Workforce Sustainability: Factors Influencing Clinical Psychology Career Decisions and Moral Injury in Mental Health Workforce

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Thesis Portfolio Abstract

Workforce sustainability within mental healthcare in the United Kingdom (UK) is being impacted by moral distress and injury, and organisational factors leading to poor retention. This, in turn, impacts the quality of patient care and outcomes. Supporting, retaining and building the mental health workforce is therefore an important part of the NHS's 10-year plan.

A systematic review found seven qualitative studies showing the organisational and systemic factors associated with moral distress and injury among UK mental health staff that are impacting staff wellbeing, retention and patient quality of care. A thematic synthesis (Thomas & Harden, 2008) was completed to find five analytical themes of 1) Systemic obstruction of morally valued care, 2) Chronic exposure to system-level moral compromise, 3) Institutional betrayal and staff disposability, 4) Internalisation of systemic failure and 5) Societal devaluation as moral context.

An empirical study followed, with 30 Clinical Psychologists (CP's) completing consensus via a 3-round modified Delphi survey, looking at conditions they needed met to increase their hours in NHS commissioned services. This was then followed by a mini-focus group with three CP's who had completed the Delphi survey, to further explore these findings. Thirteen of eighteen conditions reached consensus after round one (≥70%, IQR = 1) as very/extremely important for increasing NHS hours. The top six of these reached a strong consensus (≥80%, IQR 1) for; 'feeling able to delivery good quality care to service users', 'strong/supportive leadership/management', 'positive team culture', 'flexible working hours', 'opportunities for professional development' and 'better working environment'. Three Reflective Thematic Analysis (RTA) (Braun and Clarke, 2006) themes were: 1. Enabling Meaningful and Ethical Psychological Practice. 2. Creating Sustainable and Flexible NHS Careers. 3. Fostering Values-aligned Leadership and Team Cultures. There was some variation between career stages.

The portfolio sheds light on the organisational factors impacting the mental health workforce sustainability in the UK, with a particular focus on how to support the increase of CP's hours in the NHS. The findings of both the review and the empirical paper are discussed, alongside their strengths and clinical implications, to the limitations and recommendations for future research.

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Chapter One: Introduction to the Thesis Portfolio

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Introduction to the Thesis Portfolio

Healthcare systems vary across the world and the United Kingdom (UK) is fortunate to have a public funded healthcare system, the National Health Service (NHS), which begun in 1948, and was set up to offer free at the point of use medical care to all its British citizens (Clement, 2023). The NHS is now the UK's biggest employer, with over 1.3 million, full-time equivalent (FTE) people in its workforce (NHS England, 2026). It has seen its fair share of organisational difficulties over the years, but the recent independent investigation by Lord Darzi of the NHS in England states it's in a "critical condition, but it's vital signs are strong" (Darzi, 2024, p.11). He points to the clinical talent and skills within the NHS as one of its main strengths.

The Department of Health and Social Care's budget in England was £204.7billion in 2024/25, with 50% of this going on staff salaries (Jefferies & Purbick-Thompson, 2025). However, workforce retention has been an ongoing challenge for the NHS, and has been amplified by the recent Covid-19 pandemic. The NHS vacancy statistics in England are at 6.7% (100,165) for 2025 (NHS England, 2026), with 28.83% often thinking about leaving. NHS staff survey data show the impact Covid-19 had on staff satisfaction, as rates dropped over several years during and after the pandemic. Since 2021, this annual NHS staff survey has been aligned with the NHS People Promise (NHS England, 2021), which is what NHS staff said they value and would improve their experience in the workplace. The latest 2024 survey showed staff satisfaction had increased to pre-Covid-19 pandemic levels (NHS Staff Survey, 2024). However, satisfaction with recognition of their work was only 53.98%, with only 44.41% feeling their organisation valued their work. 32.05% were satisfied with their pay. 41.63% of staff said they felt unwell as a result of work-related stress and burnout had slightly reduced since Covid-19 but was still prominent at 30.24%. Only 34.01% felt they had enough staff in their organisation to do their job properly, with 58.08% saying they had enough resources to do their work.

Leary et al. (2024) looked at NHS data to see why healthcare professionals were leaving the NHS and found findings in line with Herzberg's two-factor motivation-hygiene theory (Herzberg et al., 1959) that they left due to being unable to meet their intrinsic motivation to practice to their professional standards. The most common factors contributing were in line with the 2024 NHS staff survey data around; poor staffing, not feeling valued, overworked, distress/mental health and lack of flexibility. Interestingly, a systematic review by Seathu Raman et al. (2024) found younger doctors and males were more likely to leave, often cited as being more open to change, travel and wanting better opportunities, while women often had to stay due to family commitments. Weyman et al. (2023), also found that despite variability between professions for reasons to leave the NHS, all rated work-related stress, workload intensity and staffing levels as primary factors. They found pay ranked in the middle of the reasons to leave, but was not a primary factor. Similarly, Bimpong et al.'s (2020) NHS staff systematic review found pay influenced job satisfaction and retention, but that improving pay alone was unlikely to improve staff retention. This has further been proven during the recent increase in industrial strike action in the last four years, especially since the Covid-19 pandemic, where issues being raised are not just limited to pay but also about patient safety, staffing numbers and subsequent staff burnout (Cullen, 2022; Essex et al., 2023). Strike action effecting the immediate patient care has continued to be discussed in the literature and wider media. However, a review by Essex et al., (2022) found little impact on patient morbidity, with almost all studies reporting no adverse outcomes.

Burnout, moral distress and moral injury are distinct but do interlink (Weisleder, 2023). "Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed", showing energy exhaustion, negativity towards the job and feeling inefficient (World Health Organisation, 2023). Moral distress differs in that it's more focused on the psychological effects of not being able to take an action in line with their professional identity (The British Medical Association, 2021). "Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological

harm” (The British Medical Association, 2021). They can all affect workforce attrition, and how reframing the challenges from individual to systemic is needed across organisations to improve working conditions and not only retain staff but also build a more resilient workforce (Sorina et al., 2025). Reviews have started to pull together UK studies showing the prevalence and factors associated with burnout in different mental health staff (Harding et al., 2025 & Stinton et al., 2025). There are yet to be any reviews looking into the same for moral distress/injury.

The British Medical Association (2026) has been monitoring data on mental health services in terms of funding, access and workforce. They noted in recent years the increase in pressure on the UK system and how the previous 2019, NHS England Long-Term Plan, did not hit its targets and as demand is outdoing resources, and patients are suffering as result. Lord Darzi’s report also points to a deterioration in the UK health linked to poor quality housing, and low/insecure employment having on health. Mental health needs have surged, and as a result the waiting lists are increasing (Darzi, 2024). To tackle this the government’s new Fit for the Future: 10-Year Health Plan for England has set about what it calls a full-system reform to focus on community care, digital technology to support care, and a focus on prevention to reduce demand (Department of Health and Social Care, 2025). Vacancy rates are also higher in the mental health sector than in other areas of the NHS, and the lack of appropriately trained staff impacts not only staff morale but also patient care (Gilburt & Mallorie, 2024). To support, retain and build the mental health workforce a focus has been put on improving working conditions and supporting staff wellbeing, to reduce burnout and improve retention, as they look to staff being better treated, given more training and better career development and therefore will be more motivated (Department of Health and Social Care, 2025). In this new plan the UK government acknowledged that “a growing weight of bureaucracy has stolen joy from work and time from patient care. In many organisations, the trend has been towards far less professional autonomy”, (Department of Health and Social

Care, 2025, p. 96). The UK government hope the proposed plans will help secure the NHS in the UK for the next generation, both as a workforce and for patient care.

The NHS is not the only provider of healthcare within the UK. The independent, private and charity sectors in the UK have continued to grow and researchers The Kings Fund (2025) now believe it to make up a core part of England's mental health provision. One in four NHS mental health inpatient beds are being outsourced (The King's Fund, 2025). The NHS is also using the private sector to support in reducing waiting list times (British Medical Association, 2024). Outsourcing and changes in services being commissioned has had an impact on job security for the workforce and questions around the quality of care for patients by other organisations and also what will happen to the quality of care in the NHS has also come into question (British Medical Association, 2024).

The overall aim of this portfolio is to contribute to the sustainability of the mental health workforce in the UK. This will be done by the completion of a systematic review looking at the factors associated with moral distress and injury among UK mental health staff.

The empirical paper will then look closer at the profession of Clinical Psychologists (CP's) and what they will need to increase their hours working within NHS commissioned services. An overall discussion and critical evaluation are provided at the end of the portfolio to bring together conclusions, recommendations for change and directions for future research within mental health workforce sustainability in the UK.

Chapter Two: Systematic Review

Prepared for submission to Mental Health & Prevention

Author Guidelines are available in Appendix A

Factors associated with moral distress/injury in mental health staff in the United Kingdom: A Systematic Review

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Abstract

Background: Moral distress and injury have been found among mental healthcare staff within the United Kingdom (UK) and have huge implications for workforce retention, wellbeing and patient outcomes.

Objectives: This systematic review sought to identify the factors associated with moral distress and injury for mental health staff in the UK.

Methods: Systematic searches of seven electronic databases identified peer-reviewed papers meeting criteria for inclusion. Screening was conducted at all stages by the primary and secondary researchers, and quality assessed using the Critical Appraisal Skills Programme UK (CASP) qualitative studies checklist (Critical Appraisal Skills Programme, 2024). A thematic synthesis (Thomas & Harden, 2008) was completed, following the guidance by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) (Page et al., 2021) and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guidelines (Tong et al., 2012).

Results: Seven qualitative studies were included in the review. Five analytical themes highlighted the organisational, structural, societal and relational factors associated with moral distress and/or moral injury in UK mental health staff; 1) Systemic obstruction of morally valued care, 2) Chronic exposure to system-level moral compromise, 3) Institutional betrayal and staff disposability, 4) Internalisation of systemic failure and 5) Societal devaluation as moral context.

Conclusions: The review tentatively shows the impact of some system and organisational factors contributing to moral distress and injury that need addressing to support staff wellbeing, retention and patient quality of care.

Keywords: Moral distress; moral injury; UK; mental health staff; mental healthcare workforce

1. Introduction

The British Medical Association (BMA) (2021) defines moral distress as "psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action.... Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological harm." Although moral distress and injury are not diagnosable conditions, the American Psychiatric Association (APA) have now included 'moral problem' within their newest update of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) (APA, 2025). Moral distress and injury are relatively new constructs in healthcare research; Jameton (1984) was the first to coin the term moral distress and created a moral distress framework model relevant to nursing ethics that has since been adapted to other contexts.

> Researchers in collaboration with the American Psychological Association (APA) and Harvard University, including VanderWeele et al. (2025), define 'moral distress' as: distress that arises because personal experience disrupts or threatens: (a) one's sense of the goodness of oneself, of others, of institutions, or of what are understood to be higher powers, or (b) one's beliefs or intuitions about right and wrong, or good and evil'. When that distress becomes sufficiently persistent it constitutes 'moral injury' (Brownstein, 2025).

In this growing research field systematic reviews have begun to synthesize the current research on moral distress/injury with healthcare workers across the globe (Beadle et al., 2024). Moral distress and injury have negative implications for a workforce's well-being, retention, and negatively affect the quality of patient outcomes (Reis & Lesandrini, 2025). Research has shown healthcare systems across Europe are facing a workforce crisis (Almeida-Meza et al., 2025). Understanding and addressing psychological distress, particularly burn-out, at an organisational level rather than an individual level support

occupational outcomes (Almeida-Meza et al., 2025). Healthcare research has also shown the link between burnout and moral distress/injury (Sorina et al., 2025) and how despite it being around before the Covid-19 pandemic, it was amplified by this and still remains relevant in the post-pandemic area (Best, 2021). Moral distress/injury has also been found to be linked with anxiety, depression, PTSD (Amsalem et al., 2021), compassion fatigue within healthcare staff (Albaqwai et al.,2025). Impact of moral distress/injury on quality of patient care (higher medical errors and lower patient satisfaction) has been linked to staff struggling to focus, empathise and give consistent care (Reis et al., 2025). Moral distress/injury has often been found within studies/inquiries even when it has not been the intended focus (Best, 2021). When Leary et al (2024) looked at reasons NHS staff were leaving they found moral distress was caused by cognitive dissonance of them providing care that went against their own moral values resulted in it effecting the staffs' wellbeing. Staff tried to resolve this by working harder and longer and this led to burnout. Harding et al. (2025) also recently found that not being able to provide the quality of care that early career clinical psychologists (CP's) wanted to, was the main reason they wanted to or did end up leaving the NHS.

Due to heterogeneity in moral distress and injury measures used across studies (Griffin et al., 2025), prevalence data of moral distress and injury is therefore varied across healthcare staff, and settings due to the different measures used (Brennan et al., 2024). A recent review by Brennan et al. (2024) found a pooled prevalence rate of 45% for clinical relevant moral injury within global healthcare workers. Another recent synthesis of nursing data showed higher moral injury burden in more acute, high-intensity environments, than other clinical settings (Sorina et al., 2025). Westwood et al. (2026) review was unable to identify the prevalence data for NHS mental health staff and suggested further research is needed among this staff group.

To the authors knowledge a systematic review is yet to be conducted of all factors associated with moral distress and injury for mental health staff in the UK. In many reviews physical and mental health staff are reviewed together (Beadle et al., 2024), however they

are often working in different environments, with varying duties in their roles and with differing patient groups. Understanding the factors associated with moral distress and injury specifically within mental health staff may help mental health organisations (both NHS and independent) understand and clarify how staff can be supported and possibly improve mental health staff retention in UK's healthcare systems. Including staff from the UK' s mental health independent sector within the review was important as the independent sector makes up a core part of England's mental health provision, with one in four NHS inpatients beds being outsourced (The Kings Fund, 2025), so these staff are a key part of the workforce.

The main aim for the review was to explore the determinants of moral distress and moral injury in mental health staff working in the UK. Specifically, the research question for this review was:

What are the factors associated with moral distress/injury in mental health staff in the UK?

Understanding these factors may help to provide insight into the retention of mental health staff within the UK and it is hoped to inform support for staff mental wellbeing and inform better retention in systems like the NHS.

2. Methods

2.1. Study Design

The protocol for this review was pre-registered on the International Prospective Register of Systematic Reviews (PROSPERO) on 28th October 2025 (CRD420251054927). The review follows the guidance by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) (Page et al., 2021) (Appendix B) and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guidelines (Tong et al., 2012) (Appendix C).

2.2. Search Strategy and Information Sources

Studies were identified for this review following a systematic search for research papers by the primary reviewer (HB) on the following databases on the 29th of October 2025: Cumulative Index to Nursing and Allied Health Literature (CINAHL - Ultimate), Embase - Ovid, MEDLINE - Ultimate, PsycINFO, PsycARTICLES, Academic Search Ultimate and Web of Science. No restriction was placed on the search in terms of publication period.

The search strategy (see Appendix D) was created using keywords, MeSH terms and Boolean operators to capture all potentially relevant research and discussed in consultation with an academic librarian to ensure sensitivity.

2.3. Eligibility Criteria

Only clinical mental health staff, working in a mental health setting in the UK were included. A list of the example job roles included can be found in Appendix E.

2.3.1. Inclusion:

- studies containing mental health professionals (under allied healthcare, general mental health staff, psychological professionals),
- English language publications,
- studies using UK samples,
- quantitative studies, qualitative studies, mixed-method studies,
- peer-reviewed journal articles,
- studies including primary data (original research, not secondary data),
- studies could include trainees,
- and studies relating to the contributory factors of moral distress/injury in the identified population.

2.3.2. Exclusion:

- studies exploring the psychological concepts on patient groups,
- studies including non-mental health staff (i.e., physical healthcare, administrators, teachers),
- non-English language publications,

- studies using non-UK workforce samples,
- studies with poor descriptions of the methodology, analysis or results where key data could be extracted, grey literature (e.g., unpublished articles, conference proceedings, master's dissertations, doctoral theses, book chapters, and commissioned reports, literature reviews),
- studies referring only to prevalence statistics of moral distress/injury,
- studies referring to only post-traumatic distress (PTSD)
- and studies where the full-text was not accessible.

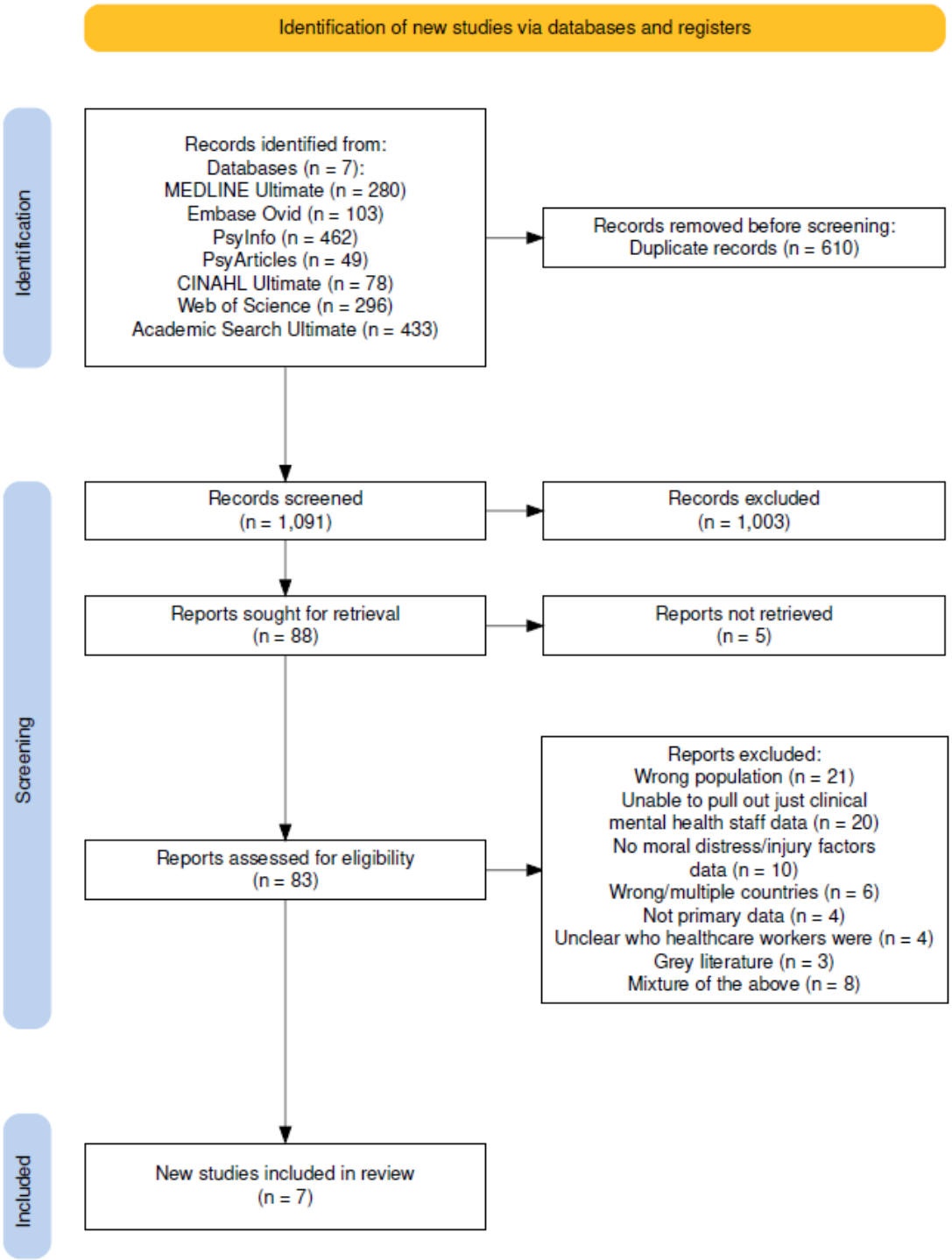
2.4. Selection Process

A total of 1,701 studies was retrieved from the database searches, and 610 duplicates were removed using Rayyan (Ouzzani et al., 2016). The titles and abstracts of 1,091 articles were then screened by the primary reviewer (HB), against the inclusion/exclusion criteria. To ensure consistency, 25% of the titles and abstract screening were independently blind rated by a second reviewer (KB). Percentage agreement was 98.2% and Cohen's Kappa was calculated as moderate (k = 0.54) for inter-rater reliability. Discrepancies were discussed between HB and KB and resolved through consensus.

The primary reviewer then completed a full-text review on the remaining 83 articles, leaving 7 articles (n=7) in the final review (see Figure 1). To ensure consistency, 25% of the full-text screening was also independently assessed by the blind second reviewer (KB). Percentage agreement was 86% and Cohen's Kappa was calculated as substantial (k = 0.64) for inter-rater reliability. Discrepancies were discussed between HB and KB and resolved through consensus.

Figure 1.

PRISMA Flow Chart (created using Haddaway et al., 2022, PRISMA2020: An R package and Shiny app for producing PRISMA 2020-compliant flow diagrams)



2.5. Data Extraction

Data were extracted by the primary reviewer for the final seven studies and can be seen in the data extraction table (Appendix F). To ensure consistency, 25% of the data extraction was independently done by a second researcher (KB). Given the narrative nature of the extracted qualitative data, the inter-rater agreement statistics were not able to be

calculated; so, consistency was ensured through independent extraction and consensus discussion.

2.6. Quality Assessment

Both reviewers (HB & KB) independently assessed the quality (rigour) of 100% of the final seven studies remaining using the Critical Appraisal Skills Programme UK (CASP) qualitative studies checklist (Critical Appraisal Skills Programme, 2024). The CASP qualitative checklist was selected as it is widely used in UK health and psychology research, endorsed by Cochrane (Noye et al., 2019), and is well aligned with interpretivist qualitative methodologies. Inter-rater agreement was evaluated using Cohen's Kappa for two items where Cohen's Kappa could be calculated (0.46 to 0.7, indicating moderate to substantial agreement). Percentage agreement was also reported for each item, and ranged between 71% to 100%. Any discrepancies were discussed and resolved through consensus.

A quality score was assigned in discussion between both reviewers according to how well the study met each criterion; 0 = not met at all, 1 = somewhat achieved, 2 = achieved. This systematic review used the same scoring system used by the Beadle et al. (2024) to assess the quality of studies using the qualitative checklist, as the CASP qualitative does not have its own cut-off score. An overall score was given to each study between 0 and 20; scores <10 were rated 'poor', scores between 10–15 'fair', scores of 16–18 'good' and scores of 19–20 'excellent'. The agreed summary of quality assessment is shown in Appendix G. All seven studies fell between 'fair to 'excellent'.

2.7. Data Synthesis

It was not possible to complete data synthesis via meta-analysis due to all the remaining studies being qualitative designs. Therefore, the qualitative findings were synthesised inductively using thematic synthesis (Thomas & Harden, 2008), to describe the factors associated with moral distress and injury in UK mental health staff. Thematic synthesis was chosen for the synthesis of this review over other qualitative syntheses as it develops new hypotheses and theory by understanding experiences and can therefore help

to inform policy change (Thomas & Harden, 2008). This systematic review can then help organisations better understand the factors associated with moral distress and injury among UK mental health staff, and may contribute to policy improvements that can help to reduce this.

Only findings directly relevant to the review question were extracted and synthesised. This included participant quotations and corresponding author interpretations. Findings not addressing the review question were not coded in the synthesis. Thomas and Harden's (2008) three step approach was used to code the data line by line, then organise codes in descriptive themes, and then interpret these to produce analytical themes. The synthesis was conducted in accordance with Cochrane guidance for qualitative evidence synthesis (QES) (Noyes et al., 2019) to show transparency in how the review was conducted and reported. Those using thematic synthesis also classify it as taking a critical realist position on the realist-idealist knowledge continuum (Barnett-Page & Thomas, 2009).

The review team regularly met to reflect on how our personal and professional backgrounds as mental health professionals (trainee/clinical psychologists and a cognitive behavioural therapist) may have influenced the study inclusion and interpretation. The review attempted to mitigate these through discussion.

3. Results

3.1. Study Characteristics

Seven qualitative studies met the inclusion criteria after full-text screening and were included in the synthesis. The studies were conducted across the UK in both NHS acute and mental health trusts and independent organisations, and in a range of mental health settings including inpatient care and community teams. The 120 participants involved were all multidisciplinary (MDT) staff such as nurses, healthcare assistants, social workers, psychiatrists, CP’s and allied health professionals. Information regarding gender, age, ethnicity, area of the UK, education level and time worked in their role was given for several of the studies. See Table 1 for details.

The studies had varied aims and used different designs (focus groups, semi-structured interviews, diaries, ethnographic study), but all discussed staff experiences of factors associated with moral distress and/or moral injury. Five studies were during or after Covid-19.

Table 1

Study Characteristics

Author (Year)	Study Design	Setting (NHS or Independent)	Sample size (gender)	Job Title	Age Range	Ethnicity	Region of the UK	Length of Service
Hegarty et al. (2022)	Qualitative interviews	14 NHS (both acute and mental health) trusts	30	Clinical frontline HCWs from the NHS CHECK study cohort. Mental health status, job role and sex recorded for all but not broken down into physical and mental health staff.	Not reported	Unclear for mental health staff only	England	Not reported
Hemmington (2024)	Qual - Ethnographic study and semi-structured interviews	Approved mental health professional service	4	Approved mental health professionals (AMHP)	Not reported	Not reported	England	Not reported
Jones and Crossley (2012)	Qualitative - focus group	NHS trust - inpatient psychiatric care	14 (six men and eight women)	Mental health professionals were made up of psychiatrists, social workers,	From early 20 to 55 years	Not reported	Wales	All had different lengths of

				occupational therapists and mental health nurses.				service and experience.
Liberati et al. (2021)	Qualitative - semi-structured interviews	NHS (inpatient and community mental health) - Community Mental Health Teams (CMHT), Early intervention for psychosis (EIP), Crisis Teams, Acute hospital wards, Secure Forensic services	35 mental health workers (19 Female, 11 Male, 5 people did not provide this information)	Psychiatrists (including 13 trainees and 4 consultants), 10 Mental health nurses (including care coordinators, clinical leads, non-clinical prescribers), 5 Psychotherapists (including CBT therapists and systemic family therapists), 3 Clinical psychologists	Not reported	24 White, 3 Asian, 2 Mixed ethnicity, 1 from 'any other ethnic group', 5 people did not provide this information	4 North East, 7 North West, 2 East Midlands, 5 West Midlands, 4 Greater London, 2 East of England, 3 South East, 3 South West, 5 people did not provide this information	Not reported

Lloyd et al. (2024)	Qualitative semi-structured interviews	Two medium-secure wards in a mental health unit	6	Barry Gaff Health-care assistant Steve Associate specialist Hana Mardi Associate specialist Medic Consultant forensic psychiatrist Jerry Nurse associate Donald Occupational therapy technical instructor	Not reported	Not reported	West Midlands	27 years 12 years 3 years 8 years 11 years 9 years
Matthews and Williamson (2016)	Multi-method qualitative approach - diaries and semi-structured interviews	Independent sector – two female secure mental health wards	10 (seven females and three males) Seven participants held undergraduate or postgraduate degrees.	Healthcare assistants	Aged between 21 years and 43 years	Not reported	England	2 permanent and 8 casual positions, who worked regularly and with a minimum of 6 months experience.

Wall et al. (2022)	Qualitative - semi-structured interviews	NHS trust	21 (nine males, twelve females)	Community mental health professionals; 13 were employed as community mental health nurses and social workers, physiotherapists, support workers and staff from managerial positions	Not reported	Not reported	North-West England	Staff had worked for the trust for different durations ranging from 1 month–31 years

3.2. Thematic Synthesis

Thematic synthesis of the data (example of synthesis coding in Appendix H) discussing moral distress and/or moral injury was extracted, coded and 15 descriptive themes emerged which were then interpreted by five analytical themes (Table 2). These themes highlight the organisational, structural, societal and relational factors associated with moral distress and/or moral injury in UK mental health staff.

Table 2

Thematic Synthesis Themes

Analytical theme	Descriptive themes
Systemic obstruction of morally valued care	• Organisational tasks over patient focus • Physical health over wellbeing • PPE affecting care • Reduced quality of care
Chronic exposure to system-level moral compromise	• Bed shortages • Resource demand • Staff compromise
Institutional betrayal and staff disposability	• Staff feeling disposable • Resource demand • Systems dictating
Internalisation of systemic failure	• Shame • Powerlessness • Guilt • Anxiety
Societal devaluation as moral context	• Societal mental health stigma

Each analytical theme will be discussed. As a collective they demonstrate how moral distress and/or moral injury among UK mental health staff is founded in structural and organisational conditions that impact ethically valued care, rather than it being about individuals responding to the challenging work. This then leaves staff feeling that it challenges their professional and moral integrity.

3.2.1. Systemic obstruction of morally valued care

Across multiple studies (Hegarty et al., 2022; Jones & Crossley, 2012; Liberati et al., 2021; Wall et al., 2022), mental health staff felt that there were many barriers to delivering the care they wanted in line with their professional values and what they considered “good” mental health support. This was a major contributing factor to moral distress.

Factors associated with this obstruction of care were having to prioritize organizational tasks over patient care. For example, Jones and Crossley (2012) participants discussed administration tasks, physical care, and ward schedules getting in the way of therapeutic rapport.

Throughout the studies completed during Covid-19 (Hegarty et al., 2022; Liberati et al., 2021; Wall et al., 2022), the focus was on mitigating physical health risk to staff and patients, and they explored how PPE affected the quality of patient’s mental health care. Liberati et al. (2021) discussed the effects of isolation for patient wellbeing, staff taking longer to attend incidents due to having to put on PPE and this leading to an increase in aggression from patients to staff. “Participants reported feelings of deep dissatisfaction with the support they were able to provide for service users during the pandemic”, (Liberati et al., 2021, p. 7) leading to moral injury.

3.2.2. Chronic exposure to system-level moral compromise

Hemmington (2024) highlighted the impact of resource demands, beds shortages, and the system feeling oppressive in nature, leading to enduring moral distress/injury for mental health staff. Approved Mental Health Professionals (AMHPs) have a very important role within the mental health system to safeguard individuals who are often at their most

vulnerable when being assessed under the mental health act. However, Hemmington (2024) found that bed shortages and sending patients miles away from their support network had an impact on AMHPs making these tough decisions.

> AMHP's are often left making decisions with the resources they have over their moral and professionals values: AMHPs are experiencing apparent paradoxes and dilemmas from servicing an ostensibly oppressive system but holding to a (more radical?) social perspective. Resources will always be limited to a lesser or greater degree, but if AMHPs follow their professional and moral codes, they cannot remain silent (Hemmington, 2024, p. 774).

3.2.3. Institutional betrayal and staff disposability

Mental health staff, similar to physical health staff in one of the studies (Hegarty et al., 2022) believed theirs and patients' needs were deprioritised by management, particularly during Covid-19 to meet admission and discharge targets. Psychotherapists were told to reduce their mental health interventions, leaving staff feeling that interventions were not adequate for complex patients' recovery. Staff felt this "led to moral conflict for mental health professionals who predicted this would exacerbate the 'revolving door of patients', leaving and reentering the system, that predated the pandemic", (Hegarty et al., 2022, p. 8). Staff also reported feeling like they were treated as disposable, leading to them feeling betrayed by the system and likely impacting their motivation.

3.2.4. Internalisation of systemic failure

As well as recognising the organisational and system factors on the impact of patient care, most of the participants in the studies were then often internalising these failures themselves (Jones & Crossley, 2012; Lloyd et al., 2024; Matthews & Williamson, 2016 & Wall et al., 2022). Staff reported feelings of shame, guilt, powerlessness, and they

questioned themselves on have they done enough. This would likely lead moral distress into moral injury.

The studies completed during the pandemic like Wall et al. (2022) showed “the governmental and organisational response to the pandemic removed CMHT staff's professional autonomy, producing feelings of powerlessness” (p. 383). However, evidence from pre-pandemic studies show how this feeling has been around for some time. Matthew and Williamson’s (2016) study reported how different participants discussed moral distress and compassion in a high-risk environment, “Lucy attempts to disengage her conscious and primal instincts to engage a professional persona. However, she struggles to disengage entirely and adopt the depersonalized approach of the organization, as she fears the consequences to both the patient and herself” (p. 1047). This highlights the difficulties of finding the right balance between organisationalism and compassion. In the most recent study Lloyd et al. (2024) discussed how positive policies like the ‘least restrictive practice’ in psychiatric inpatients can also lead to staff feeling moral distress, “perceived sense of powerlessness in situations where patients with decisional capacity made choices considered to be detrimental to their physical health condition” (p. 311).

3.2.5. Societal devaluation as moral context

Jones and Crossley, (2012) study brings the stigma of mental health care to the forefront. It highlights how not only are other professionals stigmatising against them as staff for working with mental illness, but it also is often a job that can be scrutinised by the general public and have attached feelings of shame. “Mental health professionals spoke of feeling exposed and wishing to withdraw or hide away” (Jones and Crossley, 2012, p. 134), which they discuss is illustrating moral distress due to the challenging nature of the work.

This study is important in showing the wider socio-political landscape that impacts moral distress and moral injury for mental health staff in the UK, alongside the organisational factors.

3.3. Recommendations for Mitigation

For all of the seven studies in the review, any recommendations for how moral distress and moral injury are being or could be mitigated were also extracted and can be found in Table 3 below.

Table 3

Moral Distress/Injury Mitigation Recommendations

Author (Year)	Recommendations for mitigation
Hegarty et al. (2022)	"Utilizing the supervisory relationship to help mental health professionals externalise blame for adverse patient outcomes", (p. 9).
Hemmington (2024)	"Safety and wellbeing being paramount within operational considerations and promote a culture of open and honest communication", (p. 774).
Jones and Crossley (2012)	Training, staff meetings.
Liberati et al. (2021)	"Schwartz rounds – multidisciplinary forums where staff convene to discuss their work – are rich in potential and their role (perhaps using online methods) should be evaluated further. Participants highlighted that while formal support for staff was signposted by their employers, it may not be easy to use, suggesting that availability of support may not be enough on its own and not accessing support that is nominally available can become a source of stress in its own right", (p. 10).
Lloyd et al. (2024)	"The inclusion of bioethics into professional discussions and training could provide health-care professionals with knowledge on how to achieve the right balance in their duty of care ultimately improving their well-being and the organisation's ethical climate", (p. 312).

Matthews and Williamson (2016)	"Consistent peer and professional support is considered to significantly reduce burnout and moral distress", (p. 1049).
Wall et al. (2022)	Debriefing, feelings of a collective responsibility as a team, buddy system, weekly wellbeing check ins.

4. Discussion

This review synthesised findings on factors associated with moral distress and moral injury among UK mental health staff. Seven qualitative studies met the criteria for inclusion. Findings from this review suggest moral distress and injury among UK mental health staff are more associated with system, organisational and relational constraints that impact professional and morally valued care and leave staff feeling institutionally betrayed, than it being just caused by the exposure to clinically challenging events. The findings suggest moral distress can lead to moral injury among mental healthcare staff, and that the Covid-19 may have amplified this, but that it was apparent long before this and remains after. The findings may go as far to suggest that UK mental health services have somewhat come to normalize these working conditions in both NHS services and the independent sector.

The themes from this review suggest mental health organisations have been focused on hitting targets and completing administrative tasks and this is perceived by staff as coming before the wellbeing of the staff. It goes beyond burnout to moral distress (Jameton, 1984) and then over time moral injury (BMA, 2021), as staff feel them like the can't deliver the quality of care they want to in line with their values due to many factors like time, resource, focus on physical health during Covid-19. Staff in these reviews have discussed the lack of autonomy (powerlessness) they have in making decisions, and that decisions are made top-down and staff are just expected to follow. This all leads to feelings of institutional betrayal. The articles in this review did not directly discuss clinical diagnosis such as depression and post-traumatic stress disorder (PTSD), which are often associated with

moral distress and injury in the wider healthcare literature (Amsalem et al., 2021). However, it did find emotions linked to these when staff were internalising the system failures and feeling shame, anxiety, powerlessness and guilt. The psychological discomfort that is caused can be explained by cognitive dissonance theory (Festinger, 1957) as staff know what good care looks like and they are being made to act in a way that contradicts it. Therefore, staff want to reduce this internal discomfort, so if they feel powerless this may lead to learned helplessness (Seligman, 1972) and they may leave if they feel like that's the only way they feel they can maintain their morals. Litz (2025) suggests moral injury is separate to these clinical diagnoses and as such research should look at treating it separately.

Just like the Beadle at al. (2024) systematic review on factors associated with moral distress and injury among both physical and mental health staff, worldwide, this review highlights the need for decisions of patient care to be a team decision and that moral distress sits at an organisational level. Both the reviews show how this has been seen to be normalised, expecting staff to just get on with it, especially after the Covid-19 pandemic where moral distress and injury were exacerbated.

As we know the UK mental health system is under increasing pressure, and as seen in Lord Darzi (2024) report of the NHS as a whole, managers aren’t to be blamed, as they focus on keeping the teams running day to day, mental health of the general population has deteriorated, leading to more pressure on the system and longer waiting lists etc. Therefore, to support the mental health system in the UK, it is important to look at the system as a whole, including all areas contributing to the system (NHS, private, independent sectors, charities to social care, housing, etc.). The new Fit for the Future: 10 Year Health Plan for England therefore has prevention as one of it’s primary focuses to support the UK health system, which includes working on preventing mental health problems in the UK population and supporting the wellbeing of UK mental health staff (Department of Health and Social Care, 2025).

4.1. Clinical Implications

This review draws more evidence of moral distress and injury being present among UK mental health staff and what factors are contributing to it but also suggests several ways to help start mitigating it happening or reducing it where it already exits. If moral distress and injury are not thought about within UK mental health systems, organisations, teams and the individuals, then its likely the UK mental health workforce wellbeing will continue to be impacted and that retention issues will remain.

Organisations and systems in UK mental health need to first be aware of what moral distress and moral injury are and then secondly they need to acknowledge that it likely exists within their organisation and/or teams. Thirdly, having open discussions and communication (Hemmington, 2024; Reis and Lesandrini, 2025) about it with their staff, and that they want to help reduce this. As this review and other healthcare reviews have found (Bolton et al., 2025), senior leadership support around distressing events and situations can help mitigate moral distress and injury. As other moral distress and injury reviews have found (Reis & Lesandrini, 2025) this can be done through many avenues like supervision (Hegarty et al., 2022), debriefs, check-ins, buddy system (Wall et al., 2022), peer support (Matthews & Williamson, 2016) and reflective practice/staff meetings and Schwartz rounds (Jones and Crossley, 2012; Liberati et al., 2021). Staff training was also highlighted to support staff to find the right balance between quality of care and their wellbeing (Jones and Crossley, 2012; Lloyd et al., 2024; Reis & Lesandrini, 2025). Liberati et al. (2021) also highlighted that individual staff support was not always easy to access, and this also led to further stress for individuals. Keyworth et al. (2022) suggested organisations should be clear about what staff services offer and provide training to managers so they can support staff to access these. However, how easy these suggestions are to implement is changing, due to increased financial pressures on NHS trusts and healthcare providers in recent years. The NHS mental health trusts are making difficult decisions, and cuts to services, training and recruitment have increased (Jefferies & Wickens, 2025). Ideally, in the long term, more financial

investment is needed by the government into healthcare, social care and societal factors affecting mental health in the UK, alongside improving system efficiency with artificial intelligence (Darzi, 2024). In the meantime, it might help to utilise the skills of team managers and clinical psychologists within services to support their colleagues more, but this may take time and resources away from direct patient care. However, without the time and resources given to supporting staff wellbeing, moral distress and injury will likely increase and lead to poorer retention and even poorer patient care.

4.2. Strengths, Limitations and Future Research

There are many methodological and conceptual strengths to this review. The qualitative findings give a rich description of differing examples of moral distress and injury within UK mental healthcare.

The review followed systematic and transparent Cochrane guidance from predefined inclusion criteria, data extraction and inductive thematic synthesis following Thomas and Harden (2008) to produce analytical themes that can help inform systematic change and future policy. This means findings are also reproduceable. It also identified the system, relational and societal contributions to moral distress and injury which means it doesn't pathologize the staff's responses to these challenging working environments.

The review also highlights how all areas of UK mental health services are impacted by moral distress and injury, regardless of whether they are NHS or independently run. A limitation of having all areas together in the synthesis may overlook the differences and so future research may want to look closer at the differences in different mental health settings, to be able to tailor some of the mitigation strategies needed. The term 'independent' or 'independent sector' was not used in the search terms, as when the literature was reviewed, this term did not appear to be used to describe a study or study setting. However, this may have meant some studies were missed within this review.

Several limitations of the review are the lack of quantitative research it found where the factors associated with moral distress and injury among UK mental health staff could be

differentiated from physical healthcare staff data. Many studies did not meet inclusion for the study (both quantitative and qualitative) where they had both physical and mental healthcare staff in the study, as they combined their results. This also therefore meant a lack of valid measures for moral distress and injury and other diagnostic criteria. However, there still remains a lack of suitability and agreement on what moral distress and injury measures should be used with mental health staff (Morris et al, 2022).

This review may have missed other factors associated with moral distress and injury among UK mental health staff that have not yet reached peer-review publication. Therefore, future research looking into factors associated would benefit from not only more quantitative mental health staff studies, with validated outcome measures for mental health staff being used but also should be open to other factors being missing from peer-reviewed articles.

Despite the review containing predominately good quality studies (reviewed by the CASP quality checklist), some of the themes were only supported by one study, therefore with only a small sample, and this impacts the rigour of the synthesis and the generalisability of the findings. However, this is common with a review with limited studies meeting inclusion criteria. The review also included studies where the main focus was not to explore moral distress and injury, but was an important unexpected finding. This also meant limited data on moral distress/injury in some studies.

5. Conclusions

This qualitative evidence synthesis tentatively demonstrates some of the factors associated with the cause of moral distress that sometimes led to moral injury among UK mental health staff. It suggests, alongside the nature of the work being challenging, that moral distress and injury are being shaped and sustained by system and organisation factors that have led to chronic exposure to system-level moral compromise, societal devaluation, institutional betrayal and staff feeling disposable, staff internalising this systemic failure as staff feeling like they cannot provide the quality of care they want to.

Addressing moral distress and injury in UK mental health services, therefore, requires more than just a focus on how to support individual resilience; organisations need to be aware of moral distress and injury being prevalent and widespread across all areas of UK mental healthcare, and that it may have similarities but also differences in how it impacts mental healthcare staff compared to physical healthcare staff. Then system-wide change and support is needed to help reduce and mitigate moral distress and injury. Some recommendations have been given on how to support organisations to do this through open communication within teams, training and supporting leadership. This is in addition to more appropriate resourcing, but we acknowledge that further research may be needed to help organisations know how to best implement these recommendations. With these improvements to the system, moral distress and injury is likely to decrease, and it could have positive implications on staff wellbeing, workforce retention and ultimately the quality of mental health care in the UK.

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Katie Brooke: Data screening & quality assessment.

Thomas Westwood: Conceptualisation, involvement in supervision

Dr, Rachel Russell, Dr. Sheryl Parke & Dr. Jinnie Ooi: Conceptualisation, supervision, writing (review and editing).

Highlights

- Moral distress/injury in UK mental health staff is associated with organistional, structural, societal and relational factors.
- System-wide change is needed to mitigate moral distress and injury in UK mental health staff, as well as individual resilience.

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Chapter Three: Bridging Chapter

Word Count: 546

Bridging Chapter

This chapter links the systematic review findings of the factors found to be associated with moral distress and moral injury among UK mental health staff, with the empirical paper's focus on what conditions are needed for CPs to increase their hours working in NHS commissioned services.

The synthesis of findings from the systematic review showed moral distress and injury among mental health staff were shaped and sustained by systemic and organisational issues, stopping them from delivering the quality of care that they felt morally and professionally they should. The review highlighted issues from the societal scrutiny on mental health professionals, to the staff feeling resourcing was not adequate to deliver the quality of care needed (Hemmington, 2024) and staff feeling leadership treated them as disposable and prioritised organisational tasks and targets over quality of patient care (Hegarty et al., 2022; Jones and Crossley, 2012). It also reflected the complexity of moral distress leading to long-term moral injury among mental health staff in the UK. Whilst Covid-19 led to an increased focus on physical health care of mental health patients and staff (Hegarty et al., 2022; Liberati et al., 2021 & Wall et al., 2022), the synthesis showed moral distress and injury before, during and after the pandemic. It also suggested mental health staff internalise the system failures, leaving them feeling shame, guilt and powerless (Jones & Crossley, 2012; Lloyd et al., 2024; Matthews & Williamson, 2016 & Wall et al., 2022).

As previous research has shown (Sorina et al., 2025) moral distress and injury impact mental health staff retention, and mitigating these may help improve workforce sustainability and could help to bring back professionals who have partly left the NHS already. The synthesis showed recommendations for good supervisory support, open and honest teams/cultures, importance of staff training, meetings, and feeling part of a supportive team.

With UK mental health staff being so varied across clinical professions and settings, it is likely different professionals will be impacted by different factors. Psychological therapy

within mental health services is a key area that the NHS is looking to improve on and expand its workforce. CP's bring vital skills to this provision with knowledge in assessment, formulation, evidence-based therapy, service development and supervision of other psychological professionals. However, they are a group also leaving the NHS and moving into private practice due to the 'push' factors like moral distress/injury and stress and burnout (Harding et al., 2025; Stinton et al., 2025), and recent evidence suggests CP's, especially in early career, intend to reduce their NHS hours via mixed NHS and non-NHS employment (Harding et al., 2025). There currently is a gap in the literature for how the NHS can get those CP's who have left to come back to NHS commissioned services. Research with CP's has focused so far on how to try and retain them (Harding et al., 2025). Whereas research for other health professionals like nurses and speech and language therapists (Coombs et al., 2007; Loan-Clarke et al., 2010) has already examined how to encourage those who have left to return. Therefore, the following empirical paper is aimed at exploring the next step of what conditions (organisational factors) CP's who have partly left the NHS, need to have met to increase their hours in the NHS.

Chapter Four: Empirical Paper

Prepared for submission to Mental Health & Prevention

Author Guidelines are available in Appendix I

Title: Clinical Psychology Workforce Sustainability: a Delphi survey and mini-focus group looking into the conditions needed to return to working full-time within National Health Service commissioned services

Short title: *Clinical Psychology Workforce Sustainability in the National Health Service*

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Abstract

This study explored the organisational conditions required for Clinical Psychologists (CP's) in mixed employment (seeing NHS-commissioned and private practice patients) to increase their hours within NHS-commissioned services, and whether these conditions differ by career stage.

A modified three-round Delphi survey (n = 30 in round one) looked to find a consensus on the importance of each condition suggested in previous research that looked at CP retention. A mini-focus group was then conducted to explore themes in more depth.

Thirteen of eighteen conditions reached consensus after round one (≥70%, IQR = 1) as very/extremely important for increasing NHS hours. The top six of these reached a strong consensus (≥80%, IQR 1) for; 'feeling able to delivery good quality care to service users' (93.33%), 'strong/supportive leadership/management' (90.00%), 'positive team culture' (83.33%), 'flexible working hours' (80.00%), 'opportunities for professional development' (e.g. CPD) (80.00%) and 'better working environment' (80.00%). Pay was rated very/extremely important but showed the lowest consensus after three rounds (54.54%, IQR = 2), with greater consensus and importance for early and mid-career CPs. Qualitative findings found three main themes: 1. Fostering Values-aligned Leadership and Team Culture. 2. Creating Sustainable and Flexible NHS Careers. 3. Enabling Meaningful and Ethical Psychological Practices. There was some variation in what different career stages needed to increase their NHS hours.

The findings can be explained through two occupational motivation theories. Systemic improvement is needed by the NHS to strengthen the Clinical Psychology workforce.

Keywords: clinical psychologists, national health service, organisational conditions, workforce sustainability

Data availability statement: tbc

Acknowledgments:

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No conflicts of interest to declare.

Introduction

The NHS Long Term Plan (NHS England, 2019) outlined a commitment to increasing mental health provision to an additional two million UK people between 2019/20 to 2023/24, however, funding struggled to keep up with the demand on services (Gilburt & Mallorie, 2024). The new Fit for the Future: 10 Year Health Plan for England therefore has no numeric target, but is focused on community care, digital access and prevention (Department of Health and Social Care, 2025). The UK therefore still has a gap in provision and lack of access to mental health services (Health and Social Care Committee, 2022).

According to the latest figures, 1 in 7 healthcare professionals are leaving the NHS (Weyman et al, 2023), and over 28% of NHS staff in the 2024 survey said they were thinking of leaving their organisation (Survey Coordination Centre, 2025). CPs are a key part of expanding the psychological provision within mental health services. They support and supervise wider psychological professional colleagues as well as delivering clinical interventions and leading services. Of these numbers it is unclear exactly how many of these are Clinical Psychologists (CP's).

In 2013, Knight and Proctor wrote about the increase in Psychologists numbers in the private sector 'quietly' growing. Rhodes (2019) discussed the findings of a 2019 survey conducted by the British Psychological Society (BPS), where over 5,700 members (17% of its total members) shared their views on their working lives. The survey results raised challenges with financial constraints, widespread vacancies, excessive workloads, emotional exhaustion and poor work life balance. The survey also highlighted that CPs were the group in this survey most likely to report stress and burnout. NHS England has since increased funding to the Clinical Psychology Doctorate programmes to increase places for trainee CP's (Health Education England, 2020).

After the 2019 BPS survey a Scottish health board, NHS Greater Glasgow & Clyde looked into CP's leaving their health board or reducing their hours to work privately (Tolland & Drysdale, 2022). Over 160 psychologists completed an anonymous survey (65% response

rate). Of these 160 psychologists, 21% were found to have reduced their hours in the previous three years. Seventy-one percent of participants shared the most common factor was caring responsibilities, likely due to the majority of the profession being women. This was followed by work-life balance (65%) and work-related stress (21%) being next largest reason for reduced hours. Approximately 8% of leavers in the last three years had moved to the private sector and left their NHS completely. Ten percent of staff were working part-time in the NHS and a private practice role. Another 43% of the responders planned to reduce their hours in the future, and 22% of these would do it to take on private work. The most common reasons why responders were considering leaving the NHS were financial rewards and work-life balance. Lack of career progression and work-related stress also contributed and there was mention of increased paperwork, bureaucracy of the NHS and wanting to work in different areas. They suggested to reduce the number leaving, should work on reducing work-related stress. Well-being support had increased since the Covid-19 pandemic in their health board, but they suggest CP's may not have the time to access these. A Psychology staff bank system was also suggested to increase flexibility of working hours.

Rosairo and Tiplady (2024) have however reviewed the latest data from the NHS leaver rate in the mental health workforce and Electronic Staff Record (ESR) 2023/2024 and have suggested these do not confirm this significant anecdotal loss of CPs to private practice. They suggest that the psychologist turnover is around 18%, with only 10% of leavers leaving the NHS for non-NHS commissioned services. They found data suggested the psychological workforce is growing. However, they do suggest that 'active intervention' is needed to create a compassionate and diverse workforce for the future.

When looking at the retention of mental health workforce, organisational factors and culture play a huge part in ensuring manageable workloads, staff feeling well supported and feeling able to deliver good quality care (Long et al., 2023). New research shows how stress, burnout and moral injury are leading CPs to leave the NHS for private practice (Harding et

al., 2025; Stinton et al., 2025). Harding et al. (2025) and Stinton et al. (2025) latest findings shared similarities with research conducted in other healthcare professions that NHS leavers cited excessive workload, stress/burnout, poor pay and, not feeling able to deliver quality patient care (Loan-Clarke et al., 2009; Seathu Raman et al., 2024). Interestingly, systematic reviews looking at NHS staff (Bimpong et al., 2020; Seathu Raman et al., 2024) found pay influenced job satisfaction and retention, but that improving pay alone was unlikely to improve staff retention. This has been proven during the recent increase in industrial strike action in the last four years, especially since the Covid-19 pandemic, where issues being raised are not just limited to pay but also about patient safety, staffing numbers and subsequent staff burnout (Cullen, 2022).

A work stress model that has been used to help explain how important job satisfaction is when thinking about retention (Harding et al., 2025; Stinton et all., 2025), and how burnout and poor work-life balance effect this is the Effort-Reward-Imbalance Theory (Siegrist, 1996; Siegrist et al., 2004; Siegrist & Li, 2016). The model looks at reciprocity of exchange at work, where high-cost and low gain conditions are considered stressful (Siegrist, 1996). It also combines information on extrinsic and intrinsic factors in someone's health. Therefore, high effort in combination with low reward causes strong negative emotions and stress responses with negative long-term effects on health.

Another model that can help understand the psychosocial work environment and its impact on mental healthcare professionals is the Demand-Control-Support Model, originally introduced by Karasek (1976). This model highlights the importance of balancing job demands, having control how you work and the support from the employer to help manage stress and wellbeing. Research has already shown the importance of this model in advising management strategy in supporting the well-being of British mental healthcare professionals (Wood et al., 2011).

The allied healthcare workforce research has also examined what those who have left the NHS need to return, and found returners did so due to flexible hours, work location,

professional development and pension provision (Loan-Clarke et al. (2009). Therefore, it's important to progress the research from why CPs are leaving the NHS (Harding et al., 2025; Stinton et al., 2025) to examine what support CP's who have partly left NHS services need to return to the NHS.

Current Study's Aims

This study aims to look at what conditions are needed for CPs to return to the NHS. It will be helpful to get a preliminary consensus from CPs about the main factors that would draw them out of private practice work and increase their hours in the NHS. This will help the NHS know what areas they should focus on improving to support the Clinical Psychology workforce in the NHS. The research questions for this study were:

1. What conditions (organisational factors) need to be met for CPs in mixed employment (both NHS commissioned services and private practice) to return to full-time NHS commissioned services?
2. Do these conditions differ based on career stage (e.g., early-career 0-5 years, 6-10 years, 10+ years qualified)?

Materials & Methods

Study Design

The study used a mixed-methods design and took a critical realist approach (Leung & Chung, 2019). Critical realists search for causation to help to explain social issues and recommend ways to address these (Fletcher, 2017). The study first used a quantitative online Delphi survey to gain consensus on CP conditions needed to return to the NHS. The Delphi technique is established across health research to reach consensus on issues of importance and used when there is no or little research into an area or issue (Shang, 2023). An online Delphi survey helped to remove group conformity and dominance (Nasa et al., 2021). As the research adopted a critical realist perspective it then followed with a mini-focus group, with all career stages to gain more understanding about why they have selected those conditions as needed to be met to return to the NHS.

Participants

Thirty CPs completed the Delphi survey round one (7 early career, 0-5 years qualified; 13 mid-career, 6-10 years qualified; and 10 later career, 10+ years qualified) from the 45 invited. Dropout rate of 33.33%. 25 then completed round two (5 early career, 0-5 years qualified; 11 mid-career, 6-10 years qualified; and 9 later career, 10+ years qualified), dropout rate 16.67%. Then 22 (4 early career, 0-5 years qualified; 9 mid-career, 6-10 years qualified; and 9 later career, 10+ years qualified) then completed round three of the Delphi survey, with a dropout rate of 12%.

The demographics for the Delphi participants are shown within Table 1. Overall round one of the Delphi had 90% of participants who were female, 70% were aged 30-39 years old, 76.67% were White (English, Scottish, Northern Irish or British), 70% had been in private practice for 0-5 years, 70% worked 21-20 hours a week for the NHS, 70% worked 21-37.5 hours a week for NHS and private practice. The region of the UK that CPs lived (26.67%) and worked (30%) in the most was the East of England.

The overall demographics by the end of round three were 77% were female, 63.62% were aged 30-39 years old, 81.81% were White (English, Scottish, Northern Irish or British), 59.09% had been in private practice for 0-5 years, 72.72% worked 21-30 hours a week for the NHS and 72.71% worked 21-37.5 hours a week for the NHS and private. The region of the UK that CPs lived (31.81%) and worked (36.36%) was mostly the East of England.

Participants were all asked if they were open to increasing their NHS hours, and of those completing round one of the Delphi, 36.67% said yes, 40% were undecided and 23.33% said no. Of those who completed all three rounds of the Delphi, 36.36% said yes, 50% were undecided and 13.64 said no.

The Demographics were fairly similar for each career stage in each round of the Delphi. The main variation between careers stages were the early to mid-career stage were more ethnically diverse, and they were living and working in more regions of the UK than the later career stage.

Table 1

Delphi Survey Demographics

	Round 1 (n (%))				*Round 2 (n (%))*				*Round 3 (n (%))*			
	All (n=30)	Early Career (n=7)	Mid-Career (n=13)	Late Career (n=10)	All (n=25)	Early Career (n=5)	Mid-Career (n=11)	Late Career (n=9)	All (n=22)	Early Career (n=4)	Mid-Career (n=9)	Late Career (n=9)
Gender												
Female	27 (90)	6 (85.71)	13 (100)	8 (80)	22 (88)	4 (80)	11 (100)	7 (77.78)	19 (86.36)	3 (75)	9 (100)	7 (77.78)
Male	3 (10)	1 (14.29)	0 (0)	2 (20)	3 (12)	1 (20)	0 (0)	2 (22)	3 (13.63)	1 (25)	0 (0)	2 (22.22)
Age (years)												
30-34	13 (43.33)	5 (71.42)	3 (23.08)	0 (0)	6 (24)	4 (80)	2 (18.18)	0 (0)	5 (22.72)	3 (75)	2 (22)	0 (0)
35-39	8 (26.67)	2 (28.57)	9 (69.23)	2 (20)	11 (44)	1 (20)	8 (72.72)	2 (22.22)	9 (40.90)	1 (25)	6 (66.67)	2 (22)
40-44	3 (10)	0 (0)	1 (7.70)	2 (20)	2 (8)	0 (0)	1 (9.09)	1 (11.11)	2 (9.09)	0 (0)	1 (11.11)	1 (11.11)
45-49	3 (10)	0 (0)	0 (0)	3 (30)	3 (12)	0 (0)	0 (0)	3 (33.33)	3 (13.64)	0 (0)	0 (0)	3 (33.33)
50-54	1 (3.33)	0 (0)	0 (0)	1 (10)	1 (4)	0 (0)	0 (0)	1 (11.11)	1 (4.54)	0 (0)	0 (0)	1 (11.11)
55-59	1 (3.33)	0 (0)	0 (0)	1 (10)	1 (4)	0 (0)	0 (0)	1 (11.11)	1 (4.54)	0 (0)	0 (0)	1 (11.11)

60-64	1 (3.33)	0 (0)	0 (0)	1 (10)	1 (4)	0 (0)	0 (0)	1 (11.11)	1 (4.54)	0 (0)	0 (0)	1 (11.11)
Ethnicity												
White - English, Scottish, Northern Irish or British	23 (76.67)	5 (71.42)	8 (61.54)	10 (100)	20 (80)	4 (80)	7 (63.63)	9 (100)	18 (81.81)	3 (75)	6 (66.67)	9 (100)
White - Irish	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
Any other White background	2 (6.67)	0 (0)	2 (15.38)	0 (0)	2 (8)	0 (0)	2 (18.18)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
Asian or Asian British - Indian	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
White and Black African	1 (3.33)	1 (14.29)	0 (0)	0 (0)	1 (4)	1 (20)	0 (0)	0 (0)	1 (4.54)	1 (25)	0 (0)	0 (0)
Caribbean	1 (3.33)	0 (0)	1 (7.70)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Any other mixed or multiple ethnic background	1 (3.33)	1 (14.29)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Years Qualified												
0-5	7 (23.33)	7 (100)	-	-	5 (20)	5 (100)	-	-	4 (18.18)	4 (100)	-	-

6-10	13 (43.33)	-	13 (100)	-	9 (36)	-	9 (100)	-	9 (40.90)	-	9 (100)	-
10+	10 (33.33)	-	-	10 (100)	11 (44)	-	-	11 (100)	9 (40.90)	-	-	9 (100)
Region of the UK (live)												
East of England	8 (26.67)	2 (28.57)	1 (7.70)	5 (50)	8 (32)	2 (40)	1 (9.09)	5 (55.56)	7 (31.81)	2 (50)	0 (0)	5 (55.56)
London	6 (20)	2 (28.57)	2 (15.38)	2 (20)	5 (20)	1 (20)	2 (18.18)	2 (22.22)	5 (22.72)	1 (25)	2 (22)	2 (22)
Midlands	2 (6.67)	1 (14.29)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
North East	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
North West	5 (16.67)	1 (14.29)	3 (23.08)	1 (10)	2 (8)	1 (20)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
Scotland	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
South East	6 (20)	1 (14.29)	4 (30.77)	1 (10)	6 (24)	1 (20)	4 (36.36)	1 (11.11)	6 (27.27)	1 (25)	4 (44.44)	1 (11.11)
South West	1 (3.33)	0 (0)	0 (0)	1 (10)	1 (4)	0 (0)	0 (0)	1 (11.11)	1 (4.54)	0 (0)	0 (0)	1 (11.11)

Region of the UK (work)												
East of England	9 (30)	2 (28.57)	2 (15.38)	5 (50)	9 (36)	2 (40)	2 (18.18)	5 (55.56)	8 (36.36)	2 (50)	1 (11.11)	5 (55.56)
London	5 (16.67)	2 (28.57)	1 (7.70)	2 (20)	4 (16)	1 (20)	1 (9.09)	2 (22.22)	4 (18.18)	1 (25)	1 (11.11)	2 (22)
Midlands	3 (10)	1 (14.29)	1 (7.70)	1 (10)	2 (8)	0 (0)	1 (9.09)	1 (11.11)	1 (4.54)	0 (0)	0 (0)	1 (11.11)
North East	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
North West	5 (16.67)	1 (14.29)	3 (23.08)	1 (10)	2 (8)	1 (20)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
Scotland	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
South East	4 (13.33)	1 (14.29)	3 (23.08)	0 (0)	4 (16)	1 (20)	3 (27.27)	0 (0)	4 (18.18)	1 (25)	3 (33.33)	0 (0)
South West	2 (6.67)	0 (0)	1 (7.70)	1 (10)	2 (8)	0 (0)	1 (9.09)	1 (11.11)	2 (9.09)	0 (0)	1 (11.11)	1 (11.11)
How long in part-time in private practice (years)												

0-5	21 (70)	7 (100)	9 (69.23)	5 (50)	16 (64)	5 (100)	7 (63.63)	4 (44.44)	13 (59.09)	4 (100)	5 (55.56)	4 (44.44)
6-10	4 (13.33)	0 (0)	3 (23.08)	1 (10)	4 (16)	0 (0)	3 (27.27)	1 (11.11)	4 (18.18)	0 (0)	3 (33.33)	1 (11.11)
11-15	4 (13.33)	0 (0)	1 (7.70)	3 (30)	4 (16)	0 (0)	1 (9.09)	3 (33.33)	4 (18.18)	0 (0)	1 (11.11)	3 (33.33)
26-30	1 (3.33)	0 (0)	0 (0)	1 (10)	1 (4)	0 (0)	0 (0)	1 (11.11)	1 (4.54)	0 (0)	0 (0)	1 (11.11)
Hours a week for NHS and private												
0-10	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
11-20	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
21-30	8 (26.67)	2 (28.57)	2 (15.38)	5 (50)	8 (32)	2 (40)	2 (18.18)	4 (44.44)	7 (31.81)	1 (25)	2 (22)	4 (44.44)
31-37.5	13 (43.33)	4 (57.14)	6 (46.15)	3 (30)	10 (40)	2 (40)	5 (45.45)	3 (33.33)	9 (40.90)	2 (50)	4 (44.44)	3 (33.33)
More than 37.5	6 (20)	1 (14.29)	3 (23.08)	2 (20)	5 (20)	1 (20)	2 (18.18)	2 (22.22)	5 (22.72)	1 (25)	2 (22)	2 (22)

Hours a week for NHS												
0-5	1 (3.33)	0 (0)	0 (0)	1 (10)	1 (4)	0 (0)	0 (0)	1 (11.11)	1 (4.54)	0 (0)	0 (0)	1 (11.11)
11-15	1 (3.33)	0 (0)	1 (7.70)	0 (0)	1 (4)	0 (0)	1 (9.09)	0 (0)	1 (4.54)	0 (0)	1 (11.11)	0 (0)
16-20	5 (16.67)	0 (0)	2 (15.38)	3 (30)	3 (12)	0 (0)	1 (9.09)	2 (22.22)	2 (9.09)	0 (0)	0 (0)	2 (22)
21-25	9 (30)	3 (42.86)	3 (23.08)	3 (30)	9 (30)	3 (60)	3 (27.27)	3 (33.33)	8 (36.36)	2 (50)	3 (33.33)	3 (33.33)
26-30	12 (40)	4 (57.14)	6 (46.15)	2 (20)	9 (30)	2 (40)	5 (45.45)	2 (22.22)	8 (36.36)	2 (50)	4 (44.44)	2 (22)
30+	2 (6.67)	0 (0)	1 (7.70)	1 (10)	2 (8)	0 (0)	1 (9.09)	1 (11.11)	2 (9.09)	0 (0)	1 (11.11)	1 (11.11)
Open to increasing NHS hours												
Yes	11 (36.67)	3 (42.86)	4 (30.77)	4 (40)	11 (44)	2 (40)	4 (36.36)	4 (44.44)	8 (36.36)	2 (50)	2 (22)	4 (44.44)
No	7 (23.33)	1 (14.29)	4 (30.77)	2 (20)	3 (12)	1 (20)	2 (18.18)	1 (11.11)	3 (13.64)	0 (0)	2 (22)	1 (11.11)

I'm undecided	12 (40)	3 (42.86)	5 (38.46)	4 (40)	11 (44)	2 (40)	5 (45.45)	4 (44.44)	11 (50)	2 (50)	5 (55.56)	4 (44.44)

Three CP's took part in the mini-focus group after completing the Delphi rounds, (1 early career, 0-5 years qualified and 2 later career, 10+ years qualified). The demographics for the mini-focus participants are shown within Table 2. There was no mid-career stage taking part in the mini-focus group, four had shown interest but were unable to attend the group on the date/time it was run, and the subsequent dates/times offered for an alternative group.

Table 2

Mini-Focus Group Demographics

	N (%)
Gender	
Female	1 (33.33%)
Male	2 (66.66%)
Age (years)	
35-39	2 (66.66%)
50-54	1 (33.33%)
Ethnicity	
White - English, Scottish, Northern Irish or British	3 (100%)
Years Qualified	
0-5	1 (33.33%)
10+	2 (66.66%)
Region of the UK (live)	
East of England	3 (100%)
Region of the UK (work)	
East of England	3 (100%)
How long in part-time in private practice (years)	
0-5	2 (66.66%)
26-30	1 (33.33%)
Hours a week for NHS and private	
21-30	1 (33.33%)
More than 37.5	2 (66.66%)
Hours a week for NHS	
0-5	1 (33.33%)
16-20	1 (33.33%)
26-30	1 (33.33%)
Open to increasing NHS hours	
Yes	1 (33.33%)
I'm undecided	2 (66.66%)

In line with the Delphi rounds the majority of the mini-focus group participants (two of them, 66.66%) were in their thirties and had worked 0-5 years in private practice (66.66%). All three were living and working in the East of England (100%) and were White (English, Scottish, Northern Irish or British). In contrast to the Delphi rounds, two of them (66.66%) were male, were undecided about being open to increasing their NHS hours (66.66%), and worked more than 37.5 hours a week for NHS and private (66.66%). They all worked differing hours for the NHS, ranging from 0-30 hours a week.

Inclusion Criteria

Participants were qualified CPs registered with the Health and Care Professions Council (HCPC) in the United Kingdom. The CPs were working part-time in NHS commissioned services (this may have include charities or private companies commissioned to see NHS patients) and part-time in private practice (self-funding or private health insurance cover). The BPS defines early career CPs as those who have qualified within the last 5 years (K. Seisay, personal communication, April 12, 2023).

Exclusion Criteria

CP's working full time in the NHS, part-time in the NHS and part-time in research or academic roles, or full time in private practice were excluded. CP's working in academia and research are seen as a key part of the process of training the new Clinical Psychology workforce and contributing to evidence-based treatment. CP's who have entirely left the NHS may have different conditions needed to return to the NHS. So, for the purposes of this study, they were not included but could be important to look at in future research.

Measures

Demographic Information

The participants' age, gender identity, ethnicity, current region they live and work in the UK and time since qualifying as a CP were collected via the survey as demographic information. These demographic categories are based on those asked by the UK

government in the 2021 consensus and held by the Office of National Statistics (2024). They provide a context in which the findings were interpreted.

Delphi Survey

The Delphi was an online, internet-based survey created on Microsoft Forms (Appendix J). This is the most efficient and cost-effective way to deliver a Delphi survey and helps for a quick turn-around of analysis and can reduce drop-out rates (Shang, 2023). This study used a modified Delphi method (Avella, 2016; Custer et al., 1999), following Nasa et al. (2021) quality assessment (Appendix K) where a quantitative survey was created by researchers to start round one. The survey questions were based on the results from two projects (Harding et al., 2025. & Stinton et al., 2025) looking into reasons why CPs choose to stay or leave the NHS. Their questionnaire and interview topic guide was developed from the Weyman et al. (2023) findings about the reasons NHS staff chose to stay or leave the NHS. Questions for this Delphi survey were also based on reviewing private practice job descriptions and company benefits, and findings from the Tolland and Drysdale (2022) survey of CP's choosing to leave a Scottish health board.

Patient and public involvement (PPI) members also reviewed the survey and advertising poster before ethics was submitted, to make sure it is user friendly. These PPI members were CP's that met the study's inclusion criteria (i.e., CP's working in mixed employment). The survey was kept as condensed as possible, as the higher number of items on a Delphi survey the lower the response rate (Gargon et al., 2019). The survey used a five item Likert-scale (ordinal data), as this is the most commonly used Likert-scale, and most popular by participants (Lange et al., 2020).

Mini-Focus Groups

A topic guide (Appendix L) was developed after the last Delphi round with questions to be explored in the mini-focus groups. The questions asked about why they believe the top conditions selected are most important and how they will help support the Clinical Psychology workforce. Questions were also asked around if they felt important conditions

were not asked about in the Delphi survey. PPI members again reviewed the questions and themes to be asked about in the focus groups.

Procedure

Ethical Considerations

Ethical approval for the study was granted by UEA's Faculty of Medicine and Health Sciences Research Ethics Committee (ETH2526-1205; Appendix M). Ethics was also considered in line with the British Psychological Society's (2021) Code of Human Research Ethics. Participants gave informed consent after reading the participant information sheet before completing the Delphi survey (Appendix N) and again before completing the mini-focus groups (Appendix O & P). A debrief form was provided to participants at the end of the survey (Appendix Q), as not everyone would be taking part in the focus groups, and at the end of the mini-focus groups (Appendix R).

Recruitment

The participants were recruited via purposive sampling through social media platforms, such as LinkedIn, Facebook, WhatsApp and Instagram, and within the professional networks such as the Psychological Professionals Network. The study was also advertised via email by the research team to contacts within NHS trusts from UEA emails. CP's who had also signed up to a participation pool for the clinical psychology sustainability working group at UEA were sent a copy of the research advertising poster. There is no defined number of participants for Delphi surveys, but research does suggest between 30-50 participants is sufficient for a homogenous Delphi (Nasa et al., 2021), so recruitment allowed room for potential dropouts between Delphi rounds.

Three participants were needed for a focus group to be feasible (Morgan, 1997) therefore, the group would be a mini-focus group as coined by Krueger and Casey (2014). However, if possible, five participants were preferable, as five to seven were in each group in the Canessa et al. (2022) focus groups conducted after the Delphi rounds.

Delphi Method

Participants showed their interest in the study by clicking on the online link/QR code on the advert for the study (Appendix S, Figure 1) between July and October 2025, which took them to a Microsoft Form where they could opt-in (Appendix T) to the study by leaving their email address, career stage (early career being 0-5 years or 6-10 years or 10+ years), confirming they worked part-time for NHS commissioned services and part-time private and providing their HCPC registration number to be checked and verified to reduce fraud/bots. Time taken to fill out the opt-in form was also checked by the lead researcher to reduce fraud/bots going through to the Delphi round. Recruitment closed in October 2025. Out of the 59 participants who opted into the study via the advertisement link, 45 were deemed to be eligible to take part (HCPC registered CP's, and not bots). These 45 participants were then sent an email (Appendix U) with a link to the participant information sheet one. After reading this, participants were asked to complete consent form one, which then proceeded with the demographic questionnaire and the Delphi survey presented on a Likert scale. They were also be given the choice to participate in an hour-long mini-focus group after the Delphi survey was complete. At the end of the final survey participants were presented with debrief form one.

After each Delphi round results were analysed, and individual and group results were shared back with participants, within 2 weeks, as the latest guidance by Hohmann et al., (2025) recommends. They were asked to complete the survey again (Appendix V & W) and reconsider their previous ratings if there didn't appear to be a consensus (Shang, 2023). Reminder emails were sent each round to remind participants to complete the survey, this increases response rates (Gargon et al., 2019). There were three rounds of the Delphi survey, open for two weeks at a time (from October 2025 to December 2025), with the aim for a participant consensus of 70-80% to try and find the top conditions needed for CPs to return full-time to the NHS. Due to the time constraints of the thesis project and recent Delphi guidelines (Hohmann et al., 2025) suggested limiting the Delphi to three rounds, it was possible that it may not have reached an ideal consensus of 70-80%. A consensus of

50% is reported in some Delphi studies (Nasa et al., 2021) and so was seen as the minimal percentage needed for consensus in this study after three rounds, which all conditions reached. To further analyse a strong consensus then conditions that had over an 80% consensus and an interquartile range (IQR) of 1 or less was seen as a “strong” consensus (von der Gracht, 2012). An IQR of 1 or less shows at least half of responses fell within a single point on the Likert-scale.

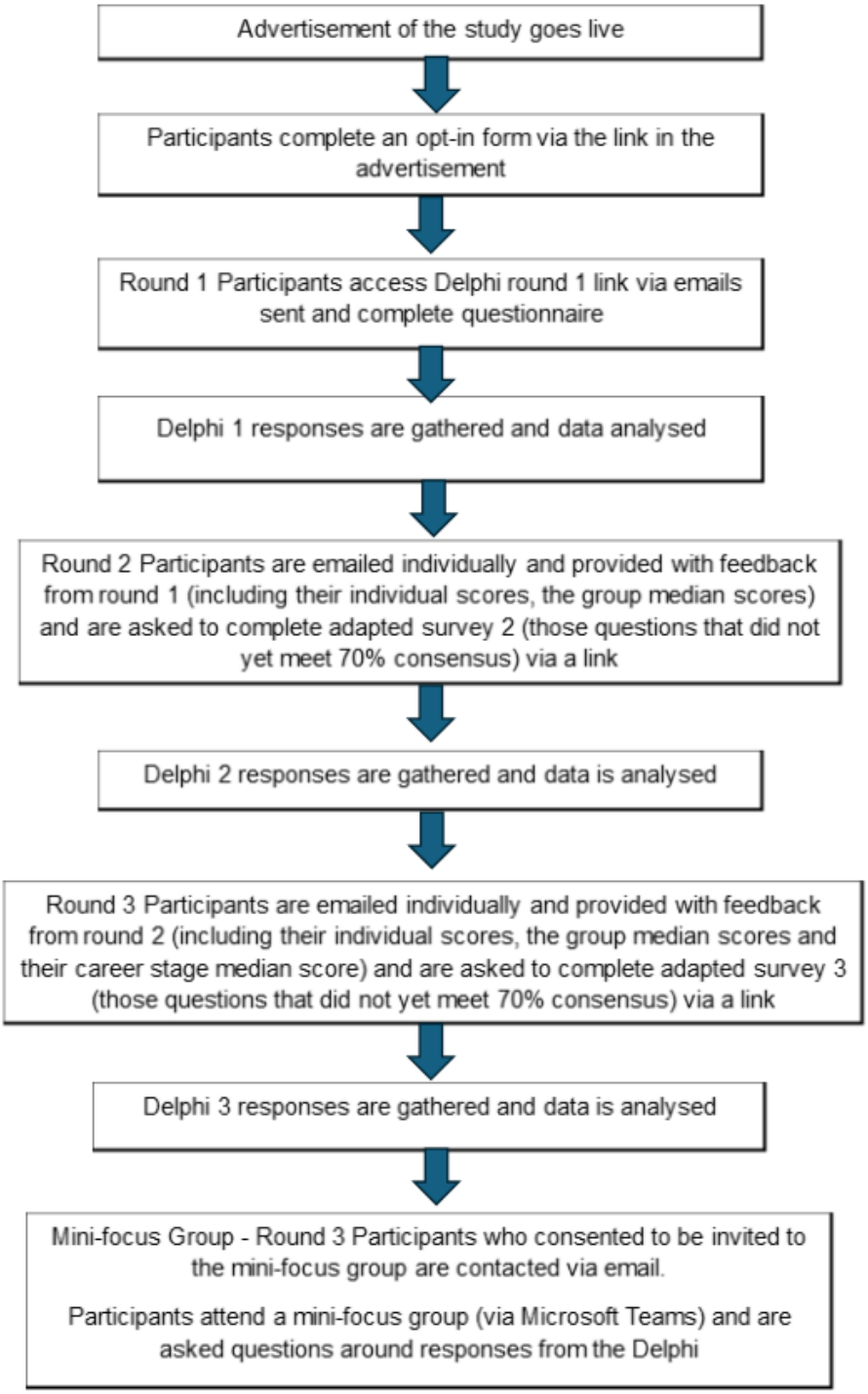
Mini-focus Groups

After the Delphi rounds had taken place and a consensus was reached, a one hour mini-focus group took place, with all career stages, of participants who had given permission at the end of the survey. Participants were invited to the mini-focus group via email (Appendix X), and several dates were offered to maximise the amount who could attend the group at the same time.

The mini-focus group took place over Microsoft Teams and was recorded and transcribed. In the invite email participants were asked to read a second participant information sheet and sign a second consent form. A debrief form was shown to participants at the end of the mini-focus group. Each participant that took part in the mini-focus group was sent an Amazon voucher worth £10 as a token of appreciation for taking part in the extra 1 hour of the study. The Delphi survey time is shorter and can be done in their own time, and as participants are paid clinicians it can be classed their CPD time, therefore participants did not receive a token of appreciation for their time at that point.

Figure 1

Diagram of the Procedure



Analysis

Demographics

The demographics were analysed using descriptive statistics.

Delphi Survey

The Delphi survey data were collected via Microsoft Forms and downloaded and analysed on a Microsoft Excel spreadsheet. It looked to see if a consensus of 70-80% had been met for the whole group, within one of three categories on the 5-point Likert scale (Not important at all, Somewhat to Moderately Important, or Very Important to Extremely Important), as this is the widely adopted and considered to be rigorous (Shang, 2023). 50% was also taken as an acceptable consensus if 70% was not reached by the third and final round. The interquartile range was also measured to see the spread of the data and the median score (Shang, 2023; Jünger et al., 2017) was reported for each condition and fed back to participants in the next round.

Analysis also examined whether there was a difference in consensus percentages, medians, and interquartile ranges between each career stage group (early career, 0-5 years; mid-career, 5-10 years; and later career, 10+ years).

Mini-Focus Groups

The mini-focus groups transcript was taken from Microsoft Teams and cleaned on Microsoft Word and then analysed using inductive Reflective Thematic Analysis (RTA) (Braun and Clarke, 2006), on Microsoft Excel. RTA works well within a critical realist paradigm as it interprets the shared experiences of the CP's that are shaped by the healthcare system they are in. Thematic Analysis followed Braun and Clarke's (2006) six-step process of;

1) Familiarisation with the dataset
2) Coding
3) Generating initial themes
4) Developing and reviewing themes
5) Refining, defining and naming themes
6) Writing up

A second researcher (SP) reviewed 50% of the codes created by the primary researcher (HB) to counter any inter-rater reliability issues. Any differences in opinion in

coding were discussed with the primary researcher and resolved through discussion. Themes and subthemes were also discussed during supervision discussions to help refine and define the themes. For transparency and credibility, The Consolidated Criteria for Reporting Qualitative Research (COREQ) (Appendix Y) was completed (Tong et al., 2007).

The analysis was completed through the lens of the lead researcher being a trainee clinical psychologist, supervised by qualified CPs; therefore, this may have influenced the interpretation of findings through this lived experience lens.

Results

Delphi

The Delphi survey results are shown in Table 3 for all three rounds. After round one 13/18 conditions reached an overall consensus of 70% or over, and had an IQR of 1, for an importance of very/extremely important for these conditions to be met for CPs to increase their hours within the NHS. The top six of these all reached an overall consensus of 80% and over, with an IQR of 1, showing a 'strong' consensus; 'feeling able to delivery good quality care to service users' (93.33%), 'strong/supportive leadership/management' (90.00%), 'positive team culture' (83.33%), 'flexible working hours' (80.00%), 'opportunities for professional development' (e.g. CPD) (80.00%) and 'better working environment (e.g. better access to therapy rooms/desk space)' (80.00%).

After round two of the Delphi the condition 'support for physical health' reached an overall consensus of 84% (IQR of 1 but with an importance rating of only somewhat/moderately important. The condition 'increased staffing levels' also reached an overall consensus of 80.00%, but a higher importance of very/extremely important.

After round three of the Delphi, the conditions; 'support for mental health' reached an overall consensus of 72.72%, (IQR of 1) as being somewhat/moderately important and 'Benefits such as: Medical/life insurance, HCPC registration paid for, indemnity insurance paid for, company car, free onsite parking, gym membership' reached an overall consensus of 59.09%, (IQR of 1) as being somewhat/moderately important. Finally, the condition with

the least overall consensus, ‘better pay’, at 54.54% (IQR 2), was however found to be very/extremely important. After the three rounds, every condition met the minimum consensus of 50% for some level of importance.

There was some variation in consensus and importance across career stages. ‘Manageable workload’ and ‘hybrid working’ were less important (somewhat/moderately important) for later career stages than early to mid-career stages (very/extremely important). Mid-career stage did not reach an acceptable consensus level of 50% when it came to how important they saw the ‘benefits’ condition. The condition ‘better pay’ appeared to be more important to early and mid-career stages (very/extremely important) than the later career stage (somewhat/moderately important).

Table 3

Delphi Survey Results

Conditions	Median (IQR) and % Round 1				Median (IQR) and % Round 2				Median (IQR) and % Round 3				Overall % Consensus (Importance Rating)
	All	Early Career	Mid-Career	Late Career	All	Early Career	Mid-Career	Late Career	All	Early Career	Mid-Career	Late Career	
Feel able to deliver good quality care to service users	5 (1) 93.33% very/extremely important	5 (1) 100% very/extremely important	5 (1) 92.31% very/extremely important	5 (1) 90.00% very/extremely important	x	x	x	x	x	x	x	x	93.33% (very/extremely important)
Strong/supportive leadership/management	5 (1) 90% very/extremely important	4 (1) 100% very/extremely	4 (1) 84.62% very/extremely	5 (1) 90.00% very/extremely	x	x	x	x	x	x	x	x	90.00% (very/extremely important)

	important	important	important										
Positive team culture	5 (1) 83.33% very/extremely important	4 (2) 71.43% very/extremely important	5 (0) 84.62% very/extremely important	5 (1) 90.00% very/extremely important	x	x	x	x	x	x	x	x	83.33% (very/extremely important)
Flexible working hours	5 (1) 80% very/extremely important	5 (1) 85.71% very/extremely important	5 (0) 92.31% very/extremely important	5 (2) 60.00% very/extremely important	x	x	x	x	x	x	x	x	80.00% (very/ extremely important)

Opportunities for professional development (e.g. CPD)	4 (1) 80% very/extremely important	4 (1) 85.71% very/extremely important	4 (1) 84.62% very/extremely important	4 (1) 70.00% very/extremely important	x	x	x	x	x	x	x	x	80.00% (very/extremely important)
Better working environment (e.g. better access to therapy rooms/desk space)	4 (1) 80.00% very/extremely important	5 (1) 100% very/extremely important	4 (2) 69.23% very/extremely important	4 (0) 80.00% very/extremely important	x	x	x	x	x	x	x	x	80.00% (very/extremely important)
Manageable workload	5 (1) 76.67%	5 (0) 100%	5 (1) 92.31%	3 (2) 60.00%	x	x	x	x	x	x	x	x	76.67% (very/extremely important)

	very/extremely important	very/extremely important	very/extremely important	Somewhat/moderately important									
Opportunities for career progression (e.g. leadership)	4 (1) 76.67% very/extremely important	4 (1) 71.43% very/extremely important	5 (1) 76.92% very/extremely important	4 (1) 80.00% very/extremely important	x	x	x	x	x	x	x	x	76.67% (very/extremely important)
Hybrid working (home and office)	5 (1) 76.67% very/extremely important	4 (1) 85.71% very/extremely important	5 (1) 100.00% very/extremely important	3 (2) 50.00% somewhat/moderately important	x	x	x	x	x	x	x	x	76.67% (very/extremely important)

				important									
Reduced bureaucracy	4 (1) 76.67% very/extremely important	5 (1) 85.71% very/extremely important	4 (1) 84.62% very/extremely important	4 (2) 60.00% very/extremely important	x	x	x	x	x	x	x	x	76.67% (very/extremely important)
Supportive supervision	5 (2) 73.33% very/extremely important	5 (1) 85.71% very/extremely important	4 (2) 61.54% very/extremely important	5 (1) 80.00% very/extremely important	x	x	x	x	x	x	x	x	73.33% (very/ extremely important)
Fits with childcare/family	4 (2) 73.33%	4 (2) 57.14%	5 (1) 76.92%	4 (1) 80.00%	x	x	x	x	x	x	x	x	73.33% (very/extremely important)

responsibilities	very/extremely important	very/extremely important	very/extremely important	very/extremely important									
Good pension	4 (2) 70.00% very/extremely important	4 (1) 85.71% very/extremely important	4 (2) 61.54% very/extremely important	4 (1) 70.00% very/extremely important	x	x	x	x	x	x	x	x	70.00% (very/extremely important)
Support for physical health	3 (2) 60.00% somewhat/moderately important	3 (2) 57.14% somewhat/moderately important	3 (2) 61.54% somewhat/moderately important	3 (1) 60.00% somewhat/moderately important	3 (1) 84.00% somewhat/moderately important	3 (0) 100.00% somewhat/moderately important	3 (2) 63.63% somewhat/moderately important	3 (1) 81.81% somewhat/moderately important	x	x	x	x	84.00% (somewhat/moderately important)

Increased staffing levels	4 (2) 66.67% very/extremely important	4 (2) 71.43% very/extremely important	5 (1) 76.92% very/extremely important	4 (1) 50.00% very/extremely important	4 (1) 80.00% very/extremely important	4 (1) 100.00% very/extremely important	5 (2) 72.72% very/extremely important	4 (0) 77.77% very/extremely important	x	x	x	x	80.00% (very/extremely important)
Support for mental health	3 (2) 43.33% very/extremely important	4 (1) 85.75% very/extremely important	3 (0) 76.92% somewhat/moderately important	3 (2) 40.00% somewhat/moderately and very/extremely important	3 (2) 52.00% somewhat/moderately important	4 (0) 80.00% very/extremely important	3 (2) 63.63% somewhat/moderately important	3 (2) 55.00% somewhat/moderately important	3 (1) 72.72% somewhat/moderately important	4 (1) 50.00% somewhat/moderately and very/extremely important	3 (1) 88.88% somewhat/moderately important	3 (1) 67.00% somewhat/moderately important	72.72% (somewhat/moderately) important

Benefits such as: Medical/life insurance, HCPC registration paid for, indemnity insurance paid for, company car, free onsite parking, gym membership	3 (2) 46.67% very/extremely important	4 (1) 57.14% very/extremely important	4 (3) 61.54% very/extremely important	3 (1) 60.00% somewhat/moderately important	3 (1) 48.00% somewhat/moderately important	3 (1) 60.00% somewhat/moderately important	4 (2) 63.63% very/extremely important	3 (1) 77.77% somewhat/moderately important	3 (1) 59.09% somewhat/moderately important	3 (1) 75.00% somewhat/moderately important	3 (2) 44.44% very/extremely important	2 (1) 78.00% somewhat/moderately important	59.09% (somewhat/moderately important)
Better pay	4 (2) 63.33%	5 (1) 100%	5 (1) 76.92%	3 (0) 70.00%	4 (2) 64.00%	5 (1) 100.00%	4 (1) 81.81%	3 (0) 66.66%	4 (2) 54.54%	5 (1) 100.00%	4 (1) 88.88%	3 (0) 89.00%	54.54% (very/extremely important)

very/extr emely important	very/extr emely important	very/extr emely important	somewh at/moder ately important	very/extr emely important	very/extr emely important	very/extr emely important	somewh at/moder ately important	very/extr emely important	very/extr emely important	very/extr emely important	somewh at/moder ately important

Mini-Focus Groups

RTA found that CP's willingness to return to full-time NHS work is contingent on whether organisational conditions allow them to practise psychology in ways that are ethically aligned, clinically meaningful, and sustainable across career stages.

Three themes with additional subthemes were constructed from the mini-focus group data (see Appendix Z for an example). Where relevant, differences across career stages (0–5 years; 6–10 years; 10+ years qualified) are discussed within the themes.

Table 4

Thematic Analysis Themes

Theme	Subtheme
1. Fostering Values-aligned Leadership and Team Cultures	1.1 Alignment with NHS Values and Moral Commitment to Public Healthcare
	1.2 Supportive and Psychologically Safe Teams
	1.3 Leadership that Recognises and Invests in Psychology
2. Creating Sustainable and Flexible NHS Careers	2.1 Flexible Working Across the Lifespan
	2.2 Workload Expectations that Protect Wellbeing
	2.3 Stability and Long-Term Security
3. Enabling Meaningful and Ethical Psychological Practice	3.1 Protected and Valued Clinical Practice
	3.2 Balancing Service Targets with Quality of Care
	3.3 Appropriate Resourcing to Reduce Moral Distress

1. Fostering Values-aligned Leadership and Team Cultures

Whether or not CPs would increase their NHS hours was also dependant on different NHS trusts valuing psychology, having safe and supportive team cultures and whether their values aligned with the trusts' values.

1.1 Alignment with NHS Values and Moral Commitment to Public Healthcare

CPs discussed the origins of the NHS in post-war Britain and how they believed in its free at point of access set-up and took pride in being part of this system for what it stood for. They felt public and political opinions on the NHS have reduced their/the national pride in the NHS and they felt it was important this was addressed. The CP's felt grateful for their clinical training to be funded by the NHS and felt it was important they gave back to the NHS for this, by working for the NHS and supervising trainees. Being able to contribute and shape the future psychological workforce was seen a motivator to increase their NHS hours.

> A later career CP stated: Another reason why I would continue working in the NHS and maybe potentially increase my hours is that I am aware of privilege in terms of having my training paid for by the NHS and I always have a trainee on placement and I. Yeah. I feel like it's important for me to give back and to support trainees and with lots of psychologists leaving the NHS, there's less experienced psychologists offering placements (Late 1).

CP's felt uncomfortable with the fact their private work was normally only accessed by those who could afford it, and that they may not be the ones who are in the most need of their support. Therefore, a push to increasing their hours comes from CP's wanting to support everybody who needs it. "I would rather probably put more time into the NHS working with people who couldn't afford to pay just because I naturally thought feel more motivated, I think. So yeah, it's difficult." (Late 1)

1.2 Supportive and Psychologically Safe Teams

All career stages agreed on the importance of compassionate teams, who share similar values and can work collaboratively together in a psychologically safe environment was important to staff retention and would be the important factors needed for them to want to increase their NHS hours. CP's felt more motivated to attend work in the NHS when they were working in a good, supportive team. "I think just like same core values really I love like working collaboratively with people, working hard, being compassionate, that kind of thing" (Late 1).

Later career stages raised their concerns the impact remote working has on team morale and preferred in-person to develop and maintain team connection.

1.3 Leadership that Recognises and Invests in Psychology

CPs acknowledged the variation in trusts leadership and how they value the skills a CP can bring to the organisation and individual teams. A trust's reputation around this and the support it offers to CP's to best deliver their care dramatically impacts whether or not CP's want to increase their NHS in certain areas of the country. "I've never worked in (***) trust, but there have been jobs that I could have applied to increase my NHS hours in (***) trust that I haven't gone for because of what I've heard" (Late 1).

They also noted how a lack of support or understanding about what CP's offer and need would lead to experienced CP's leaving trusts and taking with them their experience. Early career CP's and other staff being supervised by these more experienced staff who have left then miss out. "Psychology being held in mind and supported and understood from local to to global levels within a system" (Early 1).

2. Creating Sustainable and Flexible NHS Careers

CPs are looking for sustainable careers that can adapt to their changing life circumstances and do not lead to burnout. "It's a bit hierarchy of needs, isn't it? But you need, you need to know that you've got a reliable pastry, don't you?" (Late 2).

2.1 Flexible Working Across the Lifespan

Numerous factors were discussed by CP's about how a more flexible job role around their changing personal responsibilities; like hours worked, childcare/caring responsibilities were important to help them continue to work in NHS teams or think about increasing their hours. Private work enabled a lot more flexibility.

> A later career CPs shared: I think I've got to a point where I would increase my NHS hours again if something came up that that would fit and have some of the flexibility that I'd have with private practise. But I did the private work just because with timing of being in a part-time job that having children starting school and having a bit more time, it just fit around my kind of childcare commitments and that things look a bit different now (Late 1).

2.2 Workload Expectations that Protect Wellbeing

CP's felt the NHS culture often relied on them and their colleagues working long hours, more than they were paid, to be able to offer the complex care their patients needed. This reliance on the goodwill of staff led to burnout cultures.

> An early CP discussed this: I think the NHS we all know the NHS is funded by you know goodwill from the staff and I think it's become more and more apparent you know with the strikes over the years and where things are and you know when that good will gets burn out and withdrawn, you know, we see what happens if you know, it compounds the crumbling of the system (Early 1).

The stressed teams are then often more rigid in their approach at times like these "stressed teams and people become more rigid and inflexible" (Early 1).

It would be important for the NHS culture to stop relying on staff working unpaid overtime and have clear boundaries and appropriate job plans. “...I’d need to have boundaries...I wouldn't leave work until 7pm and it was just part of the culture” (Late 2).

There was a felt sense from CP’s that clinicians now are more likely to prioritise their wellbeing and so this impact where/how they work.

> An early CP discussed: even though I know the NHS looked different 20 years ago, but people would maybe be more likely just to slog it out and just keep going, whereas it feels like now you get more people...people are definitely prioritising well-being over some of the other reasons for working in the NHS...the struggle to have enough time with a good clinical supervisor and you know space to sit and you know resources...we know what is helpful for us, maybe that's what's reflected in what's rated higher, you know those are the things that would actually make a change (Early 1).

2.3 Stability and Long-Term Security

Historically CP’s felt the NHS offered a more stable and secure long-term career. “...it used to be thought of as the NHS you get a job in the NHS and it's a job for life. And I don't think that's necessarily true anymore” (Late 2). The CP’s felt that the NHS no longer was a “job for life” (Late 2) due to funding issues and changes, leading to redundancies when the NHS services have not been recommissioned and have been outsourced. This has led to CP’s having to work then outside of the NHS and not by choice “...so many services are farmed out to other providers” (Late 2).

Strengths the NHS still offer in terms of security is a good pension scheme, “private pensions, they're not as good. It is quite a good deal with the NHS” (Late 2), despite the previous scheme recognising the emotional burden of the work better.

> Later CPs looked back on the pension changes: Although people don't get mental health officer status anymore, I missed that by a few years... I think it was 55 or something. You could retire because they acknowledged the work is really quite hard and has a detrimental impact, kind of the emotional labour and kind of carrying being amongst other people in states of mental distress (Late 2).

> One CP said the NHS pension would be a reason they would increase their hours in the NHS: And I think that that would be why another reason why I'd go increase my NHS hours again...I could work more hours under the right conditions and then it would mean I'd be paying more into my pension for later on (Late 1).

Receiving sickness absence pay also helped retain CP's and also would encourage them to increase their NHS hours. Pay was also discussed as being a consideration for CP's returning to the NHS, as it often offered more stable income than private work. Pay was considered to be "decent" in the NHS by later career stages and less so by earlier career stages. However, an increase in pay being offered by the NHS would not increase CP's hours in the NHS if it didn't come with clear boundaries. CPs recognised and held some moral discomfort with them being paid more than other disciplines who are also impacted by the conditions in the NHS. "I would love to be paid more in the NHS, but I also don't think I wouldn't expect to be based on the reality and also the, you know, my colleagues" (Early 1)."...thinking about the privilege that we have and to get paid a decent wage and that that goes up" (Late 2).

CPs were not as motivated to return to the NHS if the NHS started offering more benefits such HCPC registration or DBS checks. "Would I move back to the NHS for having my, enhanced DBS paid for? No" (Late 2). "So yeah, to me like it would be crazy if we got HCPC registration paid for" (Late 1).

One CP liked the stability that working part-time in private and the NHS gave them.

3. Enabling Meaningful and Ethical Psychological Practice

For CPs to return to full-time NHS work the mini-focus group identified CP's need to be able to practice psychology in ways that are meaningful and align with their ethical practice.

3.1 Protected and Valued Clinical Practice

CPs wanted more time for therapeutic work and noted this reduced with career progression in the NHS, as the role became more management and strategy driven. "In order to progress in the NHS you often get further and further away from the clinical work and that's the stuff I like" (Late 2).

Private work enabled the CPs to spend time doing the clinical work they enjoyed. "I like being with people and hearing their stories. That is genuinely such a privilege and that's one of the things that I got to do less in the NHS because it was meetings, so many meetings" (Late 2).

Private work also enabled them to develop their therapeutic skills (early career) and feel more contained.

> The early career CP discussed: There's just so much more complexity to learn and the adapting and using the skills and you know the further training and things you need... refining the skills that I'd only touched on in training, could refine them and use them within the clinical private practice (Early 1).

> Later career stage acknowledged that private work was helping them to maintain their clinical skills: I'd worked in community services for erm eight years. And then I moved into an inpatient role and I kind of because I did a lot of the kind of this individual therapy whilst I was working in the community, I just, I didn't want to lose some of those skills, so the private work wasn't like the reason why I started doing

> the private work, but it also helped me keep up some of those kind of intervention skills, I guess (Late 1).

CP's felt that their private therapeutic work was helping to motivate them to do their other NHS work. "And then that gives you the energy to go into your NHS job and hopefully have a bit more emotional capacity to do, do it well and to not get overwhelmed and burnt out doing it" (Late 1). They did however recognise that private work often felt more rewarding at times due to less complexity and the client being motivated to make change and the CP then seeing this change.

> CP's need to be able to see the difference their work makes, and this is harder to do in the NHS, as there are less clear feedback loops: Wanting to be people who are helpful to others and so often the NHS, how it is or just working your way up, often at the main part of the job, it just maybe feels like you sometimes feel like how am I helping people or you don't see the direct impact often of the work you do. Whereas I think often in private practise because what we said people being paying, being motivated, being ready most of the time anyway, you see the results and it feels like you are helping people (Late 1).

CP's felt their skills in service design and formulation often weren't in line with NHS service requirements and funding.

> One CP talked about how they were involved in a new service design: Thinking together about ways in which we could meet the clinical need, knowing full well that you're probably not going to pay a consultant clinical psychologist to have a bit of a chat with someone, but actually they really need someone to have a bit of a chat with them (Late 2).

3.2 Balancing Service Targets with Quality of Care

The mini-focus group participants found the NHS' focus on data outcomes and managing large waiting lists, often meant the culture was to deliver 'good enough care' to the masses but the data did not always reflect meaningful change."It seems to be more emphasis on managing waiting lists and discharging people and not necessarily, decisions being clinically led" (Late 2)."Data for data's sake." (Early 1).

> The early CP discussed this further: I think to try and drive quality and change, it's become very, very much driven by data and proxies of good practice. But what we know working in there and seeing it is actually that doesn't actually change anything, or that doesn't mean what you think it's mean or that statistic it's not, you can't interpret that way... the emphasis on, you know, good enough care considering the population (Early 1).

3.3 Appropriate Resourcing to Reduce Moral Distress

When thinking about 'good enough care', CP's often felt that staffing, funding and thresholds into services being higher often didn't align with their values and what they wanted to be able to deliver to patients. "You know, kind of we can't, can't get perfect care because it's going to pull resources away from others, but actually within private, you are able to take a more individualised approach" (Early 1)."I think that the thresholds have perhaps gone up and I don't know, I don't know how we meet, I feel a bit politically, I feel a bit panicky about meeting the needs of people" (Late 2).

CP's felt patients would miss out on helpful interventions or conversations/formulations with a CP if it did not align with what the service offered. This would leave CP's feeling demoralised and hopeless at times.

> Early career CP discussed this further: I was going to say it's a lot of energy, isn't it? It's a lot of like, you're motivating them through your motivational systems, and that's a lot, isn't it? And, you know, keep chucking that away. It's kind of where does that? Where do you get the energy? So it can be, can be feel a really thankless, hopeless task at times plus, then all the system issues with NHS. I think that's that can be very demoralising (Early 1).

Again, these factors led to the reasons they had started private work in the first place.

Discussion

In summary, this study took, to the authors knowledge, the first steps towards exploring what conditions Clinical Psychological need met for them to increase their NHS hours supporting NHS commissioned patients. Data was gathered from CP's working part-time in the NHS and part-time private, from all different career stages (early career; 0-5 years qualified; mid-career, 6-10 years qualified; and later career, 10+ years qualified). The study also identified whether these conditions differed between career stages. Data consensus was reached using the Delphi method on the most important conditions needed to be met for CPs to increase their NHS hours. A mini-focus group was then used with some of the same CPs from the Delphi to gather richer data around why these were the important conditions needed by the CP's and to capture any important factors the Delphi may not have asked about.

Like previous research into why CPs are leaving the NHS (Harding et al., 2025; Stinton et al., 2025) this study suggests that CP's increasing their hours in the NHS is more in line with organisational changes than CP's intrinsic motivations like money (Bimpong et al, 2020). The results can be understood through these two organisational motivation theories; Effort–Reward Imbalance (ERI) Theory (Siegrist, 1996; Siegrist et al., 2004; Siegrist & Li, 2016), Demand–Control–Support Model (Karasek, 1976).

The results from the Delphi and mini-focus group were consistent with other job roles research in healthcare retention that it's also important for CP's to be able to 'deliver good quality care to their service users' (Loan-Clarke et al., 2009), have 'strong/supportive leadership', a 'positive team culture', 'flexible working hours' and 'professional development' (Bimpong et al., 2020), alongside having appropriate resourcing like 'staffing levels' and a 'manageable workload' and a 'better working environment (e.g. therapy rooms/desk spaces) for them to feel that they can do their job well and have a longevity in the NHS.

The biggest consensus given by CPs of what they needed to increase their NHS hours, with an importance of 'very/extremely', was 'being able to deliver quality care to patients'. The mini-focus further elaborated on this and also discussed the importance of how quality care is measured and there was a strong sense of number targets for admissions, discharges, etc not adequately capturing this and instead putting a lot of extra pressure on teams and often resulting in poorer quality of care (Reis & Lesandrini, 2025). The mini-focus group also highlighted the links between different conditions rated in the Delphi like quality of care provided, and CP's having enough resource, time, quality supervision, clinical time with patients and CPD time to build and harness their skills, especially therapeutically.

The Demand–Control–Support Model (Karasek, 1976) may help explain the importance of CP's feeling they have some control over their work. It would help explain such a high consensus after one round of the Delphi on why it feels important that they can give quality care to patients, and again the need for supportive leadership, supervision and teams and manageable workloads. If the workload is too high and their control and support is low, so CP's do not feel like they are giving good quality care in line with their values, then the model suggest this impacts their psychological wellbeing, so CPs would be less likely to increase their NHS hours unless this imbalance is addressed by the NHS.

The ERI theory would suggest that reward may be experienced as more than just financial within mental healthcare and relational factors like strong supportive leadership and a positive team culture, as well as career opportunities, security and recognition may be

seen as just as rewarding and therefore motivating. So then if workload and the push to meet organisational targets is more than the reward of supportive leaders, supervision, team, CPD etc, then there is an imbalance and so will impact on CP's wellbeing and may be more likely for them to leave the NHS to private practice. Therefore, it would be important for the NHS to try and restore this balance between effort and reward together to help retention and increase CP's hours in the NHS.

Like other job roles in the NHS (NHS England, 2023), CP's need the NHS to provide sustainability for the job role, to reduce moral distress and burnout in what is a highly emotional burdensome role. CPs in this study suggest job plans need to be more boundaried and flexible for CP's, so they can make this job work around caring responsibilities and their own wellbeing. There are already guidelines suggested by the BPS around what psychologists job plans should look like (Lavender et al., 2023), therefore making sure teams are using these existing guidelines within the CP NHS job plans may be important.

What differentiates CPs from other mental health staff are skills in service development and evaluation, as well as clinical skills in formulation, therapy (British Psychological Society, 2019; Health and Care Professions Council, 2023). The mini-focus group discussed wider systems, funders and senior leadership using these skills and allowing them to shape services with evidence-based support and evaluation, putting quality of care at the forefront of what the NHS offer its patients.

The NHS Pension scheme has long been a positive for staff working within the NHS and this study highlights its continued pull factor (Loan-Clarke et al., 2009) for CPs to remain or increase their hours in the NHS. Therefore, the pension scheme is something the NHS must protect and continue to offer to help with retention, as it provides staff with future stability.

The results also suggest a variation in what different career stages need from the NHS, to increase their NHS hours. Opinions about monetary incentives like more pay and benefits like their HCPC registration being paid for varied between CP's and between CPs'

different career stages. Early to mid-career stages did think ‘better pay’ was an important factor in increasing their hours in the NHS. Some explanations for this could be CP’s trying to establish themselves personally and save for housing and planning for children after years of them likely holding lower paid jobs than their peers who left University in other careers. Later career stages showed a stronger emphasis on maintaining some degree of clinical work and wanting to give back to the CP workforce by supporting trainees and early career CPs.

A key factor raised in the mini-focus group that was not asked about in the Delphi survey was the political pressures on the NHS, and the impact this and society has on its view of the NHS and then how staff feel about working for the NHS. Latest surveys show public opinion of the NHS is down, the British Social Attitudes survey 1 in 5 people (21%) in 2024 were satisfied with the way the NHS runs with is the highest level of dissatisfaction since the survey began in 1983 (Taylor et al., 2025). The latest NHS staff survey also shows how staff scores in morale may have improved since Covid-19 (Survey Coordination Centre, 2025) but strike action has remained as the workforce thinks improvements need to be made.

CPs recognised the privilege that they hold in that they can work privately, which not all their MDT colleagues can do as easily. However, a key factor raised in the mini-focus group that the Delphi survey didn’t reflect is the importance of CP’s wanting to give back to their profession by supporting with supervising trainees. This incentivises the CPs to increase their hours in the NHS to do this, as this is where most CP’s train. This implies that CPs are conscious about their profession’s workforce sustainability and know the important part the NHS played in both their training and the future of the CP training in the UK, therefore this is an important factor to help retain and help return CPs to the NHS.

Despite variation in consensus and importance of some of the conditions in the Delphi survey, what was clear from the results of this study is that not one was rated as ‘not important at all’ and there are many factors needing change to encourage CPs to increase

their NHS hours. CP's do understand the complexities of the NHS and that change in the culture in NHS mental services, to be able to provide a compassionate and psychologically safe environment for all mental health staff will take time. This will, however, help to sustain the retention and return of those who have left the NHS, including CPs.

Strengths and Clinical Implications

There are many strengths of the study, in that the Delphi captured the views and similarities and differences of different career stages within the CP's working part-time for the NHS and part-time private. The strong consensus (IQR = 1) for most conditions shows a strong agreement across all career stages. This strengthens the confidence in these findings as preliminary workforce indicators and that there is much that can be improved within the NHS that will appeal to all CP career stages.

The study had a heavy PPI involvement both within the Delphi survey creation, which was also based on previous studies findings (Harding et al., 2025 & Weyman et al., 2023), and within the creation of the topic guide for the mini-focus group. The PPI involvement ranged from supporting with the wording of the survey, to the addition of conditions not previously included in the survey ('reduced bureaucracy') and questions to ask within the mini-focus group that looked to understand more depth behind the conditions meeting consensus.

The conditions that reached the highest consensus and importance in the Delphi and were further supported as themes discussed within the mini-focus group were organisational conditions and cultures that would enable better quality of care and a supportive environment, and personal incentives like financial were secondary. Therefore, the NHS retention strategies must look to prioritise quality of care of patients, strong compassionate leadership (Bailey & West, 2022; Worline & Dutton (2017), adequate resourcing/staffing, psychologically safe team working and adequate working spaces. As reviews in healthcare have found, levels of burnout (Nagle et al, 2024), and moral distress have a direct impact of staffing retention (Beadle et al., 2024). This study was not directly looking at these factors,

but they were evidenced as reasons CPs had left the NHS and unless conditions in the NHS improved, they may also impact the likelihood CPs would return to the NHS to work more hours. As the CPs in the mini-focus group acknowledged, CPs know they are privileged in the fact they can go and work privately, which other MDT colleagues may not be able to do or do as easily. So, when trying to support their own wellbeing, CP's have been able to do this by working privately part-time. If the NHS wants to retain staff, then supporting the wellbeing of the staff is extremely important. Other factors like CPD opportunities, boundaried and flexible working are key in supporting CP career sustainability and longevity in the NHS, and these have been named as key areas of focus for the new Fit for the Future: 10-Year Health Plan for England (Department of Health and Social Care, 2025).

When targeting recruitment for different positions at different agenda for change banding levels this study would suggest the Band 7 or preceptorship roles into a Band 8a, earlier career roles in the NHS may benefit from making time for CPD training to improve their skills after training, a supportive team, work that feels contained, and having good quality supervision are protected within the job plan. Pay was also more of factor for early to mid-career stages, and so it would suggest pay at these lower bandings for psychologists needs to be adequate for the CP's cost of living, and to support young families. When targeting recruitment for those higher banded 8b/c/d roles, then the NHS may want to protect time for CP's to still have clinical time with service users (i.e. join roles across NHS services), as well as their important contribution to leadership and service design and improvement.

Psychological principles and psychology staff need to be embedded from a national perspective to local service development (Brudenell, 2026), and so the retainment of Clinical Psychologists within the NHS should be a very important part of the NHS 10 Year Plan. Delays on the publication of the new NHS workforce plan delaying the plan to support staff like Clinical Psychologists and is therefore impacting the delay in the system and cultural change needed in the NHS to also improve patient care (Brudenell, 2026).

Limitations and Future Research

The study had several limitations, the first like most Delphi's is the retainment of participants from one round to the next. 22 CPs were retained for three rounds of the Delphi study, from the 30 starting in round one (overall drop-out rate of 26.67%). However, this dropout rate is in line with research that suggests 20 to 30 may be sufficient for groups such as clinicians (Manyara et al., 2024). Naturalistic drop off due to busy workloads appeared to be factor that some emailed as a reason for their drop out both in the Delphi and for not being able to take part in the mini-focus group. Therefore, this impacted the study not being able to have 3 separate career stage mini-focus groups as originally planned. To encourage retainment, regular reminder emails were sent between Delphi rounds and before the mini-focus group and several alternative dates were offered for the mini-focus group, unfortunately only one was able to run due to variability in the CP's availability. The mini-focus group that ran was limited to three CP's, with no mid-career stage, therefore this may skew the themes created towards an early and later career focus and may have missed important reasons behind the Delphi consensus, as they were the largest career stage involved in the first Delphi round.

Another limitation of the study was lack of diversity in the study. The majority of CPs in the Delphi were in their 30's (70% in round one) and this is younger than the UK's national average of Practitioner Psychologists in their 40's (HCPC, 2023). The majority of the CP's involved in the Delphi were White (English, Scottish, Northern Irish or British) (76.67%) and all involved in the mini-focus group were. The Delphi may reflect the numbers in the wider Practitioner Psychologist workforce (77%) (HCPC, 2023), but it may also have missed key cultural differences for CP retention within the NHS. The study also did not collect any demographic information around sexuality, caring responsibilities which may be helpful data to collect in future studies. Future studies may want to look to see if there is any variation in what conditions CP's needs to be met for them in the NHS, in terms of differing demographics, outside of what career stage they fall into, like this study did. New research

by Westwood et al. (2026) have found working-class CPs are aligned with NHS values but this caused fractures between them and the system. Future studies would benefit from a wider drive to have more participants from across the different UK regions, to again see if this impacted what CP's need from the NHS. It would also be helpful to next explore what conditions CPs would need who have entirely left the NHS to be able to return, as these could look very different to those who still have a 'foot in the door' like the participants of this study who still worked part-time in the NHS.

This study gives the first, to the authors knowledge, ideas around what CP's who work part-time for the NHS and private need from the NHS for them to increase their hours. Natural progression would be to also look at what CP's who have left the NHS entirely would need from the NHS to consider returning. Also to look at CP's who choose to work part-time in academia and for the NHS or private, as these groups were excluded from this preliminary study. More qualitative studies that understand how the NHS can improve leadership, team culture and psychological safety would also feel like the next step in supporting the NHS to make these organisational changes to support not only the CP workforce, but maybe other psychological therapies and wider MDT colleagues. More in-depth qualitative studies looking at the differences in what different career stages need would also be a helpful future avenue for research.

Conclusion

Without systematic improvement in the NHS, better pay alone is not going to be sufficient for CPs to reduce their hours in private practice, to increase the hours they work with NHS commissioned patients. Despite there being some variation in consensus and importance of conditions for different career stages, overall, there was a strong consensus found for many conditions in this preliminary study. Conditions around quality of care, leadership, positive and supportive teams and cultures, flexibility and professional development suggest where the organisational improvements can be made. Addressing these changes may help improve retention and the return of CPs to the NHS, and it may

possibly also support other MDT colleagues, at varying career stage, to increase their hours in the NHS.

Key Points:

- Systemic improvement is needed by the NHS to strengthen the Clinical Psychology workforce.
- There is variability within career stages as to what Clinical Psychologists need for workforce sustainability
- Giving care to patients in line with Clinical Psychologists values is important for retention.
- Other conditions around leadership, positive and supportive teams and cultures, flexibility and professional development suggest where the organisational improvements can be made.

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Chapter Five: Extended Methodology

Word count: 1,342

Extended Methodology

This extra chapter provides further details for the empirical and systematic review papers' methodologies, which could not be included in their word counts for paper submission. It will discuss the portfolio's ontological and epistemological stance, and the rationale for the Delphi method and the mini-focus groups. It will also provide further details on the procedure for data collection and the reflexivity and rigour of qualitative findings.

Ontology and Epistemology

Before the research project began, I (the lead researcher) established that my ontological and epistemological stance aligns with the critical realist paradigm. Therefore, the ontology of a critical realist assumes that participants' experiences are shaped by underlying mechanisms that are real (NHS systems, culture etc) but not observable (Bhaskar, 1975, 1979; Sayer 2000). Epistemologically, the research then takes an interpretative stance, where researchers theorise about the participants' experience to try and understand what is going on underneath. This means that qualitative findings across the portfolio offer meaningful but partial insights into the experiences of CP's and mental health worker in the UK, and the research team theorise the mechanisms that underpin these (Fletcher 2017).

RTA aligns with critical realism by treating the themes created as interpretative constructions and supporting both semantic and latent analysis (Braun & Clarke, 2006). The mini-focus groups are socially co-constructed expressions of shared experience (Morgan, 1997). The systematic review thematic synthesis tries to identify the recurring mechanisms across the seven qualitative studies (Thomas & Harden, 2008). Critical realism provides the philosophical foundation for integrating these methods and brings together lived experience and the systematic factors that shape it.

Rationale for the Delphi and Mini-Focus groups

The use of a Delphi study in health research has become more prominent, and it uses experts to help reach a consensus on important issues (Shang, 2023). It helps to start

building research in an untouched area like how we can support CPs to return to the NHS, and it can contribute to clinical guidelines and policy (Nasa et al., 2021). It has many advantages from anonymity, controlled feedback, gathering experts' opinions from a wide geographical area, and flexibility for the choice of method and analysis (Shang, 2023). This does create some uncertainty around defining consensus (Shang 2023), and it does have ongoing difficulties with retention size.

There are different forms of a Delphi, but most are now online and involve 2 or 3 rounds for consensus. This study adopted a “modified Delphi” approach, which instead of the “classic Delphi” where traditionally the 1st round is qualitative, with open-ended questions (Shang, 2023), this Delphi went straight in with a quantitative survey already designed from exploring the literature, reviewing private job descriptions and looking a previous surveys exploring ‘push’ and ‘pull’ factors for CPs from the NHS. We also had PPI to help review the survey before it went live.

To make sure this study was not missing key conditions as to what would help CP’s return to the NHS, the mini-focus group after the Delphi was set up to bring further rigour to the study by allowing the CP’s to discuss the results of the Delphi and share their opinions on why these factors were important and also gave a chance for them to share anything the survey may have missed. The mini-focus group being via Microsoft Teams, allowed CPs from all over the UK to be able to take part, and also take less time out of the busy schedules of the NHS CPs. It also allowed the mini-focus group to be easily recorded and transcribed and stored securely. The benefits of a mini-focus group over separate individual interviews where; it allowed CPs involved to feed off each other's ideas and this can lead to new thoughts and ideas being shared (Morgan, 1997). However, researchers were aware this could also have led to some CP’s not feeling able to share their views if others dominated the conversation (Morgan, 1997), especially if they knew other CPs in the group or were at different career stages and therefore may have held more or less power than

others. Therefore, in the PIS 2, and at the start of the mini-focus group, participants were reminded they may know colleagues and that they could leave at any time.

Another limitation of a focus group is having enough participants to take part on the day. Morgan (1997) suggest over recruiting by 20% if possible, and accepting ‘mini-focus groups’ (Krueger & Casey, 2014); with as little as two members in (Fern, 2001).

Procedure Changes to the Mini-Focus Groups

The original procedure for the study was to have three separate mini-focus groups, one for each career stage. However, after round three of the Delphi, only one participant from the early career stage had shown interest in taking part in a mini-focus group, therefore this group could not be offered. Many attempts were made via email prompts to encourage those (n=10) who had shown interest from the mid and later career stages, to attend a mini-focus group for an offered date and time. Not enough CPs from each career stage were able to attend the same date/time, therefore, an amendment was made to the study procedure to offer a combined mini-focus group with all career stages, to improve the chances that some CP’s could attend a group on the same date and time. This led to a mini-focus group with 3 CP’s (one early career and two later career), which is justified when participants are experts in the topic being discussed (Morgan, 1997; Rowe & Frewer, 2019). Four mid-career CPs were still interested in taking part, so another mini-focus group was agreed with two of them, as Fern (2001) stated a mini-focus group can take part with just two members. Unfortunately, this mini-focus group did not go ahead, after a cancellation and no show on the day.

Reflexivity and Rigour of Qualitative Findings

As with most qualitative research methods, it is important to understand the influence of the researcher, and in particular, the moderator of the mini-focus group, and the researcher doing the analysis, has on the data collected (Morgan, 1997) and the themes produced (Braun & Clarke, 2023). It's important to show transparency, reflexivity and rigour

to show the trustworthiness of the research and to allow it to be insightful (Ahmed et al., 2025).

It was important the lead researcher, as an NHS Trainee CP, and the rest of the research team (CP's), were aware of this when exploring the experience of CP's and what they need from the NHS to support the UK workforce. Whilst it was a positive that the research team are knowledgeable and have lived experience within this research area, it could have potentially introduced bias, such as preconceived ideas of expected findings. Therefore, it was important to acknowledge and limit this where possible (Braun & Clarke, 2023). One example is members of the research team knew a participant taking part in the study. To try and mitigate the potential impact of this researchers made sure the protocol was followed, treated participants' equitably, reflected on data to ensure interpretations were grounded in the data and influenced as little as possible by any prior knowledge. Other ways the research team limited bias was by introducing PPI members who supported with the Delphi survey construction and topic guide, and having a second reviewer within the systematic review (Cognitive Behavioural Therapist). Supervision meetings as a research team also helped when reviewing and refining both sets of qualitative themes for the systematic review and empirical study (Noble & Smith, 2015).

To support the transparency of data analysis both the systematic review and the empirical study followed published guidance for thematic synthesis (Thomas & Harden, 2008), and for reflective thematic analysis (Braun & Clarke, 2006). To also support the rigour of the portfolio the Consolidated criteria for reporting qualitative research (COREQ) checklist (Tong et al., 2007) was used for reporting for the mini-focus group in the empirical study. The Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guidelines (Tong et al., 2012) was used for the thematic synthesis.

Chapter Six: General Discussion and Critical Evaluation

Word count: 2,501

General Discussion and Critical Evaluation

This final chapter of the portfolio will summarise the findings from both the systematic review and empirical paper. The findings will be interpreted in relation to the wider literature and evidence-base. Reflections will also be given of the research process as a whole. Strengths and limitations of the thesis portfolio will be discussed, as well as clinical implications and areas suggested for future research. The portfolio will then close with the overall conclusions drawn.

Overview of the Results

The thesis portfolio set out to explore the factors contributing to the sustainability of the mental health workforce in the UK. A qualitative systematic review and thematic synthesis of seven peer-reviewed papers was completed, which explored the factors associated with moral distress and injury among UK mental health staff. This was followed by an empirical project which focused on the workforce sustainability of CPs, and what conditions CPs working in split roles between NHS and private practice would need to increase their part-time hours in the NHS. This was done via a modified Delphi survey, followed by a mini-focus group.

Systematic Review

The systematic review and thematic synthesis (Thomas & Harden, 2008) identified seven papers that met criteria for inclusion. Five analytical themes emerged highlighting the organisational, structural, societal and relational factors associated with moral distress and/or moral injury in UK mental health staff; 1) Systemic obstruction of morally valued care, 2) Chronic exposure to system-level moral compromise, 3) Institutional betrayal and staff disposability, 4) Internalisation of systemic failure and 5) Societal devaluation as moral context.

The findings highlighted how moral distress and injury in mental health staff in the UK is more linked with institutional betrayal than being just caused by the exposure to clinically challenging events. The findings suggest that the Covid-19 pandemic may have amplified

this, but that it was apparent long before this and remains after. The findings may go as far to suggest that UK mental health services have somewhat come to normalize these working conditions.

Empirical Paper

The empirical paper's modified Delphi survey found a strong consensus for many conditions needed for CPs to increase their hours in the NHS. The top six of these rated as very/extremely important (≥80%, IQR 1) were; 'feeling able to delivery good quality care to service users' (93.33%), 'strong/supportive leadership/management' (90.00%), 'positive team culture' (83.33%), 'flexible working hours' (80.00%), 'opportunities for professional development' (e.g. CPD) (80.00%) and 'better working environment' (80.00%). Pay was rated very/extremely important but showed the lowest consensus after three rounds (54.54%, IQR = 2), with greater consensus and importance for early and mid-career CPs. This shows the importance of not looking at CPs as a homogenous group.

Qualitative findings from the mini-focus group found three main themes using Reflective Thematic Analysis (RTA) (Braun and Clarke, 2006): 1. Fostering Values-aligned Leadership and Team Culture. 2. Creating Sustainable and Flexible NHS Careers. 3. Enabling Meaningful and Ethical Psychological Practices. Both parts of the study showed there was some variation in what different career stages needed to increase their NHS hours.

Interpretation of the findings in relation to theory and literature

The findings from the mental health staff papers identified in the systematic review drew many similarities with wider healthcare research identifying the wider system and organisation having the biggest impact on moral distress and injury in the workforce (Beadle et al., 2024). It also highlighted how staff internalise the feelings of guilt, anxiety, powerlessness and shame when they could not then provide the care they wanted to in line with their values. Although not directly discussed in the papers, this could lead to clinical diagnoses of anxiety, depression, even PTSD, as found in wider healthcare research

(Amsalem et al., 2021). Cognitive dissonance (Festinger, 1957) explains the mental discomfort humans feel when their values and beliefs conflict with their behaviour. If staff then feel they have little control over changing this, learned helplessness (Seligman, 1972), they feel hopeless that they are unable to influence systemic pressure and may leave their jobs, impacting workforce retention.

Similarly, the empirical paper focusing on CPs in the mental health workforce found the Delphi survey and mini-focus group found moral distress and injury present when CPs could not work in line with their values and morals. This affected the quality of care they could provide, and they would leave to work in private practice. To increase their hours in the NHS, they needed to feel able to deliver quality care. The Demand–Control–Support Model (Karasek, 1976) may help explain the importance of CP's feeling they have some control over their work and why it feels important that they can give quality care to patients, and again the need for supportive leadership, supervision and teams and manageable workloads. If the workload is too high and their control and support is low, CP's may not feel like they are giving good quality care in line with their values and will increase work elsewhere where they can align these values. The Effort-Reward-Imbalance Theory (Siegrist, 1996; Siegrist et al., 2004; Siegrist & Li, 2016) would suggest that reward may be experienced as more than just financial within mental healthcare and relational factors like strong supportive leadership and a positive team culture, as well as career opportunities, security and recognition may be seen as just as rewarding and therefore motivating. So then if workload and the push to meet organisational targets is more than the reward of supportive leaders, supervision, team, CPD etc, then there is an imbalance and so will impact on CP's wellbeing.

Strengths and Limitations

The systematic review was, the first to the authors knowledge, to synthesize the factors associated with moral distress and injury within UK mental health staff. For transparency and rigour, the protocol was pre-registered on PROSPERO

(CRD420251054927), and it was conducted following guidance by PRISMA (Page et al., 2021) and the ENTREQ guidelines (Tong et al., 2012). The thematic synthesis followed guidelines by Thomas and Harden (2008), however the review only had a small sample of seven studies from which the analytical themes were derived which may reduce the generalizability of the findings. The empirical project delivered a modified Delphi method (Avella, 2016; Custer et al., 1999), where a quantitative survey was created by researchers, it also followed the Nasa et al. (2021) quality assessment. The survey was also formed from pre-existing literature (Harding et al., 2025; Stinton et al., 2025; Tolland & Drysdale, 2022; Weyman et al., 2023) and PPI helped review and improve the survey. The COREQ checklist (Tong et al., 2007) was then completed for transparency for the mini-focus group, that was analysed following the six steps of Reflective Thematic Analysis (RTA) by Braun & Clarke,(2006).

Theoretical and Clinical Implications

Both the papers in this portfolio expand what we know about mental health workforce retention. They show factors influencing retention go beyond stress and burnout (Harding et al., 2025; Stinton et al., 2025), to moral distress and injury, and impact the psychological wellbeing of the workforce and therefore impede its sustainability. The overarching theme linking both papers in the portfolio is the need for staff to be able to deliver quality care, in line with their values and morals. If staff feel like they cannot do this then it ultimately results in staff leaving and for the CP's it stops them increasing their hours in the NHS.

Both papers also highlight the need for all staff in the mental health workforce to not feel disposable and for their well-being to be at the forefront of organisations' priorities. To do this organisations should prioritise good quality, compassionate leadership (Bailey & West, 2022; Worline & Dutton (2017) and supervision. The papers show that this supported the quality of staff's work, it would help support CP's, especially in their early career, to develop their clinical skills, and to help mitigate moral distress and injury. This helps foster a positive/supportive team culture which was important for CPs to increase their NHS hours,

and also reduce moral distress and injury in the mental health workforce. Increasing staffing levels, having a manageable workload and more money/resources being needed were also highlighted in both papers. This calls on the government to think about focusing more monetary funds into the mental health sector to keep up with the demand, so that staff can provide safe and quality care. How easy this is to achieve by the government when the NHS and other services are in financial deficits, and are currently focused on making cuts (Jefferies & Wickens, 2025), means it's likely to take some time to change.

Looking at societal factors contributing to poorer health in the UK (Darzi, 2024) may help the government focus funds and staffing to help prevent poor mental and physical health in the new Fit for the Future: 10 Year Health Plan for England (Department of Health and Social Care, 2025). Allowing staff to have autonomy, flexible working and training/CPD was also suggested to help mitigate moral distress and injury. These conditions allow CPs to have longevity in their NHS role, so CP's stay in their roles longer, which in turn supports better supervision of early career staff across the mental health workforce and gives better quality of care for patients. Digital technology and artificial intelligence are rightly taking a lead in the NHS's next 10-year plan and this can support with reducing administrative task time for more clinical patient time and would allow for more flexible working and supporting those most hard to reach (geographically, intellectually etc.). Not all of the recommendations to improve mental health staff retention require monetary funds, however, what it does require is a clear plan for workforce sustainability, and the new NHS workforce plan has yet to be published (Brudenell, 2026). Changes in political leadership, including a new Secretary of State for Health and Social Care and new Prime Minister are likely contributing to the lack of stability in polices and plans being created and sustained long enough to make change.

Future Research

The portfolio identified current gaps in the literature for workforce sustainability in UK mental health.

The systematic review highlighted a lack of quantitative research focused on moral distress and injury within mental health staff in the UK. Those published are often mixed with physical health staff and the review completed in this portfolio found there are differences in moral distress and injury among mental health staff compared to physical health staff. The context of the work is different and therefore further studies expanding on all areas of mental health services in the UK, with a focus on different job roles will be an important next step. This may help further identify factors associated with moral distress and injury for specific job roles, so that mitigation recommendations can be more tailored to individual jobs or different sets of demographics.

The empirical project identified the first steps in what CP's need to increase their hours in the NHS. To expand on this, it would be helpful for organisations to know more about how they can implement these conditions like increasing quality of care of patients, as these are complex in nature. How can the NHS improve team culture, help staff feel psychologically safe and what training do the leadership need? This ties in with more quantitative and qualitative studies being needed around what different CP career stages need to sustain their careers in the NHS, as this study suggests some variation in terms of pay, support and supervision, clinical time and anatomy. Another natural progression is to explore what CP's who have left the NHS entirely need to return. Are the conditions the same as those who have partly left or are they distinct?

Reflections on the Research Process

During the process of developing and conducting this thesis portfolio my understanding around workforce wellbeing and sustainability has grown in ways I had not anticipated. As a trainee CP, I understand the importance of reflective practice in self-care, development and bringing about change (Riccio & Fisher, 2025). I had always been interested in the wellbeing of myself, and colleagues and I thought I had a good prior knowledge in the area, having worked in it for over 13 years. However, this process has taught me more about how complex systems can be, especially highly valued care systems

like the NHS, and especially when you are trying to bring about change on a system wide scale.

When I started the empirical research design I knew there was limited research on CP's and retention in the NHS. I also had a felt sense of loyalty to the NHS for not only my own healthcare support but my family and friends and I appreciated it was also giving the opportunity to train as a CP myself, in the hope to give back to the NHS when I qualify. I wanted to therefore understand more around those leaving the NHS to the private sector and what it would take for them to come back to the NHS. Having a mixed methods portfolio for me also became even more important to me, as it helps capture nuances within consensus, and enabled the project to hear the voices of those this research was seeking to support (Shorten & Smith, 2017). This wasn't however without its challenges, in complexity of attrition rates, lengthening data collection, data synthesis/analysis and finding an appropriate journal for dissemination (Wasti et al., 2022).

During the process of this project, I was myself surprised to find how the shift from NHS to private for CP's was often less around monetary incentives and ease of work, instead it highlighted wider issues in the NHS systems around staff well-being and staff not feeling able to deliver the care they wanted in line with their professional and personal values and morals (moral injury).

When reflecting on the project at the end, I understand even more than I did at the start, the importance of research into workforce sustainability within the UK and in systems like its NHS. This research may not have focused on a clinical patient group but without important research like this into the mental health workforce, it will directly impact the quality of the mental health care in the UK for generations to come.

Conclusions

The studies in this portfolio provide evidence of the factors affecting the sustainability of the mental health workforce in the UK. It sheds light on factors associated with moral distress and injury for mental health staff and within a particular staffing group, CP's. It

explores what organisational and system changes are needed for CPs to increase their hours in the NHS, in the hope to support the UK's mental health workforce for the next generation. Both provide evidence of the changes needed within the UK mental health service and will be important in shaping UK government, local NHS trusts and private healthcare policies, around staff wellbeing and retention, as the UK steps into the new Fit for the Future: 10-Year Health Plan (Department of Health and Social Care, 2025).

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Appendices

Appendix A

Author Guidelines for the Mental Health & Prevention Journal (April 2026)

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Guide for authors

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About the journal

Aims and scope

Mental Health & Prevention is a peer reviewed journal dedicated to the prevention of mental and behavioural disorders and mental ill health, and the promotion of mental well-being. Note, manuscripts must be relevant to both mental health AND prevention. Its scope encompasses universal, selective and indicated prevention and mental health promotion across the lifespan. All mental and behavioural disorders are covered, as well as suicide and self-injury. The journal does not cover early intervention or treatment of mental and behavioural disorders. This journal does not generally accept cross-sectional studies unless they are very large and population representative, or focussed on under-studied populations, with clear implications for mental health prevention.

Submissions are welcome on the following topics:

- Research on the need for prevention
- Research contributing to the development of interventions
- Descriptions of major programs, where there is accompanying evaluation
- Evaluations of interventions to prevent disorders or reduce risk factors, including controlled and uncontrolled trials and qualitative studies

- Protocols for trials (if data collection has not yet started, or is in early stages)
- Research on risk or protection factors that has implications for prevention
- Psychometrics of prevention measures
- Economics of prevention
- Workforce development
- Prevention policy
- Systematic reviews on any of the above topics

Keywords: Mental health, mental disorders, behavioural disorders, mental well-being, primary prevention, secondary prevention, universal prevention, selective prevention, indicated prevention, promotion, neurodevelopmental disorders, mood disorders, anxiety disorders, schizophrenia and other psychotic disorders, feeding or eating disorders, substance use disorders, impulse control disorders, personality disorders, neurocognitive disorders, disruptive behaviour or dissocial disorders, suicide and self-injury.

Article types

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- Prevention in Practice (up to 5,000 words, excluding references, and up to 2 tables/figures, describing an innovation in the practice of prevention including some evaluation data)
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Funding sources

Authors must disclose any funding sources who provided financial support for the conduct of the research and/or preparation of the article. The role of sponsors, if any, should be declared in relation to the study design, collection, analysis and interpretation of data, writing of the report and decision to submit the article for publication. If funding sources had no such involvement this should be stated in your submission.

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants, scholarships and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, it is recommended to include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Declaration of generative AI use

Authors must declare the use of generative AI in the manuscript preparation process upon submission of the paper.

Elsevier recognizes the potential of generative AI and AI-assisted technologies ("AI Tools"), when used responsibly, to help researchers work efficiently, gain critical insights fast and achieve better outcomes. Increasingly, these tools, including AI agents and deep research tools, are helping researchers to synthesize complex literature, provide an overview of a field or research question, identify research gaps, generate ideas, and provide tailored support for tasks such as content organization and improving language and readability.

Authors preparing a manuscript for this journal can use AI Tools to support them. However, these tools must never be used as a substitute for human critical thinking, expertise and evaluation. AI technology should always be applied with

human oversight and control.

Ultimately, authors are responsible and accountable for the contents of their work. This includes accountability for:

- Carefully reviewing and verifying the accuracy, comprehensiveness, and impartiality of all AI-generated output (including checking the sources, as AI-generated references can be incorrect or fabricated).
- Editing and adapting all material thoroughly to ensure the manuscript represents the author's authentic and original contribution and reflects their own analysis, interpretation, insights and ideas.
- Ensuring the use of any tools or sources, AI-based or otherwise, is made clear and transparent to readers. If AI Tools have been used, we require a disclosure statement upon submission; please see example below.
- Ensuring the manuscript is developed in a way that safeguards data privacy, intellectual property and other rights, by checking the terms and conditions of any AI tool that is used.

Finally, authors must not list or cite AI Tools as an author or co-author on the manuscript since authorship implies responsibilities and tasks that can only be attributed to, and performed by, humans.

The use of AI Tools in the manuscript preparation process must be declared by adding a statement at the end of the manuscript when the paper is first submitted. The statement will appear in the published work and should be placed in a new section before the references list.

An example:

- Title of new section: *Declaration of generative AI and AI-assisted technologies in the manuscript preparation process.*
- Statement: *During the preparation of this work the author(s) used [NAME OF TOOL / SERVICE] in order to [REASON]. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the published article.*

The declaration does not apply to the use of basic tools, such as tools used to check grammar, spelling and references. If you have nothing to disclose, you do not need to add a statement.

Please read Elsevier's author policy on the use of generative AI and AI-assisted technologies, which can be found in the generative AI policies for journals.

Please note: to protect authors' rights and the confidentiality of their research, this journal does not currently allow the use of generative AI or AI-assisted technologies such as ChatGPT or similar services by reviewers or editors in the peer review and manuscript evaluation process, as is stated in Elsevier's generative AI policies for journals. Elsevier is actively evaluating compliant AI Tools and may revise this policy in the future.

Preprints

Preprint sharing

Authors may share preprints in line with Elsevier's article sharing policy. Sharing preprints, such as on a preprint server, will not count as prior publication.

We advise you to read our policy on multiple, redundant or concurrent publication.

Use of inclusive language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Authors should ensure their work uses inclusive language throughout and contains nothing which might imply one individual is superior to another on the grounds of:

- age
- gender
- race
- ethnicity
- culture
- sexual orientation
- disability or health condition

We recommend avoiding the use of descriptors about personal attributes unless they are relevant and valid. Write for gender neutrality with the use of plural nouns ("clinicians, patients/clients") as default. Wherever possible, avoid using "he, she," or "he/she."

No assumptions should be made about the beliefs of readers and writing should be free from bias, stereotypes, slang, reference to dominant culture and/or cultural assumptions.

These guidelines are meant as a point of reference to help you identify appropriate language but are by no means exhaustive or definitive.

Reporting sex- and gender-based analyses

There is no single, universally agreed-upon set of guidelines for defining sex and gender. We offer the following guidance:

- Sex and gender-based analyses (SGBA) should be integrated into research design when research involves or pertains to humans, animals or eukaryotic cells. This should be done in accordance with any requirements set by funders or sponsors and best practices within a field.
- Sex and/or gender dimensions of the research should be addressed within the article or declared as a limitation to the generalizability of the research.
- Definitions of sex and/or gender applied should be explicitly stated to enhance the precision, rigor and reproducibility of the research and to avoid ambiguity or conflation of terms and the constructs to which they refer.

We advise you to read the Sex and Gender Equity in Research (SAGER) guidelines and the SAGER checklist (PDF) on the EASE website, which offer systematic approaches to the use of sex and gender information in study design, data analysis, outcome reporting and research interpretation.

For further information we suggest reading the rationale behind and recommended use of the SAGER guidelines.

Definitions of sex and/or gender

We ask authors to define how sex and gender have been used in their research and publication. Some guidance:

- Sex generally refers to a set of biological attributes that are associated with physical and physiological features such as chromosomal genotype, hormonal levels, internal and external anatomy. A binary sex categorization (male/female) is usually designated at birth ("sex assigned at birth") and is in most cases based solely on the visible external anatomy of a newborn. In reality, sex categorizations include people who are intersex/have differences of sex development (DSD).

- Gender generally refers to socially constructed roles, behaviors and identities of women, men and gender-diverse people that occur in a historical and cultural context and may vary across societies and over time. Gender influences how people view themselves and each other, how they behave and interact and how power is distributed in society.

Depending on the focus of a paper, sex and/or gender may or may not be relevant to the content of the paper. We recognize that beliefs, attitudes, and laws relating to sex and gender may vary. These articles do not attempt to dictate author beliefs but rather require that, where relevant to an author's research or paper, the author must provide clear explanations of how the paper and research define and use sex and gender.

Jurisdictional claims

Elsevier respects the decisions taken by its authors as to how they choose to designate territories and identify their affiliations in their published content. Elsevier's policy is to take a neutral position with respect to territorial disputes or jurisdictional claims, including, but not limited to, maps and institutional affiliations. For journals that Elsevier publishes on behalf of a third party owner, the owner may set its own policy on these issues.

- Maps: Readers should be able to locate any study areas shown within maps using common mapping platforms. Maps should only show the area actually studied and authors should not include a location map which displays a larger area than the bounding box of the study area. Authors should add a note clearly stating that "*map lines delineate study areas and do not necessarily depict accepted national boundaries*". During the review process, Elsevier's editors may request authors to change maps if these guidelines are not followed.

- Institutional affiliations: Authors should use either the full, standard title of their institution or the standard abbreviation of the institutional name so that the institutional name can be independently verified for research integrity purposes.

Clinical Trials

This journal follows the International Committee of Medical Journal Editors (ICMJE) clinical trials registration guidelines.

Registration

Clinical trials must be registered in a public trials registry. Purely observational studies, in which the assignment of the medical intervention is not at the discretion of the investigator, do not require registration.

Some important points:

- Trials must be registered at or before the onset of patient enrolment.
- The clinical trial registration number must be included in the manuscript, preferably at the end of the article abstract.
- A clinical trial is defined as any research study that prospectively assigns human participants, or groups of humans, to one or more health-related interventions to evaluate the effects of health outcomes.
- Health-related interventions include any intervention used to modify a biomedical or health-related outcome such as drugs, surgical procedures, devices, behavioral treatments, dietary interventions, and process-of-care changes.
- Health outcomes include any biomedical or health-related measures obtained in patients or participants, including pharmacokinetic measures and adverse events.

Results

Authors are required to disclose all posting in registries of results of the same or closely related work. Editors will not consider results to be a prior publication if they have already been posted in the same clinical trials registry in which primary registration resides, as long as the results are presented in the form of a brief structured abstract (fewer than 500 words) or table.

Disclosing results in other circumstances, such as in an investors' meeting, for example, is discouraged and may jeopardize consideration of your manuscript by this journal.

Reporting

Authors are encouraged to follow CONSORT guidelines when presenting randomized controlled trials, and provide the CONSORT checklist at manuscript submission, with an accompanying flow diagram illustrating the progress of patients through the trial - including recruitment, enrolment, randomization, withdrawal, completion and a description of the randomization procedure.

- Read the CONSORT guidelines.
- Follow the CONSORT checklist.

Delayed publication

If you need to delay the publication of your article for any reason, please contact the editorial office of the journal or our Journal Article Publishing Support Center at the earliest possible opportunity. While we will try to ensure that your article is not published before a certain date if you make your request on a timely basis, we cannot guarantee this. Please also note that once the agreed period of delay has expired the article may be published at any time thereafter.

Writing and formatting

File format

We ask you to provide editable source files for your entire submission (including figures, tables and text graphics). Some guidelines:

- Save files in an editable format, using the extension .doc/.docx for Word files and .tex for LaTeX files. A PDF is not an acceptable source file.
- Format Word files in a single-column layout. Double-column formatting is only permitted for LaTeX submissions.
- Remove any strikethrough and underlined text from your manuscript, unless it has scientific significance related to your article.
- Use spell-check and grammar-check functions to avoid errors.

We advise you to read our Step-by-step guide to publishing with Elsevier.

Title page

You are required to include the following details in the title page information:

- Article title. Article titles should be concise and informative. Please avoid abbreviations and formulae, where possible, unless they are established and widely understood, e.g. DNA.
- Author names. Provide the given name(s) and family name(s) of each author. The order of authors should match the order in the submission system. Carefully check that all names are accurately spelled. If needed, you can add your name between parentheses in your own script after the English transliteration.
- Affiliations. Add affiliation addresses, referring to where the work was carried out, below the author names. Indicate affiliations using a lower-case superscript letter immediately after the author's name and in front of the corresponding address. Ensure that you provide the full postal address of each affiliation, including the country name and, if available, the email address of each author.
- Corresponding author. Clearly indicate who will handle correspondence for your article at all stages of the refereeing and publication process and also post-publication. This responsibility includes answering any future queries about your results, data, methodology and materials. It is important that the email address and contact details of your corresponding author are kept up to date during the submission and publication process.
- Present/permanent address. If an author has moved since the work described in your article was carried out, or the author was visiting during that time, a "present address" (or "permanent address") can be indicated by a footnote to the author's name. The address where the author carried out the work must be retained as their main affiliation address. Use superscript Arabic numerals for such footnotes.

Double anonymized peer review

As this journal follows a double anonymized review process, author identities are concealed from reviewers and vice versa. To facilitate this process, submit your title page (including author details) and anonymized manuscript (excluding author details) as separate files. Next to the items mentioned in the title page section of this guide, the title page should also include:

- Acknowledgements. Include any individuals who provided you with help during your research such as help with language, writing or proof reading in the acknowledgements section. Include acknowledgements only in the title page, do not add them as a footnote to your title, or anywhere else in your article.
- Declaration of competing interests (when a separate declaration of interest file is not submitted)

- Corresponding author address (full address is required)
- Corresponding author email address

The anonymized manuscript should contain the main body of your paper, including references and tables. It is important that your manuscript does not contain any identifying information such as author names or affiliations, or acknowledgements.

Read more about peer review.

Abstract

You are required to provide a concise and factual abstract which does not exceed 250 words. The abstract should briefly state the purpose of your research, principal results and major conclusions. Some guidelines:

- Abstracts must be able to stand alone as abstracts are often presented separately from the article.
- Avoid references. If any are essential to include, ensure that you cite the author(s) and year(s).
- Avoid non-standard or uncommon abbreviations. If any are essential to include, ensure they are defined within your abstract at first mention.

Keywords

You are required to provide 1 to 7 keywords for indexing purposes. Keywords should be written in English. Please try to avoid keywords consisting of multiple words (using "and" or "of").

We recommend that you only use abbreviations in keywords if they are firmly established in the field.

Highlights

You are encouraged to provide article highlights at submission.

Highlights are a short collection of bullet points that should capture the novel results of your research as well as any new methods used during your study. Highlights will help increase the discoverability of your article via search engines. Some guidelines:

- Submit highlights as a separate editable file in the online submission system with the word "highlights" included in the file name.
- Highlights should consist of 3 to 5 bullet points, each a maximum of 85 characters, including spaces.

We encourage you to view example article highlights and read about the benefits of their inclusion.

Tables

Tables must be submitted as editable text, not as images. Some guidelines:

- Place tables next to the relevant text or on a separate page(s) at the end of your article.
- Cite all tables in the manuscript text.

- Number tables consecutively according to their appearance in the text.
- Please provide captions along with the tables.
- Place any table notes below the table body.
- Avoid vertical rules and shading within table cells.

We recommend that you use tables sparingly, ensuring that any data presented in tables is not duplicating results described elsewhere in the article.

Figures, images and artwork

Figures, images, artwork, diagrams and other graphical media must be supplied as separate files along with the manuscript. We recommend that you read our detailed artwork and media instructions. Some excerpts:

When submitting artwork:

- Cite all images in the manuscript text.
- Number images according to the sequence they appear within your article.
- Submit each image as a separate file using a logical naming convention for your files (for example, Figure_1, Figure_2 etc).
- Text graphics may be embedded in the text at the appropriate position. If you are working with LaTeX, text graphics may also be embedded in the file.

Figure captions

All images must have a caption. A caption should consist of a brief title (not displayed on the figure itself) and a description of the image. We advise you to keep the amount of text in any image to a minimum, though any symbols and abbreviations used should be explained.

Read how to add captions to your submission here.

Artwork formats

When your artwork is finalized, "save as" or convert your electronic artwork to the formats listed below taking into account the given resolution requirements for line drawings, halftones, and line/halftone combinations:

- Vector drawings: Save as EPS or PDF files embedding the font or saving the text as "graphics."
- Color or grayscale photographs (halftones): Save as TIFF, JPG or PNG files using a minimum of 300 dpi (for single column width: min. 1063 pixels, full page width: 2244 pixels).
- Bitmapped line drawings: Save as TIFF, JPG or PNG files, using a minimum of 1000 dpi (for single column width: min. 3543 pixels, full page width: 7480 pixels).
- Combinations bitmapped line/halftones (color or grayscale): Save as TIFF, JPG or PNG files using a minimum of 500 dpi (for single column: min. 1772 pixels, full page width: 3740 pixels).

Please do not submit:

- Files that are too low in resolution.
- Disproportionally large images compared to font size, as text may become unreadable.

Color artwork

If you submit usable color figures with your accepted article, we will ensure that they appear in color online.

Please ensure that color images are accessible to all, including those with impaired color vision. Learn more about color and web accessibility.

Generative AI and Figures, images and artwork

Please read our policy on the use of generative AI and AI-assisted tools in figures, images and artwork, which can be found in Elsevier's GenAI Policies for Journals. This policy states:

- We do not permit the use of Generative AI or AI-assisted tools to create or alter images in submitted manuscripts.
- The only exception is if the use of AI or AI-assisted tools is part of the research design or methods (for example, in the field of biomedical imaging). If this is the case, such use must be described in a reproducible manner in the methods section, including the name of the model or tool, version and extension numbers, and manufacturer.
- The use of generative AI or AI-assisted tools in the production of artwork such as for graphical abstracts is not permitted. The use of generative AI in the production of cover art may in some cases be allowed, if the author obtains prior permission from the journal editor and publisher, can demonstrate that all necessary rights have been cleared for the use of the relevant material, and ensures that there is correct content attribution.

Supplementary material

We encourage the use of supplementary materials such as applications, images and sound clips to enhance research. Some guidelines:

- Supplementary material should be accurate and relevant to the research.
- Cite all supplementary files in the manuscript text.
- Submit all supplementary materials at the same time as your manuscript.
- Include a concise, descriptive caption for each supplementary file, describing its content.
- After submission supplementary files can only be added or replaced in the revision stage of the editorial process.
- Be aware that all supplementary materials provided will appear online in the exact same way as received. These files will not be checked, formatted or typeset by the production team.

Video

This journal accepts video material and animation sequences to support and enhance your scientific research. We encourage you to include links to video or animation files within articles. Some guidelines:

- When including video or animation file links within your article, refer to the video or animation content by adding a note in your text where the file should be placed.
- Clearly label files ensuring the given file name is directly related to the file content.
- Provide files in one of our recommended file formats. Files should be within our preferred maximum file size of 150 MB per file, 1 GB in total.
- Provide "stills" for each of your files. These will be used as standard icons to personalize the link to your video data. You can choose any frame from your video or animation or make a separate image.
- Provide descriptive text in your manuscript to refer to the video content. This text helps ensure accessibility for visually impaired readers who rely on descriptive information. For journals publishing in print this is also essential, as video and animation files cannot be embedded in the print version.

We publish all video and animation files supplied in the electronic version of your article.

For more detailed instructions, we recommend that you read our guidelines on submitting video content to be included in the body of an article.

Research data

We are committed to supporting the storage of, access to and discovery of research data, and our research data policy sets out the principles guiding how we work with the research community to support a more efficient and transparent research process.

Research data refers to the results of observations or experimentation that validate research findings, which may also include software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Please read our guidelines on sharing research data for more information on depositing, sharing and using research data and other relevant research materials.

Research data deposit, citation and linking

For this journal, **Option B** instructions from our research data guidelines apply. This means that you are **encouraged** to:

- Deposit your research data in a relevant data repository.
- Cite and link to this dataset in your article.
- If this is not possible, make a statement explaining why research data cannot be shared.

Data statement

To foster transparency, you are encouraged to state the availability of any data at submission.

Ensuring data is available may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you can state the reason why (e.g., your research data includes sensitive or confidential

information such as patient data) during the submission process. This statement will appear with your published article on ScienceDirect.

Read more about the importance and benefits of providing a data statement.

Data linking

Linking to the data underlying your work increases your exposure and may lead to new collaborations. It also provides readers with a better understanding of the described research.

If your research data has been made available in a data repository there are a number of ways your article can be linked directly to the dataset:

- Provide a link to your dataset when prompted during the online submission process.
- For some data repositories, a repository banner will automatically appear next to your published article on ScienceDirect.
- You can also link relevant data or entities within the text of your article through the use of identifiers. Use the following format: Database: 12345 (e.g. TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Learn more about linking research data and research articles in ScienceDirect.

Co-submission of related data, methods or protocols

You are encouraged to publish a description of your research data, methods, or protocols related to your regular article as a co-submission article in *Data in Brief* or *MethodsX*.

This co-submission can be submitted at the same time as your regular manuscript submission to this journal. If both your regular and co-submitted manuscripts are accepted for publication, they will be linked together on ScienceDirect, thereby promoting research reproducibility, interoperability, and open science.

- Prepare a separate manuscript describing your research data, methods, or protocols using the **mandatory templates** from *Data in Brief* or in *MethodsX*.
- Submit this co-submission alongside your regular manuscript as a separate submission item; on the **'Attach files'** page in Editorial Manager, after which it will be automatically forwarded to the *Data in Brief* or *MethodsX* and assigned an editor.
- For associated Article Processing Charge (APC) details, please visit:
  - MethodsX
  - Data in Brief

Please note: Due to the automated process of submitting to *Data in Brief* or *MethodsX*, only after acceptance will you be presented with a personalized OA Article Publishing Charge based on your individual context (your country, institutional affiliation, and any society membership for example).

Please visit **co-submission Researcher Support page** for more information on how to submit a co-submission.

Journal specific information: Writing and formatting

Abstracts

You are required to provide a concise and factual abstract which does not exceed 250 words. The abstract must be structured according to headings outlined below and should briefly state the purpose of your research, principal results and major conclusions. Some guidelines:

- Abstracts must be structured with appropriate headings and adhere to the following format: Objective, Methods, Results, Conclusion. Abstracts should provide the context or background for the research and should state its purpose, basic procedures (selection of study subjects, observational and analytical methods), main findings (giving specific effect sizes and their statistical significance, if possible), principal conclusions and innovation.
- Abstracts must be able to stand alone as abstracts are often presented separately from the article.
- Avoid references. If any are essential to include, ensure that you cite the author(s) and year(s).
- Avoid non-standard or uncommon abbreviations. If any are essential to include, ensure they are defined within your abstract at first mention.

Article structure

Article sections

- Divide your article into clearly defined and numbered sections. Number subsections 1.1 (then 1.1.1, 1.1.2, ...), then 1.2, etc.
- Use the numbering format when cross-referencing within your article. Do not just refer to "the text."
- You may give subsections a brief heading. Headings should appear on a separate line.
- Do not include the article abstract within section numbering.

Footnotes

We advise you to use footnotes sparingly. If you include footnotes in your article, ensure that they are numbered consecutively.

You may use system features that automatically build footnotes into text. Alternatively, you can indicate the position of footnotes within the text and present them in a separate section at the end of your article.

Author contributions: CRediT

Corresponding authors are required to acknowledge co-author contributions using CRediT (Contributor Roles Taxonomy) roles:

- Conceptualization
- Data curation
- Formal analysis
- Funding acquisition

- Investigation
- Methodology
- Project administration
- Resources
- Software
- Supervision
- Validation
- Visualization
- Writing – original draft
- Writing – review and editing

Not all CRediT roles will apply to every manuscript and some authors may contribute through multiple roles.

We advise you to read more about CRediT and view an example of a CRediT author statement.

Appendices
We ask you to use the following format for appendices:

- Identify individual appendices within your article using the format: A, B, etc.
- Give separate numbering to formulae and equations within appendices using formats such as Eq. (A.1), Eq. (A.2), etc. and in subsequent appendices, Eq. (B.1), Eq. (B. 2) etc. In a similar way, give separate numbering to tables and figures using formats such as Table A.1; Fig. A.1, etc.

References

References within text
Any references cited within your article should also be present in your reference list and vice versa. Some guidelines:

- References cited in your abstract must be given in full.
- We recommend that you do not include unpublished results and personal communications in your reference list, though you may mention them in the text of your article.
- Any unpublished results and personal communications included in your reference list must follow the standard reference style of the journal. In substitution of the publication date add "unpublished results" or "personal communication."
- References cited as "in press" imply that the item has been accepted for publication.

Linking to cited sources will increase the discoverability of your research.

Before submission, check that all data provided in your reference list are correct, including any references which have been copied. Providing correct reference data allows us to link to abstracting and indexing services such as Scopus, Crossref and PubMed. Any incorrect surnames, journal or book titles, publication years or pagination within your references may prevent link creation.

We encourage the use of Digital Object Identifiers (DOIs) as reference links as they provide a permanent link to the electronic article referenced.

Reference style
Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the *Publication Manual of the American Psychological Association,* Seventh Edition (2020) ISBN 978-1-4338-3215-4.

The reference list should be arranged alphabetically and then chronologically. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Examples:

Reference to a journal publication:

Van der Geer, J., Handgraaf T., & Lupton, R. A. (2020). The art of writing a scientific article. *Journal of Scientific Communications, 163,* 51–59. https://doi-org.uea.idm.oclc.org/10.1016/j.sc.2020.00372.

Reference to a journal publication with an article number:

Van der Geer, J., Handgraaf, T., & Lupton, R. A. (2022). The art of writing a scientific article. *Heliyon, 19,* Article e00205. https://doi-org.uea.idm.oclc.org/10.1016/j.heliyon.2022.e00205.

Reference to a book:

Strunk, W., Jr., & White, E. B. (2000). *The elements of style (4th ed.)*. Longman (Chapter 4).

Reference to a chapter in a book:

Mettam, G. R., & Adams, L. B. (2020). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281–304). E-Publishing Inc.

Reference to a website:

Powertech Systems. (2022). Lithium-ion vs lead-acid cost analysis. Retrieved from *http://www.powertechsystems.eu/home/tech-corner/lithium-ion-vs-lead-acid-cost-analysis/.* Accessed January 6, 2022.

Reference to a dataset:

Oguro, M., Imahiro, S., Saito, S., & Nakashizuka, T. (2015). Mortality data for Japanese oak wilt disease and surrounding forest compositions [dataset]. *Mendeley Data, v1.* https://doi-org.uea.idm.oclc.org/10.17632/xwj98nb39r.1.

Reference to a conference paper or poster presentation:

Engle, E.K., Cash, T.F., & Jarry, J.L. (2019, November). *The Body Image Behaviours Inventory-3: Development and validation of the Body Image Compulsive Actions and Body Image Avoidance Scales.* Poster session presentation at the meeting of the Association for Behavioural and Cognitive Therapies, New York, NY.

Reference to software:

Coon, E., Berndt, M., Jan, A., Svyatsky, D., Atchley, A., Kikinzon, E., Harp, D., Manzini, G., Shelef, E., Lipnikov, K., Garimella, R., Xu, C., Moulton, D., Karra, S., Painter, S., Jafarov, E., & Molins, S. (2020). *Advanced Terrestrial Simulator (ATS) (Version 0.88) [Computer software].* Zenodo. https://doi-org.uea.idm.oclc.org/10.5281/zenodo.3727209.

Web references
When listing web references, as a minimum you should provide the full URL and the date when the reference was last accessed. Additional information (e.g. DOI, author names, dates or reference to a source publication) should also be provided, if known.

You can list web references separately under a new heading directly after your reference list or include them in your reference list.

Data references
We encourage you to cite underlying or relevant datasets within article text and to list data references in the reference list.

When citing data references, you should include:

- author name(s)
- dataset title
- data repository
- version (where available)
- year
- global persistent identifier

Add [dataset] immediately before your reference. This will help us to properly identify the dataset. The [dataset] identifier will not appear in your published article.

Preprint references
We ask you to mark preprints clearly. You should include the word "preprint" or the name of the preprint server as part of your reference and provide the preprint DOI.

Where a preprint has subsequently become available as a peer-reviewed publication, use the formal publication as your reference.

If there are preprints that are central to your work or that cover crucial developments in the topic, but they are not yet formally published, you may reference the preprint.

Reference management software
Most Elsevier journals have their reference template available in popular reference management software products. These include products that support Citation Style Language (CSL) such as Mendeley Reference Manager.

If you use a citation plug-in from these products, select the relevant journal template and all your citations and bibliographies will automatically be formatted in the journal style. We advise you to remove all field codes before submitting your manuscript to any reference management software product.

If a template is not available for this journal, follow the format given in examples in the reference style section of this Guide for Authors.

Submitting your manuscript

Submission checklist
Before completing the submission of your manuscript, we advise you to read our submission checklist:

- One author has been designated as the corresponding author and their full contact details (email address, full postal address and phone numbers) have been provided.
- All files have been uploaded, including keywords, figure captions and tables (including a title, description and footnotes) included. This includes any supplementary materials and videos.
- Spelling and grammar checks have been carried out.
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Appendix B

PRISMA 2020 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.	p16
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p165
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p20-21
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p21
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p22-23
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p21-22
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p169
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.	p23-24
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p24-25
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that 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.	p25
	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.	p26
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 automation tools used in the process.	p25

Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
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)).	p25
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p172-186
	13d	Describe any methods used to synthesize 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.	p25-26 & p31
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized 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).	p25, p40, p187
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	x
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.	p23-24
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	p23-24
Study characteristics	17	Cite each included study and present its characteristics.	p26-31
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p187
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.	N/A
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.	p32-37
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A

	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	x
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	x
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p37-38
	23b	Discuss any limitations of the evidence included in the review.	p40-41
	23c	Discuss any limitations of the review processes used.	p40-41
	23d	Discuss implications of the results for practice, policy, and future research.	p38-39
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p21
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p21
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	x
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	N/A
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.	N/A

Section and Topic	Item #	Checklist item	Reported (Yes/No)
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 for the review.	No
Information sources	4	Specify the information sources (e.g. databases, registers) used to identify studies and the date when each was last searched.	No
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 synthesise 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, report 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).	No
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.	N/A
Registration	12	Provide the register name and registration number.	No

Appendix C

ENTREQ Checklist *(Tong et al., 2012)*

Item	Guide and description	Reported on page__
Aim	State the research question the synthesis addresses	21
Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis and describe the rationale for choice of methodology (e.g., meta ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	25-26
Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until theoretical saturation is achieved).	22
Inclusion criteria	Specify the inclusion/exclusion criteria (e.g., in terms of population, language, year limits, type of publication, study type).	22-23
Data sources	Describe the information sources used (e.g., electronic databases (MEDLINE, EMBASE, CINAHL, psychINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar), hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources.	21-22
Electronic Search Strategy	Describe the literature search (e.g., provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research and search limits).	169
Study screening methods	Describe the process of study screening and sifting (e.g., title, abstract and full text review, number of independent reviewers who screened studies)	23
Study characteristics	Present the characteristics of the included studies (e.g., year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	28-31
Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g., for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).	23-24

Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g., assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	25
Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g., Existing tools: CASP, QARI, COREQ; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	25
Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	25
Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	187
Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g., all text under the headings “results /conclusions” were extracted electronically and entered into a computer software).	24-26, 172-186
Software	State the computer software used, if any.	23
Number of reviewers	Identify who was involved in coding and analysis.	116
Coding	Describe the process for coding of data (e.g., line by line coding to search for concepts).	26, 32, 189-190
Study comparison	Describe how were comparisons made within and across studies (e.g., subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	26, 32, 189-190
Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations or the author’s interpretation	32-27
Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g., new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	32-37

Appendix D

Search String

("moral injury" OR "moral distress" OR "ethical conflict*" OR "psychological trauma*" OR “moral resilience” OR “moral dilemma*” OR “moral conflict*” OR “values conflict”)

AND

("mental health*" OR "psychological care" OR psychiatr* OR "behavioural health" OR “community mental health” OR inpatient* OR “mental healthcare” OR “mental health service*”)

AND

("staff" OR worker* OR professional* OR personnel OR clinician* OR practitioner* OR therapist* OR nurse* OR doctor* OR psychologist* OR psychiatrist* OR “mental health practitioner*”)

AND

(NHS OR "National Health Service" OR UK OR "United Kingdom" OR Wales OR “Northern Ireland” OR Scotland OR England OR “Great Britain” OR Britain)

Appendix E

Job Roles Included in the Review

This systematic review relates to the population 'mental health staff' which includes all allied health professionals, mental health nurses, psychiatrists, healthcare assistants, as well as psychological professionals.

Inclusion Criteria:

As defined by NHS England, allied healthcare professionals are listed below:

- Art, drama, or music therapists
- Dietitians
- Occupational therapists
- Physiotherapists
- Speech and language therapists

Psychological professionals are broken into 18 different professions and listed below:

- Psychologist: Clinical, Counselling, Forensic, Health
- Associate and Assistant Roles: Clinical associate, assistant psychologist
- Psychological therapists: Cognitive Behavioural Therapists, Counsellors, Child and Adolescent Psychotherapists, Adult Psychotherapists, Family and Systemic Therapists, Psychological Therapists (Other)
- Psychological practitioners: Psychological Wellbeing Practitioners (PWP), Children and Wellbeing Practitioners (CWP), Education Mental Health Practitioners (EMHP), Mental Health and Wellbeing Practitioners. Youth Intensive Psychological Practitioner (YIPP).

Mental health staff also include clinical members of the multidisciplinary team (MDT) of mental health teams in the community and in inpatient services. This includes mental health nurses, social workers, psychiatrists, and healthcare assistants and managers in the team.

Exclusion Criteria:

- UK healthcare workers not working in a mental health setting

- Those working in a mental health setting in admin, or HR, or education

Appendix F

Data Extraction

Author (Year)	Research aims/questions	Factors associated with moral distress/injury	Study outcomes	Limitations	Author's conclusions
Jones and Crossley (2012)	In the light of unease about the quality of psychiatric inpatient care, it may be helpful to know whether people in need of mental health services, along with mental health professionals, experience shame. If so, in what circumstances and what are the effects of shame on the quality of health care. It also seems important to know how shame might affect a person's feelings about himself or herself. Knowing more about the	Shame - the mental health professionals were facing moral dilemmas concerned with providing health care to people whose rights are in some instances compromised because of mental ill health, health care and treatment regimes. In addition, some mental health professionals spoke of being caught up in organizational tasks and so doing to rather than being with another in difficult times; these were apparent throughout many self-reports. Aspects of such occurrences conceivably cause professionals to experience moral distress and perhaps to also reflect the ideas by Corrigan et al. (2004) of unintended consequences of organizational	Both service users and healthcare professionals viewed the following aspects of treatment and care as shame provoking: Admission processes, the experience of receiving treatment and care (for example ward rounds), discharge procedures and the Mental Health Act. Two themes emerged from the transcripts. Professional group members' discussions related to the following two themes: (1) Shaming and blaming; (2) Entrapment in professional roles.	This is a small research study using qualitative subjective research methods and a purposive sample and so findings cannot be viewed as representative of larger populations. The design of the research study together with the investigators' biases may have influenced the findings of this study. To some extent the investigators minimized biases by convening discussion groups with respondents following the research study.	This brief research report concerns a qualitative research study, organized in such ways as to give a voice to both people with experience of using mental health services and professional service providers. Knowledge gained from this investigation might contribute to improving the quality of care provided for mental health service users and to managing difficulties. By knowing more about situations that provoke stigma and activate feelings of shame, we may become better able to plan, deliver and manage mental health services considerately and cost effectively. We might also develop a better awareness

helpful characteristics of treatment and health care together with the possible problems, e.g. shame-inducing situations, may be important for improving professional care, for the benefit of all concerned. With this in mind, the investigators have used information gained from this research study with service users and healthcare professionals.	policies and practice. In certain instances, mental health professionals viewed other professional groups as stigmatizing them, arousing feeling of shame. In situations where professional groups stigmatized others because of their associations with mental illness, mental health professionals spoke of feeling exposed and wishing to withdraw or hide away. Again, this illustrates moral distress occurring within professional groups because of challenging work: Things like suicide reviews, there's a lot of very public scrutiny and perceived shame if your one of the professionals involved ... 30% of my admissions are detained [under the mental health act] so they are publicly scrutinized. (G. 10.5. group 1)	Shaming or blaming others overlapped with a theme identified from the patient groups.	of the complexities in relation to ways in which shame is aroused in individuals and groups of people along with its effects.

Liberati et al. (2021)	In this article, we respond to this void in the literature, reporting an interview-based qualitative study that seeks to characterise the challenges faced by those working in NHS mental health settings during the first wave of the Covid-19 pandemic in 2020.	A distinctive feature of the accounts of participants was the evidence of moral injury linked to staff feeling that they were letting service users down and that people were suffering deeply as a result. Participants reported feelings of deep dissatisfaction with the support they were able to provide for service users during the pandemic. One worry was that individuals with mental health difficulties would be left feeling isolated and without support and care; staff were deeply concerned about service users who were experiencing reductions or withdrawals of care. Other dilemmas focused on trying to balance the need to control infection risk with the need for human contact in inpatient settings. Staff explained the difficulties of providing therapy or conducting necessary assessments with service users whilst wearing	Analysis was based on the constant comparative method. Participants reported wide-ranging changes in the organisation of secondary mental health care and the nature of work in response to the pandemic, including pausing of all services deemed to be “non-essential”, deployment of staff across services to new and unfamiliar roles, and moves to remote working. The quality of participants’ working life was impaired by increasing levels of daily challenge associated with trying to provide care in trying and constrained circumstances, the problems of forging new ways of working remotely, and constraints on ability to access informal support. Participants were confronted with difficult dilemmas relating to clinical	We did not conduct any formal measurement or assessment of the mental health of participants, relying on their own qualitative narratives only. Our study was based in NHS secondary mental healthcare but did not include all point-of-care staff such as occupational therapists, healthcare assistants and peer-support workers. We also did not recruit staff from the full mental health workforce that includes social workers, helpline staff administrators and volunteers, as well as GPs. Further, we were unable to distinguish between the experiences of staff from different social groups or investigate the moderating effects of race. The study was conducted during a particular period, and may not describe the full chronology of	Those working in mental healthcare have been affected by multiple adverse experiences while living with and working through the exigencies of the Covid-19 pandemic. Their experiences resulted in grief, loneliness, psychological stress/distress, and moral injury. These findings suggest areas where improved support could usefully be targeted.

PPE. Staff also raised concerns about being able to react to emergencies rapidly because of the time taken to don PPE, and even once they had they reported some service users were startled or distressed by their appearance. In some cases, for example, service users with Covid-19 who did not agree with self-isolation protocols were, nevertheless, confined to their rooms. These measures put pressure on service users as well as staff, at times resulting in reported increased levels of distress and aggression, possibly due to frustration. In some services, frontline staff raised concerns about whether this form of restriction was ethically or legally defensible as part of care; emergency ethics committees were convened to address these and other pandemic-related dilemmas. Again, evidence of decision-making, prioritisation of care, and compromises in ability to perform the therapeutic function of their roles. Other dilemmas centred on trying to balance the risks of controlling infection with the need for human contact. Many reported features of moral injury linked to their perceived failures in providing the quality or level of care that they felt service users needed. They sometimes sought to compensate for deficits in care through increased advocacy, taking on additional tasks, or making exceptions, but this led to further personal strain. Many experienced feelings of grief, helplessness, isolation, distress, and burnout. These problems were compounded by sometimes poor communication about service changes and by staff experiences during the pandemic; it may well be that the effects we have described have changed during the subsequent peaks of Covid-19 infection that were not necessarily foreseen during the period of this investigation.

moral injury was a feature of these accounts.	feeling that they could not take time off because of the potential impact on others. Some reported feeling poorly supported by organisations.

Wall et al. (2022)	This study was designed to understand how COVID-19 affected staff working within CMHTs in one NHS Trust in the North West of England. In this paper, we draw out the ways in which organizational changes and their impacts on community mental health staff map onto the concept of moral distress.	Although necessary to minimize the spread of COVID19, the organizational response to managing the pandemic created conflicts with which CMHTs struggled. These conflicts can be aligned to the concept of moral distress. Moral distress is defined as the inability of staff to act "in accordance with their core moral values to provide good patient care" (Silverman et al., 2021). Three major themes that contributed to this conflict were; changes in the nature of contact with service users; changes to the place of work, and difficulties of balancing risks to the families of CMHT staff and service users. These conflicts were largely unforeseen at the start of the pandemic as they were overshadowed by the need to protect people's health. As the pandemic progressed, staff reported struggling with these conflicts. The	Thematic analysis. Analysis identified three major contributors to moral distress; changes in the nature of contact with service users, changes to the place of work, and difficulties of balancing risks to the families of CMHT staff and service users. This study demonstrates that necessary organizational changes instituted to minimize the spread of COVID-19, required different ways of working which were not perceived to be in the best interests of service users or the families of CMHT staff. In order to comply with Government directives, CMHT staff were forced to behave in a way which did not match their moral values causing them to experience moral distress.	The study was based within NHS community care, but did not include all point-of-care staff. Additionally, digital exclusion could potentially be a limitation as the study was only able to conduct remote interviews. Thus, only staff who felt comfortable being interviewed in this way were included. Additionally, our sample is only representative of one CMHT in the North West of England. As the study was limited to the first wave of the pandemic, future research focus on the longterm impacts to staff as the pandemic evolved.	Focusing on reducing transmission of COVID-19 placed staff in an uncomfortable position where their own moral values and professional identity were brought into conflict with family and work obligations. This study demonstrates that achieving such radical changes in service provision, while possible, often creates hidden costs which can be understood as moral distress.

governmental and organizational response to the pandemic removed CMHT staff's professional autonomy, producing feelings of powerlessness. Powerlessness, as a concept, is at the heart of moral distress. The study demonstrated the way in which the imposition of new working practices created institutional constraints that prevented staff from fulfilling what they believed was morally correct action.

Matthews and Williamson (2016)	The primary aim is to extend our understanding of how healthcare assistants construct and manage demanding situations in a secure mental health setting in the independent sector. The secondary aim is to explore the effect of this environment on healthcare assistants' health and well-being, to provide recommendations for enhancing effective coping and support.	While, Marcus believes he should comply with institutional norms and formal decision-making he is also strongly aware of his own belief system and moral values, resulting in a battle to maintain personal autonomy and consequently moral distress. Edward described feeling inferior and constrained by a senior's decision and appears to experience moral distress. Lucy goes beyond a simple acknowledgement of moral distress and describes the difficulties of decision-making in a high risk environment. Lucy attempts to disengage her conscious and primal instincts to engage a professional persona. However, she struggles to disengage entirely and adopt the depersonalized approach of the organization, as she fears the consequences to both the patient and herself, highlighting Lucy's concerns around striking an	Interpretive Phenomenological Analysis - Three inter-related themes have been selected for discussion in this paper – all are illustrated with a series of extracts from diary and interview data. The themes identified and discussed in the following section are: 'normalizing an abnormal environment'; 'between compassion and control' and 'imbalance of occupational demands and support'. It is of note that other themes identified in the data covered material around the emotionally rewarding nature of the mental health profession, emotions about physical patient restraint, the increasing burden of paperwork and bureaucracy and stigmatization of staff with mental health issues.	A limitation of this study is the sample used permanent and causal employees who worked regularly in a ward for a minimum of 6 months, although burnout and moral distress were prominent themes, permanent staff and nurses who worked in this environment for a considerable period of time may experience substantially higher levels of burnout and moral distress. Furthermore, the majority of participants were degree-educated and many were undertaking the healthcare assistant role as experience for accessing better paid and higher status careers. Moreover, seven participants were in their twenties and may not have developed the skills to manage moral distress adequately.	In summary, the findings illustrated that inpatient mental healthcare continues to be a unique and distinctive area of psychiatry, where disturbing behaviour is often normalized and separated from the outside world. Healthcare assistants often experienced a persuasive tension between their personal moral code, which drives nurses towards empathy and support and the emotional detachment and control expected by the organization, where they work, contributing to numerous emotional implications, most notably moral distress and burnout.

appropriate balance between professionalism and compassion. Interestingly, these are concepts which are often juxtaposed in contemporary nursing discourse (Pelto-Piri et al. 2014).

Hemmington (2024)	There appear to be increasing fundamental, existential problems around what 'good AMHP practice' looks like in a changing landscape. More recently, research undertaken within AMHP services suggests that this is beginning to present itself in escalating moral distress leading to an urgent need for existential reframing and, perhaps, a new form of AMHP work as relational and political activity. This is discussed within a context of research findings, outlined below.	The occupational psychic strain on AMHPs in this study represented a form of moral injury or moral distress. This arises when constraints make it impossible to do the 'right thing' and professionals perpetrate, fail to prevent or witness events that contradict their deeply held moral beliefs and expectations. AMHPs are experiencing apparent paradoxes and dilemmas from servicing an ostensibly oppressive system but holding to a (more radical?) social perspective. Resources will always be limited to a lesser or greater degree, but if AMHPs follow their professional and moral codes, they cannot remain silent. The alternative to exiting is to raise voices. Viewing AMHP work as political activity, striving for 'proper AMHP' work and asking 'who are we for?' is to recognise our moral distress but also to see it simultaneously as a source	Reflexive thematic analysis for interviews and themes from diary for the ethnographic data. The research revealed an emerging, unanticipated, picture of power struggles and fissures and a divergence between organisational and individual identities and perspectives within the AMHP service. Ultimately, the locations (i.e., the people within them) did not always work together in expected ways. AMHPs articulated their distress in different ways and, ultimately, were evidencing their struggles with some core existential matters.	The study was relatively small-scale and, as such, may be considered a pilot for future work. Additionally, my close proximity to the work means that I inevitably identify with AMHPs in this study and my interpretations may, at times, reflect this. Whether or not this is wholly a research limitation, a level of reflexivity is essential. Research such as this brings with it a position of liminality, in that the researcher is in-between practitioner and researcher, requiring the reconciliation of detailed practice knowledge and research ethics. Again a potential limitation, this also invites further practitioner-research in the AMHP world.	Evidence suggests that service restructures are creating different approaches to practice with contradictory priorities, for example, whether the work is values-driven and relational or whether approbation is attached to a 'need for speed'. AMHPs are increasingly deliberating about what makes 'proper' or 'good' AMHP practice, asking 'who are we for?' and referring to their work as 'political activity'. AMHPs' sense-making and language are indicative of moral distress. Organisational politics may lead to the work being seen as a technical-rational endeavour, not a moral one, leading to dissonance. More broadly, AMHPs and service users are, together, bearing the brunt of austerity measures and there are increasing unmet needs. Overall, there is a need to establish an ideological, theoretical and political base for practice.

of motivation for the exercise of our moral agency (Lu¨ tze´n and Kvist, 2012). Certainly, increasing experiences of moral injury do seem to be indicating a pendulum swing in this direction.

Lloyd et al. (2024)	The aim of the current study was to conduct an exploratory qualitative analysis of staff members' experiences of managing obesity in line with principles of LRP. The study also sought to explore the psychological impact it has on mental health workers.	Although no direct comparison can be made to other studies, this research is generally in line with the existing literature on moral distress in psychiatric health-care workers. The novelty of the present study lies in the second interpreted theme, which highlighted the internal restraining factors indicative of participants' moral distress. These included a perceived sense of powerlessness in situations where patients with decisional capacity made choices considered to be detrimental to their physical health condition. In the present research, the moral distress of medical professionals transpired to the author in feelings of being torn, frustrated and treading on the side of caution when discussing the implementation of restrictions related to lifestyle choices. Because obesity is unlikely to be the primary reason for a person to be admitted to the	Interpretative Phenomenological Analysis - 2 main themes. 1) The uphill battle of health promotion - subthemes of The structural asymmetry in food and activity provision and Using food as filler for the void created by detention. 2) Practicing in the least restrictive way: a juggling act on a tightrope with subthemes of A difficult cost–benefit analysis and Decisional capacity: dealing with the crux of autonomy versus beneficence dilemma and Searching for the golden mean	The phenomenological nature of this research and the homogeneity of participants preclude the generalisation of results beyond the settings in which the research took place. The study sample was pragmatically driven, and therefore, it is possible that data saturation has not been reached due to the time constraints of the project. Further quantitative research using validated measures of moral distress and a greater sample size that includes a wider variety of multidisciplinary team members would be required to establish the causative link between the moral events and the psychological distress of psychiatric health-care workers involved in obesity management.	Overall, the findings of the current study suggest that least restrictive management of obesity within secure psychiatric settings has the potential to cause moral distress for health-care professionals. Feelings of frustration, powerlessness and anxiety were evoked by environmental constraints, a legal obligation to respect patients' informed decisions despite these being detrimental to the balance in avoiding patients' health, and uncertainty about how to strike a perceived or real accusations of professional negligence or being autocratic in their decision-making. This study highlighted the multitude and complexity of issues contributing to obesity management that require further investigation.

general or forensic psychiatric
service and thus not a primary
treatment goal.

Hegarty et al. (2022)	During the COVID-19 pandemic, increased exposure to Potentially Morally Injurious Events (PMIEs) has placed healthcare workers (HCWs) at risk of moral injury. Yet little is known about the lived experience of cumulative PMIE exposure and how NHS staff respond to this. We sought to rectify this knowledge gap by qualitatively exploring the lived experiences and perspectives of clinical frontline NHS staff who responded to COVID-19.	HCWs across both physical and mental health settings believed their needs and the needs of their patients had been deprioritised by senior management during the pandemic to meet admission and discharge targets 'because all you are being told is hurry up and discharge people' (Brianna, Nurse). This created the impression that trust priorities resided in the 'NHS business model' and maintaining public optics of 'winning the war on COVID', with staff feeling 'disposable' as a result. Similarly, resource shortages led to mandates to shorten the duration of mental health interventions, leaving psychotherapists feeling that their interventions were not adequate to address the increasingly complex patient presentations. Time-limiting service provision in this way led to moral conflict for mental health	Reflexive thematic analysis. 1. Ill-equipped and under-supported to respond to crisis i. Feeling betrayed by the government ii. Systemic issues within the NHS iii. Strained working relationships with management 2. Feeling unable to fulfil one's duty of care to patients 3. Avoiding moral dissonance 4. Psychological toll of PMIEs i. Anger and guilt ii. Disillusionment with NHS iii. Deteriorating mental health 5. Adaptively managing moral distress i. Resolution of moral distress	Inherent in all qualitative designs, inferences about causality between PMIE exposure and psychological distress are beyond the scope of the research. As this study was nested within a larger cohort study, participants were self-selected from an already self-selected sample and so were inclined to engage with research and willing to speak to people about their experience. Given that PMIE exposure was a criterion for inclusion in the current study, this study does not reflect the views and experiences of HCWs who were not exposed to any PMIEs during the pandemic. Thus, by virtue of the study design, our findings are not applicable to HCWs who did not experience PMIEs. Furthermore, despite purposive recruitment of those	This study provides an in-depth insight into the experiences, views and needs of frontline HCWs routinely exposed to PMIEs during the COVID-19 pandemic. Studies to date have not included as diverse a sample, nor captured the current impact of PMIE accumulation across all waves of the pandemic. We found that the psychological toll of recurrent PMIEs is significant. This study extends the evidence base by demonstrating the interconnectedness of PMIE sub-types of betrayal and omission among NHS HCWs and highlights the urgent need to disrupt this cycle of exposure to better protect the mental wellbeing of staff and prevent organisational disengagement.

professionals who predicted this would exacerbate the ‘revolving door of patients’ leaving and re-entering the system, that predated the pandemic. Additionally, mental health crisis response was compromised. One HCW discussed routinely having to send people who were sectioned under the mental health act to remote parts of the country due to local bed shortages. a feeling of disillusionment with the perceived deterioration in standard of care provided by the NHS. While HCWs discontent.surrounding patient backlogs, resource and staff shortages was present prior to the pandemic, many HCWs conveyed that their sense of disillusionment had grown with the exacerbation of these issues since the onset of COVID-19.

exposed to MI by commission, this did not feature heavily in participants’ narratives.

Appendix G

CASP Quality Checks Agreement Summary Table

Author (Year)	Section A - Are the results valid?						Section B - What are the results?			Section C: Will the results help locally?	Overall Score	Quality Score
	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?		
Hegarty et al. (2022)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Can't tell (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	19	Excellent
Hemmington (2024)	Yes (1)	Yes (2)	Yes (1)	Can't tell (1)	Yes (1)	Yes (2)	Yes (1)	Yes (2)	Yes (1)	Yes (2)	14	Fair

Jones and Crossley (2012)	Yes (2)	Yes (2)	Yes (1)	Can't tell (1)	Yes (2)	Yes (1)	Yes (2)	(1) Can't tell	Yes (2)	Yes (2)	16	Good
Liberati et al. (2021)	Yes (2)	Yes (2)	Yes (1)	Yes (2)	Yes (2)	Can't tell (0)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	17	Good
Lloyd et al. (2024)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (1)	Yes (1)	Yes (2)	Yes (2)	Yes (2)	18	Good
Matthews and Williamson (2016)	Yes (2)	Yes (2)	Yes (2)	Can't tell (1)	Yes (2)	Can't tell (0)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	17	Good
Wall et al. (2022)	Yes (2)	Yes (2)	Yes (1)	Yes (2)	Yes (2)	Yes (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	18	Good

Appendix H

Example of Thematic Synthesis Coding

Title (Author, Year)	Factors associated with moral distress/injury	Codes	Descriptive Themes	Analytical themes
A qualitative study of experiences of NHS mental healthcare workers during the Covid-19 pandemic (Liberati et al., 2021)	A distinctive feature of the accounts of participants was the evidence of moral injury linked to staff feeling that they were letting service users down and that people were suffering deeply as a result. Participants reported feelings of deep dissatisfaction with the support they were able to provide for service users during the pandemic. One worry was that individuals with mental health difficulties would be left feeling isolated and without support and care; staff were deeply concerned about service users who were experiencing reductions or withdrawals of care. Other dilemmas focused on trying to balance the need to control infection risk with the need for human contact in inpatient settings. Staff explained the difficulties of providing therapy or conducting necessary assessments with service users whilst wearing PPE. Staff also raised concerns about being able to react to emergencies rapidly because of the time taken to don PPE, and even once they had they reported some service users were startled or distressed by their appearance. In some cases, for example, service users with Covid-19 who did not agree with self-isolation protocols were, nevertheless, confined to their rooms. These measures put pressure on service users as well as staff, at times resulting in reported increased levels of distress and aggression,	Withdrawal of care, focus on infection control over human contact, quality of care, effects of PPE on delivery of care/therapy/assessment, increases frustration and aggression due to self-isolation,	Physical health over wellbeing, PPE affecting patient care	Systemic obstruction of morally valued care

	possibly due to frustration. In some services, frontline staff raised concerns about whether this form of restriction was ethically or legally defensible as part of care; emergency ethics committees were convened to address these and other pandemic-related dilemmas. Again, evidence of moral injury was a feature of these accounts.

Appendix I

Author Guidelines for the Journal of Occupational and Organisational Psychology

(April 2026)









JOOP AUTHOR GUIDELINES

Sections

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
7. Publication Process After Acceptance
8. Post Publication
9. Editorial Office Contact Details

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Data protection:

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices-wiley-com.uea.idm.oclc.org/statements/data-protection-policy.html**.

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The *Journal of Occupational and Organizational Psychology* aims to increase understanding of people and organisations at work including:

- industrial, organizational, work, vocational and personnel psychology
- behavioural and cognitive aspects of industrial relations
- ergonomics and human factors
- industrial sociology

Innovative or interdisciplinary approaches with a psychological emphasis are particularly welcome. So are papers which develop the links between occupational/organisational psychology and other areas of the discipline, such as social and cognitive psychology.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

We welcome the following varieties of paper:

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- papers which offer new theory and conceptualisation, perhaps accompanied by a critique of existing approaches;
- narrative and/or quantitative reviews of existing research which lead to new conclusions or insights into a field of research and/or practice (All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at

anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.);

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In order to supplement innovative research produced in full paper format, the journal provides access to a wider range of investigation through the publication of research in Short Research Note format. Papers submitted as Short Research Notes will be subject to the normal double-anonymous review process. Short Research Notes should be largely empirical studies. Typically, they will do one of the following:

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- develop new measures and report on their reliability and validity;
- report contradictory findings that sharpen the interpretation of existing research;
- present new applications of an existing measure;
- report descriptive findings or case studies that will significantly develop professional practice;
- offer an informed and focused challenge to key elements of an existing study, theory or measure.

Papers submitted as Short Research Notes should not exceed 2000 words, including the abstract but not including references or tables. It is normally expected that any tables will take up no more than two printed pages, and there should be no more than about 15 references. With the exception of the items of a new or substantially revised measure, appendices are discouraged.

A paper submitted as a Short Research Note will not necessarily receive positive reviews simply because it falls into one of the categories listed above. Papers need to be located in a conceptual/theoretical context, with rigorous method and appropriate reporting. The issues they raise and/or the findings they report must be deemed to be contributing significantly to the knowledge and understanding of academics and/or practitioners in occupational and organizational psychology. Short Research Notes are not a facility for publishing on the basis of weak data and/or weak conceptual underpinning. In the majority of cases, authors will have submitted the paper in the Short Research Note format. In some instances, however, the Editors may feel that a full paper is best reviewed in a Short Research Note format, or the referees may only recommend publication under this format. All articles in this format will be officially designated and

recommend publication under this format. All articles in this format will be officially designated and published with the preface 'Short Research Note:' Acceptance for publication on this basis will be indicated in writing to the authors by the Editor or Associate Editor if the original submission was in full paper format.

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Studies conducted using only cross-sectional self-report data will be considered only in exceptional circumstances. For example; if the sample is exceptionally large, representative or multiple. In all other cases, cross-sectional self-report data should form part of a wider selection of data, including other measures such as longitudinal or experimental elements, corroborating or comparison data, third party records or psycho-physiological data.

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In the Methods section, authors should include full and accurate reporting of methods, including sampling issues and sample characteristics as applicable, as well as discuss any of the limitations thereof in the appropriate Discussion section. Sample characteristics might include race, ethnicity, gender, age, nationality, country of residence, and/or socioeconomic status. Appropriate consideration should be given to data protection and ethical aspects. Specific data should be de-identified or anonymized, so that it does not compromise participant privacy.

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- Abstract;
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- Data availability statement (see Data Sharing and Data Accessibility Policy);
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Authors will need to provide no more than 2-4 'key points', written with the practitioner in mind, that summarize the key messages of their paper to be published with their article.

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- References;

- References;
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authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

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Appendix J

Demographic Questionnaire and Delphi Round One Survey

Demographic Information

2. What is your gender identity? *

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Trans female
- ◯ Trans male
- ◯ Other
- ◯ Prefer not to say

3. What is your age range? *

- ◯ 25-29 years
- ◯ 30-34 years
- ◯ 35-39 years
- ◯ 40-44 years
- ◯ 45-49 years
- ◯ 50-54 years
- ◯ 55-59 years
- ◯ 60-64 years
- ◯ 65+ years

4. What is your ethnicity? *

- ◯ Asian or Asian British - Indian
- ◯ Asian or Asian British - Pakistani
- ◯ Asian or Asian British - Bangladeshi
- ◯ Asian or Asian British - Chinese
- ◯ Any other Asian background
- ◯ Caribbean
- ◯ African
- ◯ Any other Black, Black British, or Caribbean background
- ◯ White and Black Caribbean
- ◯ White and Black African
- ◯ White and Asian
- ◯ Any other Mixed or multiple ethnic background
- ◯ White - English, Scottish, Northern Irish or British
- ◯ White - Irish
- ◯ White - Gypsy or Irish Traveller
- ◯ White - Roma
- ◯ Any other White background
- ◯ Arab
- ◯ Any other ethnic group
- ◯ Prefer not to say

5. How long have you been qualified as a Clinical Psychologist? *

- ◯ 0 - 5 years qualified
- ◯ 6 - 10 years qualified
- ◯ 10+ years qualified

6. What region of the UK do you currently live? *

- ◯ Northern Ireland
- ◯ Scotland
- ◯ Wales
- ◯ North East
- ◯ North West
- ◯ Midlands
- ◯ East of England
- ◯ South East
- ◯ South West
- ◯ London

7. What region of the UK do you currently work? *

- ◯ Northern Ireland
- ◯ Scotland
- ◯ Wales
- ◯ North East
- ◯ North West
- ◯ Midlands
- ◯ East of England
- ◯ South East
- ◯ South West
- ◯ London

8. How long have you been working part-time in private practice (*seeing non-commissioned NHS patients*)? *

- ◯ 0 - 5 years
- ◯ 6 - 10 years
- ◯ 11 - 15 years
- ◯ 16 - 20 years
- ◯ 21 - 25 years
- ◯ 26 - 30 years
- ◯ 31 - 35 years
- ◯ 36+ years

9. How many hours a week do you work in total for NHS commissioned services and in the private sector? *

- ◯ 0 - 10
- ◯ 11 - 20
- ◯ 21 - 30
- ◯ 31 - 37.5
- ◯ More than 37.5

10. How many hours a week do you work for NHS commissioned services? *

- ◯ 0 - 5
- ◯ 6 - 10
- ◯ 11 - 15
- ◯ 16 - 20
- ◯ 21 - 25
- ◯ 26 - 30
- ◯ 30+

11. Are you open to increasing your full-time equivalent (FTE) time in NHS commissioned services if conditions changed in the NHS (*including charities and private companies commissioned to see NHS patients*)? *

- ◯ Yes
- ◯ No
- ◯ I'm undecided

12. Please rate how important each of these conditions are in terms of what would be required for you to return to full time NHS commissioned services employment (*this may include charities or private companies commissioned to see NHS patients*). *

	Not important ta all (1)	Somewhat important (2)	Moderately important (3)	Very important (4)	Extremely important (5)
Strong/supportive leadership/management	○	○	○	○	○
Supportive supervision	○	○	○	○	○
Support for mental health	○	○	○	○	○
Manageable workload	○	○	○	○	○
Flexible working hours	○	○	○	○	○
Opportunities for professional development (e.g. CPD)	○	○	○	○	○
Better pay	○	○	○	○	○
Increased staffing levels	○	○	○	○	○
Positive team culture	○	○	○	○	○
Feel able to deliver good quality care to service users	○	○	○	○	○
Opportunities for career progression (e.g. leadership)	○	○	○	○	○
Good pension	○	○	○	○	○
Support for physical health	○	○	○	○	○
Hybrid working (home and office)	○	○	○	○	○
Benefits such as: Medical/life insurance, HCPC registration paid for, indemnity insurance paid for, company car, free onsite parking, gym membership	○	○	○	○	○

	Not important ta all (1)	Somewhat important (2)	Moderately important (3)	Very important (4)	Extremely important (5)
Fits with childcare/family responsibilities	◯	◯	◯	◯	◯
Better working environment (e.g. better access to therapy rooms/desk space)	◯	◯	◯	◯	◯
Reduced bureaucracy	◯	◯	◯	◯	◯

13. If you would like the opportunity to take part in a 1-hour focus group after the Delphi rounds have ended, then please tick yes below. If you do not wish to participate in this then please tick no. *

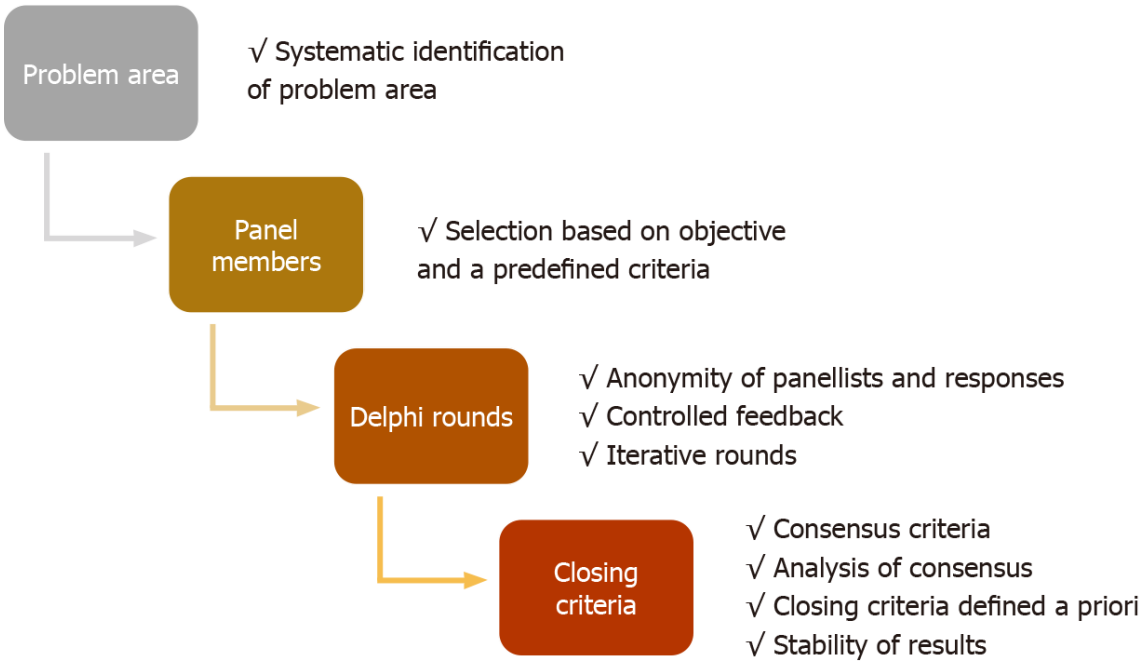
◯ Yes

◯ No

14. Please state your email address so your responses can be matched to you for the next two rounds of the Delphi, which will be sent to you to complete via email. *

Appendix K

Nasa et al., (2021) Stepwise Quality Assessment of Delphi studies



Appendix L

Mini-Focus Group Topic Guide

Format of Focus Group (60 minutes)

- **Welcome the participants**
  - ☐ Ground rules – respect others views, no right or wrong answers, answer only what you wish to
  - ☐ Discuss what to expect during the mini-focus group (e.g. time, questions that will be asked, reminder that you can leave at any point but that we cannot delete the data you may have already contributed to, reminder to keep names and identities confidential, email addresses hidden but your email addresses will be stored securely and deleted once the mini-focus group has finished, and your Amazon voucher has been sent to you and a summary of the study's findings has been sent to you).
  - ☐ Confirm that all present have read the participant information sheet and signed the consent form prior to the focus group
- **Introductions**
  - ☐ Introduce why we are running the mini-focus group (to discuss the results of the Delphi study about what conditions Clinical Psychologists need to be met to return full time to NHS commissioned services and if this varies between career stages).
  - ☐ Ask if they have any questions before the recording/discussion starts?
- **Start recording and transcript**
- **Example questions for the focus group;**
  - Everything met 50% consensus after 3 Delphi rounds, except mid-career range for benefits. Nothing was 'not important at all'.
  - Can you tell me why you think overall '*strong/supportive leadership/management'* (90% very/extremely important*) and 'deliver good*

quality care to service users' (93% very/extremely important) reached a consensus of being most important? Followed by '*flexible working hours*' (80%), '*CPD*' (80%), '*team culture'* (83%), '*better working environment*' (desk/therapy space) (80%)?

- What does this look like in practice? What is strong leadership? What about being able to deliver good quality care? Does this make the job more satisfying?
- Can you tell me why you think '*support for mental health'* (73% - somewhat/moderately important*), 'support for physical health* (84% - somewhat/moderately important) and *'benefits such as medical insurance/HCPC reg etc'* (59% - somewhat/moderately), reached a consensus of being least important?
- *'Better pay'* reached an overall low consensus of 55% (very/extremely important) after 3 rounds but early career stage (0-5 years) and mid-career stage (6-10years) reached a higher consensus/rating (88%-100% - very/extremely important) than later career (10+ years, who voted 89% for somewhat/moderate importance). Why do you think conditions like this ('*better pay*') varied for consensus and importance between career stages?
- Why do you think nothing gained a consensus of 'not important at all'?

☐ Is there an important factor that you felt that we missed in the Delphi study? If so what and why?

- **Ending – Stop recording and transcript.**
- Thank you all for your time and valuable contributions. A reminder that all information gathered during the focus group will be reported anonymously. Your Amazon voucher will be emailed to you as a token of appreciation for your time today. Put debrief link in the chat Mini-Focus Group Debrief Form – Fill out form.

Appendix M

Faculty of Medicine and Health Sciences Ethics Committee Approval

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: Clinical Psychology Workforce Sustainability: a Delphi survey and mini-focus group looking into the conditions needed to return to working full-time within NHS commissioned services

Application ID: ETH2526-1205 (significant amendments)

Dear Hannah,

Your application was considered on 9th January 2026 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 **1st October 2026**.

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.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Stanley Musgrave, Deputy Chair, FMH-sREC

Appendix N

Participants Information Sheet One and Consent Form One

Clinical Psychology Workforce Sustainability: Delphi & Mini-Focus Groups

* Required

Participant Information Sheet 1

This Participant Information Sheet tells you about the research study. This information will help you decide if you wish to take part in this study, which is being undertaken as part of a doctorate project at UEA. Please read it carefully and contact the researchers if you have any questions.

What is the study about? This research study aims to find out what conditions Clinical Psychologists would need met to return full time to seeing NHS commissioned patients and away from the private sector. We also want to know if different stages of career have different conditions needed to return to the NHS.

Who can take part in the study? We are seeking UK HCPC registered qualified Clinical Psychologists who work with NHS commissioned patients (this may include charities or private companies commissioned to see NHS patients) and have reduced your hours to also work in the private sector (seeing non-commissioned NHS patients).

Do I have to be in the study? Taking part in the study is completely voluntary and whether you choose to take part in the study or not will not affect any relations with the University of East Anglia.

Who is conducting the study? This study is being conducted by lead researcher Hannah Baily (hannah.baily@uea.ac.uk), under the supervision of Dr Jinnie Ooi (jinnie.ooi@uea.ac.uk), Dr Sheryl Parke (sheryl.parke@uea.ac.uk) and Dr Rachel Russell (r.russell@uea.ac.uk).

What does the study involve me doing? The study will firstly involve you completing a demographic questionnaire that asks questions related to your personal characteristics and job. You will then be taken to a Delphi survey. A Delphi survey is a survey administered to participants several times to try and find a consensus on a topic; in this case, what conditions Clinical Psychologist need to be met to return full time to the NHS. You will be asked to complete the survey up to three times, over a three-month period and contacted via email each time to complete it.

At the end of the Delphi survey, there will be an option for you to show interest in taking part in a follow up mini-focus group, taking one hour, on Microsoft Teams, so we can learn more about the conditions rated in the Delphi survey. £10 Amazon vouchers will be given as a token of appreciation for taking part in the focus groups. A separate Participation Information Sheet and Consent Form will be given before this part of the study.

How much time will taking part in this part of the study take? The Delphi survey will take approximately 15 minutes to complete, for up to three rounds.

Can I withdraw from this part of the study once I have started? You can withdraw from the study while completing the first Delphi survey by just exiting the online survey. However, once you have submitted the first survey form you cannot withdraw your data. You may withdraw from the study between Delphi rounds, but again your previous round data cannot be withdrawn. We encourage you to only take part if you can complete all rounds of the Delphi survey, as otherwise this can affect the results of the study.

Who has reviewed the study? All research by the University of East Anglia is reviewed by a research ethics committee. This research was approved by the FMH (Faculty of Medicine and Health Sciences Research Ethics Committee [ETH2425-2471]).

Are there any benefits from participating in the study? By participating in this study you are helping us to understand what Clinical Psychologists need from the NHS to be able to return to working more hours within NHS commissioned services and less in the private sector. This is important to help support retention difficulties faced within the NHS Clinical Psychology workforce, in turn, providing support for the huge demand on NHS services at present.

Are there any disadvantages of taking part in the study? It is possible that the questions asked in the survey could cause some distress when reflecting on any challenges that you may have faced at work. Should this arise, please consider contacting your GP and occupational health team for support.

Confidentiality and Data Management
How will we use information about you? We will need to use information from you for this research project.

This information will include your email address and demographics. People will use this information to do the research. People who do not need to know who you are will not be able to see your contact details. Your data will have a code number instead.

We will keep all information about you safe and secure by storing it securely in accordance with GDPR, under password protection on the researchers university encrypted OneDrive. 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.

Your identity will remain confidential. Your email addresses will be stored with your survey responses and deleted once a summary of the study's findings has been emailed out to you. Your data will be anonymised once the Delphi rounds have ended.

The study findings will be published as part of a doctoral thesis, with hopes to also be published in an academic journal and disseminated at research conferences. The collected non-identifiable data may also be used in future research projects.

Your data will not be shared outside the UK.

How will we use information about you after the study ends? Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. We will keep your study data for a maximum of 10 years in accordance with UEA policy. The study data will then be destroyed.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have
- You have the right to ask us to access, remove, change or delete data we hold about you for the purposes of the study. You can also object to our processing of your data. We might not always be able to do this if it means we cannot use your data to do the research. If so, we will tell you why we cannot do this
- If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

Where can you find out more about how your information is used? You can find out more about how we use your information by;

- by asking one of the research team
- by sending an email to Hannah.Baily@uea.ac.uk

If you have any concerns about the study If you would like more information or have any questions then please contact the lead researcher by email: Hannah Baily hannah.baily@uea.ac.uk (Trainee Clinical Psychologist, Doctorate in Clinical Psychology at the University of East Anglia)

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent of the study but works at UEA then please contact Professor Niall Broomfield (N.Broomfield@uea.ac.uk). If you have any data subject queries, then please contact dataprotection@uea.ac.uk.

Will I be told the results of the study? Yes, after each round of the Delphi survey you will receive results before completing the next round. If you would then like to receive results of the overall study then click on https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fforms.office.com%2FPages%2FResponsePage.aspx%3Fid%3DIYdfxj26UUOKBwhI5djwkGnC_mTvw79KvQViHQeypUZUNjM2RzZTUU5CVkYxTlZTRjhKWTVKQzRZQy4u&data=05%7C02%7CHannah.Baily%40uea.ac.uk%7C2f921f46e8d043851c6908de0023f797%7Cc65f8795ba3d43518a070865e5d8f090%7C0%7C0%7C638948351628046373%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=8JBFaX%2Fe546walisGS8D5DaqmBHkq%2BbRZ6J9QuCiJvQ%3D&reserved=0 to subscribe to a clinical workforce data pool for updates.

Thank you for reading this information and showing interest in the study. If you would like to take part in the study, then please continue to the Participant Consent Form to provide your consent to take part.

At the end of the survey you will have the opportunity to download the who survey and information and consent forms, if you wish to keep a copy of them.

Participant Consent Form 1

1. By clicking yes, I give consent to participate in the Delphi survey part of the study and I am agree to the following;

    1. I have read and understood the participant information sheet and have had the chance to ask any questions or queries.
    2. I understand that participation is voluntary.
    3. I understand that I can withdraw from the study at any point before I have submitted the first Delphi survey.
    4. I understand that I cannot withdraw my data from the study once I have submitted the Delphi rounds data, as data will be analysed immediately between each Delphi round even if I chose to withdraw from the study between rounds.
    5. I understand that the only personally identifiable information I will give is my email address so I can be contacted to take part in future Delphi rounds and then once the Delphi rounds have ended my data will be anonymised.
    6. I understand that I will only be contacted via email to partake in the focus group rounds if I give consent at the end of the survey.
    7. I understand that my personal data will be stored securely by the research team and will be not shared with anyone outside of this and that all my published findings will be anonymised.
    8. I understand that the collected non-identifiable data from this study may also be used in future research projects.

*

◯ Yes, I give consent to participate in this Delphi survey part of the study

Appendix O

Participants Information Sheet Two

Mini-Focus Group - Participants Information Sheet 2

Clinical Psychology Workforce Sustainability: Delphi & Mini-Focus Groups

This Participant Information Sheet is regarding the mini-focus group part of the research study. This information will help you decide if you wish to take part in this part of the study, which is being undertaken as part of a doctorate project at UEA. Please read it carefully and contact the researchers if you have any questions.

What will this part of the study involve me doing? This part of the study will involve you taking part in an online mini-focus group, on Microsoft Teams, with the aim of learning more about the conditions that you rated in the Delphi survey about what you think would help Clinical Psychologists return full time to working in NHS commissioned services rather than the private sector. A £10 Amazon voucher will be given as a token of appreciation for taking part in the focus group. The focus group will be recorded.

Who can take part in this part of the study? You can take part in the mini-focus group if you have completed all rounds of the Delphi survey.

Do I have to be in this part of the study? Taking part in this part of the study is completely voluntary and whether you choose to take part in the study or not will not affect any relations with the University of East Anglia or affect your contribution to the Delphi rounds prior to this.

Who is conducting this part of the study? This part of the study is still being conducted by lead researcher Hannah Baily (hannah.baily@uea.ac.uk), under the supervision of Dr Jinnie Ooi (jinnie.ooi@uea.ac.uk), Dr Sheryl Parke (sheryl.parke@uea.ac.uk) and Dr Rachel Russell (r.russell@uea.ac.uk).

How much time will taking part in this part of the study take? The online mini-focus group will run for one hour.

Can I withdraw from this part of the study once I have started? You can withdraw from the study before the focus group starts and during the focus group. However, once you have started the focus group, you cannot withdraw your data as you will be influencing the discussion in the group. Quotes from the focus group will be non-identifiable in write-up. You may know other clinicians in the focus group, and we ask that you keep this confidential and just be aware of what thoughts you therefore share in the group. You can leave the focus group at any point should you wish to not continue if you feel uncomfortable in a group with others you know.

Who has reviewed the study? All research by the University of East Anglia is reviewed by a research ethics committee. This research was approved by the FMH (Faculty of Medicine and Health Sciences Research Ethics Committee [ETH2425-2471].

Are there any benefits from participating in the study? By participating in this study you are helping us to understand what Clinical Psychologists need from the NHS to be able to return to working more hours with NHS commissioned patients and less in the private sector. This is important to help support retention difficulties faced within the NHS Clinical Psychology workforce, in turn, providing support for the huge demand on NHS services at present.

Are there any disadvantages of taking part in the study? It is possible that the questions asked in the mini-focus group could cause some distress when reflecting on any challenges that you may have faced at work. Should this arise, please consider contacting your GP and occupational health team for support.

Confidentiality and Data Management

How will we use information about you? We will need to use information from you for this research project.
This information will include your email address and demographics. People will use this information to do the research. People who do not need to know who you are will not be able to see your contact details. Your data will have a code number instead.

We will keep all information about you safe and secure by storing it securely in accordance with GDPR, under password protection on the researchers university encrypted OneDrive. 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.

Your identity will remain confidential in the final write up of the study's findings. Your email addresses will also be hidden from one another during the Microsoft Teams call. Your email address will be stored securely and deleted once the mini-focus group has finished, and your Amazon voucher has been sent to you and a summary of the study's findings has been sent to you. You are asked to check you have a good internet connection before the group starts and to be in a room on your own to keep the group confidential from others. The mini-focus group video recording and the transcript will be stored securely and only the research team will have access to this. The video recording will be deleted once the transcript has been checked and formatted.

The study findings will be published as part of a doctoral thesis, with hopes to also be published in an academic journal and disseminated at research conferences. The collected non-identifiable data may also be used in future research projects. Your data will not be shared outside the UK.

How will we use information about you after the study ends? Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. We will keep your study data for a maximum of 10 years in accordance with UEA policy. The study data will then be destroyed.

What are your choices about how your information is used?

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

· You have the right to ask us to access, remove, change or delete data we hold about you for the purposes of the study. You can also object to our processing of your data. We might not always be able to do this if it means we cannot use your data to do the research. If so, we will tell you why we cannot do this

· If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

Where can you find out more about how your information is used? You can find out more about how we use your information by;

· by asking one of the research team

· by sending an email to Hannah.Baily@uea.ac.uk

If you have any concerns about the study If you would like more information or have any questions then please contact the lead researcher by email: Hannah Baily hannah.baily@uea.ac.uk (Trainee Clinical Psychologist, Doctorate in Clinical Psychology at the University of East Anglia)

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent of the study but works at UEA then please contact Professor Niall Broomfield (N.Broomfield@uea.ac.uk). If you have any data subject queries, then please contact dataprotection@uea.ac.uk.

Will I be told the results of the study? If you would like to receive the results of the study then click on https://forms.office.com/Pages/ResponsePage.aspx?id=IYdfxj26UUOKBwhI5djwkGnC_mTvw79KvQViHQeypUZUNjM2RzZTUU5CVkYxTlZTRjhKWTVKQzRZQy4u to subscribe to a clinical workforce data pool for updates.

Thank you for reading this information and showing interest in the study. If you would like to take part in the study, then please continue to the Participant Consent Form to provide your consent to take part.

Appendix P

Consent Form Two

Mini-Focus Group - Consent Form 2

Clinical Psychology Workforce Sustainability: Delphi & Mini-Focus Group

* Required

1. By clicking yes, I give consent to participate in this mini-focus group part of the study and I agree to the following;
   1. That I have read and understood the participant information sheet for the study and have had chance to ask any questions or queries.
   2. I understand that participation is voluntary.
   3. I understand that I can withdraw from the study at any point before and during the focus group.
   4. I understand that I cannot withdraw my data from the study once I have started the focus group as I will be influencing the discussion.
   5. I understand that the only personally identifiable information I will give is my email address so I can be contacted for my £10 Amazon gift voucher after the mini-focus group has finished.
   6. I understand that my email address will be hidden from other participants in the mini-focus group.
   7. I understand that the focus group will be recorded and transcribed by the lead researcher and data will be anonymised for analysis.
   8. I understand that my personal data will be stored securely by the research team and not shared with anyone outside of this, and all published findings will be anonymised.
   9. I understand that the collected non-identifiable data from this study may also be used in future research projects. *

◯ Yes, I give consent to participate in this focus group

Appendix Q

Debrief Form One

Delphi Debrief Form

Clinical Psychology Workforce Sustainability: Delphi & Mini-Focus Groups

Participant Debrief Form 1

What are the conditions needed for Clinical Psychologists to return to the NHS?
Thank you for participating in the Delphi survey part of this study. Your time and effort is so appreciated.

As stated in the Participant Information Sheet, you will not now be able to withdraw your data now that you have submitted your survey responses. You may withdraw from the study between Delphi rounds, but again, your previous round data cannot be withdrawn, and we encourage you to take part in all the Delphi rounds, as this can affect the results of the study if you withdraw between rounds.

Should the questions asked in the survey evoked some distress when reflecting on the challenges that you may have faced at work, please use support agencies such as your GP or your occupational health team or staff support. If you are in need of more immediate support/out of hours support, then please use mental health support option when calling 111, or attend your local A&E if you do not feel you can keep yourself safe.

If you would like more information or have any questions, then please contact the lead researcher by email: Hannah Baily hannah.baily@uea.ac.uk (Trainee Clinical Psychologist, Doctorate in Clinical Psychology at the University of East Anglia)

Thank you again for taking the time to participate in the study.

Appendix R

Debrief Form Two

Mini-Focus Group Debrief Form

Clinical Psychology Workforce Sustainability: Delphi & Mini-Focus Groups

Participant Debrief Form 2

What are the conditions needed for Clinical Psychologists to return to the NHS

Thank you for participating in the mini-focus group part of this study. We appreciate your time and effort. As a token of appreciation for taking part in the focus group we will be emailing you a £10 Amazon voucher. We will then delete your email address after we send out a copy of the study's summary.

As stated in the Participant Information Sheet, you will now not be able to withdraw your data.

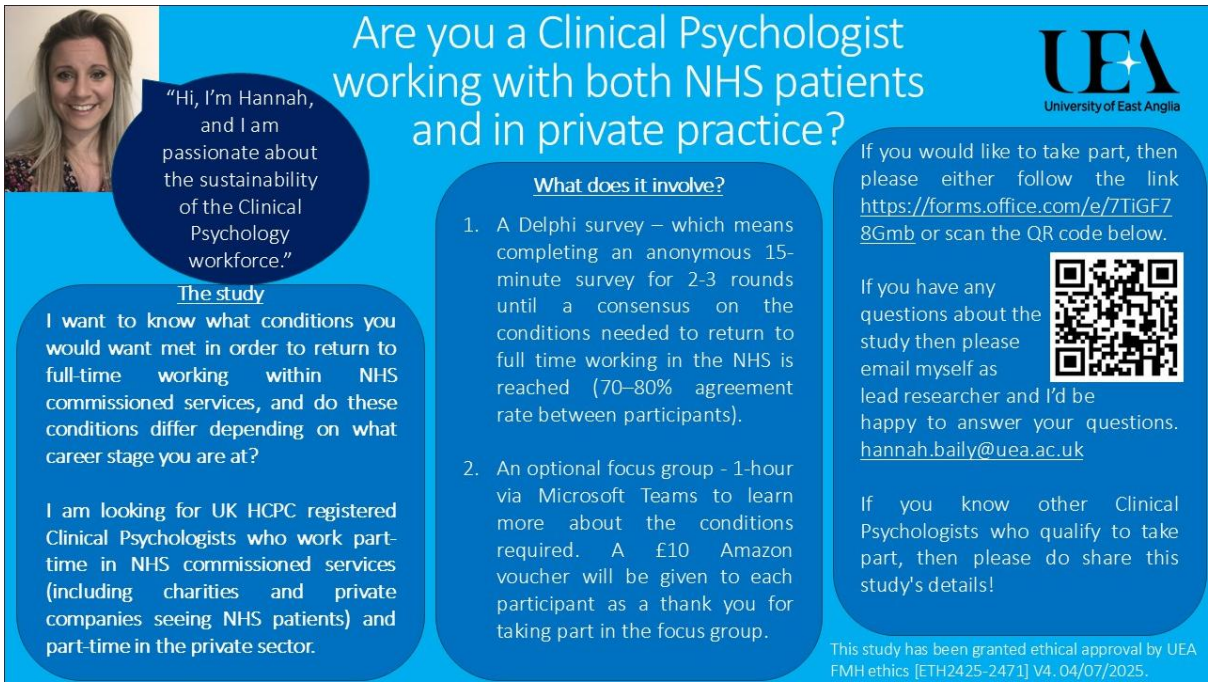
Should the questions asked in the survey evoked some distress when reflecting on the challenges that you may have faced at work, please use support agencies such as your GP or your occupational health team or staff support. If you are in need of more immediate support/out of hours support, then please use mental health support option when calling 111, or attend your local A&E if you do not feel you can keep yourself safe.

If you would like more information or have any questions, then please contact the lead researcher by email: Hannah Baily hannah.baily@uea.ac.uk (Trainee Clinical Psychologist, Doctorate in Clinical Psychology at the University of East Anglia)

Thank you again for taking the time to participate in the study.

Appendix S

Study Advert



Appendix T

Opt-in Form

Clinical Psychology Workforce Sustainability: Delphi & Mini-Focus Groups - Opt-in Form

Thank you for showing interest in taking part in this study, which is looking at what conditions Clinical Psychologists need to be met to return to full-time working within NHS-commissioned services.

Please complete this opt-in form if you work **part-time for NHS commissioned services (this may include charities or private companies commissioned to see NHS patients) and part-time in private practice (self-funding or private health insurance cover) only.** We can then contact you with further information about the study once we have enough interest in the study to start the Delphi rounds.

Please note that if we have already met the number of participants that we need for each career stage, then we may contact you to thank you for your interest but that we unfortunately have reached capacity for the study. Therefore, we would not be needing your time for this study but you may sign up to a data pool for further studies in the future.

* Required

1. Please tell us your email address so that we can contact you with further information about the study *

2. What career stage are you currently in after qualifying as a Clinical Psychologist? *

- ◯ 0 – 5 years (early career)
- ◯ 6 – 10 years (mid-career)
- ◯ 10+ years (later career)

3. What is your HCPC registration number so we can verify that you are a qualified Clinical Psychologist in the UK? (This information will be deleted once we can verify your registration, and it will not be stored with any subsequent responses in the Delphi rounds or focus groups.) *

Appendix U

Email to Invite Participants to Take Part in the Delphi Survey

Dear [insert name],

Thank you for showing an interest in this Delphi survey on conditions needed for Clinical Psychologists to return to the NHS.

I am contacting you to now invite you to take part in round 1 of the survey. At the bottom of this email you will be provided with a link to access the information sheet, consent form and demographics survey for the study before you complete round 1 of the survey.

Please complete this round by [insert date]. If you are unable to complete this round by this date or no longer want to take part in round 1, then please let me know by replying to this email.

Please click on the link below to access round1.

[insert link]

Yours sincerely,

Hannah Baily, Trainee Clinical Psychologist

Appendix V

Email Invite for Delphi Rounds Two and Three

Dear [insert name],

Thank you for completing round [insert 1 or 2] of the Delphi survey on conditions needed for Clinical Psychologists to return to the NHS.

I am contacting you to now invite you to take part in round [insert 2 or 3] of the survey. At the bottom of this email you will be provided with a link to access the next round. It will include feedback from the previous round about questions that have not yet reach consensus (70%) and you will be asked to re-rate them.

Please complete this round by [insert date]. If you are unable to complete this round by this date or no longer want to take part in round [insert 2 or 3] then please let me know by replying to this email.

Please click on the link below to access round [insert 2 or 3].

[insert link]

Yours sincerely,

Hannah Baily, Trainee Clinical Psychologist

Appendix W

Example of Delphi Survey Round 2/3

A consensus was not reached for participants. This means less than 70% of overall participants rated [insert condition] the same score. Below is the summary of the results from everyone who took part in round 1 and your own score compared.

Your previous score: [insert score]

Overall group median score: [insert score]

[Insert career stage group] median score: [insert score]

Scale:

Not important at all	Somewhat important	Moderately important	Very important	Extremely important
1	2	3	4	5

Responses (n): [insert scores]

After reading the feedback from round 1 and looking at your own rating, please re-rate your rating of [insert condition].

Not important at all	Somewhat important	Moderately important	Very important	Extremely important
1	2	3	4	5
○	○	○	○	○

[insert condition]

If you would like the opportunity to take part in a 1-hour focus group after the Delphi rounds have ended, then please tick yes below. If you do not wish to participate in this then please tick no. *

- Yes
- No

If you would like to keep a copy of the survey then you can download a copy by clicking on this link.

Thank you for taking part in this survey.*

Appendix X

Mini-Focus Group Email Invite

Dear [insert name],

Thank you for completing the Delphi surveys part of the study looking into the conditions needed for Clinical Psychologists to return to fulltime NHS commissioned services employment.

At the end of the survey, you gave your interest in taking part in a mini-focus group to learn more about the conditions required that you selected in your survey. I am therefore emailing you to invite you to take part in this mini-focus group and provide the details of this, as below.

The group will take place at [insert time], on the [insert date], on Microsoft Teams, and is intended to last for 1 hour. Your email address will be hidden from others in the group. We will video record the focus group and that and the transcript will be stored securely for only the research team to access.

For more information about the focus group, please click the link here to access the Participant Information Sheet [insert Participation Information Sheet 2]. If you are happy to take part, then please click here to sign the consent form for this part of the study before the focus group [insert Consent Form 2 link].

Please click on the link here to access the online focus group: [insert Microsoft Teams link]

If you have any problems accessing the link or have any questions or are no longer interested in taking part, then please email me.

Yours sincerely,

Hannah Baily, Trainee Clinical Psychologist

Appendix Y

COREQ: 32-item Checklist (Tong et al., 2007)

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	x
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	x
3. Occupation	What was their occupation at the time of the study?	116
4. Gender	Was the researcher male or female?	x
5. Experience and training	What experience or training did the researcher have?	116
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	116
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	x
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	116
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	75, 113-114

Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	71, 73
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	73
12. Sample size	How many participants were in the study?	68-69
13. Non-participation	How many people refused to participate or dropped out? Reasons?	115
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	73
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	x
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	68-69
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	70, 213-214
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	73, 114-115
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	73
20. Field notes	Were field notes made during and/or after the interview or focus group?	x
21. Duration	What was the duration of the interviews or focus group?	73
22. Data saturation	Was data saturation discussed?	x
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	x
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	76

25. Description of the coding tree	Did authors provide a description of the coding tree?	237-239
26. Derivation of themes	Were themes identified in advance or derived from the data?	75
27. Software	What software, if applicable, was used to manage the data?	75
28. Participant checking	Did participants provide feedback on the findings?	x
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	87-95
30. Data and findings consistent	Was there consistency between the data presented and the findings?	x
31. Clarity of major themes	Were major themes clearly presented in the findings?	87-95
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	87-95

Appendix Z

Example of RTA Coding and Theme Creation for the Mini-Focus Group

Mini-Focus Group Transcript	Familiarising self with the data	Coding	Initial themes	Developing and reviewing themes	Refining, defining and naming themes
"And and thinking about that across the services, but I think I think that the the thresholds of of perhaps gone up and I don't know, I don't know how we meet, I feel a bit politically I feel a bit panicky about meeting the needs of people."	NHS threshold for team and seeing CPs has gone up	NHS thresholds have changed for who see CPs. Politics being involved in NHS changes. CP's worried about meeting needs of patients.	Patient focused care important, NHS threshold changing	Change in service, effecting quality of care	Balancing service targets with quality of care (good enough care to reflect meaningful work)

"Yeah. No, that's fine. I was just going to go back to Ian's initial point about, you know, going into the profession, wanting to be people who are helpful to others and so often the NHS, how it is or just working your way up, often at the main part of the job, it just maybe feels like you sometimes feel like how am I helping people or you don't see the direct impact often of the work you do. Whereas I think often in private practise because what we said people being paying, being motivated, being ready most of the time anyway, you you see the results and it feels like you are helping people. And so it's maybe partly for our benefit as well as for theirs."	See results more in private practice, helps to see this as CPs. Link to Effort-Reward-Imbalance Theory	Hard to see in the NHS how you are directly helping people. Private easier to see results as people paying and motivated and this helps motivate CPs.	Clinical work motivates CP's, job satisfaction	Importance of clinical practice	Protected and valued clinical practice (meaningful work, aligned with ethical practice, motivation etc)

"Yeah, to some extent. Although I think I've got to a point where I would increase my NHS hours again if something came up that that would fit and have some of the flexibility that I'd have with private practise. But it just I did the private work just because with timing of being in a part-time job that having children starting school and having a bit more time, it just fit around my kind of childcare commitments and that things look a bit different now."	Private helped with flexibility around childcare, would increase NHS hours if can find this	Want to increase hours again but needs to be flexible like private work offers. Private work supported flexibility with childcare.	Flexible job planning	Flexible career	Flexible working across the lifespan (e.g. hours worked, childcare etc)