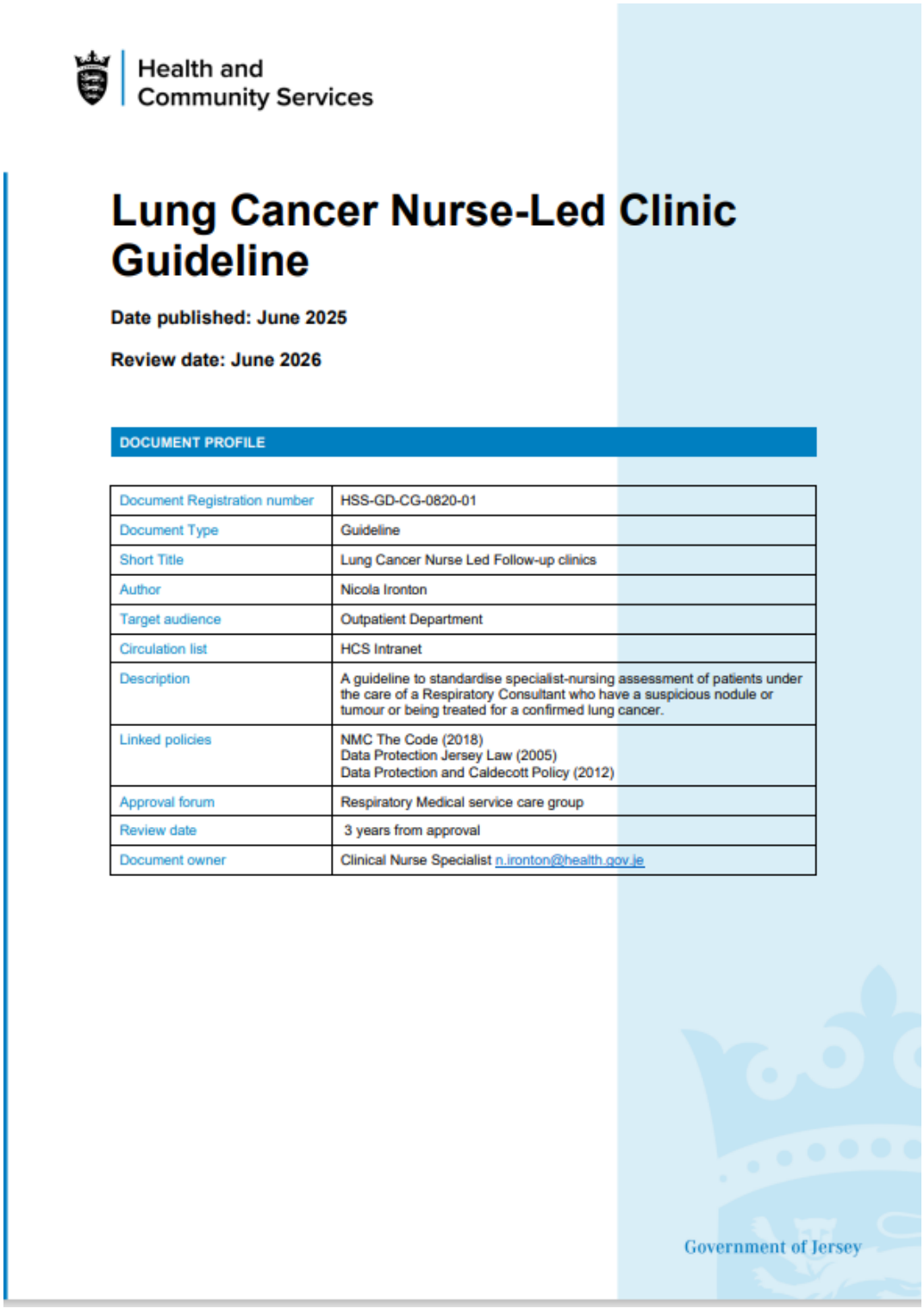
Appendices

Appendix I: Lung Cancer Nurse-led follow-up Clinic Guidelines



Health and Community Services

Lung Cancer Nurse-Led Clinic Guideline

Date published: June 2025

Review date: June 2026

DOCUMENT PROFILE

Document Registration number	HSS-GD-CG-0820-01
Document Type	Guideline
Short Title	Lung Cancer Nurse Led Follow-up clinics
Author	Nicola Ironton
Target audience	Outpatient Department
Circulation list	HCS Intranet
Description	A guideline to standardise specialist-nursing assessment of patients under the care of a Respiratory Consultant who have a suspicious nodule or tumour or being treated for a confirmed lung cancer.
Linked policies	NMC The Code (2018) Data Protection Jersey Law (2005) Data Protection and Caldecott Policy (2012)
Approval forum	Respiratory Medical service care group
Review date	3 years from approval
Document owner	Clinical Nurse Specialist n.ironton@health.gov.je

Government of Jersey

CONTENTS

1 INTRODUCTION

1.1 Rationale

This document has been produced as a guideline to standardise specialist-nursing assessment of Lung cancer patients being followed up as per national guidelines (NICE).

The guideline is limited to those patients under the care of a Respiratory Consultant who have a suspicious nodule or tumour or are being treated for a confirmed lung cancer.

Since the COVID-19 pandemic, the way healthcare is delivered has changed globally (Fraser et al, 2022; Vas et al, 2021). Nurse-led virtual clinics are now established within many specialities (Pham et al, 2021;Bourke et al, 2022), allowing nurses to undertake clinical assessment either by phone or face to face. This new method of nurse-patient communication allows for continued monitoring of patients for lung cancer recurrence or relapse after primary curative treatment.

1.2 Scope

Patients that have been, discussed at Lung MDT with final pathology staging and treatment agreed as per NICE guidelines.

1.2.1 Inclusion criteria

Patients who have undergone curative treatment for Non-Small Cell Lung Cancer (NSCLC) or Squamous Cell Lung Cancer (SCLC) including:

- post-Surgery [+/- Adjuvant chemotherapy/radiotherapy] or
- post Radical Radiotherapy or
- SABR
- Limited Stage Small Cell Lung Cancer – radically treated

1.3 Timing of clinical review

Reviews will be undertaken at the following time points of their pathway:

- post-operatively via telephone or face-to-face two weeks post surgery following the discharge summary being received for any advice and support needed or/and wound review.
- post Review by the Thoracic Surgical team and subsequently discharged.
- post review by their Respiratory Consultant Physician and deemed suitable for transfer from Physician-Led follow up to Nurse-Led follow up.
- following their 8/52 post surgery CT scan
- patient who have completed adjuvant treatment and subsequently discharged from the clinical Oncology team, post radiotherapy telephone or face-to-face clinic.
- 2 weeks post treatment to review any side effects from radiotherapy and offer advice and support as needed.

Post review by their Respiratory Consultant Physician 8/52 with CT Scan results and deemed suitable for transfer from Physician-Led follow up to Nurse-Led follow up.

1.4 Clinic Structure

The clinic will be held in on a Thursday in the Outpatients Department between 13.00 and 17.00 hours.

Appointment slots will be 30 minutes with a maximum capacity of 6 appointments.

A thorough clinical examination of the respiratory system and Holistic Needs Assessment will be undertaken.

The Clinical Nurse Specialist (CNS), as identified during the appointment will initiate referrals to other specialities.

1.5 Principles

This Guideline has been produced to ensure that quality care is delivered in a safe effective manner, with uniformity throughout, within the Respiratory and Oncology department at the Jersey General Hospital.

2 GUIDELINE PURPOSE

With increasing demand on the capacity within the Respiratory and Oncology Outpatient's department, and consultants receiving referrals for new patient reviews; there is a need to develop a more flexible, cost-effective approach to follow-up care. This can be facilitated by enabling an appropriate qualified, experience and skilled cancer nurse to expand their role.

The CNS is a nurse that possesses specialist knowledge and skills in their area. They have in-depth knowledge and experience and are able to help, advise and support, providing an effective service to the patient, their families and colleagues (Ulit et al., 2020)

Having a named CNS as a key-worker can help improve the patients overall experience during their treatment journey as this provides a constant link for patients and families to support them, reassure them and have open contact when necessary (Kerr et al., 2021)

3 EDUCATION AND COMPETENCE

The CNS running the clinic will have completed as a minimum the following education:

- Understanding the Principles of Lung Cancer (Master's Level)
- Completed the Advance Clinical Practise Programme
- Systemic Anti-Cancer Therapy Module (SACT)

The Respiratory and Oncology Consultants will support ongoing education and supervision.

Additional learning will include:

- attendance at the annual Lung Cancer Nursing Conference
- participation in the SACT update study day
- self-directed study through membership in the Lung Cancer Nursing UK Society

4. CORPORATE PROCEDURE

1. Take clinical history, assessing for:
   - red flag symptoms
   - persistent cough
   - haemoptysis
   - shortness of breath
2. If indicated by symptoms undertake clinical examination
3. Show patient chest X-ray or CT and explain result
4. Review Holistic Needs Assessment (HNA) and based on clinical assessment discuss potential interventions or onward referrals to appropriate:
   - Primary Care
   - local authority
   - third sector service providers
5. CNS will schedule follow up
6. Ensure patient has CNS contact card
7. Dictate clinic outcome letter with copy to Respiratory Consultant Physician or Oncology Consultant
8. Liaise with the Respiratory team or Oncology team to request subsequent chest X-ray or scans.
9. Liaise and refer to other specialities as appropriate.

5 CONSULTATION AND DEVELOPMENT PROCESS

A record of who is involved in the development of this document. This may include HCS committees, service users and other agencies.

5.1 Consultation Schedule

Name and Title of Individual	Date Consulted	Response received (Y / N)
Dr Sudheeram Alapati Consultant	05/03/2025	y
Dr Mohammed Butt Consultant	05/03/2025	y
Respiratory Governance Meeting Team	22/04/2025	Y
Racheal Conway Unit Manager	01/04/2025	y
Harriet Holden Lead Nurse	14/05/2025	y
Matthew Doyle Interim Chief of Service	14/05/2025	y

Name of Committee / Group	Date of Committee / Group meeting
Respiratory Governance Meeting	22/04/2025
Divisional Governance	14/05/2025

5.2 Development

Applicable NICE guidance	Details of deviations
www.nice.org.uk/guidance/ng122 Lung cancer: diagnosis and management	
www.nice.org.uk/guidance/ng12 Suspected cancer: recognition and referral	
www.nice.org.uk/guidance/qs17 Lung Cancer In Adults	
ww.nice.org.uk/Diagnostics guidance [DG46] British Thoracic Society's guidelines for the investigation and management of pulmonary nodules (2015).	

If the operational practice outlined in this procedural document deviates from NICE or Royal College guidelines you must complete this form: https://forms.office.com/e/T1uTxjyM4c

6 REFERENCE DOCUMENTS

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2. Kerr, H., Donovan, M., & McSorley, O. (2021). Evaluation of the role of the clinical nurse specialist in cancer care: an integrative literature review. https://doi.org/10.1111/ecc.13415

3. Nursing and Midwifery Council (NMC), 2018. The Code: Professional standard of practice and behaviour for nurses, midwives and nursing associates. London: NMC

7 GLOSSARY OF TERMS, KEYWORDS AND PHRASES

Definitions of technical or specialised terminology used within your document.

Term	Definition
SACT	Systemic Anti-Cancer Therapy
NSCLC	Non-Small Cell Lung Cancer
SCLC	Squamous Cell Lung Cancer

8 IMPLEMENTATION PLAN

A summary of how the document will be communicated, and put into practice.

Action	Responsible Officer	Timeframe
Present at the medical clinical Governance Meeting	Nicola Ironton	Within Four weeks of completion
Present at the Oncology Governance Meeting	Nicola Ironton	Within Six weeks of Completion

9 ASSURANCE

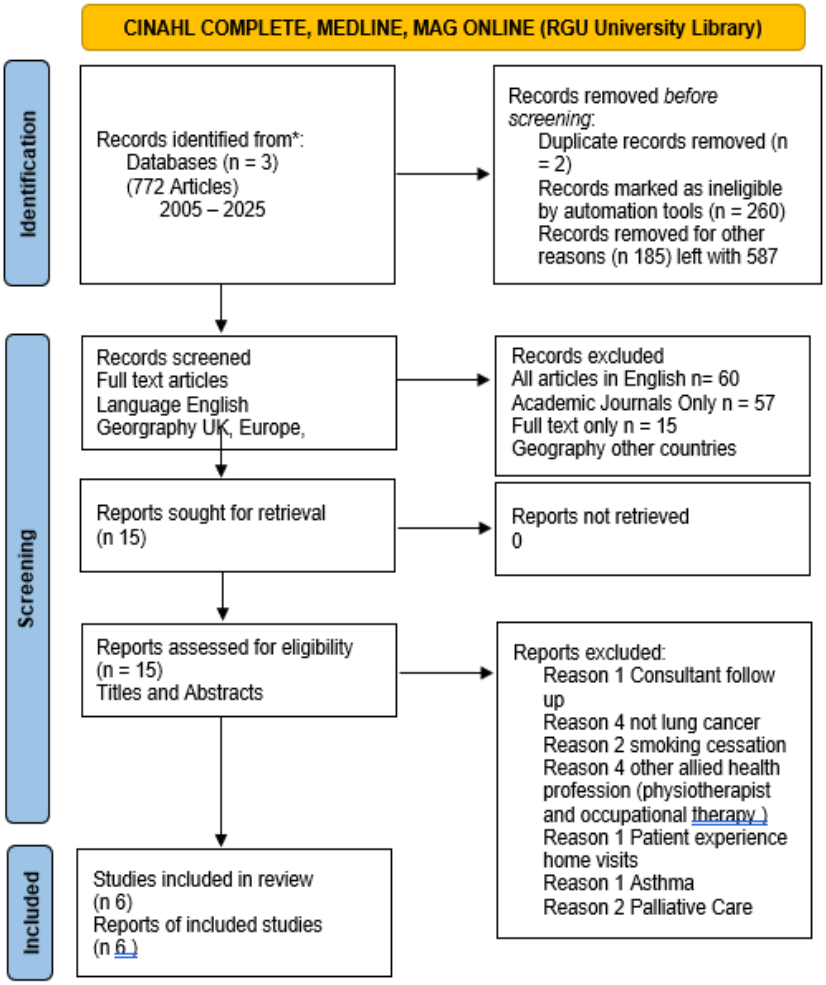
A summary of how the implementation and compliance will be monitored.

Minimum requirement to be monitored WHAT elements of compliance will be monitored	**Responsible individual** WHO is going to monitor this element	**Process for Monitoring** How will this element be monitored	**Frequency for monitoring** WHEN will this element be monitored / how often	**Responsible individual or committee** WHERE - which individual / committee will this be reported to
Number of referrals	Nicola Ironton	Audit	Yearly	Oncology/Respiratory
Patient experience	Nicola Ironton	Face to face interviews	2 Yearly	Audit Team

10 VERSION CONTROL TABLE

Version	Section	Paragraph	Rationale
New	*N/A*	*N/A*	*N/A*

Appendix II: PRISMA



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Appendix III CASP Table

Articles	Date	Country	Appropriate Methodology	CASP SCORE	Relevant	Key points noted
Article 1 Moore *et al., 2006* Nurse Specialist le follow –up in lung cancer: The experience of developing and delivering a new model of care **Medline**	2006	Published European Journal based on United Kingdom	Descriptive Qualitative (adapted)	6/10	Insightful but lacks detail	Patients rely on nurse specialists and value their expertise and continuity. Nurse specialists often become a key source of emotional reassurance during follow-up. Emotional Burden the role is emotionally demanding, requiring strong coping skills. Communication clear, compassionate, and consistent communication is central to positive experiences. Patients appreciate when care is tailored to their needs and when they feel heard. Making a difference, despite challenges, nurse specialists find the role rewarding and impactful.
Article 2	2018	United Kingdom	Service Evaluation	7/10	Practical, some method flaws	Autonomous, efficient care patients benefit from quicker,

Pears and Breen, (2018). Advance clinical practice and nurse-led clinics: a time to progress **Medline**						streamlined decisions made directly by advanced nurse practitioners. Confidence in expertise, patients need to feel that nurses are knowledgeable and capable of handling complex issues. Access and continuity, nurse-led clinics often improve access to care and continuity, leading to greater satisfaction. Holistic and Practical Support Advanced practitioners often provide comprehensive, well-rounded care that patient's value.
Article 3 The role of a nurse specialist in modern lung-cancer service **CINAHL Complete**	2014	United Kingdom	RCT Checklist	9/10	Strong evidence, good design	Choice and Flexibility by offering patients options for follow-up care, such as telephone consultations, home visits, or clinic appointments, empowers them and accommodates their preferences. Personalised Support by tailoring follow-up care to individual patient needs

						enhances satisfaction and engagement. Continuity of care by maintaining consistent contact with the same healthcare provider encouraging trust and improves patient outcomes. Collaborative decision making by involving patients in the development and implementation of follow-up protocols ensures that their concerns and preferences addressed.
Article 4 Patient satisfaction audit of a nurse-led lung cancer follow-up clinic **CINAHL Complete**	2007	United Kingdom	Audit Qualitative	8/10	Deep insight into CNS roles	Continuity of care patients valued the consistent follow-up provided by the same clinical nurse specialist, which fostered trust and a sense of security. Personalised attention The nurse-led model allowed for more individualised care, addressing specific patient concerns and needs. Emotional Support patients appreciated the emotional reassurance and support offered during follow-up

						appointments, which helped alleviate anxiety. Effective communication regarding treatment plans and expectations contributed to patient satisfaction and understanding.
						Patients in the nurse-led follow-up group reported better management of symptoms such as dyspnoea and peripheral neuropathy. Patients in the nurse-led follow-up group reported better management of symptoms such as dyspnoea and peripheral neuropathy. Higher satisfaction scores across various domains suggest that patients valued the nurse-led approach to follow-up care. Nurses identified symptom progression earlier than doctors, potentially leading to more prompt interventions. A greater proportion of patients in the nurse-led group

						died at home, reflecting a preference for end-of-life care outside of hospital settings
Article 6 The effectiveness of the role of advanced nurse practitioners compared to physician-led or usual care A systematic review **CINAHL Complete**	2021	United Kingdom	Descriptive Qualitative	6/10	Relevant, but lacks rigor	Patients reported higher satisfaction levels with ANP led care, particularly regarding communication, empathy, and involvement in decision-making. ANP-led care contributed to better control of chronic conditions, leading to improved health outcomes and quality of life for patients. ANP-led care was associated with reduced healthcare costs, including fewer hospital admissions and shorter waiting times, benefiting both patients and healthcare systems. ANP-led services often resulted in shorter waiting times and increased accessibility, enhancing patient convenience and reducing delays in care delivery.

Appendix IV: Participant Information Sheet

Participant Information Sheet (PIS)

MSc Dissertation study

Study title: How do lung cancer patients in the five-year follow-up period perceive the quality of care provided through a nurse-led clinic?

Student's name: Nicola Ironton

SERP ref. no.

Invitation and brief summary: I am inviting you to take part in a study exploring the experiences of people who have been treated for lung cancer and are now attending nurse-led follow-up clinics.

The purpose of this study is to understand how patients feel about the care they receive in these clinics during the five years after treatment. We are particularly interested in your experiences of emotional support, the care you received, and how well the clinics meet your needs.

If you decide to take part, you will be asked to sign a consent form. You will be asked to share your experiences in a one-to-one interview with a researcher. The interview will be informal, last around 30-45 minutes, and can be arranged at a time that suits you.

Your participation is voluntary, and you can choose to stop at any time without giving a reason.

If you would like to know more before deciding, please read the following full information sheet provided.

Explanation: purpose of and background to the study and invitation:

I would like to invite you to take part in a research study looking at the experiences of people who have been treated for lung cancer and are now attending nurse-led follow-up clinics.

Lung cancer is one of the most common cancers in the UK, and people who have completed treatment are usually followed up for 5 years. These appointments are important for checking recovery, spotting any signs of the cancer returning, and offering support with emotional and practical needs. In many hospitals, these clinics are led by specialist nurses who provide holistic, patient-centred care.

Although nurse-led follow-up clinics are now widely used, little is known about how patients themselves feel about these services. This study aims to explore what these clinics are like from the patient's point of view: what works well, what could be improved, and how the care provided supports your recovery and wellbeing.

To do this, I will interview around 6–10 people who have attended these nurse-led clinics within the five years after their treatment. The interviews will be an informal conversation, giving you the chance to share your experiences in your own words.

Your views will help us understand how nurse-led care following treatment works for you. I plan to use the information to guide local improvements and contribute to wider knowledge about supporting people after lung cancer treatment.

What would taking part involve?

If you decide to take part, you will be invited to take part in a one-to-one interview with me in my role as a research student. While you may know me well as the Lung Cancer Nurse Specialist, I will not be speaking to you in my nurse role. I will be acting as a research student. This means that I will not be able to give nursing advise at the meeting but can guide you to the right support service.

The interview will last about 30–60 minutes and can take place at a time and place that is convenient for you, such as at the hospital, or a place of your choosing if you prefer.

During the interview, you will be asked about your experiences of attending nurse-led follow-up clinics after your lung cancer treatment. There are no right or wrong answers. I am simply interested in hearing your personal views and experiences.

With your permission, the interview will be audio-recorded so that I can make sure nothing is missed. Only myself and my academic supervisor will listen to the recordings, and these will be kept securely.

Taking part is completely voluntary. You can choose not to answer any questions, or you can stop the interview at any time without giving a reason. Your decision will not affect the care you receive now or in the future.

There are no direct risks to you in taking part, although talking about your experiences may bring up memories or feelings that are emotional. If this

happens, you can pause or stop the interview and support information will be provided.

What are the possible benefits of taking part?

Taking part in this study might not bring you any direct benefits. However, some people find it helpful to talk about their experiences and feel heard.

By sharing your experiences, you will help us improve nurse-led follow-up clinics for people treated for lung cancer in the future. Your input could also help nurses and healthcare teams understand what matters most to patients, and this could influence how care is provided.

Even if there is no immediate benefit for you, your participation could help make care better for others in similar situations.

What are the possible disadvantages and risks of taking part?

Taking part in this study is generally low risk, but there are a few things to consider:

Emotional discomfort: Talking about your experiences with lung cancer and follow-up care might bring up upsetting memories or feelings. You can pause or stop the interview at any time, and I can give you information about support services if needed.

Time: The interview will take about 30–60 minutes. Make sure this fits with your schedule.

Confidentiality: The interview will be recorded and typed up. Your information will be stored safely and anonymised to avoid your being

identified in reports or publications. There is a very small risk that someone could guess your identity, but every effort will be made to prevent this.

Stopping at any time: You can stop the interview at any point without giving a reason.

A full risk assessment has been completed for this study.

Further supporting information:

It is very unlikely that anything will go wrong as a result of taking part in this study. However, if you do have any concerns, you can contact me (details below).

If you are unhappy with any part of this and wish to complain formally, you can contact:

- my academic supervisor;
- the Jersey Faculty of Health Education Dean of Nursing, Midwifery and AHP Education; or
- Robert Gordon University's Data Protection Officer (contact details also provided below).

Support Services available to you are:

Macmillan Cancer Support (01534 498188), Patient Advise and Liaison Service (PALS) PALS@health.gov.je

What if I do not want to carry on with the study?

Taking part in this study is entirely voluntary. You are free to stop the interview at any time or withdraw from the study without giving a reason. If you choose to withdraw after the interview, you can do so up to two weeks

after the interview date. After this point, the information you have provided may already have been anonymised and included in the analysis, so it will not be possible to remove it.

How will my information be kept confidential?

All information you provide will be treated as strictly confidential. Your interview will be audio-recorded and then transcribed (typed up). Any names or identifying details will be removed so that you cannot be recognised in the study reports. Data will be stored securely on password-protected systems and only the researcher and academic supervisor will have access.

What will happen to the results of this study?

The findings will be written up as part of a Master's dissertation and presented to an invited audience at the Faculty of Health Education.

Who is organising and funding this study?

This study is being carried out by a postgraduate student at Jersey Faculty of Health Education and their partnership with Robert Gordon University as part of their dissertation.

There is no external funding.

Who has reviewed this study?

This study has been reviewed and approved by the School of Health Ethics Review Panel (SERP) at Robert Gordon University. It has also had a review and favourable opinion by the Jersey Health Research Ethics Committee.

Further information and contact details

If you have any questions or would like more information, please contact:

Researcher: Nicola Ironton n.ironton@rgu.ac.uk

Module Leader and Academic Supervisor: Dr Moyra Journeaux m.journeaux@health.gov.je

Jersey Faculty of Health Education Dean: Dr Hazel McWhinnie h.mcwhinnie@health.gov.je

Data Protection Officer: dp@rgu.ac.uk

Use of personal information (GDPR statement)

Robert Gordon University is the data controller for the personal data you provide. The university will process your personal data for the purposes of conducting this study in line with data protection legislation. Your data will be handled securely and confidentially. Personal information will be anonymised, and any published results will not identify you.

Further information on how the university manages personal data, including your rights, can be found at [Data Protection | Information Governance | RGU].

How your data is used and kept confidential by the organisation sponsoring this study

Robert Gordon University is the sponsor for this study. In this section, 'we' refers to the sponsor, not the organisation where data collection takes place.

How will we use information about you?

We will need to use information gathered from you for this study. This information will include your name and contact details. The student and their supervisor will use this information to do the study and to make sure that the study is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once finished the study is completed, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- by asking one of the study team
- by sending an email to [n.ironton@rgu.ac.uk], or
- by ringing us on [01534 442585], or
- by contacting RGU Data Protection Officer (dp@rgu.ac.uk).

Version control: Version 1

08/09/2025

The SERP reference number: 25-24

Appendix V: Consent Form

CONSENT FORM

Title of Project: *How do lung cancer patients in the five-year follow-up period perceive the quality of care provided through a nurse-led clinic?*

Name of Researcher: Nicola Ironton Lung Cancer Clinical Nurse Specialist.
Please initial box

I confirm that I have read the information sheet dated 22 October 2025 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary ☐

I understand that after anonymisation and data combination, my data cannot be identified or removed, and withdrawal of my data will no longer be possible. ☐

I understand that where it is possible to withdraw, I can do so without giving any reason and without my legal rights being affected. ☐

I agree to the interview to be audio recorded to enable accurate data collection. ☐

I agree to take part in the above study. ☐

Name of Participant	**Date**	**Signature**
Nicola Ironton		
Name of Person seeking consent	**Date**	**Signature**

When completed: 1 for participant; 1 for researcher site file

Appendix VI: Data Management Plan

Effective data management is vital for maintaining confidentiality, integrity, and legal compliance (UK Data Service, 2025). Research will be conducted in compliance with the Data Protection Law (Jersey) 2018.

Signed consent forms will be collected either in physical or electronic format. Physical consent forms will be stored in a locked cabinet accessible only to the research team. After data collection and verification, the physical consent forms will be scanned and securely shredded in accordance with HCJ data disposal procedures. Scanned physical forms will be stored with electronic consent forms in a password-protected and access-restricted folder on a password-protected computer and deleted at the end of the data retention period. Consent forms will be stored separately and unlinked from transcripts or recordings.

All interviews will be audio recorded using a secure recording app HCJ approved Microsoft Teams.

Audio files will be transferred immediately after the interview. The recording will be downloaded from Teams and securely transferred to a password-protected and access-restricted folder on a password-protected computer.

Transcription will be conducted by the lead researcher.

All identifying information (e.g., names, addresses, clinic locations) will be removed or replaced with pseudonyms during transcription.

Quotations used in the dissertation or future publications will be anonymised to minimise the risk of participants being recognised.

Contextual details that might indirectly identify participants (e.g., specific medical circumstances) will be generalised or omitted.

Data will be retained in accordance with Jersey law, which requires that data be kept for as long as necessary. As a general rule of thumb, this means data will be retained for 10 years following its last use, typically after the completion of the dissertation.

After the retention period, all data will be securely destroyed: digital data will be permanently deleted, and any physical copies shredded.

Data Deletion Procedures

Once the transfer of interview recording has been verified, the original recording stored in Microsoft Teams will be permanently deleted. This will involve deleting the recording from the Teams meeting chat and ensuring that it is also permanently deleted from the SharePoint location. Deletion will be completed within 24 hours of confirming the successful transfer.

Only the securely stored version on the password-protected computer will be retained for research purposes, in accordance with the approved data retention and destruction schedule

it will be stored securely with a file name to indicate the data deletion date.

Appendix VII: Risk Assessment

Risk	Likelihood	Impact	Level of Risk	Mitigation Strategy
Emotional distress for patients during interviews	Medium	High	High	Offer immediate support; refer to counselling services if needed. Macmillan provide a holistic needs assessment for all cancer patients locally and have counselling services if required. I will include support details on the participant information sheet and gain informed consent prior to beginning.
Breach of patient confidentiality	Low	High	Medium	Ensure data is anonymised at all times and stored securely to protect participant's identity. All identifying information (e.g., names, addresses, clinic locations) will be removed or replaced with pseudonyms during transcription. Audio recordings will be deleted once transcription accuracy is verified. Recordings and transcriptions will be permanently deleted form one drive. Password protected folder used to store anonymised data online. The Data Protection (Jersey) Law 2018 will be adhered to. Quotations used in the dissertation or future publications will be anonymised to minimise risk of participants being recognised. Contextual details that might indirectly identify participants (e.g., specific medical circumstances) will be generalised or omitted.
Low recruitment or participation rate	Medium	Medium	Medium	Engage stakeholders early; use clear patient-friendly materials. A participation information sheet will be provided. This will be written clearly in plain English using layman terms. To ensure accessibility, I will use the Hemingway Score to grade this and ensure it falls between a Grade 6-8 as an indication of reading age 11-13.
Researcher bias in data interpretation	Medium	Medium	Medium	Peer review will be used where possible. I will have a named research supervisor as a strategy for mitigating researcher bias in qualitative data analysis. I will have regular supervision with critical feedback and guidance, to help identify and address potential biases in coding and interpretation throughout the analysis.

Miscommunication regarding clinic role	Low	Medium	Low	I will clearly define separation and differences between remit in clinic and research roles in participant materials and verbally.
Data loss (technical failure or mishandling)	Low	High	Medium	Regular backups; secure data handling procedures. Continuous monitoring throughout the process. Interviews will be recorded and transcribed and saved in a password protected folder.
Researcher safety while a lone worker during interviews	Low	Low	Low	I will follow the hospital's lone worker policy (Health and Community Services, 2024) at all times, ensuring that someone knows where I am, how long I expect to be there, and I will contact them once I have returned safely.

Appendix VIII: Permission to Access the Site

Nicola Ironton
Faculty of Health Education
Harvey Besterman Education Centre
Peter Crill House, Gloucester Street, St Helier, Jersey, JE1 3QS

Postgraduate Student – MSc NUM100 - Advancing Practice Dissertation
MSC ADVANCING PRACTICE (PT) - JERSEY
Jersey Faculty of Health Education and Robert Gordon University n.ironton@rgu.ac.uk
01534 442585

01/10/2025
Harriet Holden (Lead Nurse for Medicine)
General Hospital, The Parade, St Helier, Jersey JE1 3QS

Subject: Request for Permission to Access Site for Research

Dear Harriet
I am a postgraduate student at RGU, and the Jersey Faculty of Health Education, currently undertaking my Master's dissertation as part of the MSc Advancing Practice Dissertation programme. I am writing to request permission to access to Jersey General hospital (Lung Cancer Nurse Led follow up clinic) to conduct my research study entitled:

"How do lung cancer patients in the five-year follow-up period perceive the quality of care provided through a nurse-led clinic?"

Research Aim: To explore and critically evaluate the livid experiences and perceptions of individuals receiving follow in the lung cancer nurse led clinic.

Research Objectives:

1. To examine lung cancer patients' experiences of follow-up care within a nurse-led clinic over the five-year survivorship period.
2. To identify key aspects of care (communication, continuity, accessibility, holistic support) that influence patients' perceptions of quality.
3. To explore how nurse-led follow-up compares with patient expectations of ongoing cancer care and support.
4. To investigate the impact of nurse-led follow-up on patients' physical, psychological, and social wellbeing.
5. To generate evidence-based recommendations for enhancing the delivery and quality of nurse-led follow-up services for lung cancer patients.

This will be a qualitative study using semi-structured interviews with patients who are within the five-year follow-up period after a lung cancer diagnosis and who have received care through a nurse-led clinic.

Participation will be voluntary, and all participants will receive clear information about the study before giving written consent. Ethical approval will be sought from RGU University ethics committee and, Jersey Island Research Ethics Committee. Strict measures will be taken to ensure confidentiality, data protection, and compliance with all ethical requirements. (Following Jersey Data Protection Law and UK and RGU research Data Management Policy).

I would be grateful for your consent to access to Jersey General Hospital (Lung Cancer Nurse Led follow up clinic) to allow this study to proceed. I am happy to provide the full research proposal, participant information sheet, consent form, or confirmation of ethical approval upon request.

Thank you very much for your time and consideration.
Yours sincerely

Nicky Ironton

MSc NUM100 - Advancing Practice Dissertation Candidate IRONTON (2329213)

If you are happy to agree to this, please can you sign the statement at the end of this letter?

- I can confirm that we are happy to provide permission for you as the lead researcher for the project to access our service and recruit participants.
- I can confirm that the research team may use our site to set up confidential interviews with participants.
- I can confirm data gathered from interviews with the participants can be used (with their consent) to write up a research report to share with our service and for any future publications arising from this.

Signed:

Date: 6th October 2025

Appendix IX: RGU SERP Approval

Name: Nicola Ironton

Date: 07.01.26

SERP reference number:25-24

Dear Nicola,

Research proposal name: How do lung cancer patients in the five-year follow-up period perceive the quality of care provided through a nurse-led clinic?

Thank you for submitting your application for ethical approval. The School of Nursing, Midwifery & Paramedic Practice Ethics Review panel has now reviewed the above research proposal. Your proposal has been approved and can now be submitted to the Jersey REC. SERP approval is valid for 1 year from the date of this letter. If your data collection period progresses beyond 1 year, please notify the SERP convenor. Please include your SERP reference number in a footer on all documents related to your study. If you require further information, please contact the committee by email at SNMP-SERP@rgu.ac.uk

Yours sincerely

Dr Nick Adams

The School of Health ethics co-convenor on behalf of the committee.

Appendix X: RGU Sponsorship

Dear Nicola Ironton

This letter is to confirm that Robert Gordon University will 'in principle' act as sponsor for the project stated below.

Agreement in principle is subject to the research receiving approvals from the School of Health Research Ethics Panel and the relevant local health research ethics committee.
Project Reference: SH/25/24 Project

Title: 'How do lung cancer patients in the five-year follow-up period perceive the quality of care provided through a nurse-led clinic?'

Chief Investigator: Nicola Ironton

Academic Supervisor: Dr Moyra Journeaux

Yours sincerely

Appendix XI Jersey Ethical Approval

Health and Care Jersey

Research Ethics Committee
Peter Crill House
Gloucester Street
St Helier, JE1 3QS

Private and Confidential

Please note: This is a favourable opinion of the REC only and does not allow you to start your study at the research site until conditions are met and until you receive organisational permission to do so.

10/12/2025

Dear Nicola,

Study title: *How do lung cancer patients in the five-year follow-up period perceive the quality of care provided through a nurse-led clinic?*

REC reference: 2025HCJREC15

The REC reviewed the above application in November 2025.

Ethical Opinion
The members of the committee gave an outcome of the above research on the basis of the research described in the application and supplementary documentation.

Requirements
There are 5 requirements before a favourable outcome can be noted:

- Recruitment: As the Clinical Nurse Specialist for the caseload of patients who you are drawing your participants from, how can you ensure there is now power imbalance/coercion and avoid patients feeling they have to participate in the research – please can you include this in a recruitment strategy within the proposal.
- How will you minimise bias during the interview process and ensure participants are able to freely discuss their experience?
- Please forward your university outcome once you have it as this REC outcome is pending a favourable outcome from the university and agreement to sponsor the research.
- Consistency is needed between documents. Is the interview anticipated to be 30-45 minutes or 30-60 minutes? It is different in different documents.
- Simplify the consent form to make it explicit about when they can and cannot withdraw.

Amendments to the original documents should be in red font.

Please note, it is the responsibility of the sponsor to ensure that the research is carried out as per that described in the application, research protocol and supplementary documentation. Data collection cannot commence until the conditions have been met.

You should let us know if there are any significant changes to the proposal that might raise any further ethical issues.

Please let us have an end of year update and a brief final report to confirm when the research has been completed.

We wish you well in this research and look forward to hearing how it goes. Once completed, please can you consider submitting a copy of any report of publication to the Jersey Island Repository database. https://www.islandrepository.ac.je/
They can be contacted on: rees.monet@jicas.ac.je

Yours sincerely

Kate Melyn
Secretary HCJ Research Ethics Committee

D +44 (0)1534 443337
E HCSResearchEthicsCommittee@gov.je

Copy:

The HCS REC intranet site can be found:
https://soj/depts/HSS/ClinicalSupportGovernance/Pages/Ethics-committee.aspx

Research Ethics Committee
Peter Crill House
Gloucester Street
St Helier, JE1 3QS

Health and Care Jersey

Private and Confidential

Please note: This is a favourable opinion of the REC only and does not allow you to start your study at the research site until conditions are met and until you receive organisational permission to do so.

16/01/26

Dear Nicola,

Study title: *How do lung cancer patients in the five-year follow-up period perceive the quality of care provided through a nurse-led clinic?*

REC reference: 2025HCJREC15

REC review 27 November 2025.
Revisited following updated information 16 January 2026

Ethical Opinion
It is now possible to give a favourable outcome on the basis of the research described in the updated application and supplementary documentation.

The REC is satisfied with the amendments and additional information supplied. The REC also acknowledge that Robert Gordon University have agreed in principle to act as sponsor the research and this agreement is subject to them having a copy of this favourable outcome.

Please note, it is the responsibility of the sponsor to ensure that the research is carried out as per that described in the application, research protocol and supplementary documentation.

You should let us know if there are any significant changes to the proposal that might raise any further ethical issues.

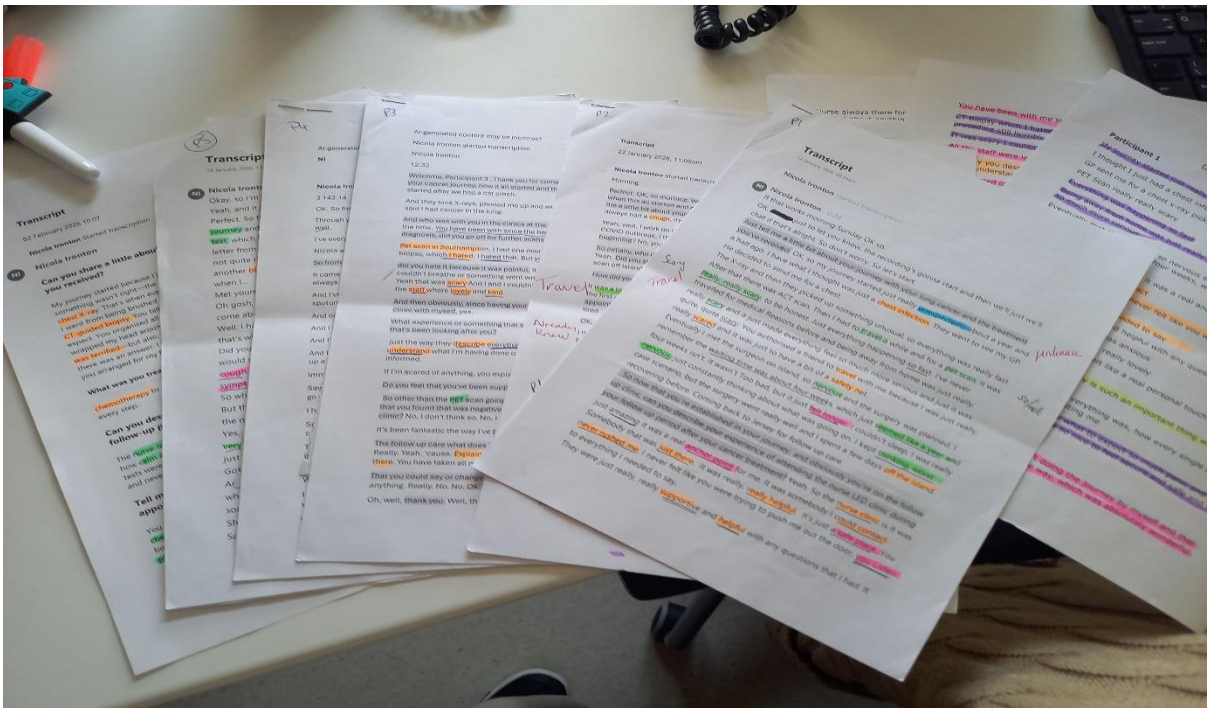
Please let us have an end of year update and a brief final report to confirm when the research has been completed.

We wish you well in this research and look forward to hearing how it goes. Once completed, please can you consider submitting a copy of any report of publication to the Jersey Island Repostitory database. https://www.islandrepository.ac.je/
They can be contacted on: rees.monet@jicas.ac.je

Yours sincerely

Appendix XII Participant Transcripts

Evidence of Initial Coding and Data Familiarisation



Appendix XIII Mind Map Illustrating Development of Codes to Themes