The Sustainability Challenge in NHS Psychological Professionals. Understanding and Correlating the Experiences of Stress, Burnout and Workforce Retention.

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Thesis Portfolio Abstract

Workforce shortages and staff burnout present a persistent challenge in the National Health Service (NHS; Deakin, 2022). This research aimed to understand the factors correlating to stress and burnout among NHS Psychological Professionals (PPs), particularly focusing on the early-career experiences of clinical psychologists (CPs) and the employment decision-making factors influencing their choices to stay, split, or leave NHS employment. A systematic review identified four papers and indicated that compassion fatigue is the strongest correlate of burnout in trainees, while psychological job demands are the strongest correlate for qualified PPs. Multiple correlates were also examined, as they rarely exist in isolation. An empirical study followed. Eighteen early-career clinical psychologists (ECCPs) completed one-to-one interviews. Using Braun & Clarke's reflexive thematic analysis (RTA; Braun & Clarke, 2022), the study identified four interconnected and perpetuating themes: *The Wounded Healer: The Emotional Toll, Values: The Moral Toll*, *(Mis)Understanding the role of a Clinical Psychologist* and *Systemic Barriers*. The portfolio sheds light on multiple challenges NHS PPs and, specifically, ECCPs face, including psychological job demands, moral injury, burnout inevitability, misunderstanding and devaluation of their role and being a sole clinician, resulting in employment decision-making away from the NHS to foster career longevity. The strengths and limitations of both studies were considered. Future research, utilising a longitudinal approach and exploring training experiences on influencing employment decision-making, to add to the scarce evidence base, is crucial for PPs' workforce sustainability.

Access Condition and Agreement

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Declaration

Material submitted by the portfolio's author for the Thesis Proposal as part of the Doctorate in Clinical Psychology at the University of East Anglia has been updated and adapted throughout the thesis portfolio.

Chapter One

Introduction to the Thesis Portfolio

Introduction

"[…] in so great and novel an undertaking" (Bevan, 1948) from the beginning of the National Health Service (NHS) in July 1948 and to the present day, it is often regarded as one of the United Kingdom's (UK) greatest establishments (Imperial College Health Partners, 2014). NHS England currently employs 1.5 million people (Mallorie, 2024), making it the UK's largest employer and the world's fifth (Rolewicz et al., 2024). Yet 77 years after its commencement, Lord Darzi's recent independent review of NHS England, concluded "The National Health Service is in serious trouble" (Darzi, 2024, p. 1).

Workforce shortages and staff burnout are two salient challenges the NHS faces (Bimpong et al., 2020; Buchan et al., 2017; House of Commons, 2021). Results from the NHS Staff Survey indicate staff reflections on the magnitude of these issues and the comparable stability over the years. Only 32.4% of staff respondents felt there was sufficient staff to be able to do their job properly in 2023, compared to 26.39% in 2022, and 27.08% in 2021 (NHS Staff Survey [NHSSS], 2024). Staff feeling always or often burnt out has remained comparably stable, also, with 30.38% of NHS staff always or often burnt out because of their work (2023), 33.97% in 2022 and 34.49% in 2021 (NHSSS, 2024). Burnout and moral injury are cyclical to each other and often exhibit in the individual, yet start from within the organisation (Weisleder, 2023). Moral injury in healthcare workers is considered "being unable to provide high-quality care and healing […]" (Talbot & Dean, 2018), the impact of consistently failing to meet patients' needs at the heart of it and adversely affecting workers' well-being. Moral injury occurs when integrity, our values and beliefs, are betrayed (Čartolovni et al., 2021), and staff are organisationally bound to act in ways that do not align with said values and beliefs (Campling, 2023). Insufficient staff has been stated as the most common cause of moral distress (British Medical Association [BMA], 2021) and chronic understaffing noted as a

key systemic cause of experiencing potentially morally injurious events in UK healthcare workers (Rabin et al., 2023). Prolonged moral distress results in moral injury, however, literature has also considered the move away from the term moral distress in favour of moral injury (Heide & Olff, 2023). An institution to promote the well-being of the public yet risks the 'health and well-being of 1 in 20 of its national workforce' (West, 2020), and two in five staff report unable to work due to work-related stress (Mallorie, 2024). NHS staff sickness is twice the level of the private sector (West, 2020), resulting in higher-than-UK-average work-stress-related sickness and absences than any other UK job sector (Ravalier et al., 2020).

The juxtaposition is evident: the NHS, established to safeguard the physical and mental well-being of the public, yet leaves its workforce vulnerable to poor physical health, compromised well-being, burnout, and moral injury. Workforce shortages, burnout and moral injury are perpetual. Staff leaving the NHS for health reasons or to seek a better work-life balance has tripled since 2011 and reflecting why NHS staff are leaving in their droves (Mallorie, 2024). This is despite well-known retention strategies to minimise workplace stress and promote well-being (West et al., 2020). As Frances fittingly concluded: "This crisis in workforce morale and retention is the most pressing of the many difficulties the NHS is now suffering" (Frances, 2023, p. 51).

Psychological professionals (PPs) are one staffing group in the NHS and are set to be the fastest-growing professional group within it (Whittington, 2024). The commitment to increase training places for clinical psychology and child and adolescent psychotherapy by 26% by 2031 (NHS England, 2023), along with expansions in other PPs training routes in the Psychological Professionals Workforce Plan (Health Education England [HEE], 2021), seemingly, the NHS Long Term Workforce Plan's (NHS England, 2023) first priority, 'Train', a success. Yet little is considered for the plan's second priority, 'Retain'.

Retention and workforce shortages present serious concern among PPs, as all practitioner psychologists' roles remain on the UK Shortage Occupation List (SOL) in 2024 (Morris, 2025), and most of the 971 PPs surveyed reported the NHS as their main employer (85%), but 77.6% stated staff shortages affected safe and effective patient care delivery (Rao et al., 2023). Fifty-seven per cent of 281 clinical psychologists (CPs) reported a shortage of one or more CPs in their service (Association of Clinical Psychologists [ACP-UK], 2020). PPs' workplace well- being has decreased, with lower overall scores on the Psychological Professionals Well- Being Survey in 2023, compared to 2019, lower general well-being than the national average (Rao et al., 2023) and 41% of 281 CPs feel demoralised (ACP-UK, 2020). This is a cause for concern given the emotive nature of PPs' roles and the heightened risk for burnout due to associated emotional demands of the helping profession (Brotheridge & Grandey, 2002; Maddock, 2024; Volpe et al., 2014).

There is a dearth of research understanding stress and burnout experiences among PPs, and even more scarce regarding CPs specifically. The thesis portfolio aimed to meaningfully add to the evidence base by understanding the correlates of stress and burnout in trainee and qualified PPs, how early-career clinical psychologists (ECCPs) experience newly qualified life and how this impacts NHS retention.

Chapter Two

Systematic Review

Correlates of Stress and Burnout in Three Groups of Trainee Psychological Professionals and Qualified Talking Therapies Practitioners in the National Health Service: A Systematic Review and Synthesis without Meta-Analysis.

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Abstract

Occupational stress and burnout in staff remain critical challenges in the National Health Service (NHS). Extensive research explores stress and burnout correlates in other NHS professions; evidence for psychological professionals (PPs) is limited. Given the emotionally demanding nature of their work, PPs face heightened risk of stress and burnout. This systematic review (PROSPERO: CRD42024543006) aimed to synthesise the strongest correlates of stress and burnout in trainee and qualified PPs following A Synthesis without Meta-Analysis (SWiM; Campbell et al., 2020) guidance. Systematic searches of five databases (EMBASE, Medline, PsycINFO, CINAHL, and Web of Science) in November 2024 identified four studies meeting inclusion criteria. Only seven job roles, predominantly from NHS Talking Therapies (TT), were explored. No studies explored stress. Compassion fatigue was the strongest correlate of trainee burnout, and psychological job demands, the strongest burnout correlate for qualified TT practitioners. PPs face complex, interconnected personal and organisational risks of burnout. Scarce, heterogeneous studies highlight the need for further, consistent research, especially as TT practitioners work in a unique service context. The review calls for the need to urgently address the correlates of burnout to safeguard this workforce's sustainability, particularly in NHS TT, and therefore, patient accessibility to psychological interventions.

Keywords: stress, burnout, National Health Service, psychological professionals, correlates

Introduction

Burnout among National Health Service (NHS) staff remains a pressing issue, jeopardising workforce sustainability (French et al., 2022; Millar, 2019). Stress and burnout are reported to be more prevalent in mental healthcare staff due to the emotional labour involved (Johnson et al., 2018), as well as the consequences of chronic underfunding (Gilburt, 2015; Unger, 2020). Reports of burnout among NHS staff show consistent levels over the last three years (2021-2023). In the 2023 NHS Staff Survey, 30.38% reported feeling burnout, compared to 33.97% in 2022 and 34.49% in 2021 (NHS Staff Survey [NHSSS], 2024).

Determining the current prevalence of stress and burnout in NHS professionals is challenging. Estimates consider moderate to high levels of burnout in NHS staff (Millar, 2019), with higher levels among clinical staff (NHS Employers, 2025) and NHS staff 50% more likely to suffer high levels of work-related stress compared to the general working population (West, 2020). Stress due to workload is a known risk factor for burnout (Chu et al., 2023) and has been cited as the top reason staff leave the NHS (Weyman et al., 2023).

Burnout, first conceptualised by Freudenberger (1974), describes a psychological syndrome of gradual emotional depletion and reduced motivation. The most widely accepted model of burnout encompasses three dimensions: emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach et al., 1997). Further work modified the conceptualisation to consider disengagement as pertinent to burnout development (Demerouti et al., 2001), and lack of personal accomplishment, a consequence of, over an antecedent of burnout (Schaufeli et al., 2001).

Understanding what causes burnout is complicated, multifaceted, non-linear or static, despite a wealth of research exploring healthcare professionals' burnout (Dolan,

1987, Dreison et al., 2018; Gupta, 2021; Hinderer et al., 2014). Prosser et al. (1997) used The Perceived Stress Scale (PSS; Cohen et al., 1983) and concluded that insufficient people resources, responsibility without power and too much administration were the top three determinants of stress for mental health workers. Furthermore, feeling undervalued by pay, colleagues, and management were the greatest reported determinants of stress not covered by the PSS. Individual factors, including age, gender, ethnicity, personality and length of service, are influential to burnout (Grailey et al., 2023; Lawrence et al., 2022; O'Connor et al., 2018; Rupert & Kent, 2007; Simionato & Simpson, 2018). However, work-related factors are considered more influential (Morse et al., 2012). Job characteristics pertinent to burnout include high caseloads, job control/autonomy, role ambiguity, work setting and professional background/training (Alacron, 2011; Dreison et al., 2018; Nelson et al., 2009; Wintour & Joscelyne, 2024).

Paradoxically and perpetually, burnout relates to an increased workload (Alarcon, 2011), poorer employee well-being (Weyman et al., 2023), staff physical and mental health deterioration (Vivolo et al., 2022), ineffective team dynamics (Gisick et al., 2024), staff absenteeism (Lee et al., 2023) and increased job dissatisfaction (Iliffe & Manthorpe, 2019). Factors that are well documented to increase the likelihood of experiencing burnout in the helping professions (Morse et al., 2012; O'Connor et al., 2018; Vivolo et al., 2022).

The emotional demands of NHS helping professions contribute to burnout. Those in the helping profession are likely to experience distress (Volpe et al., 2014), which can equate to increased staff turnover (Gupta et al., 2012). The perpetual challenge between burnout and workforce shortages saw anxiety, stress, depression, or other psychiatric illness, the most reported reason for NHS staff sickness in July 2024, accounting for over 606,800 full-time equivalent days lost (NHS England, 2024). As a result, the NHS experiences higher-than-UK-average levels of stress-related sick absences compared with

any other UK job sector (Ravalier et al., 2020).

The impact of the Coronavirus pandemic (COVID-19) on healthcare workers and their experience and level of burnout cannot be ignored (French et al., 2022). Of 765 UK healthcare workers, 63% met the threshold for burnout (Denning et al., 2021), with the strongest correlate of burnout being patient-facing.

One group of mental health professionals in the NHS are psychological professionals (PPs). Recent NHS workforce data would suggest an increase in PPs, with 25,406 whole-time equivalent PPs in April 2023 (NHS Benchmarking Network, 2023). There is a dearth of research on stress and burnout correlates specific to PPs, as research commonly explores different settings or specialities (e.g. Child and Adolescent Mental Health Services [CAMHS]) or groups of various staff (Hinderer et al., 2014; Morse et al., 2012; Prosser et al., 1997). Organisational and personal factors are known to influence PP's work-related stress and burnout. Rupert & Kent (2007) concluded that the top correlates of emotional exhaustion in their US-based sample of applied psychologists (n = 595) were total hours worked, administrative hours, negative client behaviours and overinvolvement with clients. In Simpson et al.'s (2019) sample of clinical and counselling psychologists (n = 433), the majority Australian (n = 230), older age was a predictive factor in experiencing less emotional exhaustion. The majority of their sample (79%) reported experiencing work-related stressors adversely affected their ability to do their job. Due to the emotive nature of PPs' work, burnout is considered to potentially adversely affect professional competency and, therefore, is an ethical obligation to tackle (McCormack et al., 2018). Emotional exhaustion is considered the most salient domain of burnout in psychologists (Di Benedetto & Swadling, 2014; Rupert & Kent, 2007; Simpson et al., 2019) and was highest in psychology compared to other mental health disciplines, including psychiatry, counselling and nursing (Dreison et al., 2018).

Conversely, depersonalisation is lower in practitioner psychologists compared to other mental health professionals (MHPs), including psychiatrists and social workers (Billings et al., 2003; Nelson et al., 2009; Prosser et al., 1999).

Unique experiences at different career stages, such as trainee versus qualified, may offer valuable insights into correlates of stress and burnout. A recent systematic review of stress and burnout in trainee and qualified PPs (Harding, 2025) postulated that trainees may be entering the qualified workforce already burnt out from their training experiences. Lower rates of emotional exhaustion in clinical mental health staff have been associated with longer clinical experience (Prosser et al., 1999), which could adversely affect trainees. This is particularly imperative as 32% of 637 trainee PPs stated they wanted to leave their training programme, with stress the most common reason behind their intention to leave (National Education Training Survey, 2023).

There has been no systematic exploration of the correlates of stress and burnout among NHS PPs. Stress and burnout are known to affect absenteeism and presenteeism, leading to financial ramifications for the NHS, which adversely impacts the quality of patient care and reduces retention, thereby affecting workforce sustainability (Millar, 2019; NHS Employers, 2024). A deeper understanding of stress and burnout correlates would enable the implementation of changes to mitigate the damaging effects of these adverse experiences.

Particularly, understanding the correlates of stress and burnout in trainee PPs may help to ameliorate a proportion leaving during training, support trainees from entering the workforce already burnout, improve the well-being of newly qualified PPs, to lessen the risk of early departure from the NHS, thus improving retention.

As such, the current review aimed to answer the following questions:

1) What are the correlates of stress and burnout in trainee and qualified NHS

psychological professionals?

2) What are the most reported correlates of stress and burnout in trainee and qualified NHS psychological professionals?

Method

The review protocol was pre-registered with the International Prospective Register of Systematic Reviews (PROSPERO) on September 4th, 2024 (CRD42024543006). The review follows guidance provided by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement (Page et al., 2021) and checklists (Appendix B).

Data sources and search strategy

A search strategy (Appendix C) was developed and reviewed with the research team and in consultation with academic librarians. Five electronic databases were searched: Embase, MEDLINE EBSCO, PsycInfo, CINHAL and Web of Science. Searches were completed on November 6th, 2024. Hand-searching the reference lists of the included studies ensured the maximised possibility of relevant study inclusion.

Eligibility Criteria

The review employed the umbrella term PPs to encapsulate the 19 job titles in line with the NHS's Psychological Professions Workforce Plan for England (Health Education England [HEE], 2021) (Appendix D). Inclusion and exclusion criteria are detailed in Table One.

Table 1.

Inclusion and exclusion criteria

Inclusion	Exclusion
Nineteen job titles under NHS 'Psychological Professionals' – trainee and/or qualified	Studies referring only to prevalence data of stress and/or burnout
UK-centric, in English language	
Quantitative methodology, or mixed methods where quantitative data can be extracted	
Validated psychometric measure on stress and/or burnout	
Contributory factors of stress and/or burnout	
Clear descriptions of methodology, analysis and results, to facilitate data extraction	
Peer-reviewed journal articles of primary data	

Screening and selection of studies

A total of 5488 studies were yielded from the database searches. Duplicates were removed utilising Rayyan software (Figure 1). A further 29 studies were included from reference list searching.

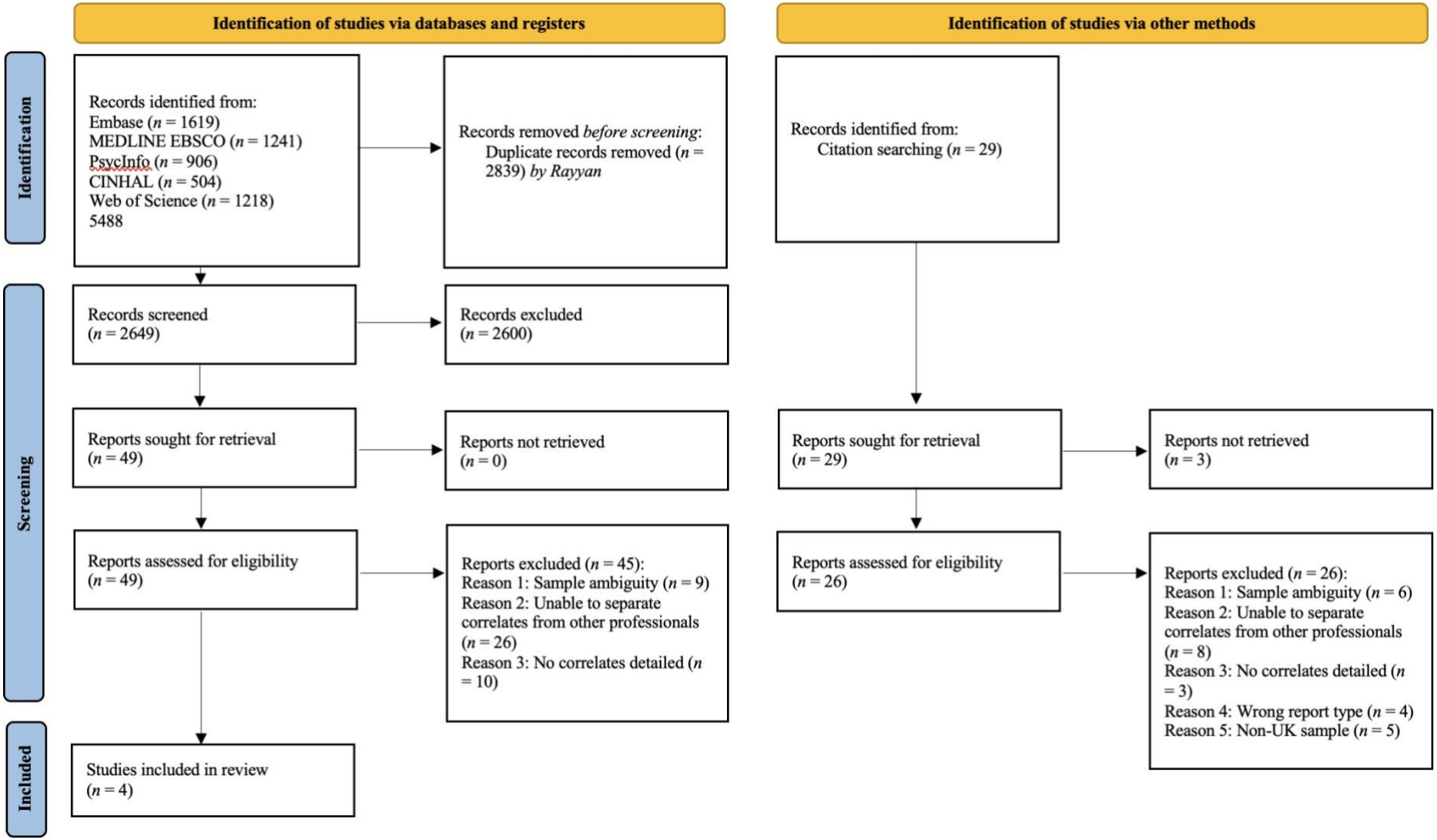

Figure 1. PRISMA flow chart

Studies were first screened at the title and abstract level by the first author (MS). AH independently screened a randomised 25% of titles and abstracts. Percentage agreement was 89% and consultation between MS and AH regarding the eligibility criteria resolved disagreements. For full-text screening, the first author screened all studies, and AH independently screened a randomised 25%. At full-text screening, the percentage agreement between the two raters was 70%, and disagreements were consulted on until a consensus was reached.

Data extraction

The first author extracted and summarised the data from the four included studies. The data extracted included the characteristics of the papers (Table 2): author(s), date, research aim(s), sample size and characteristics, setting and context, outcome measure(s) and burnout dimension(s) measured. The results tables (Tables 3-6) extracted the following: correlate(s), outcome (burnout, emotional exhaustion, depersonalisation, disengagement and/or lack of personal accomplishment) and correlation. Full results from the included papers are detailed in Appendix E.

To ensure accuracy, 25% of included studies were cross-checked for consistency of data extracted (Daniels, 2019) independently between the first (MS) and secondary authors (AH), resulting in no disagreement.

Data Synthesis

Due to the heterogeneity of methodology, outcome measures and statistical analyses, a meta- analysis was not feasible. Therefore, results were synthesised using the Synthesis Without Meta-Analysis (SWiM) guidance (Campbell et al., 2020). However, due to statistical heterogeneity across the included studies, transformation statistics were

required to enable the synthesis of comparable statistics (Borenstein et al., 2009). Transformation from odds ratio (Westwood et al., 2017) to Pearson's r allowed for synthesis with other correlations (Beaumont et al., 2016; Rose et al., 2019). Standardised regression coefficient (β_i) (Steel et al., 2015) and unstandardised regression coefficient (b) (Westwood et al., 2017) were reported and are not directly comparable to correlation coefficients because the multiple regression analyses consider multiple variables (correlates) to predict an outcome (dimension of burnout) (Field, 2009). The research team agreed with the subsequent evidence statements made in the review (Daniels, 2019).

There were no included studies on correlates of stress; therefore, it was excluded from the synthesis and the research questions. As dimensions of burnout were investigated, these were added to the research questions. The scarcity of data prevented the pooling of correlates, requiring updates to the research questions. Due to the limited number of studies included and the inconsistencies in samples, comparisons within and between trainee and qualified PPs were explored, where feasible.

Assessment of methodological quality

The Joanne-Briggs Institute (JBI) checklist for analytical cross-sectional studies (Moola et al., 2017) was utilised to assess the quality of the studies. The tool evaluates eight elements to inform the synthesis and interpretation of results. JBI does not prescribe cut-off categories to determine the risk of bias, and therefore, the inclusion or exclusion of a study is not specified. This assessment was conducted blindly by two appraisers. The first (MS) and secondary (AH) authors completed the assessment for all included studies, achieving a percentage agreement of 100% (Appendix F).

Results

Data extraction outcome

Four papers met the inclusion criteria for this review. The four studies investigated disparate correlate(s) of burnout, the outcome measured (burnout, and/or its dimensions), the measures used, the data analysis conducted, and subsequent statistics reported. This heterogeneity resulted in updated research questions and statistical transformations (Borenstein et al., 2009).

Study Characteristics

Table 2 shows the key characteristics of the included studies. The publication date ranged from 2015 to 2019. A total of 563 participants were included across the four studies. Two papers investigated qualified PPs (n = 295), and two focused on trainees (n = 268). No papers researched both trainee and qualified PPs. Psychological well-being practitioners (PWPs) and High-Intensity Therapists (HITs) were the most frequently studied professionals (n = 280). In 50% of the studies, PWPs accounted for 145 participants and HITs, 135 participants. PWPs and HITs are qualified PPs, only one study included another type of qualified PP (Steel et al., 2015), clinical psychologists (n = 6) and 'other' Improving Access to Psychological Therapies (IAPT) therapists (n = 9). Both studies that concerned qualified PPs (Steel et al., 2015; Westwood et al., 2017), the service context was NHS Talking Therapies (NHS TT). Most of the studies (n = 3) were mixed samples of different PPs. Only Rose et al. (2019) studied one group of PPs: trainee clinical psychologists.

Overall, only seven types of PPs were explored from the 19 included job titles; therefore, the term psychological professionals' is not reflective of the narrow range of clinicians the results relate to. The results of this review relate to trainees (trainee clinical psychologists, student cognitive behavioural psychotherapists and person-centered counsellors) hereinafter referred to

as ‘trainees’ and qualified professionals (PWPs, HITs, clinical psychologists and ‘other’ IAPT professionals), all of whom worked in the service context of NHS Talking Therapies, hereinafter referred to as ‘TT practitioners’.

Table 2.

Study Characteristics

Authors(s) and date	Aim(s)	Design	Sample size and characteristics	Setting and Context	Measure(s) used	Outcome: Burnout/ dimension(s) measured
Steel et al. (2015)	H[1]: IAPT therapists will not experience a high level of burnout similar to levels found in mental health workers in general H[2]: Therapists' emotional involvement with their work will not explain additional variance in therapist burnout after demographics and GMB	CS survey	Total sample size: 116 Subsample (*n* = 94) PWP = 42.6% (40) HIT = 41.5% (39) CP = 6.4% (6) 'Other' = 9.6% (9) Female = 79% (74) Male = 21% (20)	Eight out of 15 IAPT services approached and agreed 44.3% response rate (*n* = 262) Therapists with < 2 completed clients in two-month period (*n* = 13) and partially completed data (*n* = 9) were excluded	MBI JCQ Coping Survey TWIS	EE, DP & PA

	predictors are accounted for		Age, *M* = 36.8 years (SD 9.99 years) White ethnic background = 91.5% (86) CBT, main modality = 88.3% (83) Years in practice, *M* = 1.9 (SD 1.3)			
Beaumont et al. (2016)	What are the relationships between self-compassion, well-being, compassion fatigue and burnout in student counsellors and student cognitive	CS survey	Mixed sample of student cognitive behavioural psychotherapists and person-centred counsellors (*n* = 54)	Students were in their final year of training, approached at one university during teaching sessions	ProQOL The Self-Compassion Scale sWEMWBS CFO	Burnout

	behavioural psychotherapists?					
Westwood et al. (2017)	To estimate the prevenance of burnout in IAPT practitioners To examine which individual and job characteristics predicted EE, DP and burnout among IAPT practitioners	CS survey	201 sample size PWP (*n* = 105) Male = 14.3% (15) Aged 40+ = 19% (20) BME = 17.1% (18) Years in current IAPT service *M* = 1.8 (SD 1.12) HIT (*n* = 96) Male = 22.9% (22) Aged 40+ = 50.0% (48)	IAPT practitioners working ≥ 35 hr/week from 15 IAPT services, predominately in the South of England, (*n* = 212) 33.4% response rate Recruitment via BABCP website/magazine (*n* = 50) One counsellor excluded and	OLBI Two subscales of the MHPSS: 1. Organisational structure and processes 2. Relationships and conflicts with other professionals	EE, DP & burnout

			BME = 13.5% (13) Years in current IAPT service *M* = 2.5 (SD 0.95)	those working < 35 hr/week		
Rose et al. (2019)	H[1]: Poorer perceived reciprocity in relationships is associated with and contributes to greater indications of burnout H[2]: Reciprocity in relationships is related to higher psychological well-being H[3]: Self-efficacy in associated with and	CS survey	214 CP trainees Male = 11.5% (24) Female = 88.5% (185) Age range = 23-55, *M* = 29.46 (SD 4.64) Year 2 = 50.9% (109) Year 3 = 47.7% (102) Year 4 = 0.5% (1) Year 5 = 0.9% (2)	Trainees from year two to completion of clinical psychology training, from 26 out of 34 training courses (76.5%)	The Reciprocity Questionnaire (revised) MBI WEMWBS CPI	EE, DP, PA & burnout

		contributes to greater psychological well-being and lower levels of burnout

Note: IAPT: Improving Access to Psychological Therapies. GMB: General Model of Burnout. CS: Cross-sectional. HIT: High Intensity Therapist. PWP: Psychological Well-being Practitioner. CP: Clinical Psychologist. SD: Standard deviation. CBT: Cognitive behavioural therapy. MBI: Maslach Burnout Inventory (Maslach et al., 1997). JCQ: Job Content Questionnaire (Karasek et al., 1998). TWIS: Therapist Work Involvement Scale (Orlinksy & Rønnestad, 2010). EE: Emotional exhaustion. DP: Depersonalisation. PA: Lack of personal accomplishment. ProQOL: Professional Quality of Life measure (Stamm, 2010). sWEMWBS: The short Warwick and Edinburgh Mental Well-being scale (Stewart-Brown et al., 2009). CFO: The Compassion for Others scale (Pommier et al., 2019). BME: Black/Minority ethnic group. BABCP: British Association for Behavioural and Cognitive Psychotherapists. OLBI: Oldenburg Burnout Inventory (Demerouti & Bakker 2008). MHPSS: Mental Health Professionals Stress Scale (Cushway et al., 1996). WEMWBS: Warwick-Edinburgh Mental Well-being Scale (Tennant et al., 2007). CPI: Clinical Psychology Inventory (Matharu, 2012).

Demographic reporting was inconsistent. Gender and age were the most reported variables (Rose et al., 2019; Steel et al., 2015; Westwood et al., 2017), ethnicity was reported in two papers (Steel et al., 2015; Westwood et al., 2017). Year of training was reported by Rose et al. (2019), all participants in Beaumont et al. (2016) were in the second year of training. No other demographics were reported (Beaumont et al., 2016).

There was little consistency with the outcome measures used to measure burnout and its dimensions. The Maslach Burnout Inventory (MBI, Maslach et al., 1997) was used twice (Steel et al., 2015; Rose et al., 2019). The Oldenburg Burnout Inventory (OLBI, Demerouti & Bakker, 2008) was used once (Westwood et al., 2017). The Professional Quality of Life Scale (ProQOL, Stamm, 2010) was used once (Beaumont et al., 2016) to measure burnout as conceptualised as one of three factors in compassion fatigue (secondary traumatic stress (STS) and moral distress, the other two factors).

Furthermore, data analysis and subsequent reporting varied across all studies. Two reported correlation coefficients (Beaumont et al., 2016; Rose et al., 2019). While two reported regression coefficients (Westwood et al., 2017; Steel et al., 2015). To add to the synthesis, for a more meaningful comparison of correlates, the proportional variance (R^2) data (Steel et al., 2015) was transformed to provide an estimated *r* (Pearson's correlation coefficient). However, this is only possible for the first independent variable in the multiple regression analysis due to multicollinearity with the addition of the other predictor variables (Field, 2009). The reported odds ratio (Westwood et al., 2017) was also transformed (*r*). Full results were extracted from each paper that informed the statistical transformations (Appendix E). None of the included studies referenced statistical cut-offs for interpretation. For consistency of interpretation throughout the synthesis, the following cut-offs were used for correlation coefficient effect sizes (*r* and r_s): .10 'small', .30 'medium' and ≥ .50 'large' (Cohen, 1992; Hemphill, 2003).

Quality assessment and findings

The JBI Critical Appraisal Checklist (Moola et al., 2017) was utilised, and the quality assessment captured (Appendix F). While all papers were included in the review, their quality varied significantly. The JBI identified areas where studies lacked information, which consequently reduced their quality rating. The four studies did not explicitly outline their inclusion and exclusion criteria. One study stated that no such criteria were applied (Beaumont et al., 2016). The studies differed in their ratings concerning study subjects and settings. Study subjects encompassed demographics of the sample, including age and gender (Rose et al., 2019; Steel et al., 2015; Westwood et al., 2017), ethnicity (Steel et al., 2015; Westwood et al., 2017) and setting details included years of experience (Steel et al., 2015; Westwood et al., 2017). Although the year of study was reported for trainee clinical psychologists, there was no service context(s) reported for where the trainees were currently on placement (Rose et al., 2019).

Beaumont et al. (2016) provided limited demographic details, noting only that participants were in their second year of study, and lacked contextual information about the setting, which impacted its overall quality.

Westwood et al. (2017) was the only study to explicitly consider bias during recruitment. Their research considered the importance of language during recruitment to help mitigate the potential for IAPT practitioners who felt more negative about their work to be more likely to participate, therefore creating bias and distorting results.

The measurement of the ‘exposure’, question three in the JBI checklist, here conceptualised as potential correlate(s), heterogeneity affected the quality. A revised version of The Reciprocity Questionnaire (van Horn et al., 1999; van Horn et al., 2001) was used by Rose et al. (2019). While a focus group of trainee CPs, akin to the sample, revised the questionnaire to be more suitable for trainee CP experiences, nonetheless, the

revised questionnaire nonetheless lacks validity.

Furthermore, the same paper (Rose et al., 2019) used the Clinical Psychology Inventory (CPI; Matharu, 2012). While specific to self-efficacy in clinical psychology and developed via a focus group, it is an unvalidated measure from an unpublished thesis (Matharu, 2012). One study (Westwood et al., 2017) utilised two subscales of the Mental Health Professionals Stress Scale (MHPSS; Cushway et al., 1996). Omitting the other five subscales, thus compromising the reported validity (Cushway et al., 1996; Mehrotra et al., 2000). The use of multiple and hierarchical regression analyses (Rose et al., 2019; Steel et al. 2015; Westwood et al., 2017) can control for some influence of confounding variables (Wang & Cheng, 2020). All studies used well-researched, validated measures to measure burnout and/or its dimensions ('outcome', as per question seven). Three utilised online questionnaires (Rose et al., 2019; Steel et al., 2015; Westwood et al., 2017), compared to one that used paper questionnaires in person (Beaumont et al., 2016). The JBI considers objectivity to be compromised due to the risk of over- or under-reporting in self-report questionnaires. All studies were assessed to use the appropriate statistical analysis approach.

Correlates of burnout in trainees

1) What are the strengths of correlates of burnout, and its dimensions, in trainees?

Table three summarises the strongest reported correlates of burnout in trainees from two studies (Beaumont et al., 2016; Rose et al., 2019).

Table 3.

Summary of the strongest correlates of burnout and its dimensions in trainees

Correlate	Outcome	Correlation
Compassion fatigue	Burnout	$r = .580^{1}$ **
Well-being	Burnout	$r = -.555^{1}$ **
Self-judgement	Burnout	$r = .545^{1}$ **
Self-compassion	Burnout	$r = -.486^{1}$ **
Self-efficacy (general)	Emotional exhaustion	$r_s = -.386^{2}$ **
Placement team RR	Emotional exhaustion	$r_s = .201^{2}$ ***
Emotional exhaustion	Depersonalisation	$r_s = .365^{2}$
Self-efficacy (clinical)	Depersonalisation	$r_s = -.235^{2}$ *

Note: [1]Beaumont et al. (2016), [2]Rose et al. (2019). RR: Relationship reciprocity. *p <0.05 level, ** $p < 0.01$ level, *** $p < 0.005$ level, **** $p < 0.001$ level. Effect size cut- offs: .10 'small', .30 'medium' and ≥ .50 'large' (Cohen, 1992; Hemphill, 2003).

For burnout, the strongest correlates were compassion fatigue, well-being and self-judgement, with large effect sizes (ESs) (r = .580 to .545). Additionally, self-compassion significantly, negatively correlated to burnout with a medium effect size (ES) (r = - .486).

Regarding emotional exhaustion, general self-efficacy had a significant negative correlation with a medium ES (r = - .386). Relationship reciprocity with the placement team was significantly correlated to emotional exhaustion, with a small ES (r = .201).

For depersonalisation, the strongest correlate was emotional exhaustion, although not significant. Clinical self-efficacy had a significant, negative correlation to depersonalisation with a small ES (r_s = - .235).

Table four captures further transformation statistics (R^2 to r) that demonstrated the strongest correlations of combined self-efficacy variables (n = 3: general, clinical and academic) and the relationship reciprocity variables (n = 7: cohort, university, clients, clinical supervisor, placement team, trust and personal) on the three dimensions of burnout (Rose et al., 2019).

Table 4.

Summary of the strongest combined correlates of burnout dimensions in trainees

Combined correlates	Outcome	Correlation
Self-efficacy and relationship reciprocity	Emotional exhaustion	$r = .491$
Self-efficacy	Emotional exhaustion	$r = .465$
Self-efficacy and relationship reciprocity	Personal accomplishment	$r = .466$
Self-efficacy	Personal accomplishment	$r = .437$
Self-efficacy and relationship reciprocity	Depersonalisation	$r = .390$
Self-efficacy	Depersonalisation	$r = .303$

Note: Effect size cut-offs: .10 'small', .30 'medium' and ≥ .50 'large' (Cohen, 1992; Hemphill, 2003).

The combination of all three self-efficacy variables and seven relationship reciprocity variables correlated to emotional exhaustion, lack of personal accomplishment and depersonalisation, with medium ESs ($r = .491$ - $.390$). The combination of the three self-efficacy variables accounts for the greatest influence across the three dimensions of burnout, all with medium ESs ($r = .465$ - $.303$).

Correlates of burnout in qualified NHS Talking Therapies Practitioners

2) What are the strengths of correlates of burnout, and its dimensions, in qualified NHS Talking Therapies Practitioners?

Transformation of reported R^2 (Steel et al., 2015) and odds ratio (OR) (Westwood et al., 2017) to *r* allowed for comparable statistics. Table five summarises the strongest reported correlates of burnout in qualified TT practitioners from two studies (Steel et al., 2015; Westwood et al., 2017).

Table 5.

Summary of the strongest correlates of burnout and its dimensions in qualified Talking Therapies Practitioners

Correlate	Outcome	Correlation
Relationships & conflict	Burnout	$r = .426$[2] (PWP) *
Organisational structure & processes	Burnout	$r = .328$[2] (PWP) **
Organisational structure & processes	Burnout	$r = .237$[2] (HIT) *
Supervision received	Burnout	$r = -.221$[2] (PWP)*
Male	Burnout	$r = -.209$[2] (PWP)
Relationships & conflict	Burnout	$r = .208$[2] (HIT)
Psychological job demands	Emotional exhaustion	$r = .596$[1] **
In-session feeling of anxiety (stressful involvement)	Emotional exhaustion	$r = .44$[1]
In-session feeling of anxiety (stressful involvement)	Depersonalisation	$r = .41$[1]
Therapist Age	Depersonalisation	$r = -.263$[1] *

Note: [1]Steel et al. (2015), [2] Westwood et al. (2017). *$p < 0.05$ level, ** $p < 0.001$ level. Effect size cut-offs: .10 'small', .30 'medium' and ≥ .50 'large' (Cohen, 1992; Hemphill, 2003).

For burnout, the strongest correlate was feeling pressure due to relationships and conflicts with colleagues, with a medium ES ($r = .426$) of statistical significance ($p < 0.005$ level) for qualified PPs. However, there were differences between the qualified TT practitioners regarding the relative strength of this correlate of burnout. For PWPs, relationship conflicts were more influential to burnout ($r = .426$, medium ES) compared to their HIT colleagues ($r = .208$, small ES).

Concerning feelings of pressure due to organisational structure and processes, there were differences among qualified TT practitioners. Organisational structure and processes were a significant correlate to burnout in PWPs, with a medium ES ($r = .328$). For HITs,

feelings of pressure due to organisational structure and process were the strongest, significant correlate of burnout, with a small ES (r = .237). Of note, feelings of pressure due to organisational structure and processes, and relationships and conflict with other professionals were conceptualised as consequences of burnout and removed from the analysis (Westwood et al., 2017) yet, demonstrate the strongest correlates of burnout. Beyond these, the strongest correlate was hours of supervision received, which showed a small, inverse relationship with burnout (r = - .221). Fewer weekly supervision hours received were associated with a higher risk of burnout for PWPs. Additionally, gender was a factor; being male was negatively correlated with burnout (r = - .209), with a small effect size, suggesting females were at greater risk.

Concerning emotional exhaustion, the strongest, significant correlate was psychological job demands, with a large ES (r = .596). Psychological job demands are postulated as the mental workload, encompassing general psychological demands, role ambiguity, concentration and mental work disruption (Karasek et al., 1998). However, this result is taken from the first step in a multiple regression analysis and transformed from the reported R^2 and into r and, therefore, should be interpreted cautiously. One specific part of the stressful involvement subscale, the in-session feeling of anxiety, was demonstrated as a moderate correlate to emotional exhaustion and depersonalisation, with a medium ES (r = .44 & r = .41). Therapist age was a significant correlate to depersonalisation with a small ES (r = .263).

Furthermore, considering that correlates of burnout and its dimensions may not exist in isolation, additional transformation statistics highlight the combined influence of multiple correlates, including organisational and personal aspects, summarised in Table six.

Table 6.

Summary of the strongest combined correlates of burnout dimensions in qualified Talking Therapies practitioners

Combined correlates	Outcome	Correlation
Psychological job demands, decision latitude & stressful involvement	Emotional exhaustion	$r = .6761$
Psychological job demands & decision latitude	Emotional exhaustion	$r = .620$[1]
PWP, female, hours inputting data & overtime (per week)	Emotional exhaustion	$r = .520$[2]
HIT, hours of patient contact & telephone contact (per week)	Emotional exhaustion	$r = .361$[2]
Therapist age, psychological job demands & stressful involvement	Depersonalisation	$r = .555$[1]
Therapist age & psychological job demands	Depersonalisation	$r = .378$[1]
PWP, BME, time in current service, hours of overtime & supervision received (per week)	Disengagement	$r = .566$[2]
HIT, hours of patient contact & telephone contact (per week)	Disengagement	$r = .400$[2]
Length of training, coping control, decision latitude & healing involvement	Personal accomplishment	$r = .571$[2]
Length of training, coping control & decision latitude	Personal accomplishment	$r = .454$[2]

Note: [1]Steel et al. (2015), [2]Westwood et al. (2017). BME: Black/minority ethnic group, Effect size cut-offs: .10 'small', .30 'medium' and ≥ .50 'large' (Cohen, 1992; Hemphill, 2003).

As correlates of burnout are unlikely to occur in isolation, the transformation of multiple regression analyses to comparable correlation coefficients (R^2 to *r*) showed that the combination of psychological job demands, decision latitude and stressful involvement positively correlates to emotional exhaustion with a large ES (*r* = .676).

Decision latitude refers to task control and skill use (Karasek et al., 1998) and is more commonly considered as autonomy at work. Job strain is considered the highest risk when psychological job demands are high and low decision latitude (Karasek et al., 1998). Stressful involvement from the Therapist Work Involvement Scale (TWIS; Orlinksy & Rønnestad, 2010) considers therapists' anxiety, boredom, avoiding therapeutic engagement and professional self-doubt. These four elements, plus psychological job demands and decision latitude, were the strongest correlates to emotional exhaustion in qualified TT practitioners, out of any single or combined correlates.

For depersonalisation, the strongest combination correlates are therapist age, psychological job demands and stressful involvement, with a large ES (*r* =.555). Being a female PWP with longer time in service, more weekly overtime hours and fewer hours of supervision received per week, strongly correlated to disengagement with clients, with a large effect size (*r* = .566). The length of training, control coping, decision latitude and healing involvement were the strongest correlates of lack of personal accomplishment, with a large ES (*r* = .571). Control coping is one of three coping strategies for job stress (escape and symptom management, the other two), associated with improved results as the worker attempts to proactively gain control over the stressful situation (Latack, 1986). Healing involvement relates to the level of client investment (Steel et al., 2015).

Discussion

The current review included data on correlates of burnout, and its dimensions, in

NHS PPs, trainee and qualified, from four studies. It is the first systematic review and synthesis on this topic and population.

Due to the paucity of included studies, it was not possible to pool the most cited correlates of burnout, as per the original research questions. However, the data synthesised explored the strength of the correlate(s) to burnout and its dimensions, in trainee and qualified TT practitioners. The correlation(s) described reveal important relationships between various organisational and personal factors on burnout. The correlations do not imply causality; cause and effect cannot be established as the variables are measured concurrently (Field, 2009).

For trainees, the strongest correlates of burnout were compassion fatigue and self-judgement with large effect sizes (ESs) (r = .580, r = .545). Moreover, well-being was negatively correlated to burnout, with a large effect size (ES) (r = - .555), indicative that as well-being reduces, burnout increases. In comparison, there were no correlates of burnout for qualified TT practitioners with a large ES. The strongest correlate to emotional exhaustion in qualified TT practitioners was psychological job demands (r = .596), with a large ES.

General self-efficacy beliefs were negatively correlated with emotional exhaustion with a medium ES (r = - .386), suggesting that as trainees perceive their general self-efficacy to decrease, their emotional exhaustion increases. For qualified TT practitioners, relationships and conflicts with colleagues were correlated to burnout, with a medium ES (r = .426). There were differences between the impact of organisational structures and processes and their correlation to burnout, depending on the type of qualified TT practitioner; for PWPs, a medium ES (r = .328) and for HITs, a small ES (r= .237). One aspect of stressful involvement, the in-session feeling of anxiety, was correlated to emotional exhaustion and depersonalisation with medium ESs (r = .44 & .41).

Noteworthy, feeling pressure due to organisational structures and processes, and relationships and conflict with colleagues were conceptualised as consequences of burnout and not predictors (Westwood et al., 2017). However, the synthesis showed a correlation to burnout with medium effect sizes. While directionality cannot be established, there is clear reciprocity between these constructs. Relationships between employees, including lack of support and trust, and unresolved conflict, increase the risk of burnout (Maslach & Leiter, 2016).

Organisational structures and processes was one subscale of the MHPSS used (Westwood et al., 2017), and includes factors such as lack of managerial support, supervision, conflict resolution and policies. Variables that are well-documented to increase the risk of burnout (Maslach & Leiter, 2016; McCormack et al., 2018; Morse et al., 2012).

Concerning dimensions of burnout, the combined correlates revealed that self-efficacy and relationship reciprocity were correlated to emotional exhaustion, personal accomplishment and depersonalisation, with medium ESs (r = .491 - .390). This demonstrates that over-investment in relationships (increased relationship reciprocity) and low beliefs in self-efficacy (decreased self-efficacy) are predictors of emotional exhaustion, depersonalisation and lower personal accomplishment. Yet, hierarchical regression analyses (Rose et al., 2019) revealed self-efficacy beliefs as more influential than relationship reciprocity across the three dimensions of burnout. Boosting self-efficacy as a psychological coping resource can help buffer against the effects of work stress and emotional exhaustion (Gil-Almagro et al., 2024).

For qualified TT practitioners, the combined correlates were also significant. Psychological job demands, decision latitude, stressful involvement, being a PWP, being female, longer hours spent inputting data and working overtime weekly, were strongly

and positively correlated to emotional exhaustion, with large ESs (r = .676 – .520). With 56% of NHS staff reported to work over their contracted hours each week (The King's Fund, 2020), longer working hours are a real driver towards burnout (House of Commons, 2021).

Being female is also considered a risk factor in predicting burnout (Spännargård et al., 2023), which is a concern within this female-dominated profession (NHS Benchmarking Network, 2023). There were also large effect sizes on the other three dimensions of burnout. Regarding depersonalization, age, psychological job demands, and stressful involvement were strongly correlated with a large ES (r = .555). However, therapist age negatively correlated across the multipleregressions, suggesting that older qualified TT practitioners are less likely to experience depersonalisation. Hypotheses as to why this phenomenon may exist include the possibility that older age is associated with longer clinical experience (Simionato & Simpson, 2018) and better coping strategies over time (McCormack et al., 2018). A systematic review of personal risk factors and burnout among psychotherapists (Simionato & Simpson, 2018) found younger age to be a risk factor of burnout in 13 papers that explored age. Nevertheless, a meta-analysis of 62 studies (O'Connor et al., 2018) concluded that increased age was associated with an increased risk of depersonalisation. Therefore, evidence is ambiguous regarding age as a risk factor of burnout and its dimensions.

Compassion fatigue was the strongest correlate of burnout in trainees (Beaumont et al., 2016), similar to findings in nursing populations (Hinderer et al.,2014). While there may be reciprocity between compassion fatigue and burnout, they are regarded as separate constructs (Pehlivan & Güner, 2017; Sabo, 2011) and demonstrate pertinent findings among trainees, particularly as compassion fatigue has been coined a unique form of burnout in caregiving professions (Joinson, 1992). Moreover, older age is also associated

with increased compassion satisfaction (Sodeke- Gregson et al., 2013). Suggesting that younger trainees may be at heightened risk of compassion fatigue due to reduced compassion satisfaction, as compassion satisfaction may mitigate compassion fatigue (Garner et al., 2023). Compassion satisfaction describes the positive aspects of helping others, even when faced with work-related stressors (Stamm, 2010). Compassion is a vital characteristic of a PP, and compassion fatigue can lead to reduced occupational commitment (Bride & Kintzle, 2011), affecting NHS retention. Compassion fatigue is also linked to increased self-criticism (Ondrejková & Halamová, 2022) and may disproportionately affect trainees and younger clinicians, especially in the context of the influence of self-efficacy on burnout dimensions. Qualified PPs are also at risk of compassion fatigue and, therefore, burnout and STS (Figley, 2002).

Psychological job demands are the strongest correlate of emotional exhaustion in qualified TT practitioners (Steel et al., 2015). Job demands have been evidenced to strongly predict burnout across professional fields (Skinner & Roche, 2021; Udushirinwa et al., 2022; Xanthopoulou et al., 2007), and in early and later career practitioner psychologists (Sim et al., 2016). Psychological job demands relate to mental workload, organisational constraints on work completion and conflicting demands (Karasek et al., 1998). These constructs are rife among NHS professionals (Ravalier et al., 2020) and are known to adversely impact job satisfaction and occupational commitment (Satoh et al., 2017), which predicts high staff turnover (Yanchus et al., 2017).

The difference in correlates between trainees and qualified TT practitioners highlights a significant research discrepancy and the difficulties in meaningful, accurate comparisons. For trainees, the data in this review detailed more on individual factors as correlates of burnout, compared to organisational factors as correlates of burnout in qualified TT practitioners. Trainees, though essential to the workforce, are often

supernumerary and move placements regularly, so may be consciously or subconsciously shielded from organisational stressors, potentially biasing research on burnout correlates in trainees.

Furthermore, given the dearth of literature, it is possible that research on organisational factors correlating to burnout in trainees has not yet been conducted. Additionally, organisational factors and burnout in qualified TT clinicians relate to one unique service context: NHS Talking Therapies. A service known for emphasis on key performance indicators (KPIs), waiting list targets and high caseloads (Clarke et al., 2018; Harper et al., 2020) amid high workforce turnover and staff burnout (Kell & Baguley, 2018). Evidence suggests organisational factors are more pertinent to mental health professionals experiencing burnout (Lim et al., 2010; McCormack et al., 2018; Morse et al., 2012; O'Connor et al., 2018) than personal characteristics.

Limitations and future research

The current review has influential limitations. Pivotally, the scarcity of identified studies included in the review and high heterogeneity across them.

The use of 13 different outcome measures across the four studies highlights a key barrier to obtaining meaningful and comparable results. The JBI checklist demonstrated the lack of validity in some of the questionnaires used, therefore, results should be interpreted with caution. The Clinical Psychology Inventory, from an unpublished doctoral thesis (Matharu, 2012), reports an internal consistency of 0.90, and may claim population specificity to trainees, but its use has not been reliably validated, especially regarding construct and criterion validity. Furthermore, within the same study (Rose et al., 2019), the Reciprocity Questionnaire was adapted to better target the sample but was initially developed regarding teacher and student reciprocity (van Horn et al., 1999). While the process behind these adaptations are not detailed explicitly in the paper (only via a focus group

from one Doctorate in Clinical Psychology course), it reports good convergent validity with another reciprocity measure, which has demonstrated the link between low relationship reciprocity and burnout (Thomas & Rose, 2010). Furthermore, only two of the seven subscales of the MHPSS were used (Westwood et al., 2017). While perhaps reducing participant burden, this omits the influence of other potential organisational burnout correlates, including lack of adequate staffing and resources, and workload. High workloads in NHS TT are evident and demonstrable to clinician burnout (Golden, 2011; Harper et al., 2020; Lee et al., 2017). The justification for use of these two subscales was previous research highlighting organisational issues and conflicts with colleagues in predicting burnout. However, by excluding the other subscales, the paper failed to consider the influence of client-related difficulties on burnout. These may be especially pertinent to the emotional demands associated with the helping professions (Green et al., 2014) which may be interconnected with organisational issues and conflicts with colleagues. Additionally, there was great variety in the measurement of outcomes; some papers considered burnout in its entirety, compared to others focusing on individual dimensions. This added to the difficulties in data synthesis. Future research should consider only using reliable and validated measures and greater consistency in exclusively measuring burnout or its dimensions, which would allow for future systematic pooling of correlates.

Furthermore, the overall small sample size from the four studies limits the generalisability of these results. The total sample size (n = 563) would suggest that the included research only considers 2% of the NHS PPs workforce (NHS Benchmarking, 2023). For more meaningfully applicable results, future research should increase sample sizes.

Additionally, only one study considered the bias of non-responders on their results (Westwood et al., 2017); hypothesising non-responders may be more burnt out and,

therefore, not participate. PPs who work less than 35 hours a week were excluded (Westwood et al., 2017). While the number of working hours is correlated to burnout (Lin et al., 2021), the type of work and work setting (Rupert & Kent, 2007; Volpe et al., 2014; Vredenburgh et al., 1999) may be more salient in this professional group. However, considering experiences across different working hours and patterns is crucial, as excluding 'part-time' workers, especially workers who may work less than 35 hours in one service (e.g. the NHS) and work more hours in another (e.g. private practice), overlooks important insights into burnout.

The Cochrane PROGRESS-Plus (Cochrane Methods Equity, n.d.) highlights the lack of included variables of interest: language, social capital, and personal characteristics associated with discrimination. While a working level of English proficiency is required for working in the NHS, practitioner psychologists from a non-English-speaking country are at increased risk of emotional exhaustion (Simpson et al., 2019), and stressful relationships (outside of work), and lack of social support are risk factors to burnout (Simionato & Simpson, 2018). Future research would consider the influence of PROGRESS- Plus variables when determining correlates of burnout.

The type of placement may impact burnout correlates of trainees. Placement experiences are known to influence stress and burnout, with greater work adjustment problems and interpersonal conflict on intellectual disability placements, compared to adult mental health placements (Kuyken et al., 1998). Future research should ensure the reporting of placement and setting contexts, as no placement details were provided (Beaumont et al., 2016; Rose et al., 2019).

None of the reviewed papers were conducted post-2020; therefore, leaving the impact of COVID-19 unexplored. Redeployment, personal protection equipment availability concerns (Ferry et al., 2020) and the "hero" narrative of NHS staff (Sumner &

Kinsella, 2021) increased the risk of burnout. PPs faced unique pressures during the pandemic, due to expectations to support other staff's health and well-being (NHS England, 2020). Future research is vital to understanding COVID-19's impact on PPs, especially trainees whose placements were significantly disrupted.

The scarcity of literature and other systematic reviews demonstrates that individual professional groups are not researched (Morse et al., 2012; O'Connor et al., 2018) and highlights a need for research into specific professionals. The current findings may not transfer to other PPs, as only seven PPs were explored across the studies, excluding the other 12 job titles under the umbrella term (HEE, 2021).

All included studies were cross-sectional. Future research would utilise a longitudinal approach to ascertain correlates exclusive to the trainee and qualified stage, and persevering ones. These limitations mean that only some correlates of burnout were investigated, causation cannot be determined, and statistical transformations require cautious interpretation.

Practical implications

Burnout in trainees adversely affects academic, patient-related outcomes and work-life balance (Pakenham & Stafford-Brown, 2012). With moderate levels of stress reported in trainees (Harding, 2025) and chronic stress postulated as a precursor to burnout (Bayes et al., 2021), support during training is crucial for trainee well-being and future workforce retention (Kaeding et al., 2017; Pakenham & Stafford-Brown, 2012). Early training stressors of uncertainty, vast information and theory-to-practice applicability expectations (Owen et al., 2022) could be mitigated with simple, targeted interventions.

Compassion fatigue is the strongest correlate to burnout in trainees (Beaumont et al., 2016), putting them at risk of enduring cycles of stress, compassion fatigue and burnout. With the changing expectations and transitions faced in newly qualified life (Borsay,

2020; Davies et al., 2022; Levinson et al., 2021), and early-career practitioner psychologists reporting higher levels of burnout (Page et al., 2024), there is an elevated risk of entering the qualified workforce already burnt out. This undermines NHS workforce retention goals (NHS England, 2023) and the NHS People's Promise for a safe and healthy workforce (NHS England, 2021), ultimately threatening workforce sustainability.

While not present in the current review, evidence suggests that a salient antecedent to healthcare professionals' burnout is a history of mental illness, which can increase the likelihood of moderate to severe burnout four-fold (Ferry et al., 2020). These findings are pertinent for mental health professionals, who are considered less likely and/or to delay seeking support for their mental health (Edwards & Crisp, 2017). Evidence suggests that some burnt-out PPs also meet the clinical threshold for depression, post-traumatic stress disorder, and STS (Lemieux-Cumberlege et al., 2024; Makadia et al., 2017; Volpe et al., 2014).

Addressing workplace well-being and mental health of PPs in the NHS is complex and interconnected. Building A Caring Work Culture (Rao et al., 2021) highlights the issues facing this workforce and postulates numerous ideas to support their mental well-being.

Ascertaining accurate prevalence data on stress and burnout in PPs is challenging, estimates suggest moderate stress among trainees (Harding, 2025). Emotional exhaustion is the most common dimension of burnout reported among practitioner psychologists and mental health professionals (McCormack et al., 2018; O'Connor et al., 2018). Burnout in the caring professions leads to increased waiting lists, increased workload, poorer job satisfaction, retention and work-life balance, and increased likelihood of mental illness and staff absenteeism (Maslach et al., 2001; Millar, 2019; Morse et al., 2012; Rupert et al.,

2015). These consequences compromise patient care and carry economic repercussions (Daniels et al., 2022; Millar, 2019), and therefore, perpetuate burnout cycles and underscore the urgent need for organisational reform and evidence-based interventions. As aptly stated, burnout is about your workplace, not your people (Moss, 2019).

Teams, services and organisations should be aware of compassion fatigue. Managers who are attuned to signals indicating a reduced capacity for compassion, a risk factor for burnout (Smith & Moss, 2009), especially with the emotive work of PPs. Ensuring access to good-quality supervision (Bhutani et al., 2024; Martin et al., 2021) and creating a psychologically safe culture where professionals feel safe and supported in disclosing compassion fatigue (Rao et al., 2021) are fundamental. Urgent attention is required from organisations regarding the presence and impact of psychological job demands, which necessitates relaying further upstream to funding, commissioning, service planning and government levels.

Organisational constraints are fundamental in psychological job demandand include staffing levels. The impact of understaffing on presenteeism, well- being, morale, turnover, and patient care is well-documented (Hricová & Lovašová, 2018; Morse et al., 2012; Sim et al., 2016; Yanchus et al., 2017). This review calls for crucial adherence to the NHS Psychological Professionals Workforce Plan (HEE, 2021) to safeguard safe staffing in PPs and help mitigate against one facet of organisational constraints. The greatest adverse impact is high psychological job demands and low decision latitude (Karasek et al., 1998; O'Connor et al., 2018; Xanthopoulou et al., 2007). A simple countermeasure would be to ensure PPs have genuine autonomy in and over their work, helping mediate some of the effects of psychological job demands.

Conclusion

To our knowledge, this review made a first attempt to systematically review the correlates of burnout in trainees and qualified TT practitioners working in the NHS, addressing a known evidence gap. The synthesis shows that organisational and individual characteristics strongly correlate with burnout.

Methodological approaches ensured independent rigour and quality throughout, but the scarcity and heterogeneity of the studies demonstrate the crucial need for more research in this area. Future research within this diverse professional population should attempt to capture unique and universal correlates of burnout so that systemic change and interventions can be implemented to help assuage the demoralising and perpetual impacts of burnout on the professional workforce and, ultimately, the patients the workforce serves.

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Data availability statement

Full data extracted from the studies and used for statistical transformation can be found in Appendix E.

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Chapter Three

Bridging Chapter

Bridging Chapter

The systematic review aimed to explore the correlates of stress and burnout in psychological professionals (PPs) in the National Health Service (NHS). The findings indicate that individualist and organisational factors contribute to burnout. Synthesis of the findings from four included studies showed that compassion fatigue is the strongest correlate of burnout in trainees (Beaumont et al., 2016) and psychological job demands in qualified Talking Therapies practitioners (Steel et al., 2015). Various correlates of burnout and its dimensions, emotional exhaustion, depersonalisation, lack of personal accomplishment and disengagement from patients (Demerouti et al., 2001; Maslach et al., 1997) were explored, meaning that direct comparisons of the same correlates between different PPs were not possible. The current literature review does not provide evidence to determine the impact of compassion fatigue on qualified PPs or the effect of psychological job demands on trainees. However, it would be premature to assume that qualified PPs are unaffected by compassion fatigue, especially as compassion fatigue worsens with the number of years worked (Dasan et al., 2015), or that trainees are not vulnerable to the effects of psychological job demands, as they are a key part of the workforce (NHS Benchmarking Network, 2023). Both sub-groups of PPs are likely to experience these challenges despite the lack of existing research.

One specific profession within the umbrella term PPs is clinical psychologists (CPs).The review shows that CPs are conceivably excluded from research. None of the included papers were specific to CPs. Of the four studies, the total sample size was 563, and only six CPs included. Therefore, CPs in the systematic review represent only 0.096% of CPs, and only 0.023% of PPs, from the latest workforce census (NHS Benchmarking Network, 2023). This is a cause of concern given CPs are the largest proportion (23%) of

the PPs workforce (NHS Benchmarking Network, 2023). Trainee CPs entering the qualified workforce are stressed and at risk of burnout (Cushway, 1992; Cushway & Tyler, 1994; Harding, 2025a), which has implications for the return investment on commissioned training and the sustainability of the qualified workforce. It is well documented the relationship between burnout and poor retention (Iliffe & Manthrope, 2019; Salvagioni et al., 2017; Tamata & Mohammadnezhad, 2022) and, therefore, the impact of workforce shortages felt across the NHS (Deakin, 2022; Weyman et al., 2023), impeding the ability of the remaining staff to deliver the quality care they want to deliver, and patients expect (Best, 2021).

The current context of clinical psychology within the NHS is complicated. CPs are on the National Occupational Shortage List (SOL) for the first time in a decade, (Migration Advisory Committee [MAC], 2019), all practitioner psychologist jobs remain on the UK SOL in 2024 (Morris, 2025), and the current average CP vacancy rate is 19.6% (NHS Benchmarking Network, 2023). Yet, Health Education England (HEE) dedicated funding to increase commissioned training places on the Doctorate in Clinical Psychology (DClinPsy) by 25% in 2020/21 (HEE, 2021). The transition to qualified life is associated with risk factors increasing vulnerability (Borsay, 2020; Davies et al., 2021; Garner et al., 2023), yet little is known about the experiences of early-career clinical psychologists (ECCPs).

The following empirical paper aimed to explore the experiences of ECCPs and their decision-making factors for staying, splitting, or leaving NHS employment.

Chapter Four

Empirical Paper

"I really lost my love for the job when I was in the NHS" – Experiences of Early-Career Clinical Psychologists and the Sustainability of the Clinical Psychology Workforce in the NHS

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Abstract

As of April 2024, the Health and Care Professions Council (HCPC) reported 16,786 registered clinical psychologists (CPs) yet only 6,421 whole-time-equivalent CPs were employed in NHS England (NHS Benchmarking Network, 2023). Anecdotally, the narrative murmurs of CPs leaving the NHS in their droves, though empirical evidence remains limited. Notably, CPs were added to the Shortage Occupation List (SOL) in 2019, for the first time in a decade (Migration Advisory Committee, 2019), with all practitioner psychologist roles, across the United Kingdom (UK) remaining on the SOL in 2024 (Morris, 2025). This study aimed to explore the experiences and employment decision-making factors influencing early-career clinical psychologists (ECCPs) in their decisions to stay, partially or fully leave the NHS within the first five years of qualifying. To add to the paucity in the current evidence base by understanding the experiences of ECCPs, factors that retain them to NHS employment and those that drive them away, to use this information to increase NHS retention of this workforce. Semi-structured interviews of 18 participants were analysed using Braun & Clarke's reflexive thematic analysis (Braun & Clarke, 2022). Four interconnected and perpetuating themes were constructed: *The Wounded Healer: The Emotional Toll, Values: The Moral Toll*, *(Mis)Understanding the role of a Clinical Psychologist* and *Systemic Barriers*. The findings highlight the salience of employment decision-making factors away from the NHS, including being a sole clinician, values misalignment from working in an underfunded, under-resourced and undervalued system that is not flexible or supportive of the needs of this early career population. Findings emphasise the urgent need to address systemic challenges to improve retention and support the sustainability of the NHS clinical psychology workforce.

Keywords: early-career Clinical Psychologists, National Health Service, moral injury, retention, workforce sustainability

Introduction

The National Health Service (NHS) is a British institution, designed to "improve our health and wellbeing, supporting us to keep mentally and physically well" (Department of Health & Social Care [DoHSC], 2023, p. 3). The NHS is grounded on a set of shared principles and values, 'The NHS Constitution' (DoHSC, 2023) to ensure it operates fairly and effectively to provide high-quality, safe, effective and equitable care. However, various factors impede the NHS's ability to sustain the idealised Constitution that patients and staff expect. Austerity (Merry & Gainsbury, 2023), low staff morale (Best, 2021), burnout (Weyman et al., 2023), the impact of the Coronavirus-19 pandemic (COVID-19; Liberati et al., 2021), and high staff turnover (Moscelli et al., 2024) are salient yet not exhaustive.

One pivotal area impacting the NHS's ability to provide equitable and effective quality care is workforce shortages. Simon Stevens, former NHS chief executive (2014-2021), acknowledged the unprecedented decrease in staffing levels at the time (Ham, 2017), exacerbated by the pandemic (House of Commons, 2021), which impacts patient accessibility (Care Quality Commission, 2024) and varies considerably geographically (Rolewicz et al., 2024), further reducing service equitability. Fewer staff to deliver NHS services reduces the quality of the service provided (Kelly et al., 2022) and adversely affects patient outcomes (Tamburello, 2023).

Workforce shortfall is not new. Before the COVID-19 pandemic, only 29% of NHS Trust leaders reported confidence in their workforce numbers to provide good quality care (NHS Providers, 2020). On staff shortages, a House of Commons report (2022) stated the NHS is "facing the greatest workforce crisis in their history" (p. 3). Widespread workforce shortages contribute to moral injury (British Medical Association

[BMA], 2021; Shemtob et al., 2023) and burnout among remainingstaff due to increased workload (Deakin, 2022) anddecreased job satisfaction (Loan- Clarke et al., 2010; Weyman et al., 2020). Paradoxically and perpetually, burnout relates to an increased workload (Alarcon, 2011), poor employee well- being (Weyman et al., 2023) and moral injury (Rabin et al., 2023). Psychological professionals (PPs) are one discipline within the NHS workforce suffering from shortages.

Clinical psychologists (CPs) account for 23% of the PP workforce and, therefore, the largest individual job role (NHS Benchmarking Network, 2023). However, workforce shortages see CPs on the National Occupational Shortage List (SOL) for the first time in a decade (Migration Advisory Committee [MAC], 2019), and all practitioner psychologist jobs remain on the UK SOL in 2024 (Morris, 2025). With average CP vacancy rates across all NHS areas at 19.6% (NHS Benchmarking Network, 2023) and specific areas experiencing up to 34%, staff shortages are a key issue for the NHS clinical psychology workforce.

Typically, the NHS responds to workforce shortages via recruitment initiatives (NHS Confederation, 2020) and new staff training (Storey et al., 2009). This materialised in The NHS Long Term Plan (NHS England, 2023), which detailed three priorities: Train, Retain and Reform. Health Education England's (HEE) 2021 Psychological Professions Workforce Plan for England 2020/21 to 2023/24 aimed to ameliorate PP workforce shortages by necessitating an additional 2,520 full-time-equivalent practitioner psychologists by 2023/24. This focused on an increase in training places on the Doctorate in Clinical Psychology [DClinPsy]. As 2023 saw the first 'expansion' cohort qualify (HEE, 2021), it appears the first priority, 'Train', has come to fruition. However, as seen in other NHS workforces, increased training does not equate to retention (Weyman et al.,

2020) and ignores the crux of why staff are not being retained in the job they were trained to do. The King's Fund (2022) demonstrated that hitting the 50,000 nurses' recruitment target, as per the 2019 Conservative Party manifesto, (stated in Holmes, 2019) will not solve workforce shortages (Holmes & Maguire, 2022), as demand-driven pressures and poor staff well-being likely exacerbate leaver rates.

Occupational psychology literature can help postulate on retention and employee decision-making factors for staying or leaving employment. Siegrist's (2012) Effort-Reward Imbalance (ERI) theory hypothesises the necessity of mutual reciprocity between employer and employee for job satisfaction and, therefore, retention. While not a healthcare-exclusive model, ERI indicates that effort from employees is compensated by adequate rewards from the employer, which are threefold: money, esteem, and career opportunities, including job security.

Research has applied ERI theory to various NHS professionals to postulate factors influencing retention. Professional development and pension strongly correlate to allied health professionals' (AHPs) intention to work for the NHS (Coombs et al., 2010). Excessive workload, pressure and stress, childcare, flexible hours and good/better pay were crucial drivers for AHPs leaving the NHS (Loan-Clarke et al., 2010). Job satisfaction is associated with retention (Bimpong et al., 2020), and various extrinsic and intrinsic factors have been demonstrated to contribute towards job satisfaction. Monetary compensation (Siegrist, 1996), work environment (Bakker et al., 2004), including the level of managerial support (Kumar et al., 2011), emotional demands (Bakker & Demerouti, 2014), and burnout, (Freudenberger, 1974) are considered influential but not fully comprehensive. ERI in the workplace can adversely affect perceived resilience among practitioner psychologists (Kolar et al., 2017).

ERI is associated with an increased likelihood of leaving NHS employment (Coombs et al., 2010; Loan-Clarke et al., 2010; Weyman et al., 2023). The aptly titled 'Should I stay or should I go?' Institute for Policy Research (IPR) report (Weyman et al., 2023) found the top three reasons staff left the NHS were stress (66%), staff and resource shortages (62%) and pay (55%). Conversely, job security, making a difference, and job satisfaction from caring for patients were three consistent reasons staff continued to work for the NHS. Pay is more often associated with job demands (Weyman et al., 2023), subsequent ERI (Siegrist, 1996; Weyman et al., 2020) and ultimately, job dissatisfaction (Bimpong et al., 2020). Storey et al. (2009) found that pay may have a greater influence on nurses leaving primary and community care, over feeling undervalued and poor working conditions. Anecdotally, lucrative salaries in private or non-NHS employment are indicated; however, evidence suggests this may not materialise or may be lower (Buchan, et al., 2020; Frijters et al., 2007; Meadows et al., 2013).

Moreover, a unique position for NHS staff is the potential moral tie to accessible healthcare. Personal commitment to the NHS has been demonstrated as influential in staff retention (Weyman et al., 2023). The NHS relies on the 'goodwill' underpinning this moral commitment (Vaughan, 2018) of its staff, who often overcommit and overwork (Weyamn et al., 2020), increasing their risk of poorer well-being (de Jonge et al., 2000).

There is a disparity between the reported high NHS employment rates of CPs after qualifying, their presence on the SOL and high vacancy rates. Data shows, of those that returned data (n = 550) of the 2023 qualifying cohort (n = 770 (2020 entry)), that 94% were working as a CP (or equivalent post) in the NHS (or other publicly funded position) after qualifying (Clearing House, 2023). So, while 'Train' may appear to be a fulfilled objective, there is little focus on the 'Retain' priority regarding CPs working in the NHS.

Burnout and work-related stress are common among practitioner psychologists, with prevalence rates estimated between 44.1% and 59% (Cushway & Tyler 1994; Rupert & Kent 2007; Rupert & Morgan 2005), and psychologists in public settings experiencing higher levels of burnout compared to those in private practice (Ackerley et al., 1988). Tolland and Drysdale (2022) found the most common employment decision-making factors for CPs (in one Health Board) reducing their NHS hours (n = 33) were caring responsibilities (71%, n = 24), work-life balance (65%, n = 22) and work-related stress (21%, n = 7). However, literature is scarce on CPs' employment decision-making for staying or leaving the NHS, especially within the first five years of qualifying.

The present study aimed to address the paucity in the evidence base by:

1) exploring the experiences of ECCPs,
2) how these experiences can help understand why some ECCPs stay, partially, or fully leave the NHS,
3) what factors mitigate against ECCPs partially or fully leaving the NHS?
4) and how this information can be utilised to increase ECCPs' retention in the NHS.

Method

Study Design

This cross-sectional qualitative study utilised semi-structured one-to-one interviews to explore the experiences of ECCPs and their employment decision-making. Critical realism asserts that "the way we perceive facts, particularly in the social realm, depends partly on our beliefs and expectations" (Bunge, 1993, p. 231), which allows for

the realities of each ECCP to be heard but not fully understood as the individual interprets them. This also positions the lead researcher as an integral part of the iterative process by aiming to give a voice to interviewees' (Braun et al., 2022) experiences.

Participants

Nineteen ECCPs were interviewed. The British Psychological Society (BPS) defines ECCPs as those qualified in the last five years (K. Seisay, personal communication, April 12, 2023). The majority identified as female (n = 14) and within the age range of 31-35 years old (n = 10). For two ECCPs, their first role after qualifying was not in the NHS. One interviewee completed the interview but later withdrew their transcript; the total analysed sample was 18.

Participants were grouped by employment category prior to interview based on their answers to previous and current employment questions: *'Stayers':* ECCPs who work exclusively for the NHS, (n = 5). *'Splitters'*: ECCPs employed by the NHS and elsewhere, academia, private practice/company, (n =5). *'Leavers'*: ECCPs who have no NHS employment, working as a CP in academia, private practice/company, (n = 5). These employment groups were discussed and defined with the Patient and Public Involvement (PPI) group and research team. The concept of data saturation is not aligned with the values underpinning the research or reflexive thematic analysis (RTA; Braun & Clarke, 2021b). Information power (Braun & Clarke, 2022) over saturation was employed to ensure the richness of data was emphasised rather than by the number of participants.

During data collection, a fourth employment category became apparent: '*NHS+'*: ECCPs who work full-time in the NHS and have additional employment, including private practice/company and/or academia, (n = 3). For further information about participant demographics, see Appendix H.

Eligibility criteria meant participants were commissioned trainees on a UK DClinPsy programme, who had graduated within the last five years and were registered with the Health and Care Professions Council (HCPC) as a clinical psychologist.

Materials

The PPI group were consulted on all participant-facing materials, including the topic guide (Appendix I) and provided feedback. Consultation between the research team further refined the topic guide. Mock interviews, with the research team trialled the topic guide before participant interviews. The interview explored experiences of the early career period, including where they had worked and the salient factors behind their employment decision- making. Example questions include, *"What factors have influenced you to stay where you are currently working?"*; *"Reflect on whether being a commissioned trainee has had any influence on your employment decision-making."*

Procedure

The current study was granted ethical approval by the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee (ETH2324-0082) (Appendix J).

Participants were recruited via purposive, snowballing sampling on social media and alumni email distribution lists. Recruitment away from employers is associated with greater sincerity (De Vos & Meganck, 2009), so employer routes were not utilised. As part of a sister study, participants first completed a demographic and employment decision-making questionnaire (Harding, 2025) and then could opt in for an interview.

The participants completed a semi-structured, one-to-one interview, with the primary researcher via Microsoft Teams with the transcription function enabled, lasting

approximately 60 minutes. The interviews took place between February and October 2024.

In keeping with RTA, a review of interviews and transcripts after the first four interviews was completed to assess the suitability and appropriate depth and breadth of content generation (Braun & Clarke, 2022).

Participants were verbally debriefed at the end of the interview and emailed a debrief sheet detailing appropriate avenues of support if required. Participants received a £10'Love2Shop' voucher as a compensatory token for their contribution. Interviews were transcribed verbatim aided by the auto-generated transcript.

Data Analysis

A reflexive approach to thematic analysis (RTA) was taken to recognise the impact of the researcher's personal experiences and attitudes upon the analytical process to provide nuanced, complex, and sometimes contradictory insights into the topic area from each individual's perspectives, between and within the four employment groups.

The six key phases of RTA outlined by Braun and Clarke (2022) were utilised to analyse interview data. Due to the iterative approach, the phases of data analysis were not linear and involved revisiting and working across phases. *Data familiarisation* was led by the primary researcher, involving deep immersion in the data, listening and re-listening to interview recordings, transcribing interviews and re-reading transcripts alongside field notes. *Coding* involved further data familiarisation and organising segments of the data set into semantic and latent codes. This process was inductive and aimed to capture concepts within and across the data, resulting in data-led codes while recognising the influence of the researcher in this process and using subjectivity as a strength (Braun & Clarke, 2022).

Candidate themes were created from the codes that captured the data set and were subsequently *developed and reviewed* around a core concept of shared meaning. Theme development and review took numerous stages, exploring relationships between and within themes supported by the codes, the data set and contextualisation in wider research. Themes were then *refined, defined and named* by a process to arrive at "meaning-unity and conceptual coherence" for each theme (Braun & Clarke, 2022, p. 146), supported by the secondary researcher (RR). Drawing thematic maps considered the themes as distinct categories and how they relate to each other and reflect the whole analytic story, and then, *written up*.

Reflexivity and Rigour

A reflexive journal was maintained throughout, as it is considered best practice (Phillippi & Lauderdale, 2018) and provided space for critical reflection on subjectivity (Jamieson et al., 2023).

Considered too burdensome on the PPI group, they were not consulted on theme generation and refinement. Time limitations of the project also did not allow for participant theme consultation. Participants were offered the opportunity to review their transcripts; all bar one declined. This participant withdrew their transcript. With these limitations, consideration of a second coder was considered, however, it is not encouraged or "even desirable for quality" in RTA (Braun & Clarke, 2021a, p. 333).

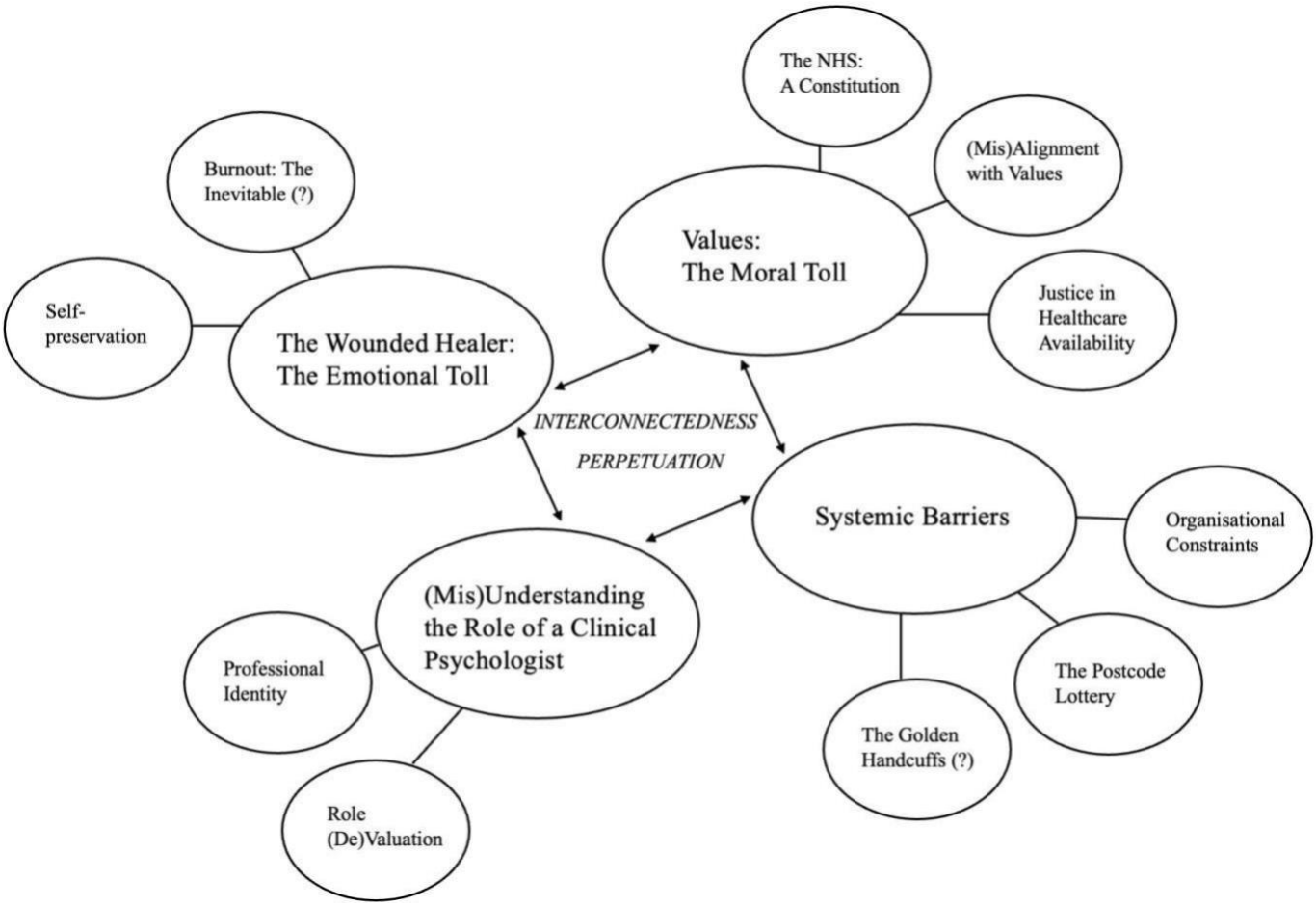
Theme consultation and refinement were conducted between the primary and secondary researchers (RR). This allowed for discussions on assumptions and personal reflexivity that influenced the analysis and consultation around their impact. The Consolidated Criteria for Reporting Qualitative Research (COREQ) (Appendix K) checklist yielded transparency and credibility (Tong et al., 2007).

Findings

From reflexive thematic analysis, four overarching themes were generated: '*The Wounded Healer: The Emotional Toll'*, '*Values: The Moral Toll'*, '*(Mis)Understanding the Role of a Clinical Psychologist'* and '*Systemic Barriers'*.

Figure 2.

Themes and Subthemes



Each theme and the associated subthemes are presented and discussed below, illustrated by individual verbatim quotes. Codes have been used to protect participant anonymity and categorised together by employment group: Stayer (*St*), Splitter (*Sp*), Leaver (*Le*) or *NHS+*.

Theme One: The Wounded Healer: The Emotional Toll

The theme describes the disparity between the aspirations of working in the helping profession and the realities. It speaks to the tension felt because of this incongruence and how many ECCPs felt pushed into employment decision- making to decrease this tension and increase the likelihood of career sustainability. One *NHS+* pondered, “I’m under no illusions that I can continue to do 37.5 hours a week in the NHS for the rest of my career […] because I think the nature of the systems we work in are really difficult […] (*NHS+ 2*). The theme highlights the emotional toll experienced and its cyclical impact on patient care, where emotional strain diminishes care quality, and substandard care, in turn, deepens the emotional burden.

Burnout: The Inevitable (?)

Anticipating burnout was common. A sense that burnout in the NHS was perhaps inevitable and, therefore, did not equate to career longevity. One *Splitter* said, "The clinical side of it ... Yes, I can't see myself doing that forever" (*Sp 1*).

> "I don't know how sustainable it is to work in a service like that long term. And I genuinely wanted this to be my long-term […] You know, this was the role I was aiming for in the location I was aiming for and, but I've been questioning how many years I can manage it for, to be honest". (*St 2*)

> “I might say something different in five years, 10 years when I’m, you know, I’m totally burned out and I just want an easy life and they’re [private practice] paying me four times as much.” (*NHS+ 2*)

The impact of systemic constraints exacerbated the perceived likelihood of experiencing burnout, yet the perceived expectation to keep working against those systemic constraints: a *Stayer* reflected, “It’s just non-stop, I use every second genuinely in my working hours […] I don’t take a lunch break because I just can’t” (*St 2*).

> "[…] an acknowledgement that working in a system with three-year waiting lists for assessment has a detrimental impact on the well-being of those people offering that assessment. But you’re putting them [staff] into a situation of constantly feeling like they're failing." (*NHS+ 2*)

Burnout was a pivotal factor behind employment decision-making away from the NHS, as it was linked with depleted job satisfaction. As one *Leaver* commented, “[…] running around like a headless chicken and like trying to, juggling all the balls and I’m like I’m gonna drop something, this is not humanly possible to keep doing this” (*Le 2*). It also impacted ECCP’s ability to do their job effectively: “The responsibilities of my role in the NHS job was to facilitate reflective practice, I didn’t feel safe and scaffolded and supported, like I had quite high levels of threat in that role, so, to then try and provide any kind of safety for other people, it’s like I’m trying to pour from this cup that’s already like really empty” (*Le 3*).

Burnout adversely affected ECCPs outside of their employment. One *Leaver* reflected: “When I was in the NHS, even on my non-working days, it was just the weight on me, there’s a constant weight and I feel like I have the freedom in my currentrole and it just permeates out into the rest of my life, I can just relax and enjoy my life, in a way that I wasn’t even remotely enjoying it before” (*Le 4*).

> “I really love this job, I love CAMHS [Child and Adolescent Mental Health Service], but, you know, is this the best thing for…? It might be great for my career, but is this the best thing for me personally? And in terms of my mental health and my family, so it’s just like that constant, all of that going through my mind at all times.” (*St 2*)

Self-preservation

Considering burnout may be inevitable led some ECCPs to make employment decisions to create self-preservation. This felt necessary to ensure they could continue being a clinical psychologist and foster their own steps towards career sustainability. As one *NHS+* said, "That's probably the main reason why I left the [NHS] post is that I couldn't operate in the way I wanted, and I cared about the patient group too much" (*NHS+ 1*). Some ECCPs felt pushed into employment decision-making as an NHS career was no longer sustainable.

> "I did apply and I had an interview and I pulled out the interview at the last minute, which was the hardest career decision I've ever made, because that was my dream. I always thought that's what I would do, but I think in the end, I chose to prioritise my well-being and my family." (*Le 4*)

This disharmony between life and organisational factors resulted in employment decision-making away from the NHS.

> “I eventually came to the conclusion that like this is basically that we don’t have any option when you look at like finances plus the wellbeing of our

> children like this is the only option that is going to work for us [to leave the NHS] […] am I going to regret that I left the NHS so soon? Or will I regret like going and working while my children are really really young and like potentially that having a big impact in terms of like my whole family's well-being?" (*Le 2*)

Greater harmony between the organisation and life factors helped create a work- life balance and self-preservation for career longevity. As a *Leaver* said, "[…] because they were a private organisation they were able to offer me more in the way of wages which then meant I don't have to do this five days a week, I can work for three for the equivalent I was working in the NHS so by that point I was over the self-sacrificing and I really needed to just get a bit of a work-life balance and you know, prioritise myself […]" (*Le 3*).

Moreover, discussions concluded that individual factors must drive self-preservation and career longevity, as waiting for systemic changes was not viable.

> "I felt so panicked at the thought of just being caught up in a system where you're desperately trying to say like 'we need to do things differently', no one listens and then something goes awfully wrong, erm so it felt a little bit like I need to get out before something awful happens." (*Le 4*)

One *Stayer* reflected on their return after sick leave: "[…] and when I did go back, I was quite a bit more boundaried in terms of working hours, referrals that I would accept and because I was like, this isn't sustainable at this level" (*St 4*). The concept of resilience also factored into discussions around self-preservation and career longevity, but again, how this

was located in the individual, “There is a narrative in CAMHS […] either you’re cut out to be in CAMHS or you’re not cut out to be in CAMHS and a huge part of that is how resilient you are” (*St 2*).

Theme Two: Values: The Moral Toll

Moral injury was common across employment groups. ECCPs reflected on the juxtaposition felt by contradictions between their personal and professional values and how they could work as a CP. Throughout the theme, there were lots of dialectics held that often resulted in dissonance and ultimately led to employment decision-making in attempts to reduce the dissonance.

(Mis)Alignment with Values

Experiences of working aligned or not with personal and professional values were varied across and within the employment groups. Misalignment of values focused on ECCP’s experiences with patients: “I feel really hurt that I can’t meet the needs of this group of people that really have really acute, really palliative demands because a system won’t let me, so I needed to avoid that pain” (*Le 3*). Various systemic barriers (discussed in Theme Four) further exacerbated this misalignment.

> “I’ve got the skills and the ability and the knowledge to help this person and I’m not allowed to because of the NHS and the red tape […] the way services are funded, they have quite a narrow criteria all of the time […] he [the patient] ‘doesn’t fit under our service’.” (*Le 1*)

For other ECCPs, working aligned with their values also focused on attunement with

their colleagues and team, which mitigated some work-related stressors: “It’s very person-centred and I think for me that’s such a powerful thing that even in a, you know, like most services where we’ve got a big waiting list […] but despite all of that kind of going on, we need to look after the people that we work with […] it’s a real draw to staying within the team” (*St 5*). However, the misalignment of values with organisational realities was decisive in leaving NHS employment.

> “In the NHS, it’s just, I think I always experienced gossip or badmouthing because everybody was so burnout, whilst where I am now when I say there’s none of that, there really is none of that […] it is one of the company’s morals and values about how they manage conflict.” (*Le 5*)

Improved alignment between values and employment experiences was achieved by some through changing teams and employers, alleviating the burdensome effects of moral injury. One *Leaver* commented “[…] you as an individual practitioner are heading and wanting to head in the same direction that the organisation wants to head in, so that is a big part of it, there’s much less likelihood of experiencing moral injury” (*Le 3*). The greater the alignment, the greater the reported job satisfaction and optimism for career sustainability.

> “[…] the service was very ACT focused which is like my main modality, I just love it, and I was like yeah this is something I can see myself doing.” (*St 2*)

Justice in Healthcare Availability

Data may not support the anecdotal narrative of an increase in CPs leaving the NHS (Rosairo & Tiplady, 2024), subjectively, experiences and beliefs concerning this were split.

One *Leaver* commented, “There seems to be a narrative that lots of people qualify and then disappear off into private practice immediately, and I just don’t think that’s true” (*Le 1*). In contrast, another *Leaver* said: “There’s a huge amount of psychologists now that would be like ‘no way like you’re doing the wrong thing [working privately as an ECCP], this shouldn’t be allowed like it’s unethical” (*Le 2*).

Furthermore, ECCPs reflected on the moral injury felt towards their NHS colleagues: “The idea of leaving the institution, but also leaving behind people who are working really hard to try and keep the ship running, that sense of is it reasonable for me to just, you know, abandon everyone else who’s trying to keep things going and saying I’m not having a part of it, I’m done” (*St 3*). Similar values-based reflections regarding the availability of free healthcare were discussed as a mitigating factor against fully leaving the NHS, one *Stayer* stated: “My brain is like well CAMHS have really long waiting lists so actually they need me potentially more than private work would” (*St 2*).

> “I like the sort of ethos behind the NHS, I know that a lot of the people that I see, you know, can’t work because they’ve had a brain injury or they’ve got MS or something like that and I think it would be so unfair for them not to be able to have a service because of money.” (*St 4*)

The privatisation of healthcare felt like a contentious struggle that created frustration and division among ECCPs and the degree of alignment with their values. As one *Leaver* said: “Yeah, it just doesn’t sit right with me, I mean not necessarily that private companies exist, but that private companies have NHS contracts” (*Le 1*). One *NHS+* commented: “I was very conflicted early on around whether I wanted to do private work at all, as there was elements in me that felt a bit of class traitor […] believe that, you know, healthcare should be free at the

point of use" (*NHS+ 2*). With increased privatisation, vacancies not being filled and an overall loss of CP hours in the NHS, the core issue lay in the cumulative impact on patients.

> "I really struggle with the idea of going into private practice. I understand why people do it, but I also think it fundamentally disadvantages a lot of marginalised people [..] I think there are more creative ways to do our jobs outside of going private […]." (*St 3*)

However, the dialectic dilemma of wanting to work in a system more aligned with their values and the beneficence of contributing to the availability of free healthcare. This moral tie was not enough to retain NHS employment, as a *Leaver* reflected, "I was always drawn to working with these really kind of vulnerable children that have experienced real difficulties and my sense is if I'm leaving the NHS, I'm never gonna see those kids. Those kids can't afford to like to come to private practice" (*Le 4*).

The NHS: A Constitution

Individual, generational and societal narratives around the NHS impacted employment experiences and decision-making for ECCPs. One *Stayer* reflected "Generally working in the NHS is something that I feel quite strongly about […] I very much believe in the NHS in general, I think it is an incredibly important resource that we are lucky to have access to" (*St 2*).

> "[…] that desire to help people in some way and I think working for the NHS, there is a, I think, a sense of pride to it, there's prestige to it as well." (*Le 1*)

This values-based narrative around the importance of the constitution of the NHS aligned for some around being a CP: "I guess whenever I've thought about being a clinical psychologist, it's all I've always imagined in the NHS" (*St 4*). This same narrative also created tension for ECCPs who left NHS employment:

> "To be honest, I feel quite embarrassed when like, and ashamed, that I don't work for the NHS anymore, so I feel embarrassed that I've, kind of, turned my back on what I suppose I should be doing, I do think that I've always had a really strong sense of like I should work in the NHS." (*Le 4*)

Furthermore, despite the presence of this implicit and explicit moral connection to the NHS, ECCPs were not blindsided by its limitations, summarised by one *Stayer*, "A drive to be part of the NHS, I have that drive, other drivers of personal values around nationalised healthcare, but you cannot have that drive and values for supper" (*St 1*). The moral connection to the NHS Constitution was inadequate to retain NHS employment.

> "I'm thinking like what, like a stage in my life what do I wanna prioritise like? Do I wanna prioritise working for the NHS? Or do I wanna prioritise having some kind of sanity as a family?" (*Le 2*)

Judgement from others associated with the moral toll arose for both ECCPs who worked in and out of the NHS. As for one *Leaver:* "You feel some unspoken loyalty to stay there [in the NHS] you know […] I'm not going in the NHS, I have a job already, and he [tutor] was like, well, you need to be really careful who you're saying that to because that's quite offensive, interesting choice of words. Why would that be offensive that I have decided

not to be in the NHS?" (*Le 5*).

> "If I can go and earn a better salary [privately] so that I don't have to worry about my mortgage or rent […] Actually, people think you're insane staying, my friends cannot understand why I stay in the NHS." (*NHS+ 3*)

Further judgement was experienced concerning the commissioned training of the DClinPsy, which created a sense of indebtedness and, therefore, amplified the moral tie to the NHS.

> "So, I was very much one of those people that was like, you know, the NHS has paid for my training, I should work in the NHS, I owe it to them […]." (*Le 4*)

> "Your duty to work in the NHS, like they paid for your training, you work in the NHS […] it feels like you shouldn't leave the NHS after 18 months to go and work fully private, like they [NHS] paid for your training." (*Le 2*)

While this narrative resonated across employment groups, ECCPs critically viewed it and reflected on the mutual reciprocity. An *NHS+* said: "[…] that we think we are lucky to have done it [DClinPsy] that it's been gifted to us, and in a way, we are a bit but in a way, you know, actually the NHS wouldn't be paying for that if it didn't need us to function well" (*NHS+ 2*). Lastly, the moral toll surrounding the narrative of indebtedness was challenged, stressing that career choices should not be governed by obligation. Instead, systemic changes should foster commitment to the NHS rather than a sense of indebtedness.

> "I think there is a sense of loyalty [to the NHS] and I'm very, very grateful that the NHS funded the training […] you should kind of pay the NHS back, that feels the wrong way round, stick rather than carrot, they should change services to make people want to stay and be able to stay in those services rather than make people feel they have to stay." (*Le 1*)

Theme Three: (Mis)Understanding the Role of a Clinical Psychologist

This theme describes the perceived misunderstanding, recognition and value of the complexity and variety of work that CPs do. From these misunderstandings came significant reflections on job dissatisfaction and multifaceted career disillusionment, which included salary discontent. For example, one Leaver said: "By the time I'd qualified, I'd worked in mental health services for something like 12 years in one capacity or another [..] if I was in another career, I'd probably be on like a hell of a lot of money" (Le 3).

> "[…] in terms of the level of training, the level of expertise, the risk that we hold and what we're able to bring, I am in the camp of I think we need to be paid in a way that reflects that." (St 3)

Professional Identity

Some participants felt that systemic barriers restricted their professional identity and therefore, the depth and breadth of their skills were not being utilised.

> "All these pressures from above, to meet numbers […] there's a lot of focus on the paperwork and to prove things and to make standard national criteria,

> that it sometimes it can get in the way of you, uh, doing your job as the clinician you'd like to be." (*NHS+ 1*)

Plus, how these restrictions may result in career stagnation and contradict a core part of their professional identity, one *Stayer* said: "[…] it's really tricky and obviously we're supposed to take the stance that we're always learning right, but how can we always be learning if we don't get given the opportunities to keep learning because it's too much money" (*St 3*). There was a variety of experiences among participants regarding the fundamental parts of being a CP, dependent on the employer. For example, an *NHS+* commented, "I can't do research, I've been told that's not what we do here" (*NHS+ 3*), compared to a *Leaver*, "[…] it feels nice to have that extra part [research, grant applications, academic connections] of my professional identity actually being used" (*Le 4*).

Participants spoke to the disappointment in the reality gap of being drawn to the profession and the actual practice, as one *Leaver* said: "The reason I wanted to go into it [clinical psychology] kind of, there's something about the depth of psychology, but then I never really got to do anything in particular in any depth in my role" (*Le 3*).

These discussions regarding the underutilisation of CP skills extended further, with some reflecting on broader misunderstandings of the profession in its entirety.

> "[…] people don't reward you or understand what you're doing. You're not respected. […] because no one understands what the fuck a psychologist does, work twice as hard to be understood. […] so therefore, we look overpaid, we look expensive on paper, you don't let us do what we need to do." (*NHS+ 3*)

Moreover, organisational pressures resulted in reduced time to uphold one's

professional identity, as a *Stayer* commented, “My initial role felt like firefighting rather than really taking the time to think about a lot and you know, where do I go with this? How do we work with this? Let’s make a plan over several weeks, kind of thing, a lot of it was sheer firefighting” (*St 4*).

> “It’s often we don’t get thinking time, and that’s what people expect from us, like to think outside the box so they ask you to do your job but they don’t give you time to do your job […] like we have, we hold power, so everything we say can have an impact on people’s lives.” (*NHS+ 1*)

Contrary, it appeared that more time, afforded by employment away from the NHS, increased alliance to one’s professional identity and subsequently increased job satisfaction, “I really like my role in terms of it’s very attachment focused, I have a lot of time, which is a luxury” (*Le 3*)

Understanding and valuing the role of a CP was seen to have a positive impact on career experiences, as one *Stayer* said: “There is no sort of questions about why we’re paid what we’re paid, and there’s a good understanding that you know, when we work with people, its long term […] and actually we can’t fix everyone, and there’s a much better recognition of the need for supervision and allowing time for that” (*St 4*).

Moreover, valuing the role of a CP was convoluted among the agenda for change (AfC) bandings. Many described the disparity between imposed expectations from self and others due to their banding versus the newly qualified reality. One *Stayer* said, “In a multidisciplinary team and I was one of the highest paid there as a newly qualified, so you kind of feel like, well, I should know everything […] I’ve been at uni for like 10 years, so then going into somewhere and being like ‘oh crap, I really don’t know’. It’s daunting” (*St 4*).

> "You are referred to as pay band, 'you're a band seven, you can do it', just because maybe you're paid more, and yes it comes with more responsibility, doesn't mean that we are automatically more resilient necessarily." (*Sp 5*)

Many had key reflections on the diverse complexities of therapeutic work and how this impacted their perceived career satisfaction and sustainability. A *Stayer* commented, "[…] colleagues look into other types of employment, in the sense that having some breaks in complexity can be quite, can bring you job satisfaction to have successful, completed therapeutic interventions" (*St 1*).

> "Do you know what would be nice, have some really straightforward low-responsibility clients cause in CAMHS I got the trickiest, most kind of stuff, you know, so part of me feels like maybe that would be like a bit of kind of breathing space form that sort of burnout sense in the NHS." (*Le 2*)

Role (De)Valuation

Recruitment and retention issues, including vacancy-driven up and down- banding, meant ECCPs felt misunderstood and undervalued. One *Stayer* said: "The role that I left [in the NHS] has now changed, it's been banded upwards and there are two people now" (*St 4*)

> "They made the decision not to replace his [consultant] post […] all while I was in the post they weren't gonna be pushing to get a new consultant in because I could just cover it […] as soon as I handed my notice in, they put the consultant job out and said that no one else coming into this job will cope." (*Le*

4)

The impact of perceived career stagnation in the NHS was also a way that ECCPs experienced role devaluation. For one *Stayer* commented on: "A reduction in the number of 8D, 8C psychologist roles, so in terms of career progression, that's changing" (*St 3*).

On the other hand, ECCP experiences in private practice reflected more role valuation that was conducive to career progression:

> "I was employed as an 8A as well so that obviously appealed to me and now I'm on a six-month plan to become an 8B and in the NHS you would never get that in this time scale, you'd just be stuck." (*Le 5*)

Furthermore, participants' experiences of role devaluation related to systemic barriers by a lack of understanding and utilisation of different disciplines within multidisciplinary teams. One *Stayer* commented: "Psychologists are used in a very general sense […] you're used as more like a general senior CAMHS practitioner, you do a lot more like the key working care coordinating type role and less of the specific psychology work" (*St 2*). Role devaluation also exacerbated a sense of expectation versus reality of being a CP and questioned professional identity, which resulted in employment decision-making away from the NHS.

> "This classic CAMHS situation where basically we were all doing the same job regardless of what background you're in […], no one was getting therapy, we had a huge therapy waiting list, it was ridiculous […], managers for various political reasons didn't like some aspects of this because psychologists

> were doing different jobs to the nurse which one would think would be a sensible idea but apparently not." (*Le 4*)

Theme Four: Systemic Barriers

This theme explores various challenges ECCPs experienced where a lack of ground-level insight among organisational hierarchies impacted frontline clinicians and, therefore, patients. The significance of this varied and depended on where the ECCP worked. A Leaver commented: "[…] ultimately people who work in the NHS have their patients, their service users' best interests at heart, the polices get in the way of them doing that, and again, I don't think that's a management decision, I think it's a higher, political, government decision" (Le 1).

Organisational Constraints

Participants described how multifaceted resource limitations, policies, and processes can impact care delivery and quality. As one *Stayer* summarised, "When I come across barriers to doing the work that the people I'm there to serve are having, ultimately it scales right back to systemic and organisational issues" (*St 3)*. The apparent disconnect between the organisation's and clinician's way of working, as one *NHS+* said: "I had this rigid format to fill in about my clinical activity and because I was being very flexible and meeting patient needs […] I kept flagging up as underperforming and like having poor clinical utilisation and got threatened with performance management" (*NHS+ 3*). Multifaceted resource limitations discussed included lack of funding, appropriate clinical and therapeutic spaces, staffing and resources.

> "Both of the jobs I've had since qualifying there's been a real issue of having

> spaces that feel therapeutic, I do really believe in that idea of, if my environment is looked after, then I feel looked after and I feel that way for my clients that if I can show, you know, that hopefully they are looked after". (*St 3*)

Conversely, these same policies and processes were also considered to provide organisational protection, especially when not working in the NHS, as one *Leaver* reflected: "I miss having the kind of rules that contain because you do have to do a lot of the thinking yourself" (*Le 1*).

> "There are times when that [procedural governance] can go too far and can be really unhelpful […], but I think that means that being in the NHS for me is safer at the moment." (*St 3*)

Moreover, the dominance of the medical model was an instrumental organisational constraint of the NHS. The impact of working under a system run with a different conceptualisation of mental health to CPs resulted in tension, frustration and despondency for change.

> "You're going to be thinking in a different way to everyone else in the team, the medical model is what you have to adjust to, you're not going to be able to use your skills as much, you might not get listened to […] like it's not going to change so either bear this or go." (*Sp 5*)

> "I think the NHS struggles with that [acknowledgement and respect of

> different ways of working] because of the legacy of the medical model and you know the hierarchy of the system." (*St 3*)

Organisational constraints were exacerbated by rigid service provisions, which impacted the ability to provide good quality care and were also subject to geographical disparity. For example, a *Stayer* commented, "[…] strict referral criteria or a lot of gaps in [location] and services […] people are batted around […] none of the systems are communicating with each other […]" (*St 4*). Organisational constraints impeded the delivery of good quality care to patients, which was shared across the employment groups and for some, challenged the altruistic values that drew them to the profession.

> "I've got 16 sessions to work with someone who was sexually abused basically every day for their whole childhood in the NHS, and privately, I can see her for as long as she needs to be seen. And like, I'm going to have to leave my NHS case in a place where things aren't finished, and that doesn't feel okay or satisfying, and that's really kind of demoralising." (*Sp 2*)

> "I feel like a really crap psychologist because I haven't had time to like, think about this and reflect on what I've done all week and actually, anything I've said moved anything on for anyone? Have I achieved? […] you might get really self-critical cause actually you're not really being given the time, the space to do the work well." (*NHS+ 2*)

As a result, the complex organisational constraints and lack of foreseeable change made employment decision-making to leave the NHS feel inevitable, particularly to

safeguard long-term career sustainability.

> "There's not quite the same kind of restraints that you get in NHS services in terms of like the number of sessions that you have to stick to or quite high thresholds for being able to receive care, long waiting lists […] so I can absolutely see how it [private practice] would have a similar draw to it." (*St 2*)

> "I really don't have any faith in the system at all […] I think it is all about the organisation, like protecting the organisation, which is really sad to say […] I know that it isn't gonna get better until the people higher up stop focusing on their own, getting their own voice heard more than actually thinking about, how can we help the kids?" (*Le 4*)

The Postcode Lottery

Geographical and service disparities were significant factors in experiences and employment decision-making, varying both within and between employment groups.This was noticeable at the local level, involving individual supervisors, managers, and teams, leading to negative experiences. For example, one *Leaver* remarked, "I think supervision felt really inconsistent, umm, yeah, and just really feeling undervalued within that service, and yeah, which had a massive negative effect on my mental health essentially" (*Le 1*). Conversely, others shared more positive experiences; one *Stayer* noted, "That [support] is about the team that I'm in rather than the NHS as an institution" (*St 4*). The positive experiences of supportive managers and teams slightly alleviated the effects of the organisational constraints discussed.

> "I'm lucky to work in the Trust, and its team and have a manager who value

> that [variety in a CP role] and willingly put that in sort of job planning. There's always that pressure isn't there to do more with less. But a big part of the role is resisting that […]." (*NHS+ 2*)

Further afield than individual teams and services, the postcode lottery of inequitable service provision was postulated as financially driven and adversely impacting rural locations. This threatened career longevity in the NHS.

> "We [as a county] are quite financially deprived, I notice that the jobs that are more innovative, the jobs that are pushing boundaries in terms of what clinical psychology can do, are in major cities […] Would I stay in the NHS if it wasn't for this job? Probably not." (*St 3*)

The Golden Handcuffs (?)

Nuanced discussions around organisational terms and conditions saw some reflect on the benefits that help to retain ECCPs in the NHS, as one *Stayer* said: "[…] even that [salary increment] is an incentive to stay in the NHS" (*St 4*). However, the same salary increments were also negatively regarded: "The agenda for change, you know, and how we have to wait for five years before you can go up a salary increment and how that's essentially a way of not paying us for five years […]" (*St 4*).

Various employment terms and conditions were discussed among all participants. ECCPs reflected on how these impacted them individually to do their job, which was qualitatively different to the organisational constraints. Flexible working, or the lack of, pension and salaries, parental and sick leave, were salient across the employment groups yet inevitably varied across individual experiences and the relevant salience on employment

decision-making.

> "I'd asked to reduce my hours and that had been agreed, and then when I returned, they said 'Actually, no you can't'. So, my first day back [after maternity leave], I was told no, we can't do that." (*Le 4*)

On the contrary, after leaving the NHS to work in private practice, flexible working around childcare was a crucial necessity afforded, as a *Leaver* commented: "I had kids and I tried to go back [to the NHS], I tried, I tried it, and I was like miserable, my child was miserable […] the only way I would have stayed in the NHS is if I had the same level of flexibility that private work did" (*Le 2*). A similar sentiment was echoed by another *Leaver*: "The flexibilities are a big, big thing for me, it's just the ability to like, my son's first sports day on Monday, of course, I'm going […] if I was in the NHS, I would have to book leave or something, I'm just going and as long as I get my work done, it's fine" (*Le 4*).

However, different terms and conditions outside of the NHS resulted in reduced employment safety.

> "[…] but the conditions aren't as good […] a lot of it was the terms and conditions because I just remember thinking and actually you know if you break your leg or something, that's six weeks and this private company you would be on half pay by that point." (*Le 1*)

Furthermore, monetary-related terms and conditions were discussed as drivers to stay in NHS employment, one *Stayer* commented "I'd like to take advantage of the really good mat [maternity] leave that we get compared to other places and I think we have one of the best

pension schemes out there" (*St 4*). These factors created a sense of job security associated with staying in NHS employment:

> "You're guaranteed a salary whether there are patients or not, right?" (*St 4)*

> "Overall, the job security, the fact that you know, there's even things like the pension plan and all of that sort of adds to feeling safer in a role." (*St 5*)

Anecdotally, the dominant discourse around leaving the NHS for greater pay privately was a sentiment not wholly supported. For some, financial stability was a decisive factor away from the NHS.

> "The math just doesn't work once you have kids and you have to pay for childcare […] I've got a good job, like why can't I afford to go to work?" (*Le 2*)

Additionally, an *NHS+* said, "[…] it's astronomically different and if anything, it's roughly four times, three or four times the NHS salary hourly to do the private work, erm so in terms of financial reward that you get from it is really significant" (*NHS+ 2*).

Furthermore, there was dissonance between pay and career satisfaction, with a sense that the dedication to becoming a CP did not procure financial satisfaction while working in the NHS. An *NHS+* said: "There is this sense of actually that, you know, in terms of like financial reward of this work isn't always comparable to if you think about the level of training and education that we go through, I would argue that our NHS pay is not necessarily reflective of that" (*NHS+ 2*).

> "I should easily be making my life work financially because I kind of like did what I was told, like I worked hard, I did all the academics, I went into a job that's like what, its well known for being like better paid than other jobs […] Why am I, my finances still not working out, umm, so I think like yeah, then you start looking into private work." (*Le 2*)

However, this financial drive towards private practice was not shared by some, one *Stayer* said: "I'm not considering going private just for the money, there has to be some other kind of incentive for me" (*St 5*). Plus, the truth behind the murmurs of inflated private pay, compared to the NHS, was dispelled by the realities from one *Leaver*.

> "[…] it looks like a lot of money on the surface, I totted it up and I think for last year, […] I pay myself kind of essentially the NHS rate [...] people don't take into account those extra costs, they just see that figure and assume that's how much people take home." (*Le 1*)

Interconnectedness and Perpetuation

Two salient threads connected the themes: interconnectedness and perpetuation. One Splitter summarised, "[...] the impact of working in such a constrained environment with limits on what you're able to do and the service is not aligning with your values, which is a big recipe for burnout" (Sp 5). Seemingly, how organisational challenges can cause conflict with personal and professional values, which can increase the likelihood of burnout. Ultimately exacerbating the risk of leaving the NHS. The perpetual nature of these factors were frequently reflected upon.

> "[…] you're going to have to make your job more attractive to stop people from leaving and that's what, like you're gonna have to pay them more and if you pay them more, you'll probably have more staff and can like, then you'll have less burnout because there'll be more staff. " (Le 2)

The perpetual interconnectedness of the themes impacts the accessibility and equitability of quality patient care and, therefore, contradicts the NHS Constitution, as one Stayer commented: "The service that's actually under special measures at the moment because we can't recruit and retain enough staff to run a fully functioning service" (Le 1).

Furthermore, the NHS Constitution also serves the staff who work for it and recognises that "[…] patient safety, experience and outcomes are all improved when staff are valued, empowered and supported" (DoH&SC, 2023, p. 4). ECCPs' experiences did not always match those principles and values, which created drivers away from NHS employment.

> "I have two children and a long-term health condition, and NHS always say, 'Oh we're flexible', but what they mean by that is if you still meet our, they call it an outcomes framework [OF], if you meet NHS OF basically you can be flexible, but you can't meet NHS OF by being flexible." (Le 5)

> "The big thing was the lack of support and the feeling undervalued and being micromanaged, and all of that is completely free and just needs to be managed differently." (Le 1)

Ultimately, the intersectionality of these findings threatens the sustainability of the future clinical psychology NHS workforce.

> "a by-product is that [working privately] there are increasingly fewer and fewer and fewer senior psychologists in the NHS to then supervise and then influence the culture and structure of teams to make it work well." (Le 2)

This also has implications for the availability and quality of future placements for DClinPsy trainees. As one Leaver remarked: “It was already difficult to find placements […] there just will be no places for people if there’s no one to supervise” (Le 2), which will further exacerbate and perpetuate the challenges discussed.

Discussion

This qualitative study explored the experiences of ECCPs, factors driving their early-career employment decision-making and how these can be used to understand greater ECCP retention in the NHS. RTA of 18 interviews developed four overarching themes: ‘The Wounded Healer: The Emotional Toll’, ‘Values: The Moral Toll’, ‘(Mis)Understanding the Role of a Clinical Psychologist’ and ‘Systemic Barriers’. There were various multifaceted challenges ECCPs faced, including carving a professional identity against systemic and organisational difficulties, navigating a lack of understanding and valuing of their role and disillusionment across numerous areas from anticipated to actual careers.

Moreover, the challenges experienced influenced ECCPs’ employment decision-making away from, splitting or retaining their NHS employment are perpetual and interconnected. Resulting in an adverse effect on the availability and quality of patient care, a contradiction to the values underpinning the NHS Constitution. This increased the likelihood of ECCPs experiencing moral toll and, therefore, reducing NHS hours or leaving entirely. This circularity, summarised by Frances (2023), “Failing services are unhappy places to work, and people vote with their feet, nudging those services further into a downwards spiral” (p.

70).

The current findings paint a difficult picture for ECCPs, due to multiple experiences of moral toll in the workplace, most notably in the NHS. Moral toll can be contextualised in the continuum regarding moral distress, suffering, adversities and injury (Papazoglou & Chopko, 2017; Rushton, 2023; Weisleder, 2023), which can contribute to compassion fatigue and traumatisation. Here, conceptualised as the continual, explicit and implicit expectation to work at odds with one's values and training, cultivating in enduring moral hurt, as moral injury was not explicitly asked during interviews. Experiencing continuous moral toll from working in a system at odds with personal and professional values (Rosairo & Tiplady, 2024) was a key employment decision-making factor away from the NHS for Leavers and Splitters, as seen among other healthcare professionals (French et al., 2022). The current study revealed stressed and morally injured CPs early in their career from working under organisational constraints that oppose their values and training, similar to medical doctors, and impede their ability to provide safe, good-quality patient care (BMA, 2021). Many ECCPs posited systemic challenges and barriers as key to their moral and emotional distress, as Weisleder (2023) commented on moral injury, "[…] make evident that the clinician is not broken; it's the system that is broken" (p. 262). Perpetually, organisational constraints threaten ECCPs' resilience (Kolar et al., 2017), which include systemic issues, policies, politics and culture, lack of autonomy and understaffing, and drive practitioner psychologists away from NHS employment (Tolland & Drysdale, 2022). Nonetheless, Stayers, Splitters and NHS+ experienced moral toll but wanted to continue to contribute their skills and time to the NHS, highlighting the salience of complex and interconnected employment decision-making factors.A misunderstanding of the role of CP and, therefore, skill underutilisation and undervaluation were prominent across all employment groups. Other professionals' not understanding the role of a CP adversely impacted perceived resilience, (Kolar et al., 2017)

and created skill dilution (Wintour & Joscelyne, 2024), which equated to frustration with not being able to deliver high-quality care (Coombs et al., 2010; Loan-Clarke et al., 2010; Rosairo & Tiplady, 2024). This accumulated in ERI, and subsequently, poor job satisfaction and employment decision-making away from the NHS. Conversely, for some Stayers and NHS+ who experienced this, moving jobs within the NHS was sufficient to gain greater role understanding and valuing. Thus, also highlighting the postcode lottery and inequitable service provision.

ERI theory (Siegrist, 2012) considers money as one reward to balance with effort in employment and is a salient factor in healthcare retention (Gee et al., 2022; Loan-Clarke et al., 2010; Weyman et al., 2023). The current findings indicate a more nuanced account, but overall, ECCPs experienced an effort-reward imbalance. Generally, there was a strong sense that pay is not reflective of the years of training and associated challenges to become a CP, nor the diverse skill set, and responsibilities held in the context of the suitability of NHS AfC. Pay was intertwined with other contractual benefits of the NHS, the Golden Handcuffs (?), like pension, sick pay and parental leave, thus creating job security (Loan-Clarke et al., 2010; Weyman et al., 2023), drawing ECCPs towards NHS employment. For some Splitters and Leavers, employment decision-making to private practice equated to greater effort-reward balance. Notably, increased pay allowed for a better work-life balance, mirroring key findings from Tolland and Drysdale (2022) and was a key driver for Leavers away from NHS employment.

Healthcare professionals have a sense of occupational commitment, increasing their intention to continue working in the field (Satoh et al., 2017) and for the NHS (Weyman et al., 2023). A moral alignment to providing free healthcare was strong for all ECCPs. For Splitters, a moral connection to the NHS was a key employment decision-making factor away from fully leaving the NHS.

For the Leavers, the moral alignment to the constitution of the NHS was insufficient for retention. Pragmatically, the constraints of systemic barriers, including flexible working, childcare arrangements and organisational hierarchies, outweighed this moral tie. Caring responsibilities have been identified as a key factor in reducing NHS hours (Tolland & Drysdale, 2022) and, within the current research, a driver away from NHS employment entirely due to inflexible work arrangements. As women are more likely to take on caring responsibilities (Carers UK, 2024) and twice as likely as men to request flexible working post-parental leave (Pregnant Then Screwed, 2024), addressing these demands in the context of a female-dominated industry (NHS Benchmarking Network, 2023) is crucial. Creating truly flexible work arrangements that acknowledge the demands of parenthood and are attuned to women's unique career adjustments (O'Shaughnessy & Burnes, 2016) is paramount for workforce sustainability. Of note, all NHS+ participants were male.

Hypotheses as to why this may be, include the aforementioned caring responsibilities that may lend themselves to the NHS+ working arrangements. However, due to the small sample size of the NHS+ employment group and this not being explicitly explored in interviews, conclusions cannot be drawn.

Practical implications

Accessible, good-quality supervision is a professional non-negotiable (HCPC, 2023) with numerous benefits (Nicholas & Goodyear, 2020), including reduced risk of burnout and greater retention (Martin et al., 2021). Yet current participants shared a more varied reality, especially within the NHS, for *Stayers, Splitters, NHS+,* as well as those *Leavers,* reflectingon their NHS experiences. Ensuring protected time for effective supervision is instrumental to a thriving workforce (Rao et al., 2023), which should be reflected across organisational policies, for its potential to increase ECCPs' NHS retention. This relies on mid

and later- career CPs to also be retained, but a reduction in senior psychologists in the NHS (Francis Selemo, 2023) negates the recommendation for longer-qualified psychologists to mentor ECCPs (Green & Hawley, 2009). Focus on the NHS Long Term Workforce Plan's (2023) second priority, Retain, is essential for all practitioner psychologists, not just ECCPs.

Career stagnation in the NHS, actual or perceived, was key in ECCPs' experiences. Should there continue to be fewer NHS hours worked by ECCPs/CPs, this adversely impacts the aforementioned availability and accessibility of supervision.

Furthermore, this has the potential to negatively affect the number and quality of placements available to host and support trainee CPs during the DClinPsy. Staff shortages hinder the supervision of those in training (Rolewicz et al., 2024), and training experiences directly impact qualified employment decision-making (Donald & Lindsay, 2024) and affects retention (West et al., 2020). The focus on increased DClinPsy training places does not directly translate to an increase in NHS jobs, resulting in the need for employers outside of the NHS. The *Splitters* and *NHS+* employment groups fit with Rosairo and Tiplady's (2024) reflections on the mixed model of non-NHS employment alongside NHS work. Clear pathways for career development in organisational policy would demonstrate a commitment to this workforce, supporting sustainability Moreover, a mixed model of NHS work may also perpetuate the misunderstandings of the role of a CP and role devaluation, that certain services do not need a full-time CP, and a CP can afford, not strictly relating to pay, to work on limited hours compared to other full-time colleagues in other disciplines.

Furthermore, being the sole CP in a team was demonstrated in the current findings as a risk factor for leaving or splitting NHS employment. This is supported by other findings (Kolar et al., 2017; Levinson et al., 2021) and is pivotal in-service planning and organisational policy to help adherence to safe staffing levels and skills mix (Lawes et al., 2022; Yates et al., 2024), subsequently improving ECCPs' retention.

Increased pay does not necessarily equate to better retention (Bimpong et al., 2020). Although pay was a salient discussion point by the current ECCPs, it is reductionist to view it as a primary employment decision-making factor, whether partially or entirely, to leave the NHS. Furthermore, all four employment groups reflected on the privileged position of receiving a commissioned training place. There is undoubtedly an implicit and explicit tie created from the receipt of commissioned training: "Clinicians who have been trained by the taxpayer feel a great deal more loyalty and sense of service […]" (Frances, 2023, p. 60-61).

Yet, it was not a mitigating factor against partially or fully leaving the NHS within the first five years of qualifying. These findings may also sit in contextual discussions with other disciplines, particularly nurses, who saw the nursing bursary removed in 2017, which resulted in a significant decline in applicants and therefore qualified nurses entering the NHS workforce. The salience of this amidst record nursing workforce shortages (The King's Fund, 2024) and strike action cannot be ignored, underscoring the necessity for systemic change to protect staff wages.

Burnout was anticipated and considered inevitable among ECCPs. Research demonstrates burnout among psychological professionals adversely affects their professional and personal well-being and, subsequently, their professional effectiveness (O'Connor et al., 2018; Simionato & Simpson, 2018; Vivolo et al., 2022). Factors for mitigating and managing burnout (Johnson et al., 2020; Kolar et al., 2017; O'Connor et al., 2018), including workload size and complexity, professional autonomy, supervision, conflict resolution and relationships with colleagues, would be key for careful systemic integration through policies and procedures. With hope to improve psychological safety, safeguard the workforce and increase retention (Vogt et al., 2025).

These perpetual interconnected factors underscore the necessity of systemic reform to improve working conditions and experiences for ECCPs, plus CPs and staff from other

disciplines, of which the overarching message denotes ample financial investment. Further systemic investment in the clinical psychology workforce would see procedural priorities to supervision, continued professional development, including career progression, remuneration, and health and well-being. Without, may threaten the future of the clinical psychology workforce, subsequently reducing access to psychological care for those in need.

Limitations and future directions

With a scarcity of research specific to ECCPs and their employment decision- making in the UK, the present study provided a qualitative exploration of their experiences. Therefore, providing a valuable contribution to the evidence base. The large number of individuals who signed up for an interview (n = 88) after completing the questionnaire (Harding, 2025) displays the need and interest in this novel research area and should be utilised for future research.

Cochrane's PROGRESS-Plus (Cochrane Methods Equity, n.d.) highlights that vital demographic information was missing. The impact of discrimination factors, including, but not limited to, age, disability and caring responsibilities, were not explicitly explored. These factors, and others, may have been influential to employment-decision making. Future research should explicitly examine these variables and their impact, particularly the intersectionality of age, life stages, and caring responsibilities on employment decision-making. The sample's homogeneity may reduce the findings' applicability to the experiences of other ECCPs, as 12 participants identified as 'White British' (English, Northern Irish, Scottish, or Welsh). While this may mirror ethnicity demographics across all psychological professionals, including CPs, as 76% of the workforce identify as 'White', especially as Asian or Asian British and Black or Black British (as defined by the NHS Benchmarking Network) staff are underrepresented in psychological professionals (NHS Benchmarking

Network, 2023), compared to the English working-age population. Future research should seek to further these findings among a more diverse sample of ECCPs. Particularly, as findings from the *NHS+* employment group have exclusively come from male perspectives, it would be pertinent to explore these experiences from the perspectives of other genders. Other idiosyncratic factors, including personality, have not been explicitly considered in the current research, and there may be various qualitative dispositions between the *Stayers, Splitters, Leavers* and *NHS+* influencing employment decision-making. Different personality types impact teamwork, leadership, and responses to organisational challenges and, ultimately, burnout (Grailey et al., 2023). However, generalisability was not the pursued outcome, given the philosophical underpinnings and aims of the research. The degree of resonance with the current findings will vary in alignment depending on the reader's own experiences. Readers are, therefore, encouraged to reflect on the degree to which these findings may be transferable to their own experiences and contexts (Braun & Clarke, 2022) while respecting the critical realist contextualism behind the current participants' experiences and research findings. Furthermore, the impact of specific services on burnout and stress and, therefore, employment decision-making may highlight what services are at an increased chance of not recruiting or retaining ECCPs. One hypothesis may consider the differences between inpatient and outpatient roles on job satisfaction and increased turnover (Hood & Patton, 2022), especially as CP vacancy rates are highest in children and young people's inpatient mental health services (NHS Benchmarking Network, 2023).

The purposive sampling employed increased potential for selection bias. While interviews were offered in order of sign-up from the questionnaire (Harding, 2025), its recruitment was purposive and utilised snowball sampling, which may have narrowed the participant pool. Recruitment via social media relied on those who engage with certain platforms, and voluntary interview recruitment may bias towards a particular sub-pool of

ECCPs who had a vested interest in the topic.

In addition, the research may oversimplify the complexities of employment decision-making, due to the cross-sectional nature, by not accounting for salient individual factors, such as personality, career journey prior to qualifying, gender, disability and ethnicity.

Conclusions

Despite the challenges faced by ECCPs in the NHS, there exists a strong moral connection to free access to healthcare for all, with many participants aligning with this value, irrespective of NHS employment. However, this strong moral connection is not enough to mitigate the systemic and rigid barriers perceived to obstruct patient access to equitable, good-quality care. To future-proof NHS clinical psychology and a sustained, satisfied and safe workforce, a unified voice must advocate for improved working conditions. Working conditions that balance the complexities of waitlist management, scope to deliver a variety of evidence-based psychological interventions, utilising the depth and breadth of CPs' skills, employee well-being, fair remuneration and terms and conditions congruent with the level of training and expertise.

Without changes to ECCPs' facing systemic challenges, role devaluation, and incongruence between training and work experiences, this research has demonstrated the potential threat to the sustainability of the future clinical psychology workforce in the NHS. These findings, alongside Harding (2025), can inform strategies and systemic changes to enhance the experiences of ECCPs and support retention in the NHS.

> "I don't want to give up on it [the NHS] yet. I hope that something changes." (*Sp 5*)

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Chapter Five

Additional Methodology

Additional Methodology

This chapter offers further information on the design and methodology of the empirical paper (Chapter 4) by providing additional information on the Reflexive Thematic Analysis (RTA; Braun & Clarke, 2022) methodology.

Design

Ontology and Epistemology

Ontology determines whether reality exists separate from, or reflective of human practices and understandings (Braun & Clarke, 2013) and can be considered along a continuum from realism to relativism. A critical realist stance was adopted, which allowed space for two inherent truths to be held simultaneously, assuming a knowable world that sits within the subjective and socially contextualised knowledge that the researcher can access and "admits an inherent subjectivity in the production of knowledge" (Madill et al., 2000, p. 3). Critical realism aligned the most meaningfully with the research aims and methodology, as all participants shared their experiences from their own complex, nuanced contexts, including societal, language and culture, and so the researcher from theirs.

Epistemology in qualitative research is about "what knowledge is *possible* and how you go about getting that [knowledge]" (Braun & Clarke, 2022, p. 292) and what is considered authentic knowledge (Braun & Clarke, 2013). Epistemology is also considered along a continuum from positivism to constructivism. Between these two extremes lies contextualism, whereby a sense of truth is retained but is context-dependent based on language and meaning (Braun & Clarke, 2022).

Method

Materials

The four members of the Public and Patient Involvement (PPI) group were recruited by known links in the field from the first (MS) and fourth (AH) researchers, and represented the participants. PPI members met remotely via Microsoft Teams to discuss the research aims and expectations of their involvement. The PPI Expectations Form was sent after the meeting (Appendix L), and if in agreement, PPI members were asked to sign and return the PPI Agreement Form (Appendix M). PPI members were consulted on all participant-facing materials: the shared Recruitment Poster (Harding, 2025b; Appendix N), Participant Information Sheet and Consent form (Appendix O), Interview Topic Guide (Appendix I) and Debrief sheet (Appendix P).

Procedure

After the PPI group and research team had agreed on all participant-facing materials and ethical approval was granted for both studies (Appendix J & Q), recruitment started via snowball, purposive sampling on social media. Participants were able to click a direct link or scan a QR code to a Microsoft Forms questionnaire that detailed the participant information for the sister study (Harding, 2025b), upon consent, participants completed a demographic questionnaire (jointly compiled by the first and fourth researchers): age, gender, geographic details, ethnicity, questions regarding the Doctorate in Clinical Psychology (DClinPsy) and their job(s) since qualifying. Participants then completed a questionnaire regarding their decisions on NHS employment (Harding, 2025b). This questionnaire encompassed salient drivers to stay/leave NHS employment, perceived effort-reward imbalance and employment intentions over the next five years. On completion, participants read a short debrief page (Harding, 2025b), where they could opt in for an interview associated with the current research, by leaving their name and email.

After opting-in, participants were emailed, thanked for their expression of interest and asked to read a Participant Information Sheet (PIS; Appendix O). If they wished to participate in an interview, they were asked to sign the Consent Form (Appendix O) and return it. The primary researcher and participants communicated via email to set up an interview at a mutually beneficial date and time.

Interviews were conducted via Microsoft Teams with the transcript function enabled and recorded. Participants were offered the opportunity to review their transcripts; all but one participant declined. The participant who reviewed their transcript withdrew from the research. Interviews lasted an average of 67 minutes (range: 54 minutes – 1 hour 30 minutes) and were held between February and October 2024.

Ethical Considerations

Confidentiality

The confidentiality of the participants was paramount. Participants had the right to choose whether their camera was on during the interview. The video recording, if applicable, was not used in the analysis process. All personal information was stored on the university's OneDrive with access limitations, password-protected documents and accessed on a password-protected device. Participants were given a two-week window after their interview if they wished to withdraw their transcript before it was anonymised and embedded into the analysis.

In planning for the interviews, the primary researcher and participants discussed their location and timing for the interview. This was to be mindful of the participant's confidentiality and their comfort in sharing their experiences, depending on their surroundings, and to ensure only the researcher and participant were present. The use of online interviews was to promote flexibility and UK-wide participation while minimising

environmental impact. All recordings were deleted as per timelines in the PIS (Appendix O) and research protocol.

To safeguard the participants' confidentiality regarding the sister study (Harding, 2025b), the Microsoft Forms data was only accessible by the primary researcher of this study. When recruitment finished and the questionnaire closed, the primary researcher downloaded the data and separated identifying information from the data. Data was, therefore, anonymised before being accessed by the fourth researcher (AH).

Potential for Distress

There were unknowns entering the interviews for the participants and the researcher; interviews had the potential to evoke emotive experiences and decisions that participants encountered. Each interview started by reiterating the PIS (Appendix O), that they had the right to decline any questions and to terminate the interview at any time without repercussions. Participants were verbally debriefed at the end of the interview and emailed a Debrief Sheet (Appendix P) detailing potential avenues of support should they require it.

Analysis

Analytic Process

The analysis journey can be considered to have started with topic guide development, throughout the interviews and throughout the phases of RTA. As the interviews progressed, initial ideas for codes began forming and were documented in field notes and reflected on in the reflective journal. Salient ideas coming from the interviews were reflected on and discussed in supervision to acknowledge their impact on the remaining interviews.

RTA is considered a 'telling of a story' (Braun et al., 2022) through the process of analysis, beyond simply describing what is in the data and how these stories sit within the

context of broader stories (research and literature), allowing both "'mess' and contradiction" (Braun & Clarke, 2013, p 24). The researcher's engagement with the data and this inductive process is outlined below.

Familiarisation: the primary researcher conducted all the interviews and checked the Microsoft Teams transcription against the recordings to ensure transcripts were verbatim and accurate. This allowed immersion in the data and involved considerable repetition of reading transcripts while asking questions to become critically engaged with the data. Alongside the use of field notes taken during the interviews and the reflective journal.

Coding: involved "continual bending back on oneself – questioning and querying the assumptions we are making in interpreting and coding the data" (Braun & Clarke, 2019, p. 594). From familiarisation, the researcher highlighted and annotated the transcripts using Microsoft Word, noting salient ideas, within and across transcripts related to the research questions, and used different colours for codes and code labels, semantic and latent codes.

Generating initial themes: "themes are analytic outputs developed through and from the creative labour of our coding" (Braun & Clarke, 2019, p. 594) and have a central organising concept that contains various aspects. Throughout this process, the primary researcher used Microsoft Excel to organise the work. Taking quotes from the transcript and colour coding based on ideas from the codes under potential different themes, capturing patterns in the data. Supervision was integral at this stage and allowed the researcher to let go of themes that were perhaps meaningful to them but not aligned with the research questions.

Reviewing and developing themes: developing a thematic map (Appendix R) allowed for further theme reviewing. At this stage, a full read-through of all transcripts again ensured the themes captured the meaning of the data set concerning the research questions. The

addition of another column in the spreadsheet allowed for stricter focus on the research question that ensured quotes, sub-themes, and themes were related.

Refining, defining and naming themes: this process also involved letting go and changing of the themes and subthemes' names. The researcher refined the themes through more thematic maps (Appendix S), which allowed the shaping of themes and subthemes as separate entities, plus their interconnectivity. Consultation between the primary and secondary researchers allowed for space to discuss data representativeness, especially from the four employment groups, the use of language and the boundary of the theme(s).

Write-up: the process of writing up allowed for further theme refinement as the researcher typed the story of the themes, subthemes and key quotes. The researcher had a strong desire for all participants' experiences to be equally heard; supervision was instrumental in this process, to reflect on the most demonstrative quotes for the themes that strongly related to the research questions.

Reflexivity

"Reflexivity is always a work in progress" (Braun et al., 2022, p. 438). Reflexivity is to own the researcher's position within the process and shaping of the research (Braun & Clarke, 2022; Braun et al., 2022). The primary researcher has their own experiences of working psychologically in the NHS, being a NHS patient and their own mental health experiences. The primary researcher, who co-constructed the topic guide, completed all interviews and led the analysis, is a White British female, undertaking the same doctoral qualification to qualify as a clinical psychologist, the same qualification and subsequent job as the participants. This was an intricate position for the researcher; efforts to own this position and the influence on the research were fostered by the reflective journal, through

supervision and consultation discussions, especially pertinent at latent theme generation stage. Two extracts from the reflexive journal are provided below. Firstly, an excerpt reflecting on systemic change in the NHS and what has been evoked in the researcher by conducting the interviews. The second, reflecting on the duality of being a trainee and the researcher interviewing individuals who have done the qualification and are doing the job that the researcher is working towards.

Reflective journal extracts regarding the researcher's values regarding systemic change in the NHS and the position of being a trainee conducting the research.

> "Do I have the strength and patience to sit tight and see if it will change or to be a driving force in that change? I always think that I am one small person, what change can I do? But if everyone thought this and did nothing … but then if everyone thought this and did one small thing – then the cumulation and ripple effect – would/could be monumental… why is it down to certain people to fight the system and change things? Honestly imagine how different the world can/could be without greed – am I greedy? Would others consider me greedy in some respects? Does the pursuit of a white, middle-class, elitist career make me greedy? Am I delusional to think that I can/could make longstanding systemic change? I feel very frustrated with the world and psychology at times and conducting these interviews appears, at the moment, to be exacerbating this – yet at this moment in time (16/03/2024), I do believe in the NHS as a system, as a great national institution and its ability, capacity and determination to do good, do great and care for people at their greatest time of need, to be free at the point of access […]."

"CPs [clinical psychologists] not wanting to be too negative to a trainee – the impact of that relationship as qualified and trainee and interviewee and interviewer – the impact of this on what people would honestly tell me… is this a true account of what qualified life (not just NHS) is really like? Do all this work and not like/enjoy the job at the end of it? Have we (CPs) and the public come to expect that staff are unhappy working for the NHS?"

Chapter Six

General Discussion and Critical Evaluation

General Discussion and Critical Evaluation

This chapter will synthesise findings from the systematic review and the empirical paper while considering their collaborative influences on understanding and improving psychological professionals (PPs) and, specifically, clinical psychologists' early-career experiences and the impact on the retention of this workforce in the National Health Service (NHS).

The thesis aimed to explore the sustainability of the PPs NHS workforce, by considering the correlates of burnout among trainees and qualified TT practitioners and exploring the experiences and employment-decision- making factors of early-career clinical psychologists (ECCPs). A systematic review synthesised relevant literature to explore correlates of burnout among broader psychological professionals, including clinical psychologists (CPs). Overall, the scarcity of the literature represents the lack of focused research on PPs. Of the 19 distinct roles under the umbrella term PPs, only seven were explored in the review, representing a conservative estimate of just 2% of the PPs workforce (NHS Benchmarking Network, 2023).

The empirical paper sought to understand the experiences of ECCPs and employment decision-making factors to stay, split, or leave NHS employment. Interviews from 18 participants were analysed using Braun and Clarke's Reflexive Thematic Analysis (RTA; Braun & Clarke, 2022). Findings created four key themes: '*The Wounded Healer: The Emotional Toll'*, '*Values: The Moral Toll'*, '*(Mis)Understanding the Role of a Clinical Psychologist'* and '*Systemic Barriers'*.

A key consistency across the two papers was systemic influences on burnout, its dimensions, and employment decision-making in ECCPs. One theme from the empirical paper identified the significant effects of systemic barriers (Chapter 4). Barriers that prevent

ECCPs from working aligned with their values, hinder their ability to achieve a work-life balance, face role devaluation, and lead them to conclude that career longevity in the NHS is unsustainable. Notably, the emotional and moral toll of working against these systemic constraints resulted in moral toll, driving ECCPs out of the NHS and those that remained, feeling burnout and despondent for organisational reform. Among qualified TT practitioners, feeling pressure due to organisational structures and processes was the strongest correlate to burnout, and interviews revealed the interconnected and cyclical impact of systemic constraints on experiencing moral toll. Organisational and systemic barriers in the NHS resulting in moral injury were highlighted as the main reason ECCPs intended to or did leave their NHS employment within the first five years of qualifying (Harding, 2025b).

Working misaligned with values was key to moral injury among the ECCPs (see Chapter 4). Encountering values incongruity increases the likelihood of burnout and moral injury (Maslach et al., 2001; Rabin et al., 2023). Compassion fatigue was the strongest correlate of burnout in trainees (Chapter 2); compassion fatigue is significantly associated with moral injury (Albaqawi & Alshammari, 2024), therefore demonstrating the risk to workforce well-being starting in training and enduring into qualified life.

Making the NHS a more appealing place to work has been a key message in NHS reform and policy aimed at supporting staff well-being and, consequently, retention (Beech et al., 2019). Newly qualified clinicians and their transitions to roles with increased responsibility are often inadequately supported by management, which resonated with the experiences of the ECCPs (Chapter 4). Due to a lack of regular supervision, being a sole CP, and service pressures leading to insufficient time or emotional capacity for reflective practice, these experiences seem at odds with the expectations and guidelines established by regulatory bodies and previous research findings (Beech et al., 2019; Rao et al., 2021; The British Psychological Society [BPS], 2024).

Psychological professionals are unlikely to seek help for their mental health (Edwards & Crisp, 2017) but are at increased risk of burnout (Johnson et al., 2018). It could be postulated that the lack of research is due to this perceived hard-to-reach population and the potential stigma associated with experiencing difficulties at work, especially given the well-documented perfectionistic traits of this workforce (Grice et al., 2018) and the role of perfectionism in burnout (D'Souza et al., 2011). PPs are also positioned as helpers and supporters for other NHS staff (The Psychological Professions Network [PPN], 2018), to facilitate reflective practice (Health & Care Professions Council [HCPC], 2023) and provide supervision and consultation (BPS, 2017), that may represent further barriers. Evidence shows that practitioner psychologists experience difficulties in accessing healthcare for their mental health concerns (HEE, 2019). Further, as CPs are often responsible for the supervision of other PPs, their professional well-being directly impacts their ability to maintain professional standards for their work and others. Well-being is inversely correlated to burnout (Beaumont et al., 2016; Rose et al., 2019), a workforce that is not able to look after its well-being is a recipe for a burnt-out workforce. Data from Harding (2025b) revealed that high stress levels, burnout and moral injury were extremely important factors for ECCPs not working in the NHS, akin to the *Leavers* (Chapter 4). The well-being of PPs must be an organisational priority to help mitigate burnout and moral injury, as both are cyclical to staff shortages.

Other individual-related factors were important in the overall findings. The influence of gender on burnout is inconclusive (Simionato & Simpson, 2018), results from the current review indicate being female is correlated with an increased risk of emotional exhaustion (Westwood et al., 2017, Chapter 2) and the majority of interview participants identified as female (n = 15/18, Chapter 4). This is contextually important in a female-dominated profession, as 82% identify as female (NHS Benchmarking Network, 2023). Being a

Psychological Well-being Practitioner (PWP) from a Black or Minority Ethnic background (BME) was associated with increased disengagement with clients. There are inclusive outcomes regarding underrepresented minorities and burnout (Lawerence et al., 2022). Yet, it is noteworthy that PPs identifying as Asian or Asian British (as defined in the PPs workforce census) are underrepresented among PPs compared to the English working-age population (NHS Benchmarking Network, 2023). The systematic review found older age is negatively correlated with depersonalisation (Steel et al., 2015). The evidence base is mixed determining the relative salience of age as a correlate of burnout and its dimensions (McCormack et al., 2018; Simionato & Simpson, 2018). Fifty-five per cent of the PP workforce report as under 40 years old (NHS Benchmarking Network, 2023), consistent with the empirical paper, where all participants were under 40 years old. PPs of younger age are at increased risk of overinvolvement with their clients (Simionato & Simpson, 2018), and overinvolvement is a risk factor for reduced personal accomplishment (Steel et al., 2015). Westwood et al. (2017) found PPs under 40 years old, were at slightly reduced risk of burnout compared to those PPs over 40. Several hypotheses may exist to help understand this. Age may relate to the length of the career path typically associated with being a PP, especially for a CP, with a conservative estimate of eight years (BPS, 2023) from undergraduate to qualification. Furthermore, PPs often hold multiple qualifications (Health Careers, n.d.) and undergo various training pathways before qualifying. The cumulative impact of potential repeated cycles of high stress, burnout and role duality (academic and clinical) in this competitive field (Palmer et al., 2021) warrants consideration. By the time they are an ECCP, these experiences may significantly influence employment decision-making and NHS retention. Nonetheless, the evidence base suggests, in keeping with the current findings, that organisational factors are more salient to burnout and moral injury than individual characteristics (Linzer & Poplau, 2021; Morse et al., 2012; O'Connor et al., 2018).

Strengths and Limitations

The systematic review presented is, to the author's knowledge, the first to offer a synthesis of the correlates of burnout among NHS psychological professionals. To improve research transparency, the review was conducted in accordance with PRISMA and SWiM guidelines (Campbell et al., 2020; Page et al., 2021), and the protocol was registered with PROSPERO. Nevertheless, the scarcity and heterogeneity of the four included papers mean that the results should be interpreted with caution. In particular, the correlates of burnout in trainees focused more on personal characteristics than on organisational factors, whereas the correlates of burnout in qualified TT practitioners were the opposite. Furthermore, the method of synthesising the literature lacked precision due to the transformation of statistics to allow for some level of comparability. This overlooks the relative importance of organisational factors in trainee burnout experiences and personal characteristics, such as self-efficacy, relationship reciprocity, and compassion for oneself and others, in qualified professionals' experiences of burnout. Ultimately, these issues limited the generalisability and implications of the findings. Future research should seek to investigate the relationship between organisational factors and personal characteristics on burnout experiences of both trainees and qualified PPs, using larger, more diverse samples. These samples should reflect diversity in characteristics according to the Cochrane PROGRESS-Plus criteria (Cochrane Methods Equity, n.d.), as well as diversity across the 19 job roles under 'psychological professions' (Appendix D).

The recruitment and methodology of the empirical paper may limit the transferability of the findings. Purposive, snowballing sampling via social media, relies on social media engagement and the willingness of others to share the research. However, purposive sampling is considered typical in qualitative research for data richness from participants over

generalisability intentions (Braun & Clarke, 2013). Noteworthy, those ECCPs with more decisive experiences, positive, negative, or otherwise, may have been less inclined to participate. Consequently, these voices are missing. Methodologically, RTA aligned most closely with the research aims and philosophical stance, but the findings must be viewed in the context of the participants' and researchers' experiences. Steps throughout the project hoped to utilise researcher subjectivity as a strength through engagement and reflection on their own emotions, for enhanced analysis with participant emotions (Buetow, 2025).

While there are limitations to both papers, their combination to the evidence base is vital, given the current paucity in this field.

Clinical Implications

The thesis portfolio provides numerous important clinical practice implications. Firstly, the systematic review demonstrates how job characteristics have a significant impact on staff well-being and burnout. Simply ensuring staff have a desk chair to work from was a significant finding (Westwood et al., 2017) and can be easily put into practice. Poor working conditions and lack of safe, therapeutic spaces were also key to ECCPs' NHS experiences. While not substantive on their own, they represent cost-effective approaches to help mitigate some of the effects of burnout. Furthermore, the systematic review found compassion fatigue was the strongest correlate of trainee burnout (Beaumont et al., 2016), risking the trainee population entering the qualified workforce already burnout. The influence of self-efficacy was also key to trainee burnout (Rose et al., 2019), as lower perceived self-efficacy was associated with a high risk of burnout.

Clinical and counselling psychology doctorate trainees wished for better understanding and empathy from their university regarding the difficulties of balancing life and the demands of the course (Rummell, 2015). The combination of these findings

underscores the vital need for training courses to support their trainees, echoing recommendations from Owen et al. (2022), that would be cost-effective against the economic strain associated with burnout (Daniels et al., 2022).

The qualitative study highlights the moral and emotional toll experienced by ECCPs in the NHS. Many grappled with the dialectic dilemma of beneficence of free, good-quality health care, but faced with systemic obstacles preventing alignment with their values. Additionally, the research emphasises the intersectionality and perpetual nature of these experiences. If ECCPs continue to experience value misalignment while working in the NHS, this may increase their intention and actuality to leave the NHS, resulting in fewer supervisors and good-quality placements for future trainees.

Inadequate staffing is an organisational constraint, which falls under psychological job demands (Karasek et al., 1998), and was identified as the strongest correlate to burnout in qualified TT practitioners (Steel et al., 2015). Adequate staffing is the most significant recommendation to tackle moral injury (BMA, 2021), ensuring workforce plans materialise is critical. Streamlined NHS bureaucracy was the second most important factor to be addressed to lessen moral injury (BMA, 2021). Of interest, 17.4% (of 1933 respondents) stated that 'more time for reflection' would improve moral injury, which aligns with the experiences of ECCPs who wanted more time and adequate staffing to reflect, to uphold professional standards and manage the emotional demands of the job (Chapter 4). Time restrictions and high stress are known barriers to engaging in reflection (Ooi et al., 2023), yet reflective practice in supervision is seen as beneficial and integral for practitioner psychologists (BPS, 2024). Offering reflective practice is recommended to ameliorate the risk of moral injury to NHS staff (NHS Employers, 2024; Williamson et al., 2023). Hours of supervision received also predicted lower levels of burnout (Westwood et al., 2017). Experiencing a lack of support from managers and colleagues is linked with significant moral injury (Williamson et

al., 2023). Managerial support is key to staff well-being, as well as demonstrating leadership and fostering honest and open cultures in teams and hierarchies (Rao et al., 2023). Multiple, interconnected systemic changes would work towards mitigating the emotionally and economically taxing impact of burnout and moral injury (Linzer & Poplau, 2021). A pertinent focus of the NHS Long Term Workforce Plan (2023) is the importance of retaining a healthy, looked-after workforce.

The onus of change and responsibility must not be placed just on the individual, as moral injury is not a reflection of an individual's resilience (Dean, 2022). While it is impossible to mitigate against all causes of moral injury, organisational reform would hope to reduce the frequency and intensity of morally injurious experiences. When staff do require support, it should be accessible. However, further geographical disparity sees staff access to Mental Health and Well-being Hubs inequitable (BPS, 2025). Evidence suggests that healthcare workers are not well trained to manage the impact of moral injury, especially when arising from long-term systemic challenges (Rabin et al., 2023). Alongside compassion fatigue being the strongest correlate of trainee burnout (Beaumont et al., 2016), so incorporating specific training to foster resilience, as resilience mediates compassion fatigue and moral injury (Albaqawi & Alshammari, 2024) and dealing with moral injury into training programmes is crucial for the long-term workforce well-being.

Directions for Future Research

The thesis portfolio explored trainee and qualified TT practitioner's correlates of burnout and employment decision-making in one job role within PPs, ECCPs. One main outcome from the systematic review would be for future research to consider the research of specific professionals rather than particular services or looking at multiple professions simultaneously. As mixed samples of PPs with other disciplines and professionals resulted in

exclusion from the review. This would allow for greater knowledge regarding profession-specific correlates so they can be more accurately addressed, as opposed to whole NHS staff initiatives or approaches.

A fundamental outcome from the portfolio highlights the need to explore the relative salience of training experiences on correlates of burnout and future employment decision-making. Findings from a recent systematic review found stress to be higher in trainees compared to the general population and considered the duality of roles during training contributory to high stress (Harding, 2025). It is known that stress and burnout occur, and increase during training, (Cushway, 1992; Cushway & Tyler, 1994, Lin et al., 2019), and burnout is higher in the final year of training compared to the first year of qualified working (Robins et al., 2018). Of 637 trainees, 32% stated that stress was the reason they intended to leave training (National Education Training Survey, 2023), and training experiences impact qualified job decision-making (Wareing et al., 2017).

Positioning solutions to burnout on individual responsibility is prevalent in the literature. Rummell (2015) emphasises the importance of self-care and availing of personal therapy, reflecting an implicit and explicit expectation for individuals to maintain a façade of invulnerability (Riley et al., 2021). However, there has been limited exploration of how changes to training programmes could mitigate the well- documented stressors and heightened risk of burnout. Shifting this narrative is crucial; more research should focus on systemic factors contributing to trainee stress and burnout, rather than perpetuating the tendency to individualise the issue. Furthermore, organisational challenges also impact trainees. If placements are in overstretched teams with long waiting lists of increasing complexity, with an undercurrent of colleague tensions and staff shortages, trainees experience all these factors whilst simultaneously holding the duality of training-related stressors. Addressing broader, systemic factors could lead to improved well-being of trainees

and therefore, newly qualified professionals and, subsequently, support better retention in the NHS. This would also cascade to improve placement experiences for future trainees.

Being a commissioned trainee was the only DClinPsy factor explicitly and consistently asked in interviews. Training and placement experiences naturally arose for some participants, equity would ensure that all participants were explicitly asked about the influence of their training experiences and placements on their employment decision-making. Future research should endeavour to explore the experiences and decision-making factors of non-commissioned trainees and consider the differences. The influence of perceived class background on NHS working and being a commissioned trainee may been significant in ECCPs' employment decision-making; this and other demographic variables of interest should be explicitly considered in future research. Moreover, multiple training experiences and the cumulative impact on burnout and early-career employment decisions warrant exploration. Given the "no common career path for psychology graduates" (Palmer et al., 2021, p. 7), the prolonged chronicity of training is particularly salient. For instance, in the aforementioned example, time, academic and clinical experience needed to qualify as a PWP, educated to postgraduate certificate level, followed by a further three-year doctoral level qualification to become a CP. The perceived obligation for further qualifications to enhance job prospects, autonomy, earnings and expertise, yet to be faced with systemic barriers, limiting these benefits, needs to be specifically explored. This may disproportionately affect individuals from underrepresented ethnic backgrounds and lower socioeconomic status, further perpetuating the White-centric nature of the clinical psychology field (Ahsan, 2020) and the PP workforce (NHS Benchmarking Network, 2023).

Bullying is strongly correlated to burnout (Livne & Goussinsky, 2017), race and gender-based discrimination increases psychological distress (Hussain et al., 2023) and 12.19% of NHS staff do not think the NHS acts fairly regardless of protected characteristics,

including ethnic background, sexual orientation and disability (NHS Staff Survey, 2024). Discrimination, bullying, sexism and racism were not explored as correlates of stress and burnout among trainee and TT practitioners, nor explicitly covered in the empirical paper. Future research needs to consider exploring these factors to understand their salience and impact.

None of the included studies in the systematic review were conducted after the COVID-19 pandemic, and pandemic experiences for the ECCPs were not explicitly explored. Future research should explore the impact of the pandemic on this workforce.

Conclusion

The studies contained in the portfolio provide evidence of the threat to the future clinical psychology and psychological professionals' workforce sustainability in the NHS. Evidence from these studies highlighted the excessive emotional toll, burnout, and moral injury experienced. Multiple interconnected systemic, organisational and individual factors need to be addressed to ensure a healthy and well-supported workforce is retained to serve the patients in need of psychological care. This necessitates joint working across Trusts, education provisions, NHS England Workforce, Training and Education (formerly HEE), with financial endorsement from the Government. The focus should start at the beginning of PPs' careers. Training programmes that are compassionate towards the juggling of multiple stressors (Rummel, 2015), promote transparency regarding professional self-doubt and provide expectations clarity early on in training (Owen et al., 2022) may help reduce some trainee stress. Psychological training pathways should also consider improved training on resilience, stress coping styles, reflective practice and preparation for qualified life (Albaqawi & Alshammari, 2024; Ooi et al., 2023; Owen et al., 2022).

The NHS PPs workforce cannot be expected to be resilient without systemic reform.

The portfolio calls for urgent action to address moral injury among PPs, as demonstrated by the perpetual nature of burnout, moral toll and workforce shortages. More staff, as promised by the NHS Long Term Workforce Plan (2023), would enable protected time and availability for supervision, service planning and appropriate provision so no ECCP is a sole clinician, and allow for job planning and actuality, which is more congruent with values, skill expertise and training. This would also help to ensure that mid and later-career PPs are retained to demonstrate clear career progression in the NHS, safeguard the availability of supervisors and managers to provide strong leadership and culture changes, and protect the provision of placements required to train and support future trainees.

These evidence-based strategies may help to ensure that the £16 million NHS Workforce Wellbeing Programme (NHS Charities Together, 2024) is a worthwhile investment, and so the NHS Long Term Workforce Plan (2023) comes to fruition to improve retention of PPs, especially ECCPs. Further research is essential in this area, to expand on these findings, particularly in larger and more diverse samples and the application of findings to improve working experiences to futureproof the NHS psychological professions' workforce.

> "You can only have an NHS that is "fit for the future" if you have a well workforce" (Raczka, cited in BPS, 2025b).

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Appendices

Appendix A.

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European Journal of Work and Organizational Psychology

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Contents

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Appendix B.

PRISMA 2020 item checklist and Abstracts checklist (Page et al., 2021)

Section and topic	Item #	Checklist item	Location where item is reported
Title			
Title	1	Identify the report as a systematic review.	Title
Abstract			
Abstract	2	PRISMA 2020 Abstracts checklist.	Abstract & Appendix B
Introduction			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Introduction
Objectives	4	Provide an explicit statement for the objective(s) or question(s) the review addresses.	Introduction
Methods			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were groups for the syntheses.	Method, eligibility criteria, Table 1
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched pr consulted to identify studies. Specify the data when each source was last searched or consulted.	Method, data sources and search strategy
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Method, data sources and search strategy, Appendix C

Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Method, screening and selection of studies
Data collection process	9	Specify the methods used to collect data from all reports, including how many reviewers collected data from each report, whether the worked independently, any processes for obtaining or confirming data from study investigators and if applicable, details of any automation tools used in the process.	Method, data extraction
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Method, data extraction
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Method, data extraction
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of any automation tools used in the process.	Method, assessment of methodological quality
Effect measures	12	Specify each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	Method, data extraction

Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Method, data synthesis
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling any missing summary statistics, or data conversions.	Method, data synthesis
	13c	Describe any methods used to tabulate or visually display results from individual studies and syntheses.	Method, data synthesis
	13d	Describe any methods used to synthesis results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s), to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Method, data synthesis
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. sub-group analysis, meta-regression).	Methods, data synthesis
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesised results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	Methods, data synthesis
Results			

Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Results, data extraction outcome, Figure 1
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	N/A
Study characteristics	17	Cite each included study and present its characteristics.	Results, study characteristics, Table 2
Risk of bias in studies	18	Present assessment of risk of bias for each included study.	Results, quality assessment and findings, Appendix E
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Results, Table 3-6
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	N/A
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Results, Table 3-6, Appendix E
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Results

	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesised results.	N/A
Reporting biases	21	Present assessment of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessment of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
Discussion			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Discussion
	23b	Discuss any limitations of the evidence included in the review.	Discussion, limitations and future research
	23c	Discuss any limitations of the review processes used.	Discussion, limitations and future research
	23d	Discuss implications of the results for practice, policy, and future research.	Discussion, practical implications
Other information			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state the review was note registered.	Method
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Method

	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Ethical approval
Competing interests	26	Declare any competing interests of review authors.	Disclosure statement
Availability of data, code, and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses, analytic code; any other materials used in the review.	Data availability statement, Appendix E

Selection and topic	Item #	Checklist Item	
Title			
Title	1	Identify the report as a systematic review.	Yes
Background			
Objectives	2	Provide an explicit statement of the main objective(s) or question(s) the review addresses.	Yes
Methods			
Eligibility criteria	3	Specify the inclusion and exclusion criteria.	No
Information sources	4	Specify the information sources (e.g. databases, registers) used to identify studies and when each was last searched.	Yes
Risk of bias	5	Specify the methods used to assess risk of bias in the included studies.	No

Synthesis of results	6	Specify the methods used to present and synthesis results.	Yes
Results			
Included studies	7	Give the total number of included studies and participants and summarise relevant characteristics of studies.	No
Synthesis of results	8	Present results for main outcomes, preferably indicating the number of included studies and participants for each. If meta-analysis was done, repot the summary estimate and confidence/credible interval. If comparing groups, indicate the direction of the effect (i.e. which group is favoured).	Yes
Discussion			
Limitations of evidence	9	Provide a brief summary of the limitations of the evidence included in the review (e.g. study risk of bias, inconsistency and imprecision).	Yes
Interpretation	10	Provide a general interpretation of the results and important implications.	Yes
Other			
Funding	11	Specify the primary source of funding for the review.	No
Registration	12	Provide the register name and registration number.	Yes

Appendix C.

Search strategy terms

Synonym of correlate		Participant outcome		Psychological professional		Employer and geographical area
determinant* OR risk* OR contribut* OR caus* OR driver* OR predict* OR associat* OR correlat* OR predispos*	AND	burnout OR burn-out OR "burn out" OR stress OR "occupational stress" OR "work-related stress" OR "work related stress"	AND	psycho* OR counsellor* OR therapist*OR practitioner OR "PWP" OR "CAP" OR "APP" OR "AP"	AND	NHS OR "National Health Service" OR UK OR "United Kingdom" OR England OR Scotland OR Wales OR "Northern Ireland"

Appendix D.

All job roles under the umbrella term 'Psychological Professionals'

- Clinical psychologist
- Health psychologist
- Counselling psychologist
- Forensic psychologist
- Psychological therapist (other)
- Adult psychotherapist

- Child and adolescent psychotherapist
- Family and systemic psychotherapist
- CBT therapist
- Counsellor
- Psychological well-being practitioner (PWP)
- High intensity therapist (HIT)
- Children's well-being practitioner
- Education mental health practitioner (EMHP)
- Mental health and well-being practitioner (MHWP)
- Youth intensive psychological practitioner (YIPP)
- Clinical associate psychologist (CAP) / clinical associate in psychology
- Assistant psychologist (AP)
- Art, drama and music therapists (with AHP professional leadership).

As defined by: Health Education England. (2021). *Psychological Professions Workforce Plan*. https://www.hee.nhs.uk/sites/default/files/documents/Psychological%20Professions%20Workforce%20Plan%20for%20England%20-%20Final.pdf

Appendix E.

Full extracted results and used to complete statistical transformations

Study	Outcome	Correlate	Results	Other important results
Steel et al. (2015)	EE	Psychological job demands Decision latitude Stressful involvement	$\beta = 0.596^{***}$, $R^2 = 0.355$ (35.5%) $\beta = -0.173^{*}$, $\Delta R^2 = 0.029$ (38.4%) $\beta = 0.290^{**}$, $\Delta R^2 = 0.073$ (45.7%)	In-session anxiety showed highest correlation (r =0.44)
	DP	Therapist age Psychological job demands Stressful involvement	$\beta = -0.262^{*}$, $R^2 = 0.069$ $\beta = 0.272^{**}$, $\Delta R^2 = 0.074$ $\beta = 0.450^{***}$, $\Delta R^2 = 0.165$	In-session anxiety showed the highest correlation (r = 0.41)
	PA	Length of training Coping control Decision latitude Healing involvement	$\beta = 0.250$ (p <0.05), $R^2 = 0.063$ $\beta = 0.259$ (p <0.01), $\Delta R^2 = 0.144$ $\beta = 0.063$ $\beta = 0.387$ (p <0.001), $\Delta R^2 = 0.120$	In-session feeling of "flow" showed the highest correlation (r = 0.41)
Beaumont et al. (2016)	Burnout	Self-compassion Compassion fatigue Compassion satisfaction Well-being Compassion for others	r= - 0.486** r = 0.580** r = -0.376** r = -0.555** r = -0.289*	

		Self-kindness	*r* = -0.442**	
		Self-judgement	*r* = 0.545**	
Westwood et al. (2017)	EE	Demographics:	PWPs:	HITs:
		Male	b =-1.97, *p* 0.133	b = -.086, *p* 0.380
		Age	b = 0.04, *p* 0.392	b = -0.04, *p* 0.389
		BME	b = 0.82, *p* 0.500	b = 2.1, *p* 0.077
		Mental health work experience (years):		
		Prior to current IAPT service	b = 0.16, *p* 0.160	b = -0.03, *p* 0.667
		Current IAPT service	b = 0.74, *p* 0.066	b = 0.16, *p* 0.722
		Job characteristics (hours/week):		
		Supervision/case management	b = -0.01, *p* 0.968	b = -.016, *p* 0.432
		Caseload	b = 0.02, *p* 0.303	b = 0.06, *p* 0.279
		Patient contact	b = 0.18, *p* 0.001	b = 0.20, *p* 0.005
		Face-to-face	b= 0.05, *p* 0.386	b = 0.22, *p* 0.011
		Telephone	b= 0.11, *p* 0.050	b = 0.75, *p* 0.005
		In groups	b = -0.01, *p* 0.960	b = 0.20, *p* 0.074

	Inputting Data	b = 0.29, *p* 0.003	b = 0.07, *p* 0.433
	Overtime	b = 0.92, *p* <0.001	b = 0.24, *p* 0.092
	No own desk	b = -1.04, *p* 0.260	b = 0.90, *p* 0.279
	Greater awareness of targets	b = -0.63, *p* 0.111	b = -0.82, *p* 0.029
	Supervision received	b = -1.24, *p* 0.123	b = -0.61, *p* 0.527
	Case management received	b = -.019, *p* 0.847	- -
	Organisational	b = 2.90, *p* <0.001	b = 2.21, *p* <0.001
	Relationships/conflicts	b = 3.53, *p* <0.001	b = 2.24, *p* 0.02
DE:	Male	b = -0.01, *p* 0.993	b = 0.49, *p* 0.611
	Age	b = 0.08, *p* 0.079	b = -0.07, *p* 0.121
	BME	b = 1.49, *p* 0.185	b = 1.02, *p* 0.386
	Mental health work experience (years):		
	Prior to current IAPT service	b = 0.25, *p* 0.019	b = -0.04, *p* 0.461
	Current IAPT service	b = 1.58, *p* <0.001	b = 0.26, *p* 0.541
	Job characteristics (hours/week):		
	Supervision/case management	b = -0.01, *p* 0.979	b = -0.31, *p* 0.113

	Caseload	b = 0.04, *p* 0.095	b = 0.14, *p* 0.008
	Patient contact	b = 0.15, *p* 0.003	b = 0.23, *p* 0.001
	Face-to-face	b = 0.06, *p* 0.227	b = 0.24, *p* 0.003
	Telephone	b = 0.06, *p* 0.224	b = 0.79, *p* 0.003
	In groups	b = -0.10, *p* 0.731	b = 0.25, *p* 0.024
	Inputting Data	b = 0.18, *p* 0.051	b = 0.02, *p* 0.809
	Overtime	b = 0.71, *p* <0.001	b = 0.10, *p* 0.475
	No own desk	b = -0.29, *p* 0.737	b = -0.27, *p* 0.783
	Greater awareness of targets	b = -0.25, *p* 0.502	b = -0.81, *p* 0.028
	Supervision received	b = -1.97, *p* 0.007	b = -0.85, *p* 0.370
	Case management received	b = 0.20, *p* 0.826	- -
	Organisational	b = 3.01, *p* <0.001	b = 2.65, *p* <0.001
	Relationships/conflicts	b = 3.26, *p* <0.001	b = 2.39, *p* 0.001
Burnout:	Male	OR = 0.46, *p* 0.712	OR = 0.79, *p* 0.628
	Age, 40+	OR = 0.82, *p* 0.704	OR = 0.51, *p* 0.104
	BME	OR = 1.23, *p* 0.712	OR = 0.84, *p* 0.766
	Mental health work experience (years):		

Prior to current IAPT service	OR = 1.00, *p* 0.933	OR = 0.97, *p* 0.264
Current IAPT service	OR = 1.58, *p* 0.020	OR = 1.26, *p* 0.288
Job characteristics (hours/week):		
Supervision/case management	OR = 0.99, *p* 0.916	OR = 1.01, *p* 0.901
Caseload	OR = 1.01, *p* 0.408	OR = 1.00, *p* 0.915
Patient contact	OR = 1.08, *p* 0.003	OR = 1.03, *p* 0.408
Face-to-face	OR = 1.06, *p* 0.046	OR = 1.02, *p* 0.656
Telephone	OR = 1.02, *p* 0.481	OR = 1.23, *p* 0.656
In groups	OR = 0.91, *p* 0.484	OR = 1.02, *p* 0.714
Inputting Data	OR = 1.12, *p* 0.019	OR = 0.97, *p* 0.516
Overtime	OR = 1.60, *p* <0.001	OR = 1.01, *p* 0.860
No own desk	OR = 0.46, *p* 0.716	OR = 1.81, *p* 0.152
Greater awareness of targets	OR = 0.84, *p* 0.331	OR = 0.78, *p* 0.193
Supervision received	OR = 0.44, *p* 0.034	OR = 0.90 *p* 0.832
Case management received	OR = 1.65, *p* 0.337	- -
Organisational	OR = 3.53, *p* 0.001	OR = 2.42, *p* 0.011
Relationships/conflicts	OR = 5.52, *p* 0.023	OR = 2.16, *p* 0.062

Rose et al. (2019)	EE:	SE: Academic	r_s = -0.225, β = -0.122, *p* 0.183
		SE: Clinical	r_s = -0.296, β = 0.09, *p* 0.331
		SE: General	r_s = -0.386, β = -0.452, *p* 0.000**, R^2 = 0.216
		RC: Clients	r_s = 0.146, β = 0.115, *p* 0.080
		RC: Clinical supervisor	r_s = 0.191***, β = 0.085, *p* 0.222
		RC: Cohort	r_s = 0.03, β = -0.065, *p* 0.346
		RC: Placement team	r_s = 0.201***, β = -0.030, *p* 0.674
		RC: Personal relationships	r_s = 0.114, β = 0.038, *p* 0.552
		RC: Trust	r_s = 0.011, β =-0.003, *p* 0.969
		RC: University staff	r_s = 0.073, β = 0.018, *p* 0.799, R^2 = 0.241, ΔR^2 = 0.025
		MBI: DP	r_s = 0.365***
		MBI: PA	r_s = -0.152
		Well-being	r_s = -0.4
	DP:	SE: Academic	r_s = -0.135, β = 0.120, *p* 0.230
		SE: Clinical	r_s = -0.235, β = -0.278, *p* 0.02*
		SE: General	r_s = -0.165, β = -0.140, *p* 0.141, R^2 = 0.092
		RC: Clients	r_s = 0.13, β = 0.141, *p* 0.042*

	RC: Clinical supervisor	r_s = 0.082, β = -0.032, *p* 0.660
	RC: Cohort	r_s = -0.03, β = -0.038, *p* 0.606
	RC: Placement team	r_s = 0.078, β = 0.26, *p* 0.729
	RC: Personal relationships	r_s = 0.069, β = 0.140, *p* 0.042*
	RC: Trust	r_s = -0.081, β = -0.060, *p* 0.390
	RC: University staff	r_s = -0.071, β = -0.112, *p* 0.133, R^2 = 0.152, ΔR^2 = 0.06
	MBI: EE	r_s = 0.365
	MBI: PA	r_s = -0.167
	Well-being	r_s = -0.146
PA:	SE: Academic	r_s = 0.326, β = 0.23, *p* 0.806
	SE: Clinical	r_s = 0.473, β = 0.358, *p* 0.000**
	SE: General	r_s = 0.386, β = 0.097, *p* 0.282, R^2 = 0.191
	RC: Clients	r_s = -0.195***, β = -0.020, *p* 0.258
	RC: Clinical supervisor	r_s = -0.075, β = 0.132, *p* 0.762
	RC: Cohort	r_s = -0.03, β = -0.003, *p* 0.444
	RC: Placement team	r_s = -0.121, β = -0.014, *p* 0.063
	RC: Personal relationships	r_s = -0.039, β = -0.002, *p* 0.358
	RC: Trust	

RC: University staff	r_s = 0.116, β = 0.062, *p* 0.848
	r_s = -0.113, β = -0.081, *p* 0.964, R2 = 0.217, ΔR^2 = 0.026
MBI: DP	r_s = -0.167****
MBI: EE	r_s = -0.152****
Well-being	r_s = 0.363

Note: EE: Emotional exhaustion. DP: Depersonalisation. PA: Lack of Personal Achievement. β: Standardised regression coefficient. "Flow": Experiencing "flow" state during therapy. *r*: Pearson's R. BME: Black/Minority ethnic group. Caseload: Number of patients. Organisational: Feeling under pressure due to organisational structure and processes. Relationships/conflicts: Feeling under pressure due to relationships and conflicts with other professionals. b: Unstandardised regression coefficient. DE: Disengagement. OR: Odds ratio. *p*: *p*-level from likelihood ratio levels N.B. only applicable to *p* for burnout odd ratios in Westwood et al. (2017). SE: Self-efficacy. RC: Reciprocity in relationship. r_s: Spearman's rho correlation. Significant to: **p* <0.05 level. ***p* <0.01 level. ****p* <0.001 level. **** *p* <0.005 level

Appendix F.

Methodological quality using the JBI Critical Appraisal Checklist for Cross-sectional Studies (Moola et al., 2017)

Summary of methodological quality	Study 1		Study 2		Study 3		Study 4	
	Steel et al. (2015)		Beaumont et al. (2016)		Westwood et al. (2017)		Rose et al. (2019)	
FA/SA rater	FA	SA	FA	SA	FA	SA	FA	SA
1: Were the criteria for inclusion in the sample clearly defined?	0	0	0	0	0	0	0	0
2. Were the study subjects and the setting described in detail?	1	1	0	0	1	1	0	0
3. Was the exposure measured in a valid and reliable way?	1	1	1	1	1	1	0	0
4. Were objective, standard criteria used for measurement of the condition?	1	1	1	1	1	1	1	1
5. Were confounding factors controlled for?	1	1	0	0	1	1	1	1
6. Were strategies to deal with confounding factors stated?	1	1	0	0	1	1	0	0
7. Were the outcomes measured in a valid and reliable way?	1	1	1	1	1	1	1	1
8. Was appropriate statistical analysis used?	1	1	1	1	1	1	1	1

Note: FA: First author. SR: Secondary Author. 1: Yes, 0: No/Unclear.

Appendix G.

Qualitative Research in Psychology author guidelines.

Qualitative Research in Psychology

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Contents

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Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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   For multiple agency grants
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9. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. Articles with extenders, such as infographics or video summaries, are up to 108% more likely to be downloaded (based on data in May 2024 from Plain Language Summary of Publication and Clinical Trial Protocol articles published in Future Oncology in 2023). We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article. Taylor & Francis Editing Services can help you create research promotion materials, including infographics, video abstracts, lay summaries and graphical abstracts, to support your article's impact. For more information, including pricing, visit this website.
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Queries

If you have any queries, please visit our Author Services website or contact us here.

Updated 28th October 2024

Appendix H.

Table 1.

Participant Demographics and Employment Details

Employment Group	Number of Roles[1]	Number of NHS Roles	Year Qualified	Gender	Age Range	Ethnicity Code	Broad Geographical Area
Stayer	2	2	2021	Female	31-35	1	East of England
	2	2	2021	Female	31-35	1	East Midlands
	1	1	2022	Female	36-40	2	East of England
	2	1	2021	Female	31-35	2	East of England
	1	1	2023	Female	26-30	2	East of England
Splitter	3	2	2021	Female	26-30	1	Southeast of England
	3	2	2019	Female	31-35	3	Northwest of England
	3	2	2022	Female	36-40	1	Southeast of England
	3	2	2021	Agender	31-35	2	Lothian, Scotland
	3	2	2022	Female	26-30	1	East of England

Leaver	5	2	2019	Female	36-40	1	County of Cardiff
	3	2	2020	Female	31-35	1	Southeast of England
	2	1	2021	Female	31-35	1	Northwest of England
	3	1	2019	Female	31-35	1	Northeast of England
	1	1	2023	Female	36-40	1	England[2]
NHS+	2	1	2023	Male	26-30	2	East of England
	3	2	2020	Male	31-35	1	Northeast of England
	7	5	2019	Male	31-35	1	Northeast of England

Note: [1] Since qualifying. [2] Only geographical area provided. Ethnicity codes: 1 – White English, Scottish, Welsh, Northern Irish, 2 – Other White background, 3 – White Asian

Appendix I.

Interview Topic Guide

TOPIC GUIDE / SEMI-STRUCTURED INTERVIEWS

*Variation from interview to interview in how the questions are asked (order) and depending if **full NHS (St)**, **split NHS (Sp)**, **no NHS (Le)**. Additional prompting Qs are included but may or may not be required, depending on the interviewee.*

My research Qs to keep in mind:

1. what are the experiences of ECCPs?
2. how can the experiences of ECCPs help us to understand why some CPs stay, partially or fully leave the NHS in their first 5 years of qualifying?
3. what factors mitigate against CPs partially or fully, leaving the NHS in first 5 years of qualifying?
    a. how can we use these experiences to increase retention of ECCPs in the NHS?

Beginnings

Hello. Introduce self again. Reconfirm verbal consent to participate.
Our interview today should take between an hour and an hour and a half.
You have the right to decline any questions in the interview which will not adversely affect you or the interview in any way. What would be the best way to indicate this?
You have the right to terminate the interview at any time with no adverse consequences to yourself, please let me know how you would signal that you would like to terminate the interview.
There will be an audio recording of our interview with transcription enabled. There are no right or wrong answers, this is about your own experiences.
If you would like to take a break at any time, please let me know, What would be the best way to indicate that you require a break.
Would you like a copy of all the questions put into the chat as we go through the interview today? This may help with any communication barriers or technical difficulties. For longer questions with stats or quotes, I will pop them in the chat.

ST: Before we start, please can I confirm that you are an HCPC registered CP who only works in/for the NHS? And that you were a commissioned trainee in the UK who qualified in the last 5 years? Please can you confirm what how many roles you have had in the NHS since qualifying (note not about services/teams but movement within the NHS in this early career period).

SP: I will be referring to the term splitting in this interview today, this refers to CPs like yourself who have a split employment, with one employer being the NHS and another employer, including but not limited to private practice, academia and or research. Please can I clarify what general employers/employment areas you are currently employed in? Check NHS & other employment). Please can I clarify how your split employment came about (aka full NHS and then split or full something else and then picked up split NHS). Please can I confirm that you are a HCPC registered CP, who was a commissioned trainee who qualified within the last 5 years?

LE: Before we start – Please can I confirm that you are an HCPC registered CP, who was a commissioned trainee who qualified within the last 5 years? Please can you confirm if you have worked in the NHS at any point since qualifying as a CP? (If so when? & when did you leave approx..) But that you do not currently work for the NHS – ENSURE NO NHS CURRENTLY.

1) What attracted you to being a clinical psychologist initially?

2) What do you like most about being a clinical psychologist?
    a. Do you think this has changed during your early career period? *(may tease out some disillusionment-related ideas as shown in literature)*

b. If this has changed;
   i. Was there something in the training experience that has influenced you?
   ii. Is there something in your current experiences that has influenced you?
   iii. Do you foresee any upcoming/future events or experiences (*consider the intention to leave the employer)* influencing or changing these factors, these factors being what you like about being a CP?

3) What attracted you to the role you are currently in?
   a. And do you think the factors described in Q1 still align with the role you are currently doing? (again thinking about disillusionment as per research).
   b. Do any of your prior experiences influence where you are working now, if so, in what way?

4) What factors have influenced you to stay where you are currently working? *(protective factors/reasons to stay)*

ST: What factors keep you in the NHS versus research or private or other areas as a CP?
   i. What is it like working in the NHS currently?

SP: What factor(s) keep you partially in the NHS and not fully leave the NHS?
   ii. What is it like working in the NHS currently?

LE*:* What factor(s) influenced you to fully leave the NHS [as a CP]? And were these factors missing from your employment in the NHS? And therefore do you think they were influential to you to fully leaving the NHS?

5) What factors in an employer do you think are important to help a CP do their job effectively? We know there is no perfect team or perfect employer, and we know there are challenges being a CP, and challenges in the NHS
   a. Why do you think you value these factors?
   b. Do you think these factors have changed during your career period?
   c. Are (any of) these factors missing for you and therefore may make you consider moving employer?

6) What elements do you think contribute to the early career period (<5 years) being vulnerable? We could consider vulnerability in this period to include a reduction in the perceived and actual 'protection' as a trainee, increased responsibilities, reduced supervision and other influences to be "successful"
   a. Have you experienced these in your career period?
   b. Have these factors/experiences or lack of them, made you consider leaving/changing your employment?
   c. Do you think these are contributory factors to why CPs may leave the NHS in the early career period?
   d. Are there any other wider factors/circumstances that have led you (or other early career CPs in general) to consider leaving your employer?
      i. Specific Q about MDT if it does not come about organically.
      ii. Specific Q about work-life balance if it does not come about organically.

7) ***SP:*** **So you have moved/split employers in your early career period? Can you tell me more about your experiences and decision-making factors for this?**

- Reflect on your first intention to leave versus actually leaving

LE: So you have moved employers in your early career period? Can you tell me more about your experiences and decision-making factors for leaving the NHS.

- Reflect on your first intention to leave versus actually leaving
- What does your work bring to your life compared to when you were working in the NHS

ST: **So you haven't moved employer in your early career period (thus far). Can you tell me more about your experiences and decision-making factors for this?**

- Reflect on intention to leave and not leaving *(would this pull out commitment to NHS/moral tie etc.)*

8) If you could write an open, anonymous letter to the NHS, what would you say to express your values and opinions around **staying**, **splitting** or **leaving** the NHS?
   LE: Are there conditions/changes that could be implemented that would make you consider returning to the NHS?
   SP: Are there conditions/changes that could be implemented that would make you consider returning to the NHS?

9) What do you think of the latest NHS staff survey that shows 25.6% of NHS staff are very/satisfied with their pay, down from 38% in 2019? *(NB appreciate this is not CP specific, but generally as a downward trend).* Especially as a 2006 BPS article stated that the 'ups' of a career in clinical psychology is a salary during training with relatively good pay and conditions to follow.
   a. Do you think that there is an effort-reward imbalance for CPs where you work? NB effort can include psychological demand (e.g. stress) and physical demand (e.g. workload) and rewards can include supervision, therapeutic progress, flexible working, CPD, and monetary rewards.

10) In the 2022 NHS Staff Survey, 42.9% of respondents felt able to meet all the conflicting demands on their time at work, down from 47.6% in 2020, again not specific to CPs but how has the ability to meet conflicting demands in the workplace impacted on where you have decided to work in your early career period?
   a. 26.4% of staff (NHS Staff Survey 2022) said there are enough staff at their organisation for them to do their job properly [compared to 38.3% in 2020] – how has the presence or lack of other staff influenced your employment decision-making?
   b. Do you think the impact of COVID-19 has impacted on the way that CPs work and their experiences, that has perhaps
   c. *Perhaps a more explicit Q here, if work-life balance does not come about organically. With the reported inability to meet all the conflicting demands on their time at work, how does this impact on work-life balance and how this could/would impact on someone deciding where to work?*

11) Emotional labour & burnout. 37.4% of NHS staff said in the 2022 staff survey that they often or always find their work emotionally exhausting and 34% said they often or always feel burnt out because of their work. Can we reflect on how an employer (full NHS, split NHS, no NHS) has any contribution or influence in this?
   a. Do you consider this instrumental to why ECCPs may consider leaving and do leave the NHS?
   b. Clinical psychologists often see the most complex clients that may need longer-term, multiple and/or systemic interventions, a reduced, perceived, or actual, sense of therapeutic progress may influence CPs to feel compassion fatigued and/or burnout. Discuss.

12) Reflecting on being a paid/commissioned trainee … do you think the provision of receiving a salary for training (compared to non-commissioned trainees, educational and counselling colleagues) has any influence on your employment decisions? *(tease out value of being committed to the NHS, 'Should I stay or should I go paper' & moral obligation to the NHS, but it is not just about money, that paper also alluded to a sense of pride in working for NHS – unsure if this Q actually addresses that?)*
   a. Do you ever feel and/or receive comments regarding 'gratefulness' or 'indebted to the NHS'?

b. Do you think there is a perceived/actual sense or narrative of being 'indebted' to the NHS and would/has influenced your employment decisions?

13) The BPS writes … "In Britain, most clinical psychologists work for the NHS, where the dominant model is medical. Hence most colleagues tend to see people primarily in medical terms, perhaps forgetting psychological issues. So the aspiring psychologist needs to be reasonably resilient…" ... can we reflect and discuss this statement…
    i. Do you think that this statement from our professional body is fair?
    ii. Do you think that this statement from our professional body is too focused on idiosyncratic qualities and not considering the systemic factors that may influence someone to not feel/be resilient?
    iii. Does this consider the role of the multidisciplinary team and how that may influence someone to stay, split or leave the NHS?

14) A BPS article from 2006 stated the ups and 'downs' of a career in CP, it stated "that a 'down' was working (for most CPs) in large bureaucratic organisations which can be frustrating and painfully slow. The physical environment can be rundown and basic; clients can be demanding and distressing: there are few subsidised perks and bonuses don't exist"…
    So let's reflect and discuss on these factors …
    i. Large bureaucratic organisations which can be frustrating and painfully slow.
    ii. The physical environment can be rundown and basic.
    iii. Clients can be demanding and distressing.
    iv. There are few subsidised perks and bonuses don't exist.
        1. I wonder how this statement aligns with your early-career experiences as a CP?
        2. I wonder how this statement aligns with your values as a CP?
        3. Do you think this would help or hinder aspiring CPs from considering the profession?

15) What do you think are the personal and systemic/organisational factors that contribute to longevity as a CP?
    a. Has anything in these factors changed since you changed employer
    b. Has anything in these factors changed within your early career period?

16) If you could go back to the last few months of DClinPsy and give yourself advice about your first qualified post/your early career period – what would it be and why?

Definite Last Q 17) - Is there anything you would like to add that you feel you haven't had a chance to say so far?

Endings

Thank you so much for your time!

Please be reminded that the time period to withdraw is two weeks post the interview which means your withdrawal date is **DATE.** After such time, the data is anonymised and it will not be possible for the research team to identify your personal responses so it will not be possible to withdraw after this point.

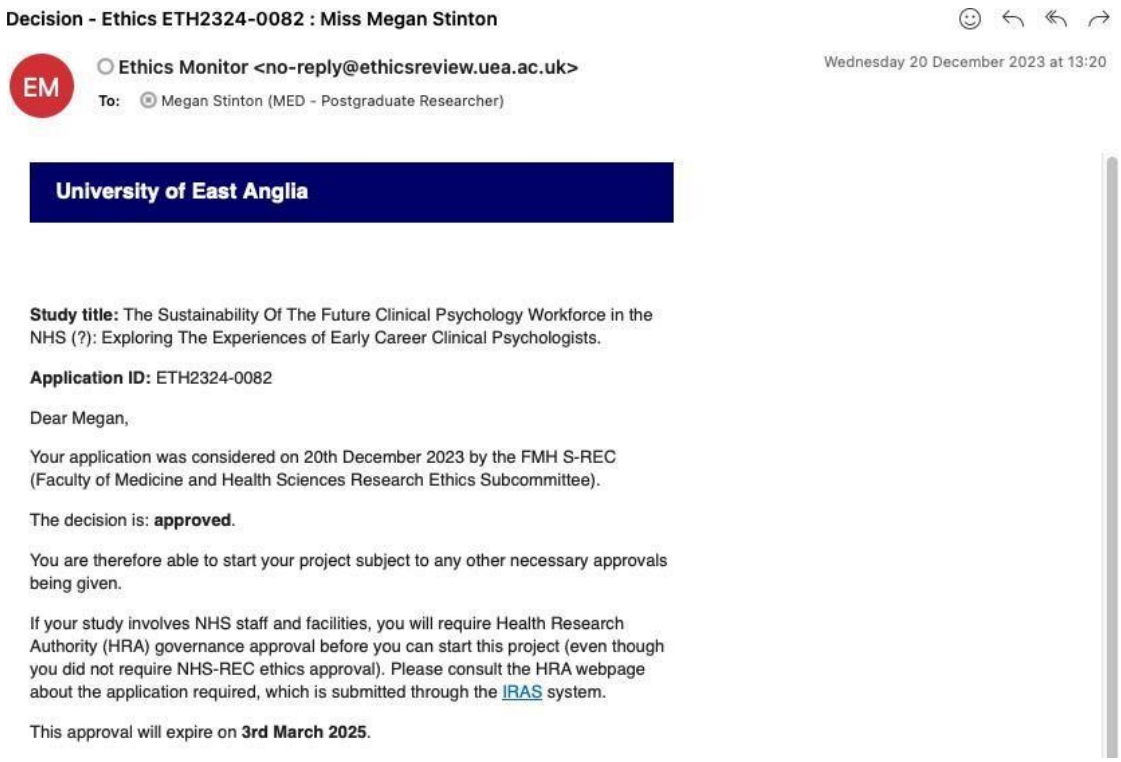
Your virtual Love2Shop voucher will be emailed to you, please can I confirm the best email address to send this to?

Please consider how you will look after yourself now our interview has finished, if you feel the interview was particularly emotionally evocative for you, please refer to the support agencies referred to in your PIS and the debrief sheet I will send in due course.

Thank you for your time and contribution to this research project.

Appendix J.

Ethical Approval



Decision - Ethics ETH2324-0082 : Miss Megan Stinton

EM

Ethics Monitor <no-reply@ethicsreview.uea.ac.uk>

To: Megan Stinton (MED - Postgraduate Researcher)

Wednesday 20 December 2023 at 13:20

University of East Anglia

Study title: The Sustainability Of The Future Clinical Psychology Workforce in the NHS (?): Exploring The Experiences of Early Career Clinical Psychologists.

Application ID: ETH2324-0082

Dear Megan,

Your application was considered on 20th December 2023 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **3rd March 2025**.

Appendix K.

COREQ Checklist

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personalcharacteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	87
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	X
Occupation	3	What was their occupation at the time of the study?	146
Gender	4	Was the researcher male or female?	146
Experience and training	5	What experience or training did the researcher have?	146
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	X
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	146
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	146-7
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	85, 140
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	87, 141
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	88, 142
Sample size	12	How many participants were in the study?	79, 86, 117
Non-participation	13	How many people refused to participate or dropped out? Reasons?	X
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	143
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	143
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	86, 199
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	87, 141, 201
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	NA
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	142
Field notes	20	Were field notes made during and/or after the inter view or focus group?	144
Duration	21	What was the duration of the inter views or focus group?	87, 142
Data saturation	22	Was data saturation discussed?	86
Transcripts returned	23	Were transcripts returned to participants for comment and/or	89, 142

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	89
Description of the coding tree	25	Did authors provide a description of the coding tree?	X
Derivation of themes	26	Were themes identified in advance or derived from the data?	88-89, 145
Software	27	What software, if applicable, was used to manage the data?	145
Participant checking	28	Did participants provide feedback on the findings?	89
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	90-116
Data and findings consistent	30	Was there consistency between the data presented and the findings?	91-122
Clarity of major themes	31	Were major themes clearly presented in the findings?	90
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	90

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix L.

Public and Patient Involvement (PPI) Expectations Information Sheet

University of East Anglia

Faculty of Medicine & Health Sciences
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ
United Kingdom

Patient & Public Involvement (PPI) Expectations Information Sheet

Please take the time to fully review this page as it sets out the expectations of you should you decide to become a PPI member.

PPI involvement is invaluable to research and helps provide alternative perspectives and different ways of thinking that the research team might be missing.

There are two projects involved in this research that we are seeking PPI involvement for;

1. The Truth Behind the Murmurs: Factors Predicting Early-Career Clinical Psychologists' Staying or Leaving NHS Employment. (Annabel Harding, Trainee Clinical Psychologist).
2. The Sustainability of the Future Clinical Psychology Workforce in the NHS (?): Exploring Experiences of Early Career Clinical Psychologists. (Megan Stinton, Trainee Clinical Psychologist).

These projects are being completed as part of the requirements for the Doctorate of Clinical Psychology (DClinPsy) at the University of East Anglia.

Both projects are interested in the factors that are contributing to Clinical Psychologists decision-making to stay, split or leave their NHS employment within their first five years of qualifying. The first five years of qualifying as a Clinical Psychologist are associated with a variety of stressors and vulnerability factors that may increase intention to leave and actually leaving the NHS. The research team believe the projects are timely and important to increase understanding of the experiences of Early Career Clinical Psychologists.

PPI expectations:

- Review and contribute (virtually) to participant facing information (participant information sheets, consent forms, recruitment posters etc.).
- Review and contribute (virtually) to questionnaires involved in the projects.
- Review and contribute (virtually) to interview guide involved in the second project.
- Review and contribute (virtually) to the overall write up of the projects. (Optional)

Involvement in the PPI group is completely voluntary. You can withdraw your partipation in the PPI group at anytime, without stating a reason.

You can decide whether you would like your participation to be anonymous or formally recognised in the projects.

Should you have any further questions about either / both projects, please do not hesitate to contact the authors of the projects.

Annabel Harding - annabel.harding@uea.ac.uk
Megan Stinton - m.stinton@uea.ac.uk

Should you have any wider concerns about the projects, please do not hesitate to contact the research supervisors.

Dr Jinnie Ooi – jinnie.ooi@uea.ac.uk
Dr Sheryl Parke – sheryl.parke@uea.ac.uk

After carefully considering the above information, and if you are happy to be involved in the research projects, please continue to the consent form.

Thank you.

Appendix M.

PPI Agreement Form

University of East Anglia

Faculty of Medicine & Health Sciences
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

Patient & Public Involvement (PPI) Agreement Form

Please read each statement carefully and tick the box to indicate your consent.

1. I consent to being actively involved in the two thesis projects that are being undertaken as part of the DClinPsy at the University of East Anglia. ☐

2. I confirm that I have had sufficient information regarding the role and expectations of being a PPI member (PPI expectations information sheet). I have had the opportunity to ask any questions that I may have about the studies and being a PPI member and I am satisfied with the answers given. ☐

3. I understand the purpose, procedure, and any benefits and risks involved with being a PPI member involved with the studies. ☐

4. I know who the research team are and how to contact them should this be necessary. ☐

5. I understand that it is my decision regarding my anonymity. While no personal information will be gathered or used about me as part of the research, I can decide, one-month prior to project completion, whether I would like my involvement to be anonymous or whether I would like to be formally recognised for my PPI contributions to these projects. ☐

6. I understand that the role of a PPI member in this research is completely voluntary and that I am free to withdraw at any time without giving a reason. ☐

7. I understand that I will not receive any monetary compensation for my time and contributions as a PPI member. ☐

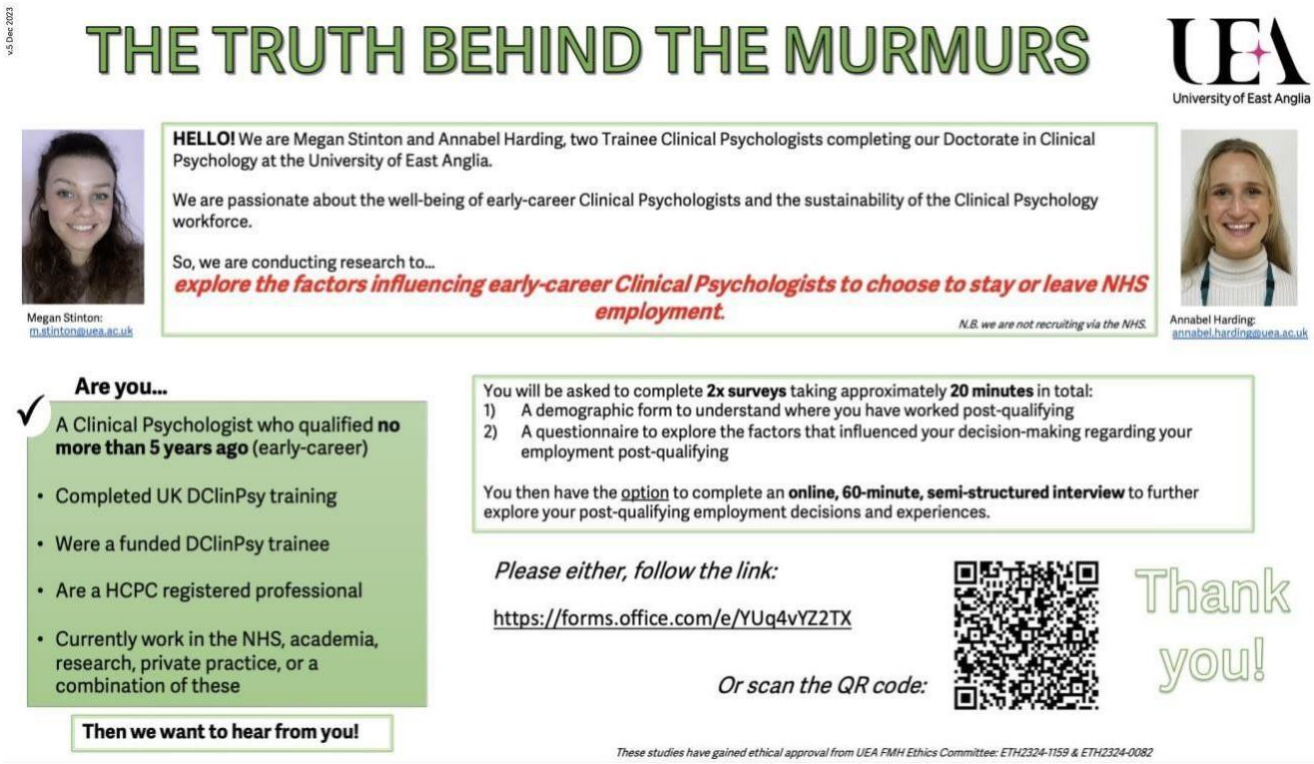
8. I understand that this research can be audited by the University of East Anglia or the regulatory authorities. I therefore give permission for these organisations to access my anonymous data. ☐

9. I agree to be a PPI member for these studies. ☐

Name (BLOCK CAPITALS)	Date	Signature
_____	_____	_____

Appendix N.

Recruitment Poster



Appendix O.

Participant Information Sheet and Consent Form

Miss Megan Stinton
Trainee Clinical Psychologist

18 August 2023

PIS & Consent, ETH2324-0082. V5. April 2024

Faculty of Medicine C Health Sciences
Norwich Medical School

University of East Anglia
Norwich Research Park
Norwich NR4 7TJ
United Kingdom

Email: m.stinton@uea.ac.uk
Web: www.uea.ac.uk

The Sustainability of the Future Clinical Psychology Workforce in the NHS (?): Exploring Experiences of Early Career Clinical Psychologists.

PARTICIPANT INFORMATION SHEET

(1) **What is this study about?**
Thank you for recently completing the survey about your decisions as an early career Clinical Psychologist, and for agreeing to take part in this second qualitative study. We are interested in your experiences as an early career Clinical Psychologist and working in the NHS, in private practice/company, in academia, in research – or in a mix of those.

This Participant Information Sheet tells you about the research study. Knowing what is involved will help you decide if you want to take part in the study. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. By giving consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.
- ✓ You have received a copy of this Participant Information Sheet to keep.

(2) **Who is running the study?**
The study is being carried out by the following researcher: Miss Megan Stinton, Norwich Medical School, , Norwich Medical School, University of East Anglia.
This will take place under the supervision of Dr Jinnie Ooi (jinnie.ooi@uea.ac.uk).

This is a parallel project alongside the quantitative study, that is being carried out by the following researcher: Miss Annabel Harding. This will take place under the supervision of Dr Sheryl Parke (sheryl.parke@uea.ac.uk)

Please see below for more details on this study.

(3) **What will the study involve for me?**
You have already completed the 2 questionnaires forming the quantitative part of the study. Thank you for completing these.
You will be asked to participate in an approximately one-hour, virtual, 1:1 semi-structured interview held by Microsoft Teams at a date and time of your choosing.
We are keen to understand your experiences of being an early career Clinical Psychologist. Questions in the interview will look to ascertain important factors that have influenced you, in your employment decision-making, this may include personal and professional influences.

An audio and video recording will be taken of the interview. The in- built transcription function will be used in Microsoft Teams. This is required for the purpose of the analysis.

You will have the opportunity to review the transcript of your interview should this be something you wish to do. If you would like the chance to review your transcript, that is captured by the in-built transcription option on Microsoft Teams, please alert the researcher at the end of your interview. Reviewing the transcript must be done within two-week withdrawal period after your interview. If you would like to review your transcript, you will be granted access permission to the OneDrive folder where it is securely stored for a maximum period of two weeks. After this two-week period, your data will be anonymised and the link to your identity will be broken. Therefore, it will not be possible for the research team to identify your personal responses after these two weeks.

(4) **How much of my time will the study take?**
A pre-requisite for this study is that you have already completed the 2 questionnaires for the parallel study. Thank you for your time and participation in that part of the study.
Participation in the semi-structured interview is estimated to be approximately one hour.
There are no further commitments after you have completed the interview.

(5) **Do I have to be in the study? Can I withdraw from the study once I have started?**
Being in this study is completely voluntary and you do not have to take part.
If you decide to take part in the study, you are free to stop the interview at any time. You may also refuse to answer any questions that you do not wish to answer during the interview.
If you later decide to withdraw from the study, within **two weeks** post your interview, your information will be removed from our records and will not be included in any analysis.
You can withdraw by contacting the primary researcher by email. You do not have to provide a reason for your withdrawal.
After this two-week period, your data will be anonymised and the link to your identity will be broken. Therefore, it will not be possible for the research team to identify your personal responses after these two weeks.

(6) **What are the consequences if I withdraw from the study?**
Your decision whether to participate or not, or later withdraw, will not affect your current or future relationship with the researchers or anyone else at the University of East Anglia now or in the future.

There are no disbenefits or adverse consequences for withdrawing from the study.

(7) **Are there any risks or costs associated with being in the study?**
While it is anticipated minimal risk to yourself associated with participation in the interview, we understand that the early-career period can be a demanding and challenging time. Some of the content arising from the interview may be personally and / or professionally emotive and / or distressing. Should this occur, the interview can be paused, rearranged or terminated as appropriate. Should you feel you wish to speak to someone regarding the distress experienced during your interview, we consider the following support avenues and agencies appropriate, if necessary:

- Your own clinical and/or managerial supervision via your employer
- Your General Practitioner (GP)
- NHS Trust Staff Support Services
- NHS staff mental health and wellbeing hubs
- The British Psychological Society
- Psychology Professionals Network
- Division of Clinical Psychology
- Association of Clinical Psychologists UK
- Samaritans
- By texting FRONTLINE to 85258 for 24/7 support for NHS staff

(8) **Are there any benefits associated with being in the study?**
The benefits of participating in this study include receiving a £10 'Love2Shop' voucher, which will be emailed to you. Your participation will also contribute to the wider clinical psychology spheres and literature on understanding, and hopefully, improving experiences and retention of early career clinical psychologists and subsequently, the clients, patients and service users we serve. With the current struggles and strains throughout the NHS and Clinical Psychology, there could be a threat to the relationship between the NHS and Clinical Psychology, and therefore, to service users, patients, and clients. The ramifications of the research could demonstrate what supports may be required to increase the retention to early career Clinical Psychologists in the NHS, if this is what they want. Furthermore, this knowledge may help assure continued funding and NHS placements for DClinPsy programmes.

(G) What will happen to information provided by me and data collected during the study?
Your name and email address will be stored for the shortest duration possible for the sole purpose of being contacted about the study, should more information be required and arranging a time and date for your interview. It will be stored on a password-protected document on the primary researcher's University of East Anglia's OneDrive, which is accessed on a password-protected device. Once the interview has been completed, your email will be used to send the debrief. After the two-week withdrawal window passes, you will be emailed your 'Love2Shop' voucher, subsequently, your name and email address will be deleted.

Your data from the recorded interview and associated transcript will be kept separate from your personal data (name and email). The recording and transcript will be stored on the primary researcher's University of East Anglia's OneDrive, which is accessed via a password-protected device. Your data from the transcript may be viewed by the research supervisor for analysis purposes if required. During the two-week withdrawal window, your interview data and transcript are not considered anonymous, which is to allow you the opportunity to withdraw. The interview recording and transcript will be saved with a unique code that is not related or identifiable to your

personal data. As described above, after the two-week withdrawal period, your interview data will begin the analysis process and is not personally identifiable.

Your personal data and information will only be used as outlined in this Participant Information Sheet, unless you consent otherwise. Data management will follow the Data Protection Act 2018 (DPA 2018) and UK General Data Protection Regulation (UK GDPR), and the University of East Anglia's Research Data Management Policy.

The information you provide will be stored securely and your identity will be kept strictly confidential, except as required by law. Study findings are part of a doctoral thesis that aims to be published in an academic journal and disseminated at relevant conferences, it may also be used for other scholarly and educational purposes such as in teaching, but you will not be identified if you decide to participate in this study. The data will be kept for at least 10 years beyond the last date the data were used. The study findings may be deposited in a repository to allow it to facilitate its reuse. The deposited data will not include your name or any identifiable information about you.

(10) **What if I would like further information about the study?**
When you have read this information, Miss Megan Stinton (m.stinton@uea.ac.uk) will be available to discuss it with you further and answer any questions you may have.

(11) **Will I be told the results of the study?**
You have a right to receive feedback about the overall results of this study.
You can tell us that you wish to receive feedback by informing the primary researcher at the end of your interview and indicating on the consent form.
This feedback will be in the form of a one page lay summary and a copy of the final thesis can be made accessible if requested.
This feedback will be available and made accessible to those participants that request feedback, after the final submission of the thesis, approximately June 2025.

(12) **What if I have a complaint or any concerns about the study?**
If there is a problem please let me know. You can contact me via the University of East Anglia at the following address:

Miss Megan Stinton
Norwich Medical School
University of East Anglia
NORWICH
NR4 7TJ
m.stinton@uea.ac.uk

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the Head of the Doctorate in Clinical Psychology Programme Sian Coker (Programme Director): s.coker@uea.ac.uk or the Chair in Clinical Psychology and Deputy Dean of Norwich Medical School, Niall Broomfield: n.broomfield@uea.ac.uk.

(13) **How do I know that this study has been approved to take place?**

To protect your safety, rights, wellbeing and dignity, all research in the University of East Anglia is reviewed by a Research Ethics Body. This research was approved by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

(14) **What is the general data protection information I need to be informed about?**
According to data protection legislation, we are required to inform you that the legal basis for processing your data as listed in Article 6(1) of the UK GDPR is because this allows us to process personal data when it is necessary to perform our public tasks as a University.

In addition to the specific information provided above about why your personal data is required and how it will be used, there is also some general information which needs to be provided for you:

- The data controller is the University of East Anglia.
- For further information, you can contact the University's Data Protection Officer at dataprotection@uea.ac.uk
- You can also find out more about your data protection rights at the Information Commissioner's Office (ICO).
- If you are unhappy with how your personal data has been used, please contact the University's Data Protection Officer at dataprotection@uea.ac.uk in the first instance.

(15) **OK, I want to take part – what do I do next?**
You need to fill in one copy of the consent form and return it to the email address on the consent form. Please keep the letter, information sheet and the second copy of the consent form for your information.

(16) **Further information**
This information was last updated on 30th January 2024.

If there are changes to the information provided, you will be notified by at the earliest convenience via the email address you provided the primary researcher with.

This information sheet is for you to keep

PARTICIPANT CONSENT FORM (First Copy to Researcher)

I,.....[PRINT NAME], **am** willing to participate in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Sheet, which I may keep, for my records, and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of East Anglia now or in the future.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study results. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that the results of this study will be used in the way described in the information sheet.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.

I consent to:

Completing an interview	YES	☐	NO	☐
Audio-recording	YES	☐	NO	☐
Video-recording	YES	☐	NO	☐
Transcript function enabled	YES	☐	NO	☐

Would you like to receive feedback about the overall results of this study?

YES ☐ NO ☐

If you answered **YES**, please provide your email address:

Email: _____

.....
Signature

.....
PRINT name

.....
Date

PARTICIPANT CONSENT FORM (Second Copy to Participant)

I,.....[PRINT NAME], **am** willing to participate in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Sheet, which I may keep, for my records, and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researchers have answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of East Anglia now or in the future.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study results. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that the results of this study will be used in the way described in the information sheet.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.

I consent to:

Completing an interview	YES	☐	NO	☐
Audio-recording	YES	☐	NO	☐
Video-recording	YES	☐	NO	☐
Transcription function enabled	YES	☐	NO	☐

Would you like to receive feedback about the overall results of this study?

YES ☐ NO ☐

If you answered **YES**, please provide your email address:

☐ Email: _____

……
Signature

……
PRINT name

……
Date

Appendix P.

Debrief Sheet

Debrief V2.Dec 2023

Debrief Sheet

I would like to thank you for your participation in the study. I really appreciate the time and effort taken to complete the interview and your unique contribution to such fundamental research.

Please remember that the deadline for withdrawal of your data is ***two-weeks*** after the completion of your interview. Please use the email address detailed below and state your name, if you wish to withdraw from the study. You do not have to provide a reason for your withdrawal.

Please see below for my contact details should you wish to discuss any aspect of the study further.

Name: Megan Stinton - Trainee Clinical Psychologist
Email address: m.stinton@uea.ac.uk

Should you have any concerns about this research that you would like to discuss, please do not hesitate to contact the research supervisor.

Name: Dr Jinnie Ooi – Clinical Psychologist
Email address: jinnie.ooi@uea.ac.uk

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the Head of the Doctorate in Clinical Psychology Programme Sian Coker (Programme Director): s.coker@uea.ac.uk or the Chair in Clinical Psychology and Deputy Dean of Norwich Medical School, Niall Broomfield: n.broomfield@uea.ac.uk.

If there was anything untoward or distressing during your interview, please consider the following support avenues that can be availed of, independently of the research team, that may provide some support.

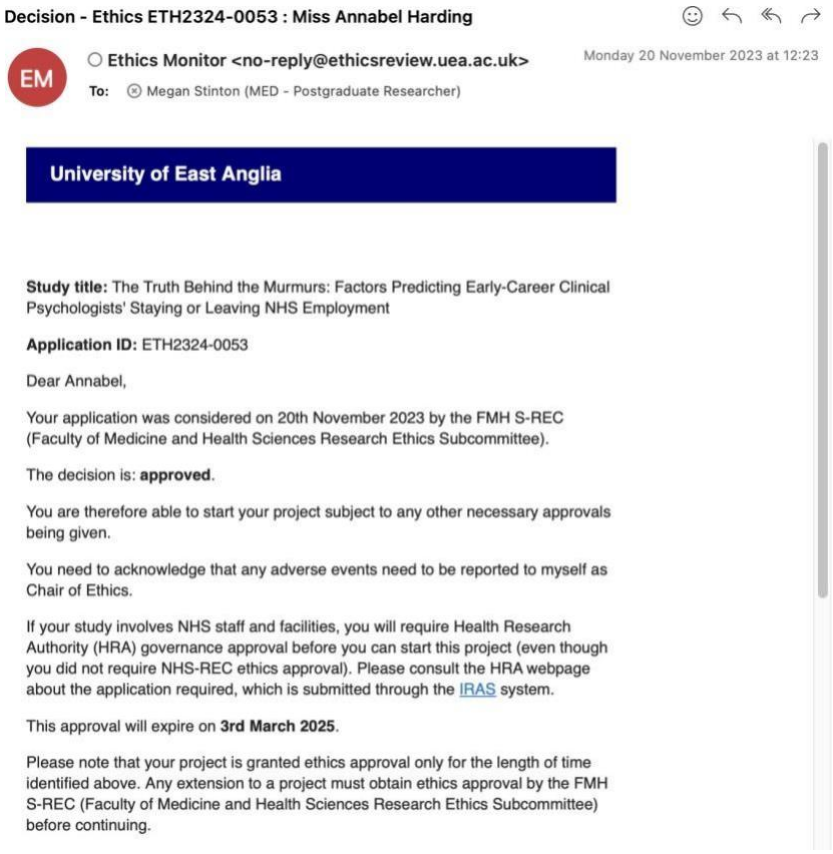
- Your own clinical and/or managerial supervision via your employer
- Your General Practitioner (GP)
- NHS Trust Staff Support Services
- NHS staff mental health and wellbeing hubs
- The British Psychological Society
- Psychology Professionals Network
- Division of Clinical Psychology
- Association of Clinical Psychologists UK
- Samaritans
- By texting FRONTLINE to 85258 for 24/7 support for NHS staff

Thank you, again, for your participation.

Megan

Appendix Q.

Ethical Approval for Sister Study (Harding, 2025b)



Decision - Ethics ETH2324-0053 : Miss Annabel Harding

EM

Ethics Monitor <no-reply@ethicsreview.uea.ac.uk>

Monday 20 November 2023 at 12:23

To: Megan Stinton (MED - Postgraduate Researcher)

University of East Anglia

Study title: The Truth Behind the Murmurs: Factors Predicting Early-Career Clinical Psychologists' Staying or Leaving NHS Employment

Application ID: ETH2324-0053

Dear Annabel,

Your application was considered on 20th November 2023 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

You need to acknowledge that any adverse events need to be reported to myself as Chair of Ethics.

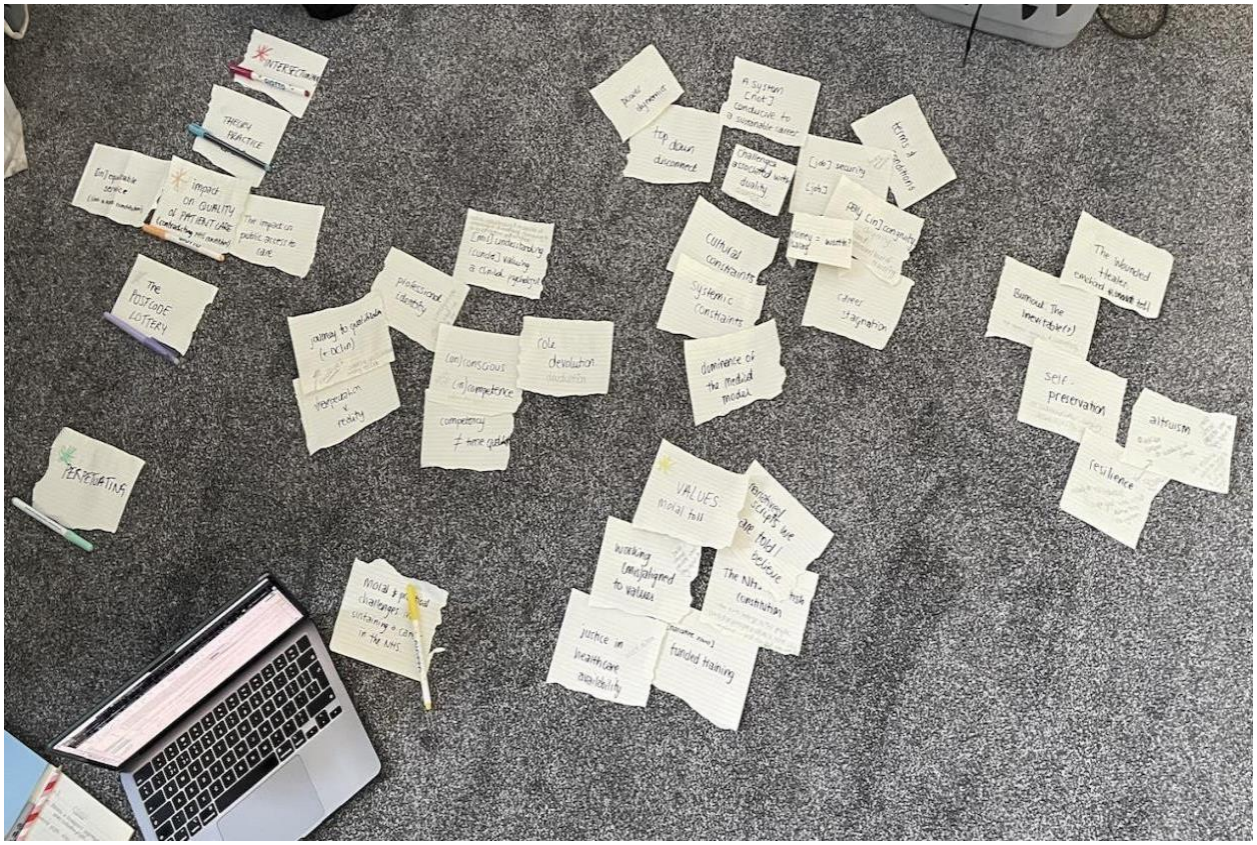
If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **3rd March 2025**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

Appendix R.

Theme Refinement, Thematic Map I



Appendix S.

Theme Refinement, Thematic Map II