The Truth Behind the Murmurs:
Exploring Wellbeing and Employment Decisions Within the NHS Psychological Professions Workforce

Annabel Harding

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University of East Anglia

Faculty of Medicine and Health Sciences

Primary supervisor: Dr. Sheryl Parke

Secondary supervisors: Dr. Jinnie Ooi, Dr. Rachel Russell

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Thesis Portfolio Abstract

The National Health Service (NHS) is the UK's national health provider and is known as such across the world. However, more recently it has become known as a service of disillusion within, and for, its workforce. With demand continuing to outstrip supply, the wellbeing of staff is being sacrificed and their desire to continue their NHS employment is being weakened. By virtue of the emotionally-taxing work that psychological professionals do, this NHS workforce is one that continues to be affected by poor wellbeing and retention challenges. With retention being a key part of the NHS Long Term Plan, and significant investments being made into the expansion of the psychological workforce, the need to understand the wellbeing and employment decisions of the psychological professionals is underscored. This thesis therefore aims to complete this exploration in order to provide insight into the sustainability of the NHS psychological workforce and guide targeted strategies to ensure its longevity.

The primary exploration into the wellbeing of the NHS psychological professions workforce was conducted through a systematic review and narrative synthesis. This explored levels of stress and burnout within trainee and qualified NHS psychological professions, as identified within nine identified peer-reviewed empirical papers. The findings revealed stress and burnout to be key challenges for the select psychological professions that were explored. Differences in stress and burnout levels were found between professions, with career stage, individual-related factors, and organisational-related factors noted to pose influence. Heterogeneity in measure use and data reporting limited the scope of the review; thus, future research must be conducted that utilises the recommendations provided.

The secondary exploration into the employment decisions of early-career Clinical Psychologists (CPs) within the NHS psychological professions workforce was conducted through a proceeding empirical paper. This explored the factors associated with early-career

CPs thoughts and decisions to stay, work part-time, or leave their NHS employment. A total of 185 early-career CPs completed the online survey. Symmetries and asymmetries are found between the factors associated with early-career CPs thoughts and decisions regarding their NHS employment. Participants reported an effort/reward imbalance in their most recent NHS role, leading to most intending to reduce their contracted NHS hours over the next five years. Notably, this intention was for part-time NHS and part-time private work. The findings highlight the need for NHS organisations to be aware of the multiplicity of factors that influence early-career CPs thoughts and decisions regarding their NHS employment, from which targeted support that ensures the retention of this profession can be provided.

The findings of the review and empirical paper are discussed and critically evaluated, informing the final conclusions, clinical implications, and areas for future research, which are provided at the end of the portfolio.

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Chapter One: Introduction to Thesis Portfolio

Introduction to the Thesis Portfolio

The National Health Service (NHS) is formally known as the UK's national health provider; yet, in recent years, has become known as a "service of disillusion" for its workforce (House of Commons, 2021). It is one of England's largest employers, with a headcount of around 1.5 million staff working across various sectors: ambulance services, community and mental health care, hospital settings, and commissioning and central bodies (Rolewicz et al., 2024). This diverse workforce has contributed to the growth of the NHS over time, of which outpaced the 6.5% population growth seen between 2011-2021 (Beazley, 2024; Office for National Statistics, 2012; 2022). However, certain workforces have faced challenges; specifically, the NHS mental health workforce, which has grown at a slower rate than the wider NHS clinical workforce (Beazley, 2024). Consequently, the NHS has struggled to keep up with the pace of the ever-increasing demand placed on the service today, and has been described as being in a "critical condition" (HM Government, 2024, para. 2). Despite 77% of the public regarding the NHS as "crucial to British society" (Buzzeli et al., 2022, p.10), these same respondents provided a pessimistic view about its current state and noted its need for improvement. The King's Fund explored the factors that have contributed to the decline of the NHS, with reduced funding, limited capital investment, and inadequate workforce planning, alongside an ever-increasing service demand, to be at the core (Ham, 2023). This has left NHS staff feeling burnt out, under-valued, and compromising patient safety (Garratt, 2024). Consequently, retention has been labelled as a 'pressure point' (Buchan et al., 2019), with staff being expected to do more with less (British Psychological Society [BPS], 2023). The most recent NHS Staff Survey (NHS England, 2023) highlighted the consequences of this pressure, with 29% thinking about leaving their organisation on a frequent basis, and 21.44% wanting to look for a new job in a new organisation in the next 12 months. Indeed, May 2024 saw vacancy rates exceeding 100,000 across England (excluding primary care; Holden, 2023), thus resulting in retention being noted as a key challenge and a threat to the current state and survival of the NHS (BPS, 2024).

To tackle the NHS workforce crisis, a long-term national approach was agreed (Holden, 2023). This attracted much policy attention in order to increase workforce supply within the NHS in England (Leary et al., 2024). Here, key targets to meet current service demand were noted. For example, The NHS Long Term Workforce Plan (NHS England, 2023) set three priority areas to grow the NHS workforce. These were to 'train' new staff, 'retain' existing staff, and 'reform' the NHS. Indeed, the primary means of expanding the NHS workforce has been noted to be through the training of an appropriate number of staff to the appropriate professions (Beazley, 2024). Accordingly, an increase of 3.1% to 3.4% of NHS staff was set for between 2024 and 2037, resulting in an estimated 1-in-11 people working for the NHS, in comparison to the 1-in-17 at present (Warner & Zaranko, 2023). Yet, this focus on training and recruitment to support retention (as noted within the NHS 'Improving Staff Retention' handbook; NHS Employers, 2022), is what has arguably led to staff feeling unsupported, undervalued, and subsequently leaving their NHS employment (Morgan, 2022). Indeed, a notion of unrest has been indicated within the NHS workforce; particularly, during 2022 and 2023 where frequent periods of extended strikes were held by many professions. Whilst NHS strikes may have become a familiar feature within our lives (Anandaciva, 2024), they indeed offer confirmation of unrest within the workforce, which continues despite workforce efforts driven by the aforementioned policy targets.

In response to calls for a more psychological NHS in England (Whittington, 2024), specific targets were set for the mental health workforce. This was particularly so given the mental health workforce growing at a slower rate to the wider NHS clinical workforce, and therefore not keeping up with the previously noted population growth (Beazley, 2024). Accordingly, the end of 2017 saw the publication of the 'Stepping Forward to 2020/2021: the mental health workforce plan for England' (Health Education England, 2017), following which the size and nature of this workforce became a priority area. This plan reported the expansion that was required to meet the service provision targets set in the 'Five Year Forward View for Mental Health' (NHS England, 2016). In relation to the psychological

professions workforce, this included a significant expansion to the Improving Access to Psychological Therapies (IAPT) workforce, and the development of new psychological roles (e.g., Clinical Associate Psychologists [CAPs], Youth Intensive Psychological Practitioners, Mental Health and Wellbeing Practitioners). Moreover, further ambitions were set relating to an increase in access to evidence-based psychological care. Here, the Mental Health Implementation Plan (NHS England, 2019b) specified the required growth per psychological profession to meet these targets. Details of these were outlined within the Psychological Professions Workforce Plan for England (Health Education England, 2021), and included a 60% growth within the psychological professions' workforce from 2019 to 2024. However, the BPS described this plan as 'ambitious' with no clear evidence of the 'tangible benefits' from such psychological workforce expansion (BPS, 2022). Again, the prioritisation of recruitment over retention has been noted as a concern (Lavender, 2019), with psychological divisions – such as that of the Division of Clinical Psychology – calling for the urgent change of this approach at an organisational level (Varcoe et al., 2012).

At present, a total of 18 psychological professions comprise the NHS psychological workforce. This is an increase of six that has been seen as a result of such aforementioned investment and expansion. Recent data note the NHS psychological professions workforce to make up under 3% of the whole NHS professional workforce (Health Education England [HEE], 2021; NHS Workforce Statistic, 2022). Whilst no comprehensive head count of psychological professions in the UK exists, HEE (2021) records an estimated 20,100 psychological professionals within their report on the Psychological Professions Workforce Plan for England (Health Education England, 2021). Indeed, Rao et al. (2023) noted the importance of the support of these professionals to wellbeing across many domains of NHS service delivery. However, a paradoxical notion has further been recognised, whereby the wellbeing of such psychological professions is in fact not reported to be faring much better to those they support (Rao et al., 2023). Evidencing this, a Psychological Professional Wellbeing survey conducted in 2021, and a series of focus groups held in 2022, revealed the

general wellbeing scores of the psychological professionals to be below the national average, and 28.9% thinking about leaving the NHS once a week in the past 12 months (Rao et al., 2023). Within an organisation (such as the NHS) and a profession that attracts many to care for others, the associated conditions and pressures they comprise have led to an uncaring culture (Hacker-Hughes et al., 2016). This is seemingly having a knock-on effect to individuals' wellbeing and desire to stay within their NHS employment. Yet, in order to have an NHS that is 'fit for the future', the workforce must indeed be well (BPS Communications, 2025), and to meet the demands placed upon it, the workforce must be available (Beazley, 2024).

Given the key target of retention, research exploring the factors driving intentions and actual leaving of NHS employment has dominated literature within the healthcare field. This has predominantly been completed through empirical, governmental, and independent think tank explorations (e.g., Nuffield Trust, The King's Fund), and have mainly focused on stress and burnout within the nursing, psychiatry, and social care NHS workforces (Anne-Moore & Cooper, 1996; Babapour et al., 2022; Dall'Ora et al., 2020; Fothergill et al., 2004; Jovanovic et al., 2016; Kinman et al., 2023). However, literature on the wider NHS workforce adds to this by noting a variety of push and pull factors influencing staff retention; those are, factors that 'push' an individual to wanting to leave the NHS, and factors that 'pull' an individual to continue working for the NHS. In terms of push factors, these have been reported to include staff shortages, poor pay, impact on mental health, time pressures, inability to provide good patient care, and inflexible working hours (Weyman et al., 2023), as well as excessive workload, family commitments, poor management, and lack of career opportunities (Loan-Clarke et al., 2010). Conversely, pull factors, have been reported to include job security, pension, personal commitment to the NHS, colleagues, opportunities for flexible and parttime working, the ability to fit around family commitments, and career opportunities (Loan-Clarke, 2010; Weyman et al., 2023).

Theoretical frameworks are of utility when understanding the role of push/pull factors

towards NHS staff's employment decisions. Siegrist's (1996) Effort Reward Imbalance (ERI) Theory, which is rooted in medical sociology, has been adopted as a more recent stress model that holds utility in understanding stress and employment decisions within health professionals; advantageously, including and acknowledging both situational (extrinsic) and personal (intrinsic) contributors to such experiences and decisions (Derycke et al., 2010). It argues that individuals' experience an inequity, or 'imbalance', between the high efforts they put into their job versus the low reward they receive in return. Research has reported this imbalance to lead to an intent to leave one's employment (Derycke et al., 2010) and/or actual leaving of their employment (Loan-Clarke, 2010). Here, intention is particularly crucial, where it has been reported to be one of the strongest predictors of actual leaving amongst nurses (Hayes et al., 2006). The Theory of Planned Behaviour (TPB; Ajzen, 1991) can be utilised to understand its role and influence upon behaviour. It states that intention of a behaviour predicts subsequent engagement in that behaviour; the stronger the intention, the more likely the engagement in the behaviour. Here, intention is noted as the primary antecedent to behaviour, yet the model also notes that intention itself is influenced by three additional components: 'attitude towards the behaviour' (of the individual), 'perceived behavioural control' (the extent to which the individual perceives they have control over performing the behaviour), and 'subjective norm' (the perceived social pressure by others to the individual to perform or not perform the behaviour). This model has been key in understanding recruitment and retention within workplaces outside the NHS (Krausz et al., 1995), and within the NHS (Arnold et al., 2006). Arnold et al. (2006) found intention (and its components of attitude, subjective norm, and perceived behavioural control) to predict qualified and unqualified nurses, physiotherapists, and radiographers, intention to work for the NHS. Moreover, Coombs et al. (2010) applied this model to push/pull factors relevant to Allied Health Professionals intention to work for the NHS. They found that such factors do not necessarily translate into an intention to work for the NHS given their complexity and interplay. Whilst this may challenge the TPB, it also highlights the way in which NHS

employment decisions are multifaceted and therefore must be explored comprehensively.

Notably, stress and burnout are two push factors that have received significant attention within both research and media discussions, given their significant threat to NHS staff's wellbeing and retention. Stress and burnout were first recognised as difficulties in the 20th century, where they were linked to workplace settings, and particularly within that of healthcare settings for those in the helping professions (Maslach, 1982; Roy, 1988). This was due to the early understanding of the significant implications that this line of work poses to an individuals' wellbeing (Sampson, 1989). Within healthcare settings, these roles comprise the navigation of highly stressful and emotionally charged situations, usually in the face of real-life human challenges leading to suffering and/or mortality, long hours, exposure to physical risk factors, and high clinical demand (Jovanovic et al., 2016; The National Institute for Occupational Safety and Health, 2023). Whilst early empirical investigation into this area initially focused on the non-psychological professions (Lee & Ashford, 1990; Parkes, 1982), Cushway (1992; 1994; 1996) conducted pioneering research on stress within the Clinical Psychology profession, with a particular focus on Trainee Clinical Psychologists (CPs). At this early stage, no formalised measure existed, leading Cushway to develop one that was later utilised within the research, and of which later researchers have since used and developed from (e.g., Cushway & Tyler, 1994; Sampson, 1989). Since then, the recognition of stress in the workplace has grown, and new, validated measures have been developed (e.g., the Perceived Stress Scale [PSS-10]; Cohen et al., 1983). For burnout, the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) remains the primary tool for the measurement of burnout since its development in 1981. Indeed, additional validated measures have been developed for further use (e.g., the Professional Quality of Life Scale [ProQOL; Stamm, 1995], yet the MBI remains the key tool from which many versions have been developed (e.g., the Maslach Burnout Inventory – Human Services Survey [MBI-HSS; Maslach & Jackson, 1981], the Maslach Burnout Inventory – 2 item version [Maslach & Jackson, 1981]).

Today, stress and burnout are widely recognised as challenges to the wellbeing of those within the helping professions. Despite only being recognised as an occupational phenomenon in healthcare workers by the World Health Organisation in 2019, it has received increasing attention within NHS staff. Here, research notes NHS staff to be 50% more likely to experience chronic stress (The King's Fund, 2020; Wall et al., 1997) by virtue of the sustained pressure NHS staff work under (Care Quality Commission; CQC, 2022). Furthermore, the most recent NHS Staff Survey (NHS England, 2023) reported 41.71% of NHS staff feeling unwell due to work-related stress, with this being reported as a key driver to burnout (The King's Fund, 2020). Moreover, 30.38% reported feeling burnt out and 34.18% reported feeling emotionally exhausted (a core component of burnout; O'Connor et al., 2018) due to their work over the last 12 months (NHS, 2023). Indeed, stress and burnout experienced by NHS staff were exacerbated by the coronavirus (COVID-19) pandemic, which placed further amounts of pressure on already highly strained staff, leading to increased levels of stress and burnout (Andhavarapu et al., 2022). In response, mental health support and wellbeing hubs were set up to support the wellbeing of the NHS workforce; an important resource that has now subsequently stopped in some areas following the ending of the pandemic. Yet, stress and burnout are still being experienced. Where these conditions have been associated with increased thoughts of leaving NHS employment (BMJ, 2022), their prevention holds important implications for the retention of the NHS workforce.

Rather poignantly, a relative silence has persisted amongst the NHS psychological workforce. This has been reflected in both the real-life and research world. Here, psychology as a profession generally remained quiet during the aforementioned strikes, and solely sporadic research has been conducted into the experiences of the psychological professions to date. The anecdotal picture for the psychological workforce has been one that has been felt to be faced with increasing retention threats. Yet, solely murmurs, grey literature (Bernard & Wang, 2021; Katie, 2023) and podcasts (Gilderthorp, 2021) have been relied

upon to inform current insight, where conflicting messages exist. Anecdotal murmurs suggest an increasing number of psychological professions and, specifically CPs leaving their NHS employment. This is confirmed by research that notes growing numbers of CPs moving to the private world on either a part-time or full-time basis (Tolland & Drysdale, 2022). Yet, a recent review of CP turnover data states that, overall, CP NHS attrition is stable or even improving due to the increasing move of CPs to part-time working (Rosairo & Tiplady, 2024). Indeed, this gap between data and anecdote, and the contributing factors, requires further exploration.

The factors specific to the NHS employment decisions of CPs therefore remain relatively unknown. Recent research from one Scottish NHS Health Board reported caring responsibilities, work-related stress (as driven by systemic and management issues and increasing caseloads), and work-life balance to be the main drivers for CPs reducing their NHS hours (Tolland & Drysdale, 2022). A more recent review of the factors that are likely relevant to the retention of CPs and overall NHS psychological professions identified the pull of the private sector, challenges in fulfilling professional roles, difficulties in CPD access, and limited career progression to be key (Rosairo & Tiplady, 2024). Indeed, it is important to note that the implications of this move of CPs away from NHS employment are vast. Clinical Psychology has had the NHS at its core, both as a key element within the training pathway and qualified profession. However, if poor retention continues and more CPs moved to parttime or non-NHS employment, the profession risks facing significant change. Here, the NHS may no longer remain central to the profession, and the Doctorate in Clinical Psychology (DClinPsy) may shift towards a model of being privately funded. During a drive for greater inclusivity within the profession, such a shift could hold unintended consequences of driving more individuals out of it. This would drain the psychological professions workforce of a key profession, challenge expansion targets, and impact psychological service provision to those in need.

Indeed, the current day sees a time of expansion in CP training, as well as for the

psychological workforce as a whole. Ham (2023) emphasised the need for “realistic targets for efficiency savings” and called for prioritising investment in “capital, education and training, and public health”. This message is crucial in underscoring the importance of effectively managing the training pathway budget for all NHS psychological professions, which involves appropriate support for wellbeing in order to ensure both development and retention. Such retention has been noted as particularly important during the early-career period, which has been associated with individual, interpersonal, community, organisational, and policy challenges (O’Shaughnessy & Burnes, 2016). It could therefore be argued that the likelihood of individuals leaving their NHS employment is highest during this period. Indeed, Salomon’s University reported 98% of its DClinPsy graduates to work in the NHS within the first 12 months after qualifying (Lavender et al., 2012), of which was supported by 2022 data from the Clearing House (Clearing House, 2022). However, questions remain regarding what happens after this period, and if it is then that exit from NHS employment occurs, which wellbeing (e.g., stress and burnout) and other aforementioned factors may contribute to.

The overall aim of this thesis portfolio is therefore to explore the sustainability of the NHS psychological workforce. Notably, this is linked with Boorman’s (2009) landmark report regarding the difficulties that the NHS faces in terms of staff wellbeing and subsequent retention. It is further aligned with the aim of the NHS People’s Promise in ‘looking after our people’ by ensuring that all NHS staff are ‘safe and healthy’, and ‘a team that is united’ to provide support and care to those working within and using the NHS (NHS England, 2020). This exploration will be done via the completion of a systematic review, which will gain an understanding of the levels of stress and burnout within trainee and qualified NHS psychological professions. The empirical paper will then explore the factors associated with early-career CPs thoughts and decisions to stay, work part-time, or leave their NHS employment. A discussion and critical evaluation will be provided at the end of the portfolio, which will inform the final conclusions, clinical implications, and directions for future

research.

In light of multiple definitions, the definition for stress utilised in this work will be that of Lazarus and Folkman's (1984) from their model of transactional stress. This defines stress as a "particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her wellbeing" (Lazarus & Folkman, 1984, p.19). The definition for burnout utilised in this work will be that of Maslach and Jackson's (1981). Here, they reformulated and operationalised the concept of burnout to be that of a psychological syndrome that emerges following prolonged exposure to chronic interpersonal stressors within a job, comprising three key dimensions including overwhelming exhaustion, a sense of ineffectiveness and lack of accomplishment, and feelings of cynicism and detachment from the job. It is important to note that stress and burnout, whilst related, hold distinct differences to related concepts with which they often get confused, and referred to interchangeably, with; that is, with the terms 'wellbeing', 'occupational health', and 'mental health'. Wellbeing refers to a broad state of positive functioning that is linked to employee quality of life and organisational performance (Rao et al., 2023). Mental health refers to a continuum that fluctuates from thriving to experiencing difficulties, with the potential for individuals to live and work well even with serious mental health difficulties if adequate workplace support is provided (Thriving at Work, 2017). Finally, occupational health refers to a medical specialty that focuses on the physical and mental health of staff within the workplace (NHS Employers, 2023). The difficulty in the distinction of these terms overall, and with stress and burnout, lies within how all such concepts intersect; for example, higher levels of stress and burnout can reduce wellbeing and contribute to mental health difficulties (e.g., anxiety, depression), leading to the requirement of occupational health support in the workplace. However, high wellbeing can coexist with mental health difficulties, particularly if workplace support is strong (Keyes, 2005; Rao et al., 2023). The conceptual overlap between these constructs can therefore create challenges in making clear distinctions between them. However,

recognising such distinctions is essential in order to establish their individual meanings, and the way in which they intersect, coexist, and influence each other. This provides clarity to the findings of the current portfolio, in turn, supporting the clear development of targeted interventions for this NHS workforce.

It is hoped that both papers, and the portfolio as a whole, will fill important knowledge gaps regarding the wellbeing of the NHS psychological professions (as specifically related to and informed by the levels of stress and burnout within this NHS population) and the NHS employment decisions of CPs nationwide, guiding regional, national, and governmental insight and strategies.

Chapter Two: Systematic Review

Prepared for submission to *Mental Health & Prevention*

Author Guidelines are available in Appendix A

Levels of stress and burnout in trainee and qualified NHS psychological professionals: A systematic review and narrative synthesis

Annabel Harding*[1], Megan Stinton[1], Jinnie Ooi[1], Rachel Russell[1], Sheryl Parke[1]

[1]Department of Clinical Psychology and Psychological Therapies, University of East Anglia, United Kingdom

*Corresponding author information: Annabel Harding, e-mail: annabel.harding@uea.ac.uk

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Abstract

Background: Stress and burnout are widespread within NHS staff, with NHS psychological professionals particularly at risk. Despite ongoing investments into the expansion of the NHS psychological workforce, the extent to which these conditions are experienced remains unclear.

Objectives: This review sought to establish levels of stress and burnout within trainee and qualified NHS psychological professionals.

Methods: Systematic searches of nine electronic databases identified published papers that met criteria for inclusion. Papers were screened at all stages, leaving nine studies that were included and quality assessed. The review conformed to Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement (Moher et al., 2009) and Systematic and Synthesis Without Meta-Analysis (SWiM; Campbell et al., 2020) guidance.

Results: Moderate stress levels were revealed for trainee psychological professionals, with comparable levels between trainee professions. No stress levels were reported for qualified psychological professionals. Low-to-moderate levels of burnout were reported for trainee and qualified psychological professions, with Trainee Clinical Psychologist's reporting the highest levels of emotional exhaustion, and qualified Psychological Wellbeing Practitioners reporting the highest levels of overall burnout, compared to qualified peers. The training period, individual-related, and organisational-related factors were noted to increase levels of stress and burnout.

Conclusions: Stress and burnout are key challenges for NHS psychological professionals, with the training period noted to pose significant influence on their development. Limited studies examining select professions were compared; therefore, future research must explore the full range of psychological professions, utilising consistent measures and comprehensively reporting all data.

Keywords: NHS; stress; burnout; psychological professions; psychological workforce; psychology; mental health

1. Introduction

NHS staff have been referred to as the “shock absorbers” of a system under pressure (Point of Care Foundation, 2017, p.3). This has led to 41.71% of NHS staff experiencing work-related stress and 30.38% experiencing burnout (NHS, 2023). Both conditions are interrelated. Lazarus and Folkman’s (1984) model outlines stress to be a transaction between person and environment, which arises when an individual perceives the demands of their environment to exceed their internal and external resources to cope. Burnout is a psychological and stress-related syndrome (Maslach & Leiter, 2016), which is a result of prolonged exposure to stressors that leads to cynicism, detachment from a job, a lack of accomplishment and, ultimately, feeling ‘burnt out’ (Maslach, 1978a). Here, a stress-burnout relationship exists and does so on a spectrum, whereby prolonged and chronic stress can lead to burnout (Carson & Kuipers, 1998). The General Model of Burnout (Maslach et al., 1996) notes it to consist of three components: emotional exhaustion, depersonalisation, and (reduced feelings of) personal accomplishment, with emotional exhaustion argued to be at the core (O’Connor et al., 2018).

Stress and burnout are widespread in the helping professions (Grant & Kinman, 2014; Maddock, 2024; Volpe et al., 2014). NHS professionals are 50% more likely to experience stress compared to the wider working population (NHS Employers, 2024; The King’s Fund, 2020), with one in four experiencing symptoms of burnout most or every day (Weyman et al., 2023). High levels of burnout have been reported for social workers, nurses, occupational therapists, and doctors (Johnson et al., 2012; Khatatbeh et al., 2021; Tonkin, 2022), with the training period specifically driving high levels of emotional exhaustion (General Medical Council, 2024; Gomez-Urzquiza et al., 2023).

NHS psychological professionals are particularly at-risk. A 2021 survey reported their wellbeing to be lower than in 2019 and below the national average, with key qualitative drivers noted to be organisational factors including poor leadership and workplace culture,

service pressures, and limited staff support (Rao et al., 2023). Moreover, the work of psychological professionals exposes them to narratives of distress, loss, and trauma (Bearse et al., 2013; Simionato et al., 2019), and other risk factors for stress and burnout including the work environment, complexity of client presentations, and high job demand (Bakker et al., 2003; Escriba-Aguiar et al., 2006; Maslach, 1978a). Where organisational factors themselves can lead to stress and burnout, together this research highlights the importance of exploring stress and burnout as key drivers to (poorer) wellbeing within this NHS workforce. Indeed, such knowledge and wellbeing concern has prompted empirical research specifically into stress and burnout as driving factors within key psychological professions; notably, Trainee Clinical Psychologists (CPs; Cushway, 1992), qualified CPs (Cushway & Tyler, 1994; Hannigan et al., 2004), and Psychological Wellbeing Practitioners (PWPs; Westwood et al., 2017). Here, trainee and qualified career stages have been explored given the associated challenges of compounding clinical and academic demands as a trainee (Pakenham & Stafford-Brown, 2012), transitions from higher education to workplace (Rao et al., 2021), and change-in-status demands as a qualified clinician (Green & Hawley, 2009; Page et al., 2024).

Concerningly, the implications of stress and burnout are far-reaching. Professionals experience a loss of energy and role purpose, and reduced concern and positive feelings for their clients (Edelwich & Brodsky, 1980; Maslach, 1978a), contributing to reduced job satisfaction and increased sick leave (Mackay et al., 2004; Maslach et al., 2001). Consequently, services obtain poorer client treatment outcomes (Kinman et al., 2023), poorer client service satisfaction (Garman et al., 2002), and higher staff turnover (Maslach et al., 2001; Palmer & Rolewicz, 2023). For NHS England, this leads to an estimated cost of £12.1 billion per year from presenteeism, use of agency staff, and sickness absence (O'Meara, 2022). Such effects are particularly alarming given the current NHS workforce shortages. The NHS Long Term Workforce Plan reported a gap of more than 112,000 vacancies in March 2023, and a predicted gap of more than 260,000–360,000 professionals

in 2036/37, should no immediate action take place (NHS England, 2023). A need to expand the NHS psychological workforce was therefore set (NHS England, 2023), with significant investments being made into psychological profession training pathways and service provision (Whittington, 2024). It is thus crucial that this NHS investment does not go to waste should stress and burnout, and their associated implications, not be addressed.

To date, research into this profession has been sporadic, focusing on particular psychological professions within certain career stages (as aforementioned), certain service types (e.g., Child and Adolescent Mental Health Services [CAMHS]; Wintour & Joscelyne, 2024), and non-UK samples (Bearse et al., 2013; Stafford-Brown & Pakenham, 2012). An overview of stress and burnout within the NHS psychological workforce does not yet exist, though its need noted (Rao et al., 2021). This review addresses this gap by exploring the extent to which stress and burnout are experienced by trainee and qualified NHS psychological professionals; a crucial first step towards prevention and the subsequent retention of this NHS workforce.

The research questions of this review are:

1. What are the levels of stress in (a) trainee, and (b) qualified NHS psychological professionals?
2. What are the levels of burnout in (a) trainee, and (b) qualified NHS psychological professionals?

2. Methods

2.1. Study Design

The protocol for this review was pre-registered on PROSPERO on 6th March 2024 (reference: CRD42024511157). This review conforms to guidance provided by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement (Moher et

al., 2009), and Systematic and Synthesis Without Meta-Analysis (SwiM) methodology guidelines (Campbell et al., 2020).

2.2. Search Strategy

A systematic search strategy was developed to identify research papers that met the reviews research questions. An academic librarian at the University of East Anglia (UEA) was consulted prior to formal searches being completed to confirm the strategy and ensure the sensitivity of the search. Searches were completed on 26th March 2024 and refreshed on 21st November 2024. The following databases were searched: Scopus, ASSIA, MEDLINE, AMED, Academic Search Ultimate, CINAHL Ultimate, EMBASE, APA PsycINFO and PsycArticles. Searches were restricted to English language publications, but no restrictions were placed on the publication period. The use of nine databases and lack of additional search restrictions were intentionally chosen to maximise inclusivity and reduce the risk of missing relevant papers; however, this broad approach likely contributed to the large number of irrelevant papers identified at the early search and screening stages. Google Scholar and reference lists of included articles were also searched to identify additional relevant papers.

2.3. Eligibility Criteria

See Table 1 below for the inclusion and exclusion criteria. Seemingly relevant papers (e.g., BPS Workforce Wellbeing Surveys [Rao et al., n.d.]; Summers et al., 2020) were excluded due to using measures that assessed broader workplace wellbeing (including positive and negative job aspects, organisational structure, and work control and autonomy), as opposed to directly measuring and reporting levels of stress and/or burnout specifically. The narrow criterion of the review ensured that only papers specifically exploring these constructs and their associated levels were included, allowing for clear comparison and accurate estimation of levels within the NHS psychological professions population.

Table 1

Inclusion and exclusion criteria.

Inclusion	Exclusion
NHS psychological professionals – trainee or qualified	Studies and/or measures exploring levels of general distress (e.g., General Health Questionnaire), constructs within broader workplace wellbeing, or determinants or domains or consequences of stress and/or burnout
English language	
Quantitative studies, or mixed-methods studies where quantitative data can be extracted	
Validated psychometric measures specifically exploring levels of stress and/or burnout	
Data reporting levels of stress and/or burnout (e.g. means, standard deviations, percentage cut-off prevalence)	
Clear descriptions of the methodology, analysis, and results facilitating inclusion of paper and extraction of data	
Peer-reviewed journal articles only	

2.4. Screening and study selection

A total of 5168 articles were retrieved via database searches, which reduced to 3617 following the removal of duplicates using Rayyan (Ouzzani et al., 2016). The primary researcher (AH) screened all titles and abstracts, where most were excluded due to being related to stress and burnout within medical fields, exploring non-NHS and/or non-psychological professions, or exploring determinants of stress and/or burnout. This resulted in 39 papers for full-text screening. The secondary researcher (MS) screened 25% of the papers at each of these stages to ensure inter-rater reliability. A double-blind screening approach was used by the researchers using Rayyan. A 91% inter-rater agreement rate was found for the title and abstract screening ($k = 0.98$), where disagreement was managed via discussion before reaching a consensus. Perfect inter-rater agreement was found for

full text screening (k = 1.0). A total of 8 articles remained, which increased to 9 following the primary researcher's manual searches and checking of reference lists (see Figure 1 for the full PRISMA flow diagram).

2.5. Quality Assessment

The Newcastle-Ottowa Scale for cross-sectional studies (NOS; Wells et al., 2000) was used to assess the quality of the included studies and their risk of bias. This tool has been modified for use on cross sectional studies. It assesses a study's quality against defined quality criteria relating to their sample size and representativeness, response rate, outcome measurement and assessment, and statistical analyses (see Appendix B). The star system allows for the semi-quantitative assessment of the study's quality, where a star score closer to 10 indicates very good quality (Stang, 2010). Both the primary and secondary researchers assessed the quality of all (100%) of the included studies, with a 100% agreement rate between raters (k = 1).

2.6. Data Extraction

The primary researcher was responsible for extracting and summarising the data from the included studies. Data extracted were: population, sample size, outcome(s) measured, validated measure used, and levels of outcome(s) measured. See Tables 2-4 for summaries per trainee and qualified populations, with the addition of the study's quality rating. The secondary researcher completed a reliability check on 25% of the papers, which was met with a 100% inter-rater agreement rate (k = 1.0).

2.7. Data Synthesis

A meta-analysis was first attempted to synthesise the data. However, due to large inconsistencies in data reporting (leading to statistical and methodological heterogeneity),

this mode of synthesis was limited. The primary researcher emailed the authors of the nine included papers to request missing data, three of whom responded, though no data were provided. Therefore, a meta-analysis could not be conducted.

A narrative synthesis utilising SwiM guidance (Campbell et al., 2020) was therefore conducted for data synthesis. Due to methodological and psychometric heterogeneity, studies were synthesised on the outcome they measured (e.g., stress or burnout). Here, relationships and comparisons across trainee and qualified populations were explored, where possible. Standard metrics used within this synthesis were means, standard deviations, and prevalence rates of the measures' established cut-offs, though these varied across and within outcomes.

Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram.

*Mixed sample of psychological and non-psychological professionals; **Other factors related to stress and/or burnout explored e.g., sources, risk factors, mediators, influences, consequences;

***Solely non-psychological professionals included in the sample.

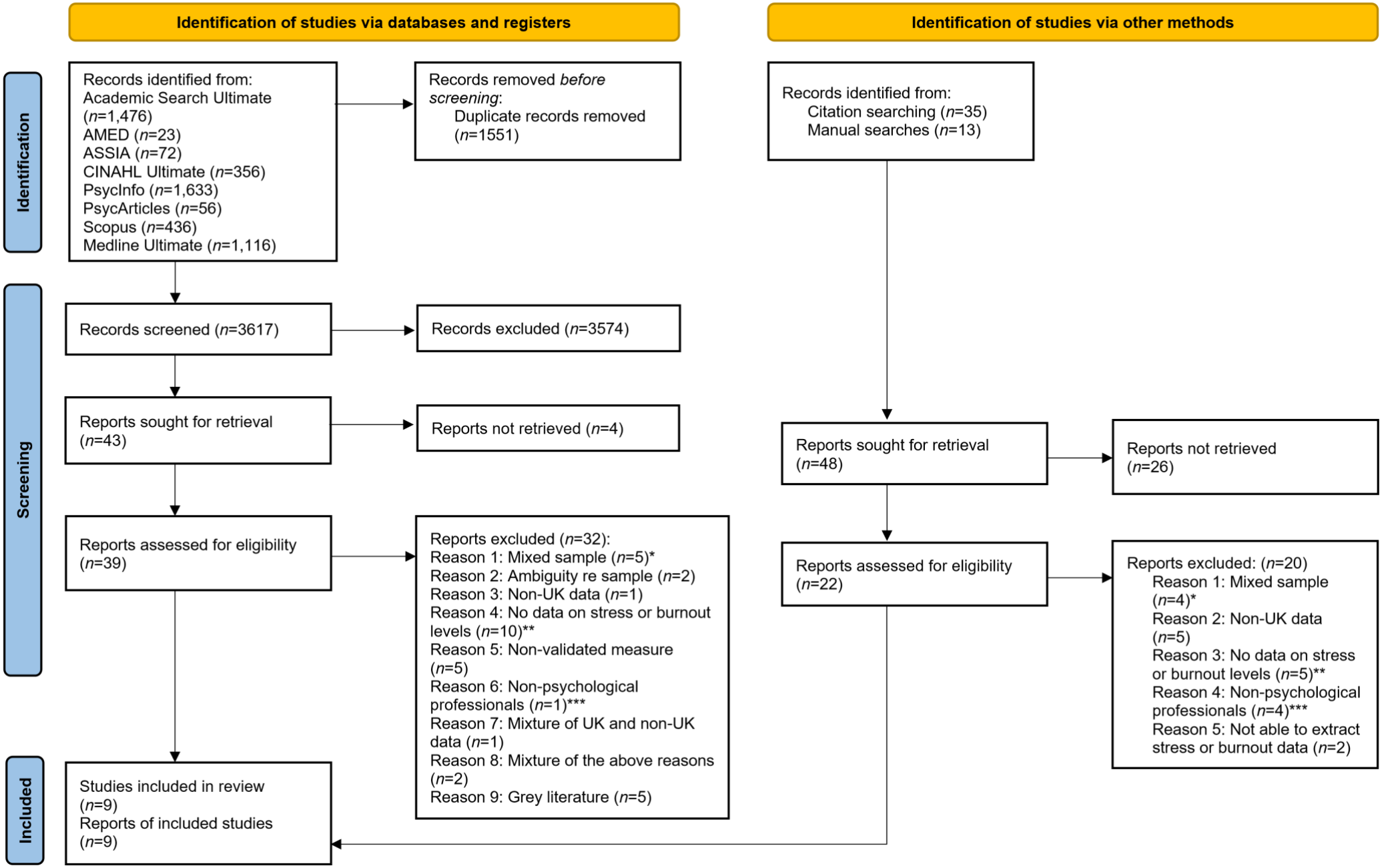

Table 2

Summary of the included stress studies for trainee NHS psychological professionals.

Author (year)	Psychological profession	Sample size and characteristics	Stress measure	Subscale M & SD	Total M & SD	Cut-off prevalence (%)	Quality rating
Kuyken et al. (1998)	Trainee Clinical Psychologists - First and second year	183	PSS-10	NR	*M* = 17.37 *SD* = 6.08	NR	Satisfactory
Carter et al. (2022)	Trainee Counselling Psychologists	45	PSS-10	NR	NR	**Low** 17.8% **Moderate** 71.1% **High** 11.1%	Satisfactory
Owen et al. (2022)	Trainee Psychological Wellbeing Practitioners – First year	90	PSS-10	NR	*M* = 15.70 *SD* = 5.75	NR	Satisfactory

Note. PSS-10: Perceived Stress Scale – 10 item version (Cohen et al., 1983); NR: Not Reported.

Table 3

Summary of the included burnout studies for trainee NHS psychological professionals.

Author (year)	Psychological profession	Sample size and characteristics	Burnout measure	Subscale M & SD	Total M & SD	Cut-off prevalence (%)	Quality rating
Rose et al. (2019)	Trainee Clinical Psychologists – Second year	214	MBI-HSS	**DP** *M* = 3.18 *SD* = 3.33 **EE** *M* = 21.65 *SD* = 9.39 **PA** *M* = 36.14 *SD* = 5.82	NR	**DP** Low = 86.4% Moderate = 12.1% High = 1.4% **EE** Low = 32.2% Moderate = 36.9% High = 30.8% **PA** Low = 36% Moderate = 42.1% High = 22%	Good
Beaumont et al. (2016)	Trainee Counsellors & CBT Therapists – Final year	54*	ProQOL (burnout subscale)	**BO** *M* = 21.60 *SD* = 5.70	NR	NR	Satisfactory

Note. *Mixed sample of professions. MBI-HSS: Maslach Burnout Inventory – Human Services Survey (Maslach & Jackson, 1981); ProQOL: Professional Quality of Life (Stamm, 1985); DP: Depersonalisation subscale; EE: Emotional Exhaustion subscale; PA: Personal Accomplishment subscale; BO; Burnout subscale; NR: Not Reported.

Table 4

Summary of the included burnout studies for qualified NHS psychological professionals.

Author (year)	Psychological profession	Sample size & characteristics	Burnout measure	Subscale M & SD	Total M & SD	Cut-off prevalence (%)	Quality rating
Delgadillo et al. (2017)	PWPs & CBT Therapists	49 PWPs: 13 CBT: 21	OLBI	**OLBI-D** PWPs *M* = 2.30 *SD* = 0.47 CBT *M* = 1.90 *SD* = 0.37 **OLBI-E** PWPs *M* = 2.40 *SD* = 0.53 CBT *M* = 2.30 *SD* = 0.48	NR	NR	Good
Westwood et al. (2017)	PWPs & High Intensity Therapists	201 PWPs: 105 HITs: 96	OLBI	**OLBI-D** PWPs *M* = 2.44 *SD* = 0.54 HITs *M* = 2.23 *SD* = 0.50 **OLBI- E** PWPs *M* = 2.64 *SD* = 0.56 HITs *M* = 2.49 *SD* = 0.50	NR	**PWP 68.6% **HITs 50%	Good
Kotera et al. (2021)	Psychotherapists	126	MBI 2-item version	**DP** *M* = 2.75 *SD* = 1.66 **EE** *M* = 1.86 *SD* = 1.48	NR	NR	Good
Steel et al. (2015)	PWPs & High Intensity Therapists	116*	MBI-HSS	**DP** *M* = 3.26 *SD* = 3.45 **EE** *M* = 20.47 *SD* = 9.7 **PA** *M* = 38.71 *SD* = 5.36	NR	NR	Good

Note. *Mixed sample of professions. **Percentage of professions categorised as experiencing problematic levels of burnout, as indicated by existing (non-validated) cut-offs. OLBI: Oldenburg Burnout Inventory (Demerouti, 1999); MBI 2-item version: Maslach Burnout Inventory (Maslach & Jackson, 1981); MBI-HSS: Maslach Burnout Inventory – Human Services Survey (Maslach & Jackson, 1981); OLBI-D; Disengagement subscale; OLBI-E; Exhaustion subscale; NR: Not Reported.

3. Results

3.1. Study Characteristics

Table 5 summarises the characteristics of the included studies. Only seven NHS psychological professions were explored in total, missing the remaining 11. Most papers were published in 2017 (*n* = 2) and 2022 (*n* = 3), explored burnout (*n* = 7), and explored qualified psychological professionals (*n* = 5). Half of the papers (*n* = 5) comprised samples of mixed characteristics, which inhibited the extrapolation of these individual data. The ways in which data were reported varied considerably.

3.2. Quality Ratings

Using the NOS (Wells et al., 2000), four studies gained ‘good’ quality ratings (stars ≥ 7), four studies gained ‘satisfactory’ quality ratings (stars ≥ 5), and one study gained an ‘unsatisfactory’ quality rating (stars ≥ 4). Ratings were strengthened by the representation and size of the sample, validated measures used, and appropriate statistical tests conducted. However, they were weakened by the self-report methodology adopted, which likely influenced the subsequent low ratings on the comparability between participants (e.g., in other outcome groups), and between responders and non-responders.

Table 5

Characteristics of included studies.

Characteristic	***n***
Year of Publication	
1998	1
2015	1
2016	1
2017	2
2019	1
2022	3
NHS Psychological Professions	
Clinical Psychologist	3
Counselling Psychologist	2
CBT Therapist	2
Psychological Wellbeing Practitioner	4
High Intensity Therapist	2
Counsellor	1
Psychotherapist	1
Sample	
Mixed Training Years	1
Mixed Trainee Professionals	1
Mixed Qualified Professionals	2
Outcome by population	
Stress	3
Trainee	3
Qualified	0
Burnout	7
Trainee	2
Qualified	4
Measure	
PSS-10	3
MBI-HSS	2
MBI 2-item version	1
ProQOL	1
OLBI	2
Reporting	
Subscale(s) – M, SD	6
Total – M, SD	2
Total – Percentage cut-off prevalence	3

Note. '*n*' indicates the number of papers that the characteristic arises within; *n*>10 for 'NHS Psychological Professions' and 'reporting' due to professions and reporting styles being present in more than one paper; *n*<10 for 'sample' due to these sample characteristics only arising in select papers.

3.3. Stress

3.3.1. Stress in trainee NHS psychological professionals

Three of the included studies explored stress in trainees, all using the Perceived Stress Scale – 10 item version (PSS-10; Cohen et al., 1983). No formalised, published cutoffs exist for this measure; however, arbitrary cut-offs were suggested (0-13 = low, 14-26 = moderate, 15-19 = moderately severe, 27-40 = severe) and used in previous research (Carter et al., 2022; Debski et al., 2021; Swaminathan et al., 2015). Using these, trainees reported moderate levels of stress; specifically, Trainee CPs (M = 17.37, SD = 6.08) reported marginally higher levels of moderate stress than Trainee PWPs (M = 15.70, SD = 5.75). The majority (71.1%) of Trainee Counselling Psychologists also fell within this moderate range.

3.3.2. Stress in qualified NHS psychological professionals

None of the included studies explored stress in qualified professionals. The exploration of research question 1b was therefore not possible.

3.4. Burnout

3.4.1. Burnout in trainee NHS psychological professionals

Two studies explored burnout in trainees. Beaumont et al. (2016) used the Professional Quality of Life Scale (ProQOL; Stamm, 1995) and reported a mean burnout score for both Trainee Counsellors and Trainee CBT Therapists combined (M = 21.60). This score falls within the ‘low’ burnout range (M = <22) and is lower than reported normative scores for general helping professions (M = 47.55; Stamm, 2010). Rose et al. (2019) used the Maslach Burnout Inventory – Human Services Survey (MBI-HSS; Maslach & Jackson, 1981). They reported Trainee CPs (in their second year of study) to fall within the ‘low’ burnout range for ‘depersonalisation’, and the ‘moderate’ burnout range for ‘emotional exhaustion’ and ‘personal accomplishment’, as per previously reported cut-offs (Maslach et al., 1996). Using recommended (Dyrbye et al., 2009), inclusive (Lin et al., 2019), and restrictive (West et al., 2009) definitions, trainees did not meet criteria for clinical levels of burnout.

3.4.2. Burnout in qualified NHS psychological professionals

Four studies explored burnout in qualified professionals. Delgadillo et al. (2017) and Westwood et al. (2017) used the Oldenburg Burnout Inventory (OLBI; Demerouti, 1999). No validated cut-offs exist for this measure; however, the authors of the inventory suggest a mean subscale score of ≥ 2.85 for 'exhaustion' and ≥ 2.6 for 'disengagement' for 'very high burnout'. Using these cut-offs, no qualified professionals in the included studies met the 'very high burnout' range. Specifically, mean scores were consistently highest for PWPs across both subscales in both studies. Furthermore, they were closest to the aforementioned 'very high burnout' cut-offs (e.g., M = 2.30 and M = 2.44 for 'disengagement' and M = 2.64 and M = 2.40 for 'exhaustion'), in comparison to CBT Therapists and High Intensity Therapists (HITs). Two studies used the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981); one using the full version (Steel et al., 2015), and one using the 2-item version (Kotera et al., 2021). Due to these differing versions and the reporting of solely subscale means in the 2item version (as opposed to summative subscale scores that are noted as necessary by LiSauerwine et al., 2020), comparisons between the two studies are not possible. Taken individually, Steel et al. (2015) reported a mixed sample of HITs and PWPs to fall within the 'low' burnout range for 'depersonalisation', and the 'moderate' burnout range for 'emotional exhaustion' and 'personal accomplishment'. Using aforementioned burnout definitions (Dyrbe et al., 2009; Lin et al., 2019; West et al., 2009), these qualified professionals did not meet criteria for clinical levels of burnout. Similarly, Kotera et al. (2021) reported Psychotherapists to also not meet criteria for burnout, as informed by research noting the mid-point value of 3 to be the cut-off for both subscales of this 2-item measure (Li-Sauerwine et al., 2020).

4. Discussion

The review synthesised findings on levels of stress and burnout within the NHS psychological professions workforce. Only a small pool of studies (*n* = 9) met criteria for inclusion, resulting in limited evidence for each construct and career stage. The findings therefore tentatively revealed moderate levels of stress for trainee psychological professions, where mean scores were higher than the general population (Cohen and Williamson, 1988;

Klein et al., 2016), normative scores for the PSS-10, and 'other healthcare professionals' (Kostaki, 2018). Supported by research that also reports moderate levels of stress within trainee psychological professions (Cushway, 1992; Lloyd, 2017), this could suggest that it is the training period that influences such levels. This hypothesis is supported by research that attributes it to the high workloads, work setting, time pressure, constant evaluation, and long commutes that trainees face (Jones & Thompson, 2017; McCormack et al., 2018). The Alternative Handbook for 2024-2025 (the British Psychological Society [BPS], 2024), an annual trainee-led guide to each UK DClinPsy course, reports 16% of trainee CPs to have caring responsibilities, 32% to have a disclosed disability, and 85% to be female (increasing the likelihood of childcare responsibilities). These demographics and additional potential influencing factors are little explored, though must be acknowledged as likely to also increase trainees' moderate stress levels.

Marginal differences in stress levels were revealed between trainee professions; notably, Trainee CPs and Trainee PWPs. This aligns with a wealth of research noting the problematic levels of stress of these trainee professions (Cushway, 1992; Hannigan et al., 2004; Owen et al., 2021; Steel et al., 2015; Westwood et al., 2017), as attributed to the simultaneous mental health clinician and university student roles they hold (Owen et al., 2021). Such comparable levels are therefore perhaps unsurprising given such dual-role similarity, and further emphasises the training period being a key influence, over and above the distinct psychological profession. Indeed, research reports that, at the start of training, Trainee PWPs experience higher stress levels compared to the general population (Owen et al., 2022), and that the stress levels of trainees exceeds the levels of their qualified counterparts (Cushway, 1992; Kostaki, 2018; Owen et al., 2021; Pakenham & Stafford-Brown, 2012). Persistent stress has been associated with an increased risk of anxiety and low mood (Carter et al., 2022), and burnout (Debski et al., 2021). Such elevated stress levels during training may therefore hold important implications for wellbeing by increasing one's risk of mental health difficulties (e.g., anxiety and low mood), and development of burnout, in turn, lowering overall wellbeing. This should be considered by both training and NHS organisations in order to ensure the potential negative effects of higher stress levels upon trainee NHS psychological professionals' mental health and overall wellbeing is prevented.

Moreover, the elevated stress levels for trainees could explain the lack of stress research for qualified psychological professionals, where chronic exposure to persistent stress during training is resulting in the entering of qualified psychological roles already burnt out from training (Carter et al., 2022). Indeed, the review revealed low to moderate levels of burnout for trainee and qualified psychological professionals. Interestingly, these challenge widespread reports of higher levels of burnout for NHS professionals (NHS, 2023), and previously cited levels for similar healthcare professions (Johnson et al., 2012; Khatatbeh et al., 2021; Tonkin, 2022). However, most stark are the comparable burnout levels between the trainee and qualified professions for studies using the MBI-HSS and the ProQOL (where trainee mean scores were only slightly lower than updated ProQOL norms for other qualified mental health professionals; Hegarty & Buchanan, 2021). Such comparable levels may be explained by the shared workplace demand (Simionato & Simpson, 2018) and organisational and environmental risk factors (Kinman et al., 2023; Morse et al., 2012; Vivolo et al., 2024; Westwood et al., 2017) that both professions face within the NHS. However, they further highlight the extent of the trainee demand that is resulting in similar burnout levels to that of qualified colleagues.

Specifically, qualified PWPs scored highest across OLBI burnout subscales in comparison to HITs and CBT Therapists. This aligns with research reporting high levels of burnout for PWPs compared to Increasing Access to Psychological Therapies (IAPT) colleagues (Steel et al., 2015), with a 69% prevalence rate (Westwood et al., 2017), and it being recognised as a key challenge to today's IAPT workforce (Health and Social Care Committee, 2021). In fact, Fishburn and Thompson (2023) report burnout to increase with PWPs training years, leading to the entering of qualified PWP positions with already high levels of burnout. Similarly, the findings of the MBI-HSS revealed Trainee CPs to score highest in 'emotional exhaustion'; a domain considered to be the core dimension of burnout (O'Connor et al., 2018). This, again, highlights the role of the training years in driving burnout. Yet, Delgadillo et al. (2017) and Westwood et al. (2017) described samples of younger and lesser experienced qualified PWPs with notably larger caseloads, making such higher burnout levels less surprising given these individual and organisational-related factors. Where burnout has been described as a developmental process (Kinman et al., 2023), its sequential model notes its progression into

depersonalisation and professional inefficacy over time (Maslach et al., 2001). This holds important implications to job performance, wellbeing, and retention (Kinman et al., 2023), additionally noted for the OLBI's disengagement subscale (Delgadillo et al., 2018). The need for prevention and early intervention during the training years is therefore crucial to prevent increased stress levels and this subsequential development of burnout, and associated job performance and retention implications. Here, a systemic approach by organisations is recommended to support qualified clinicians' wellbeing and prevent increasing levels (e.g., BPS, 2021; Kinman et al., 2023).

The findings of lower stress and burnout levels within psychological professions compared to non-psychological professions may be surprising, though align with previous research (Ben-Zur & Michael, 2007; Johnson et al., 2012). Several hypotheses are provided. First, training programmes may be sufficiently promoting and including self-care, as reported as vital within literature exploring trainee stress reduction and burnout prevention (BPS, 2021; Carter, 2021). Second, psychological professionals are required to be 'reflective practitioners' (BPS, 2017; Schon, 1983), which is emphasised during training and upon qualifying within clinical supervision (Ooi et al., 2023). Here, regular clinical supervision is unique to the psychological professions and is reported to hold restorative benefits for wellbeing (Proctor, 1988), particularly when coupled with reflection (Ooi et al., 2023). Third, psychological professions are increasingly moving to part-time NHS employment post qualifying (Rosairo & Tiplady, 2024), which can provide a buffer from NHS demands leading to higher stress and burnout levels. Finally, Summers et al. (2021) reported the role of demographic and role-related factors in influencing burnout within psychological practitioners, which should be considered when understanding and comparing such levels. Future research should explore these hypotheses to understand them as potential protective factors supporting the overall wellbeing and retention of this workforce.

Finally, the explorations into psychological professionals' stress and burnout levels are sparse; notably, only truly conducted at the latter end of COVID-19. A 17-year gap is seen between Kuyken et al.'s (1998) and Steel et al.'s (2015) papers, following which few additional papers were published. Whilst not stating that no research was completed during this period, none met criteria for the current review. Such an absence may show

how staff wellbeing (as understood as an overarching construct that is distinct from, but can be influenced by, stress and burnout [Rao et al., 2023]) was only truly regarded as a priority after the COVID-19 pandemic, at which point stress and burnout were already being experienced. For the platform upon which NHS staff wellbeing stands to improve (Rao et al., 2023), increased and consistent empirical investigation into its influencing factors, such as stress and burnout (utilising the proceeding recommendations) must be completed.

4.1. Clinical Implications, Limitations and Future Research

To the author's knowledge, this is the first review to synthesise and separate data on levels of stress and burnout within trainee and qualified NHS psychological professionals. The findings hold important implications. If trainees experience stress and burnout during training, retention within the services and organisations within which they trained is likely reduced. For the NHS, this means misspent training money, reduced workforce numbers, and challenged service delivery and treatment outcomes. Training pathways must continue to reduce stress and burnout during training, acknowledging all contributing factors to their occurrence. This should be guided by research into the determinants of stress and burnout specific to psychological professions (Stinton, 2025a). Moreover, NHS organisations must take a systemic approach (BPS; 2021; Kinman et al., 2023) to address individual and organisational contributors to stress and burnout at the qualified career stage. Where the findings confirm a picture of an at-risk workforce, the continuation of NHS Staff Mental Health Hubs in England is vital to support its sustainability (BPS, 2023).

Some limitations of the review are noted, informing areas for future research. Firstly, the review only included nine studies, with none exploring stress in qualified, nor stress and burnout in the newer, psychological professions. Whilst underscoring the scarcity of the current UK evidence-base, this was further driven by many papers being excluded due to using measures of general distress or overall wellbeing, as opposed to specifically and solely measuring levels of stress and/or burnout, and including non-psychological professions. The latter was a difficulty within few included studies, where samples of mixed characteristics (e.g., of training years and of different NHS psychological professions) prevented desired data

extraction. Indeed, data reporting was a key limitation of the included studies, where inconsistencies reduced the amount of data available, prevented the desired synthesis, and limited the conclusions drawn. This was further influenced by the use of heterogeneous measures, which limited the concise establishment of burnout levels (due to differing definitions; BPS, 2021; Dyrbye et al., 2009) and overall comparisons. Such heterogeneity was noted by Dyrbye et al. (2009), Hannigan et al. (2004), and Owen et al. (2021), yet remains a challenge. Moreover, the included studies used self-report methodology, resulting in increased bias via subjectivity. This was potentially further increased by the professional stigma of being stressed and burnt out within the helping professions (Edwards & Crisp, 2017), leading to more socially desirable responses. Finally, such methodology further reduced the included studies quality by preventing the comparison of participants, and responders with non-responders. Taken together, future research must use consistent measures that directly explore stress and burnout, report data comprehensively (e.g., to its finest levels and for all measure components), and incorporate qualitative methodologies to reduce bias and increase study quality.

5. Conclusions

The findings of the review revealed stress and burnout to be key challenges for trainee and qualified NHS psychological professionals. A variety of training stressors likely contribute to moderate stress levels in trainees, and subsequent low to moderate levels of burnout in trainee and qualified psychological professionals. Early prevention and intervention during the training years is therefore crucial, as well as a systemic approach adopted by workplaces. Notably, the review identified stress and burnout research for NHS psychological professions to be scarce, inconsistent, and even non-existent for the newer psychological professions. Future research must be conducted, using consistent measures, and comprehensively reporting all data. This will help to gain a broader picture that is vital to support the wellbeing, retention, and safe practice of this NHS workforce.

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Author contributions

Megan Stinton: Conceptualisation, data screening, quality assessment, involvement in supervision, writing (review and editing)

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Highlights

- Trainee NHS psychological professionals experience moderate levels of stress
- Trainee and qualified NHS psychological professionals experience low-to-moderate levels of burnout
- The training period is a key influence on trainee psychological professionals stress and burnout levels
- Trainee psychological professions are entering qualified roles already burnt out from training, holding implications to their wellbeing, patient outcomes, and workforce retention
- No stress or burnout research exists for the newer NHS psychological professions that have been a result of the expansion to the workforce

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Chapter Three: Bridging Chapter

Bridging Chapter

This chapter links the systematic review to the empirical paper, presenting research that outlines their association and providing rationale for the exploration conducted within the empirical paper.

The systematic review explored levels of stress and burnout within NHS psychological professionals. This was driven by research noting the increased prevalence of stress and burnout within NHS staff (BMJ, 2022; CQC, 2022; NHS Employers, 2024, NHS England, 2023), as well as NHS psychological professionals due to the many risk factors they are exposed to (Bakker et al., 2003; Bearse et al., 2013; Escriba-Aguiar et al., 2006; Maslach, 1978a; Simionato et al., 2019). Whilst prevalent pre-COVID-19 (NHS England, 2021), the pandemic placed an increased pressure on services, and subsequently exacerbated the prevalence of stress and burnout within NHS professionals (BMJ, 2021; Giusti et al., 2023). This has had a knock-on effect on retention. Here, the most recent NHS Staff Survey (NHS England, 2023) revealed 29% of NHS staff often thinking about leaving their job, 21.4% reporting they will look for a new job in the next 12 months, and 15.7% reporting they will leave their organisation as soon as an alternative role arises. Whilst these statistics may seem promising, they are indeed higher than those reported in 2019 (NHS Providers, 2024).

Yet, stress and burnout are not the only factors posing threats to NHS retention. Key threats of poor working conditions and pay resulted in extended strikes being held in 2024 by staff within the NHS in England, including doctors, nurses, and ambulance services (Garratt, 2024). Indeed, a total loss of 9.1% of NHS staff in 2022 was reported to be due to pay, though was additionally due to reward, work-life balance, progression, and health and wellbeing factors (Ahmed, 2023). This is supported by literature conducted within the wider NHS workforce (Weyman et al., 2023), which identified a variety of push/pull factors to NHS staff's employment decisions within the post-COVID-19 world. Such factors have been mirrored within NHS psychological workforce literature (Loan-Clarke et al., 2010; Rosairo & Tiplady, 2024; Tolland & Drysdale, 2022), with key recommendations for future research being noted to support further insight specific to this workforce. These included exploring the factors relevant to those who have left their NHS employment to work in private practice (Tolland &

Drysdale, 2022), and to explore the factors relevant to those who have stayed within their NHS employment (Loan-Clarke et al., 2010).

Currently, a gap in the literature exists for the empirical investigation of the push/pull factors specific to a nationwide sample of CPs, with the inclusion of the aforementioned recommendations. To date, UK empirical investigation has solely included samples of Allied Health Professions as a whole (Coombs et al., 2010; Loan-Clarke et al., 2010), or of CPs solely from one (Scottish) Health Board (Tolland & Drysdale, 2022). Otherwise, there is merely a reliance on grey literature (Bernard & Wang, 2021; Gilderthorp, 2021; Katie, 2023) and anecdotal murmurs to inform current insight on CP retention. Filling this gap is of crucial importance for several reasons. Firstly, where retention is a key part of the NHS Long-Term Workforce Plan (NHS England, 2023), and CPs form the largest proportion of psychological professionals bringing unique value to the NHS (Whittington, 2024), the need for the CP workforce to continue and grow is vital. Secondly, where significant investment continues to be made into the psychological workforce and the CP profession (e.g., via DClinPsy training places), it is crucial that these investments are not being wasted through poor NHS retention. Lastly, for a continued psychological NHS to be provided, the longevity of this key profession within the NHS psychological workforce is essential.

Chapter Four: Empirical Paper

Prepared for submission to *Health Services Management Research*

Author Guidelines are available in Appendix F

The Truth Behind the Murmurs: Factors Associated with Early-Career Clinical Psychologists' Staying or Leaving NHS Employment

Annabel Harding*[1], Megan Stinton[1], Jinnie Ooi[1], Rachel Russell[1], Sheryl Parke[1]

[1]Department of Clinical Psychology and Psychological Therapies, University of East Anglia, United Kingdom

*Corresponding author information: Annabel Harding, e-mail: annabel.harding.ac.uk

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Abstract

Objectives: This study is the first to explore early-career Clinical Psychologists' (CPs) thoughts and subsequent decisions regarding their NHS employment.

Methods: 185 early-career CPs completed an online survey. Logistic regressions, descriptive statistics, and chi square tests were run using Jamovi and Microsoft Excel.

Findings: Fleeting thoughts to leave NHS employment were associated with extrinsic professional motivators. These mirrored part-time NHS employment push factors, and resulted in reduced leaving of NHS employment. Serious thoughts to leave NHS employment were associated with organisational, service, and individual-related factors, which mirrored non-NHS employment factors, and resulted in comparable rates of staying versus leaving NHS employment. Stable characteristics of the NHS and its rewards were associated with part-time (pull factors) and full-time NHS employment. Alongside a perceived effort-reward imbalance in their NHS roles, early-career CPs intend to reduce their NHS hours via mixed NHS and non-NHS (private) employment over the next five years, suggesting their gradual NHS exit.

Conclusions: Symmetries and asymmetries were found between the factors associated with early-career CPs thoughts and decisions regarding their NHS employment. A gradual exit from NHS employment is noted. Organisations must therefore address these factors and target support accordingly to prevent full NHS exit over time.

Keywords: NHS, Clinical Psychologists, early-career, workforce sustainability

Introduction

The National Health Service (NHS) is in a workforce retention crisis, with staff being expected to do more with less [1, 2]. NHS England is the world's fifth largest employer, with a recent employment rate of 1.5 million people [3]; yet retention is labelled as a 'pressure point' [4]. The NHS Long Term Workforce Plan [5] set three priority areas to address current workforce challenges: 'train', 'retain' and 'reform'. Accordingly, a required increase of 2000 NHS psychological professionals was set for between 2024-2037, alongside a 26% increase in Clinical Psychology training places by 2031-2032 [5]. The psychological professions workforce has therefore been noted to be the fasted growing professional group within the NHS [5]. Whilst credible in recognising the expansion required to meet the increasing service demand, concern lies within this focus on recruitment to support retention, leading staff to feel unsupported, undervalued, and exit their NHS employment [6].

As of April 2024, there were 28,652 Health and Care Professions Council (HCPC) registered Practitioner Psychologists, with 16,786 being Clinical Psychologists (CPs). Whilst numbers reported within the Psychological Professions Workforce Census [7] are slightly lower, it reports Clinical Psychology to be the largest individual job role within the NHS psychological professions workforce [7]. Exact rates remain unknown; however, the consensus reports an average vacancy rate of 19.6%, a turnover rate of 18%, and a retention rate of 86% for CPs across all service pathways [7]. Yet, these are solely reflective of CPs within the services who opted to participate within the consensus. Inflation of these rates has been speculated due to methodological Issues [8], whilst murmurs and known experiences of CPs nod to an ever-increasing number leaving their NHS employment. Data from the analysis of the mental health workforce showed a leaving rate of 5.2% for applied psychologists [9]. This is lower than post-COVID-19 rates, which is attributed to the world's exit from the pandemic and many CPs committing to a mixed model of NHS and non-NHS employment [10].

To date, research has focused on the wider NHS workforce [5,11], with little inclusion, focus, or data separation for the CP profession. Here, similar push factors (e.g., factors that push an individual to wanting to leave the NHS) and pull factors (e.g., factors that pull an

individual to continue working for the NHS) emerged. Here, the push factors include: stress, high workloads, staff shortages, a lack of career progression, limited resources, reduced pay, and a lack of ability to provide high quality care [10,11, 12]. Conversely, the pull factors include: greater flexibility over work hours, support for family commitments, increased autonomy and control, reduced caseloads, and greater personal accomplishment [13, 14]. Recent research focusing on service-related factors to specific CPs in Child and Adolescent Mental Health Services (CAMHS) mirror the aforementioned, additionally including difficult relationships with management and colleagues, and negative impact on physical and mental wellbeing [15]. However, knowledge of push/pull factors relevant to all CPs is required.

The Effort Reward Imbalance (ERI) Theory [16] can be used to understand the importance of these factors to employment decisions. It notes that the imbalance and failed reciprocity between factors (underpinned by key themes of 'job effort' and 'reward') lead to negative emotions. These have been reported to drive one's intent to leave their organisation or profession [17]. Intention to leave has been noted as a key cognitive process prior to actual leaving [18], with research finding it to be the last step before actual leaving amongst nurses [19]. Here, actual leaving is the last stage of the decision-making process, where cognitions including thoughts to leave, intention to leave, and intention to actively seek a different role occur [20]. Yet, Steel et al. noted that the psychological processes underpinning intention to leave and intention to stay are not necessarily the same, resulting in asymmetrical factors related to thoughts and subsequent decisions to stay or leave an organisation [21]. Indeed, research into NHS Allied Health Professions found key differences in staying versus leaving factors [12, 22], and in the cognitive and behavioural effort with generalised thoughts of leaving and actual leaving [22]. The need to gain data regarding both intention and subsequent employment decisions from 'stayers' and 'leavers', and to explore actual behaviours of leaving aside from generalised thoughts, is thus noted [22].

The present study aims to be the first to complete such explorations specific to UK earlycareer CPs. 'Early-career' is defined as CPs who have qualified no more than five years ago, as per the British Psychological Society's (BPS) definition (K. Seisay, personal communication, April 12, 2023). A spotlight is placed upon this career stage due to research highlighting the transition from trainee to qualified professional coming with key challenges

[23], resulting in early-career CPs vulnerability. CPs form the largest proportion of psychological professionals [7], and are a key role within the expansion of the psychological professions' workforce through their provision of supervision and leadership [24]. With retention being a key part of the NHS Long Term Plan [25], the need to ensure CP retention at this early and vulnerable career stage is underscored. Moreover, such retention insight is vital to inform judgements regarding the cost effectiveness and value of money invested in CPs Doctorate in Clinical Psychology (DClinPsy) training, and subsequent training expansion as per Long Term Plan targets. The study therefore aims to explore early-career NHS CP retention, specifically via thoughts to leave and subsequent NHS employment decisions, through the following research questions:

1. To what extent are prespecified factors associated with fleeting and serious thoughts to leave NHS employment?
2. What behavioural precursors are associated with fleeting and serious thoughts to leave NHS employment?
3. To what extent are fleeting versus serious thoughts to leave NHS employment associated with subsequent leaving?
4. What factors are most important to the full-time, part-time and non-NHS employment decisions of early-career CPs?
5. To what extent have early-career CPs felt an effort-reward imbalance in their most recent NHS role?
6. What are early-career CPs employment intentions over the next five years?

Methodology

Research design

This study adopts a cross-sectional, survey design hosted online by Microsoft Forms.

Ethical considerations

The study gained ethical approval from the University of East Anglia's (UEA) Faculty of Medicine and Health Research Committee in December, 2023 (ETH2324-1159).

Participants

A total of 185 participants were recruited and completed the survey. All participants were early-career CPs, predominantly female (84%), 26-55 years old, and of White English, Welsh, Scottish or Northern Irish ethnicity (72%). A total of 119 (64%) participants worked solely for the NHS, where only three did not work in the NHS immediately after qualifying, and only four worked a split-role across NHS employment areas. A total of 41 (22%) participants worked part-time for the NHS, where the other part-time employment areas predominantly included private work, academia, and research. A total of 25 (14%) participants did not work for the NHS and left between 4 to 48 months after qualifying.

Inclusion criteria were participants having been a commissioned DClinPsy trainee at a UK DClinPsy institution, and currently being an early-career CP with HCPC registration. Exclusion criteria were CPs who were currently working, or had previously worked, in local authority or NHS funded private health providers. Using this, a national UK sample was recruited via volunteer, purposive, and snowball sampling through social media and informal networks.

Measures

Demographic Form

Participants were asked standard demographic questions regarding their age, gender, and ethnicity, and questions regarding their DClinPsy training, and first and current qualified CP job.

NHS Employment Decisions Questionnaire

No formalised measures exploring NHS employment decisions within the CP workforce currently exist. This measure was thus developed for the study, as informed by wider NHS workforce research (cited below). It explores the NHS employment decisions of early-career CPs, inclusive of their intention to leave their NHS employment, subsequent NHS employment decisions, perceived effort-reward imbalance in their most recent NHS role, and

employment intentions over the next five years. These areas are split into the subsections below. All prespecified push and pull factors included within select subsections were rated on a five-part Likert scale, ranging from ‘not important at all’ to ‘extremely important’. Free text options were also provided after each Likert scale to allow expansion on ratings.

Intention to leave NHS Employment

This subsection assessed participants intention to leave their NHS employment, as informed by the Theory of Planned Behaviour (TPB) [26], and wider NHS workforce research [11, 17, 27]. Participants were asked if they had ever experienced thoughts to leave their NHS employment (including timepoint, intensity, and frequency), and to rate 20 prespecified push factors on their level of influential importance towards such thoughts. To gain more objective-based insight to NHS employment leaving [11], participants were then asked to report what behavioural precursors they had engaged in prior to leaving their NHS employment (as noted by Sager et al. [20]). Overall intention to leave was measured by participants’ intensity of thoughts to leave (e.g., fleeting versus serious) and level of engagement in behavioural precursors.

NHS Employment Decisions

This subsection assessed the push/pull factors most important to participants NHS employment decisions. It was split into three parts, as per each employment decision (e.g., full-time NHS employment, part-time NHS employment, and non-NHS employment). Participants were to only complete the part that applied to them. All factors were identified from key NHS workforce research that explored NHS retention and contributing factors [11, 12, 22, 27, 28] where the most reported factors were included. A total of 182 participants completed this section of the survey (where data were not provided by 3 participants), and the number of factors differed marginally per each NHS employment outcome. ‘Part-time NHS employment’ was split into two additional subsections, where participants rated the pull factors that kept them working (part-time) for the NHS, and the push factors that pushed them towards working (part-time) outside of the NHS. All factors were the same, with either positive (pull) or negative (push) wording.

Effort Versus Reward and Future Intentions

This subsection assessed participants' perceived effort-reward imbalance within their most recent NHS role, and their future employment intentions over the next five years. Effort-reward imbalance was explored via participants rating their perceived level of role effort, received recognition, and effort-reward match, and the importance of receiving recognition for their effort. This was informed by the NHS People's Promise of being 'recognised and rewarded' [29], and wider NHS [11] and overall workforce [17, 30] literature. Five-year future employment intentions were additionally asked to gain more robust estimates that were not solely based off prior 'thoughts to leave' data [11]. Prespecified options were provided, with the opportunity for expansion via free text.

Procedure

A participant information sheet and consent form were provided to participants prior to their involvement in the study. Due to the anonymity of the data, participants were not able to withdraw their survey data after it was submitted. Personal information gained through the opt-in process for a qualitative sister study [31] was removed by MS prior to analysis. A recruitment poster was posted via online recruitment avenues with a URL link and QR code to the online survey. Participants were first taken to the participant information sheet and consent form, followed by the demographic form and the NHS Employment Decisions Questionnaire. At the end of the survey, participants had the opportunity to opt-in to participate in the qualitative sister study [31], before being taken to the current study's debrief form.

Analysis

The data were collected via Microsoft Forms and downloaded onto a Microsoft Excel spreadsheet. The raw data were stored and cleaned on Microsoft Excel, and the additional free-text data were grouped into further data responses. Analysis was completed using Jamovi for macOS (version 2.5). To explore the push factors (independent variables [IVs]) associated with fleeting versus serious thoughts to leave NHS employment (dependent

variables [DVs]), separate binomial logistic regressions for each push factor on thoughts to leave were run (RQ1). To explore what behavioural precursors (IVs) are associated with fleeting versus serious thoughts to leave NHS employment (DVs), separate chi square tests of association were run on each precursor (RQ2). Here, the Haldane-Anscombe correction was applied to three factors that had zero cell counts. To explore if fleeting thoughts to leave NHS employment were associated with subsequent leaving (RQ3), separate chi square tests of association were run. Here, the IVs were 'intensity of thoughts to leave' (fleeting/serious), and the DVs were subsequent leaving (e.g., leaving or not leaving, and partially leaving or fully leaving). To explore mean factor importance ratings across NHS employment outcomes, descriptive statistics were run. To explore the extent to which early-career CPs perceive an effort-reward imbalance (RQ5), and their five-year employment intentions (RQ6), descriptive statistics were again run.

Results

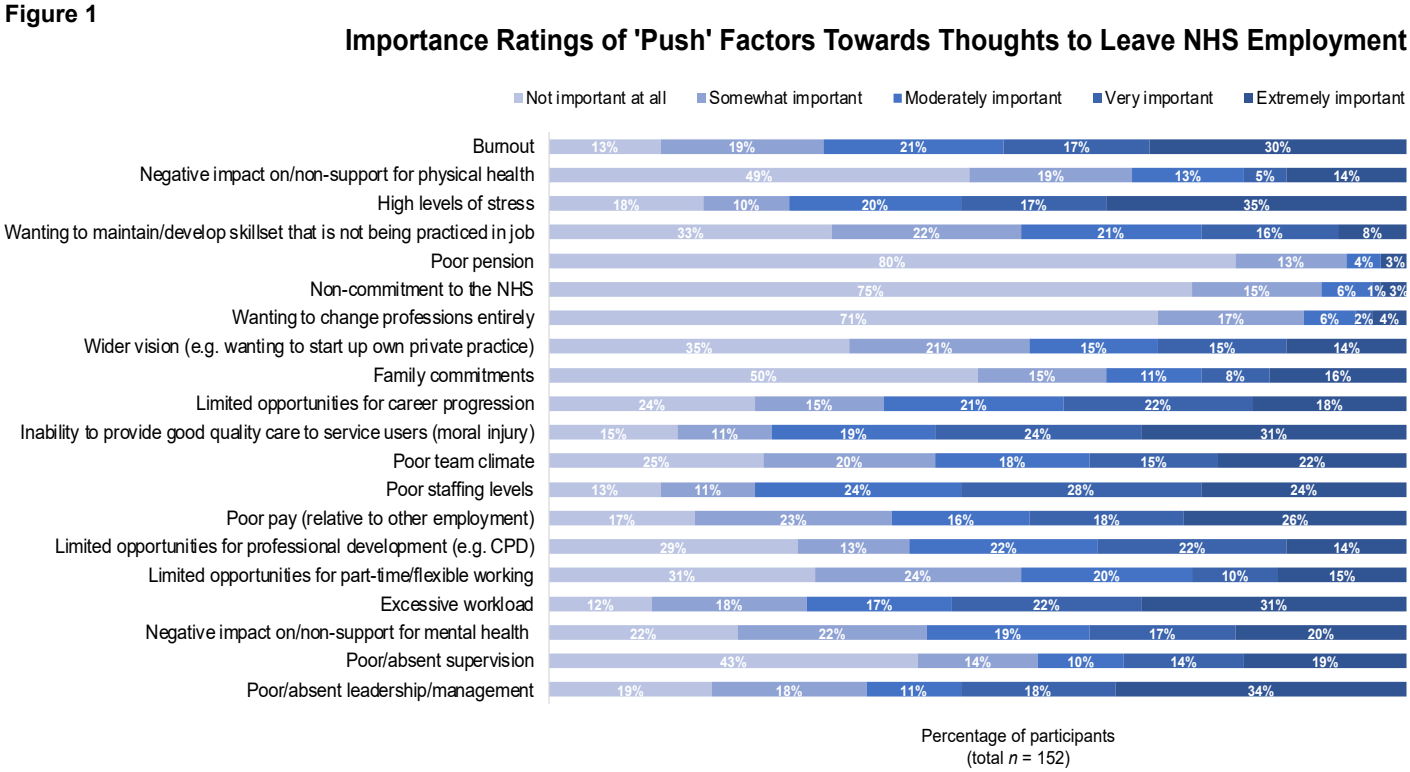
Thoughts to Leave NHS Employment

A total of 152 (82%) participants experienced thoughts of leaving their NHS employment, with 69 (45%) experiencing fleeting thoughts, and 83 (55%) experiencing serious thoughts. A total of 63 (41%) participants experienced these thoughts during clinical training (predominantly during the first and second year), and 89 (59%) participants as a qualified professional (predominantly during the first 9-12 months).

Associated Factors

Figure 1 outlines the importance ratings of each push factor towards participants thoughts to leave their NHS employment.

Figure 1



RQ1 explored the extent to which prespecified push factors are associated with fleeting and serious thoughts to leave one's NHS employment. Separate logistic regressions revealed 12 factors to be significant predictors of serious thoughts to leave one's NHS employment, with small effect sizes (Ors = 1.258 – 1.677) [33]. See Table 1 for all factors and effect sizes.

Table 1

Post-hoc coefficient table of the separate binomial logistic regressions for each push factor on thoughts to leave NHS employment.

			OR CI (95%)	
Push factors	**Estimate**	**OR**	**Lower**	**Upper**
Inability to provide good quality care (e.g., moral injury)	0.52***	1.68	1.30	2.16
Negative impact on mental health	0.51***	1.67	1.30	2.14
Poor staffing/resources	0.46***	1.59	1.22	2.07
Non-commitment to the NHS	0.44*	1.55	1.01	2.37
Negative impact on physical health	0.39***	1.48	1.15	1.89
Burnout	0.38***	1.47	1.15	1.87
Poor/absent leadership or management	0.38***	1.47	1.18	1.82
High levels of stress	0.34**	1.41	1.11	1.79
Wanting to change professions	0.30	1.35	0.94	1.93
Poor team climate	0.27*	1.32	1.05	1.65
Excessive workload	0.26*	1.30	1.03	1.64
Limited opportunities for career progression	0.24*	1.27	1.01	1.60
Poor/absent supervision	0.23*	1.26	1.02	1.55
Poor pay	0.13	1.14	0.91	1.42
Poor pension	0.07	1.08	0.71	1.62
Limited opportunities for professional development (e.g., CPD)	0.05	1.06	0.84	1.32
Family commitments	0.05	1.05	0.85	1.29
Limited opportunities for part-time/flexible working	0.02	1.02	0.82	1.28
Wanting to maintain/develop skillset	-0.11	0.89	0.70	1.14
Wider vision (e.g., private practice)	-0.13	0.88	0.71	1.10

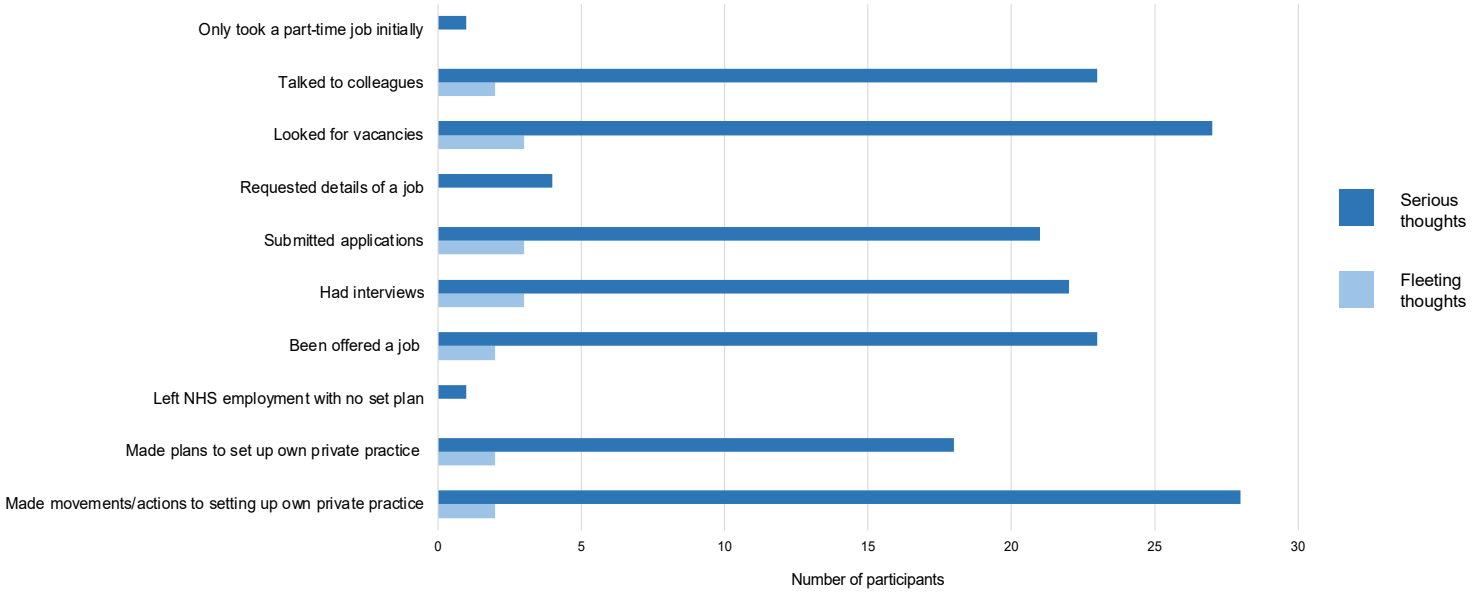
Note: CI = Confidence Interval; OR = Odds Ratio; OR effect size: 1.68 (small), 3.47 (medium), and 6.71 (large) [32] *p < .05; **p <. 01; ***p < .001.

Behavioural Precursors to Leaving

Descriptive statistics revealed that participants with serious thoughts to leave their NHS employment engaged in more behavioural precursors, with a higher rate of engagement for each precursor, compared to participants with fleeting thoughts.

Figure 2

Behavioural Precursors Associated with Fleeting and Serious Thoughts to Leave NHS Employment



Note. Participants could select more than one behavioural precursor.

RQ2 explored the behavioural precursors associated with fleeting and serious thoughts to leave one's NHS employment. Separate chi square tests revealed significant associations between eight behavioural precursors and serious thoughts to leave NHS employment, with large effect sizes (see Table 2).

Table 2

Chi square statistics and odds ratios for association between each behavioural precursor on fleeting and serious thoughts to leave NHS employment.

			OR CI (95%)	
Behavioural precursor	**X^2**	**OR**	**Lower**	**Upper**
Made plans to set up my own private practice	14.10***	18.80	2.44	145.0
Talked to colleagues	16.90***	12.80	2.90	56.80
Been offered a job	16.98***	12.80	2.90	56.80
Looked for vacancies	18.90***	10.60	3.05	36.80
Made movements/actions towards setting up my own private practice	11.60***	9.28	2.07	41.60
Submitted applications	12.40***	7.45	2.12	26.20
Had interviews	13.50***	7.93	2.26	27.80
Requested details of jobs	3.42***	7.87	0.42	149.0
Only took a part-time job initially	0.84	2.53	0.10	63.0
Left the NHS with no set plan	0.84	1.31	0.10	63.0

Note: CI = Confidence Interval; OR = Odds Ratio; OR effect size: 1.68 (small), 3.47 (medium), and 6.71 (large) [32] ***p < .001.

Leaving of NHS Employment

RQ3 explored if thoughts to leave NHS employment were associated with subsequent leaving. Table 3 shows the proportions of participants' staying versus leaving decisions, following fleeting or serious thoughts. Chi square tests revealed significant associations between intensity of thoughts to leave and staying versus leaving decisions ($X^2 = 31.7$), and partial versus full leaving decisions (fleeting thoughts $X^2 = 69$, serious thoughts $X^2 = 83$). Specifically, participants who had serious thoughts to leave were 8% more likely to subsequently leave their NHS employment, compared to those who had fleeting thoughts. Additionally, participants who had serious thoughts were 10% more likely to fully leave their NHS employment, rather than partially leave (e.g., reducing their contracted NHS hours to work part-time).

Table 3

Contingency table showing proportions of staying versus leaving decisions following fleeting and serious thoughts to leave.

Intensity of thoughts to leave	**Stayed in NHS employment**	**Left NHS employment**	***Partially left (part-time NHS employment)***	***Fully left (non-NHS employment)***
Fleeting	64 (92.80%)	5 (7.20%)	4 (80%)	1 (20%)
Serious	42 (51.60%)	41 (49.40%)	12 (29.30%)	29 (70.70%)

NHS Employment Decisions

RQ4 explored the differences in the mean importance ratings of each prespecified factor across all NHS employment outcomes. For participants who solely worked for the NHS, the factors most important to this decision were: job security, commitment to the NHS, good quality/frequent supervision, and ability to provide good quality care to service users (no moral injury). For participants who worked part-time for the NHS, the most important pull factors that kept them working for the NHS were: job security, commitment to the NHS, opportunities for part-time/flexible working, and good pension. Contrastingly, the most important push factors that pushed them to additional non-NHS employment were: having a wider vision (e.g., to set up own private practice), poor pay (relative to other employment),

inability to provide good quality care to service users (moral injury), and a desire to maintain or develop their skillset. Finally, for participants who did not work for the NHS, the factors most important to this decision were: inability to provide good quality care to service users (moral injury), poor/absent leadership/management, high levels of stress, and a poor team climate.

Figure 3

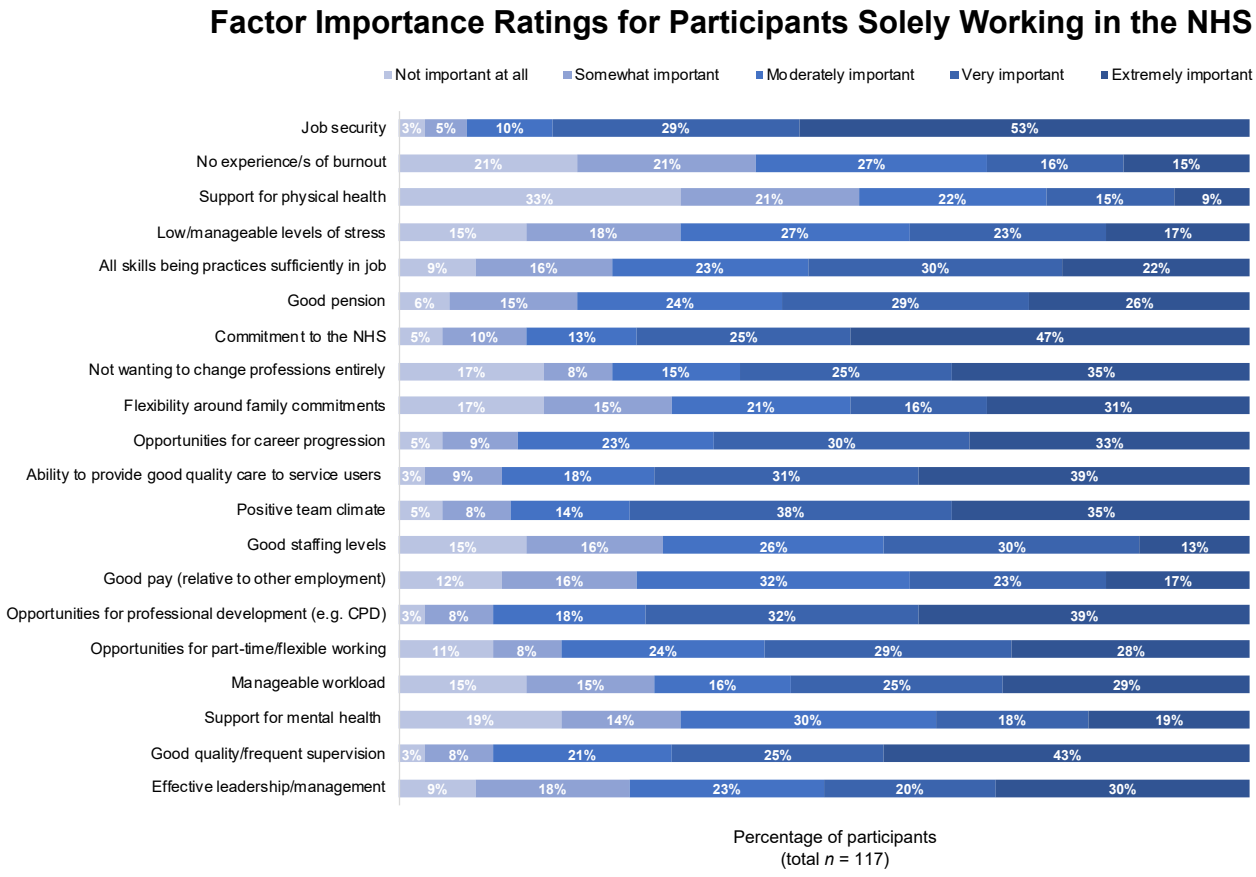


Figure 4

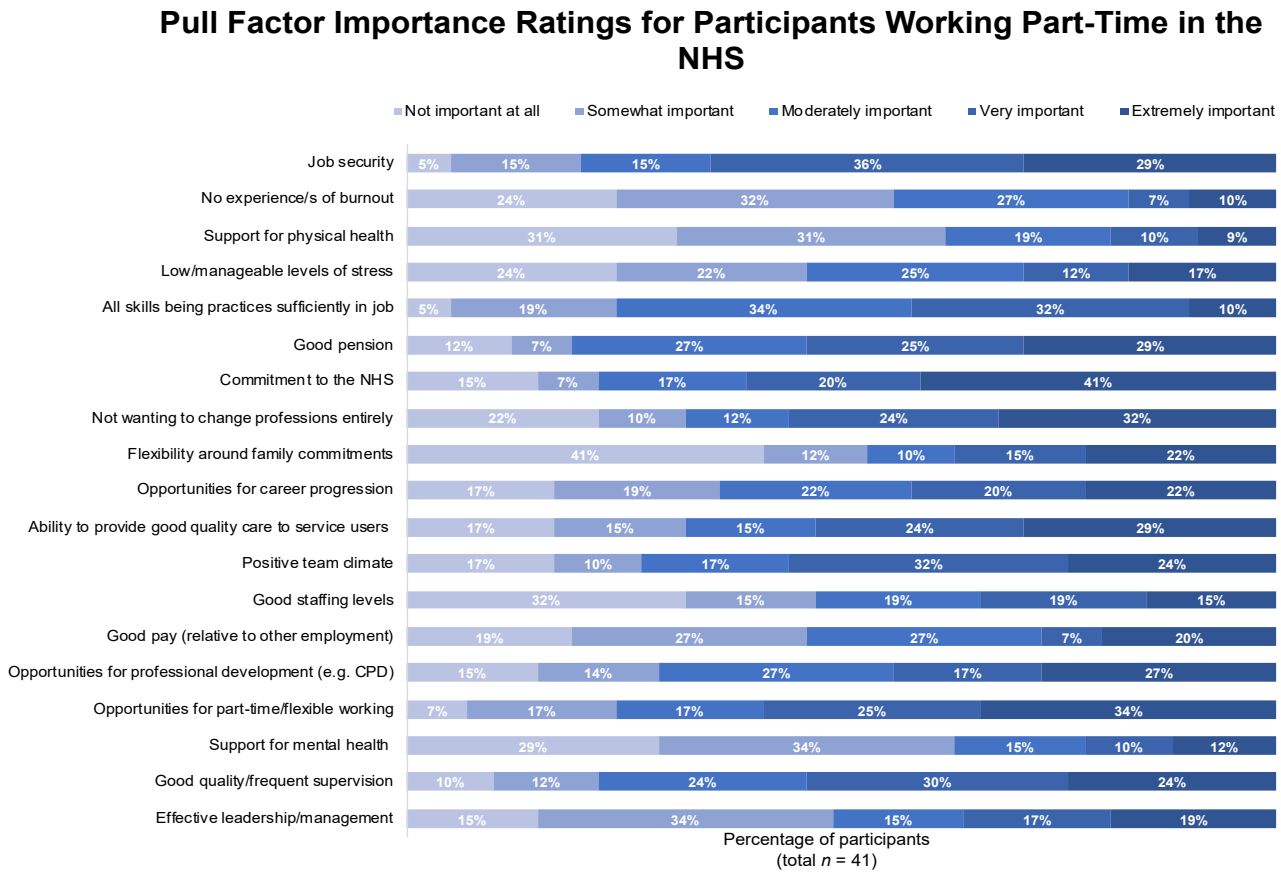


Figure 5

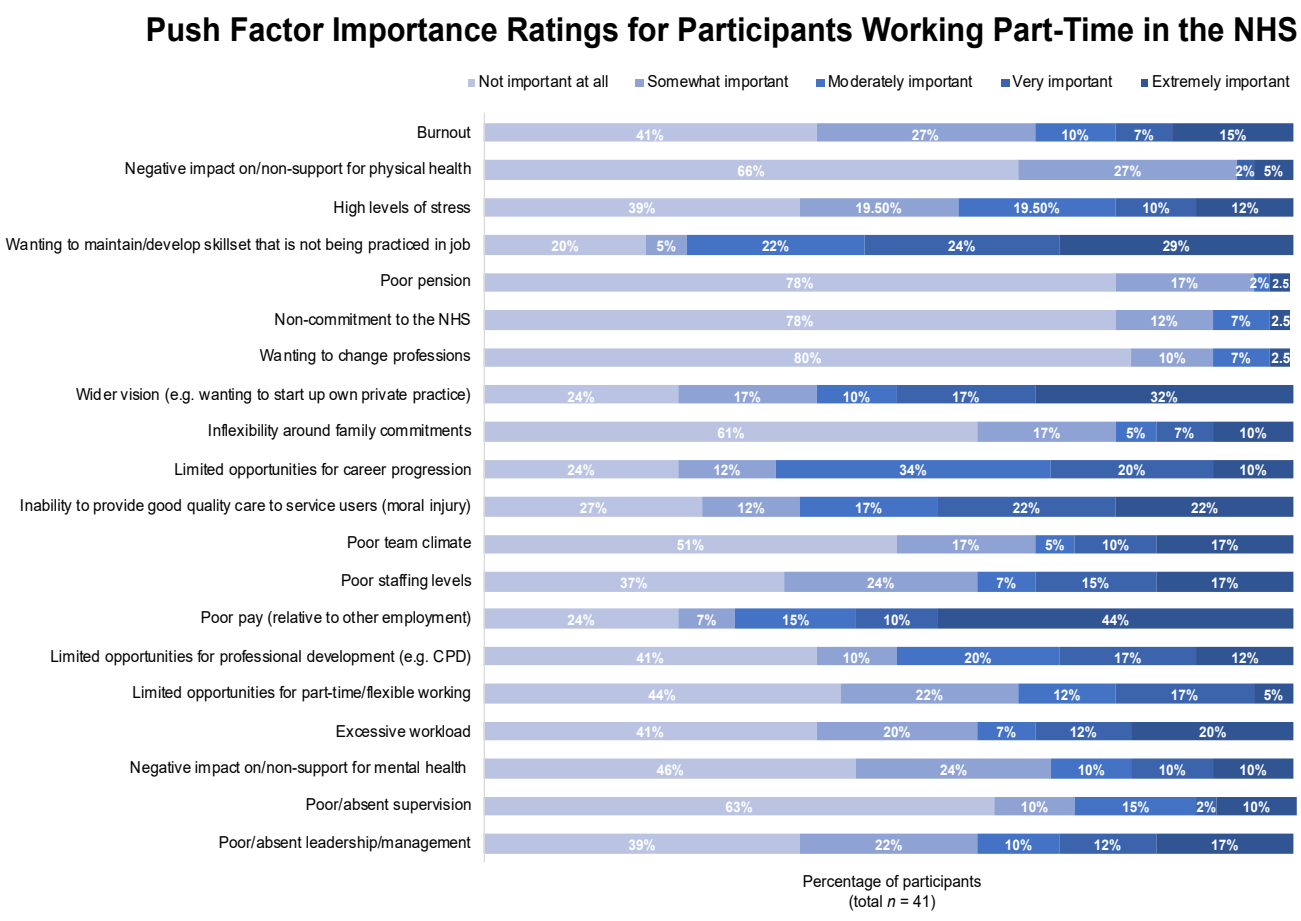
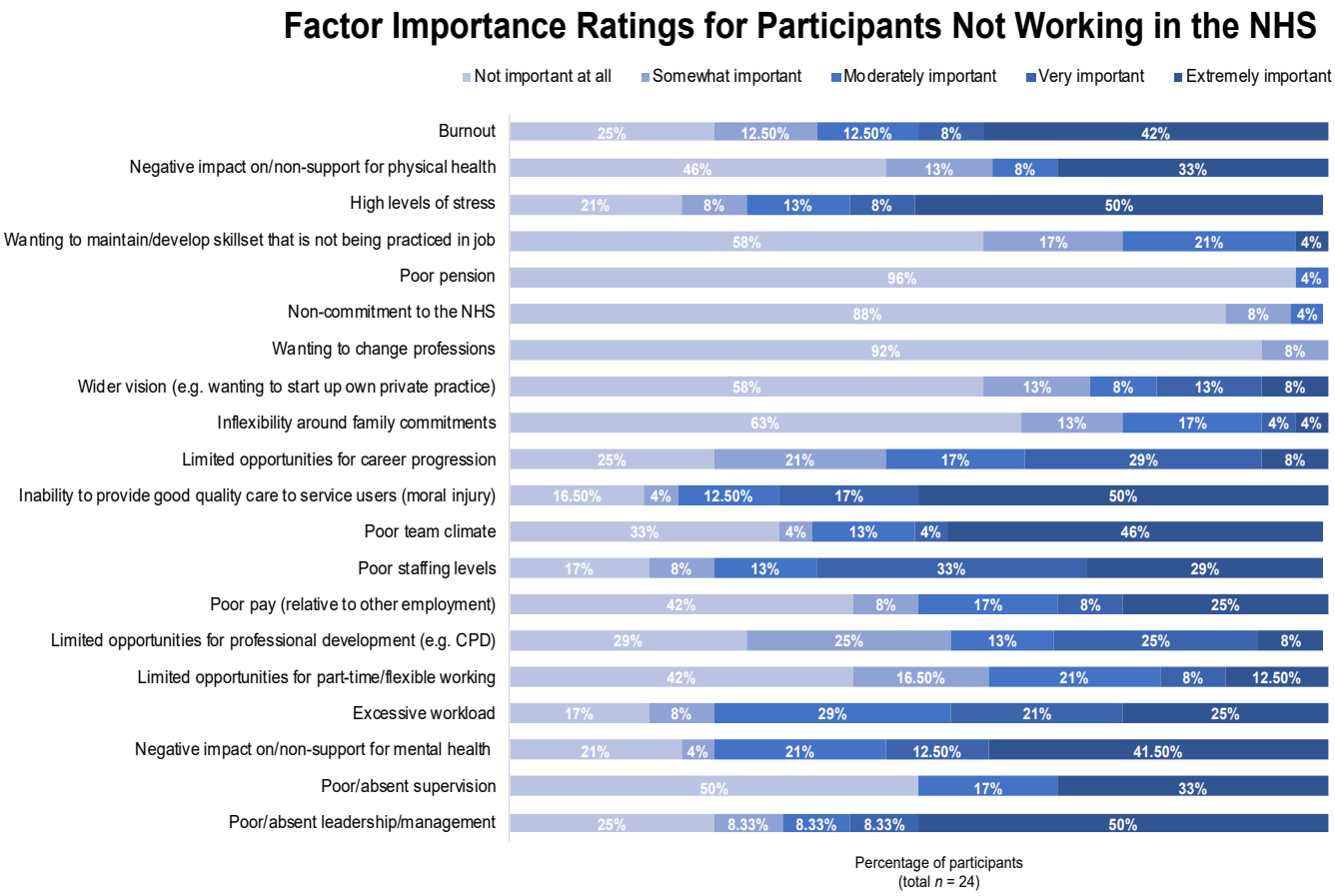


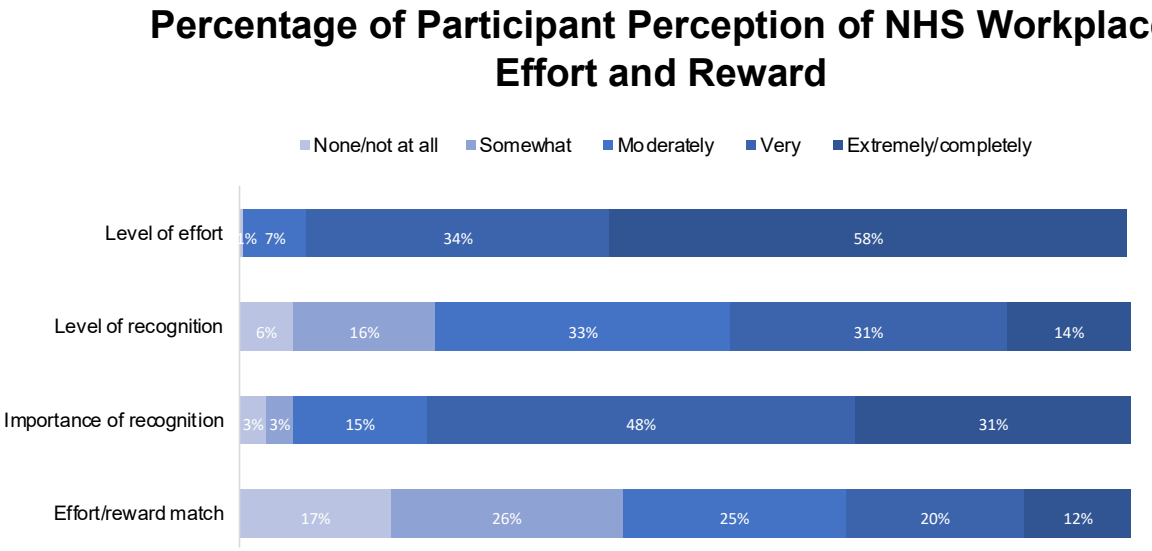
Figure 6



Effort-Reward Imbalance

RQ5 explored the extent to which early-career CPs felt an effort-reward imbalance in their most recent NHS role. Descriptive statistics explored four aspects of workplace effort and reward (see Figure 7). A total of 58% of participants felt they put in an extremely high level of effort into their most recent NHS role, yet only 14% felt they received an extremely high level of recognition in return. Moreover, 31% of participants reported receiving recognition for the level of effort they put into their work to be extremely important. However, only 12% reported the level of effort they put into their most recent NHS role and the rewards they received in return to be completely matched.

Figure 7

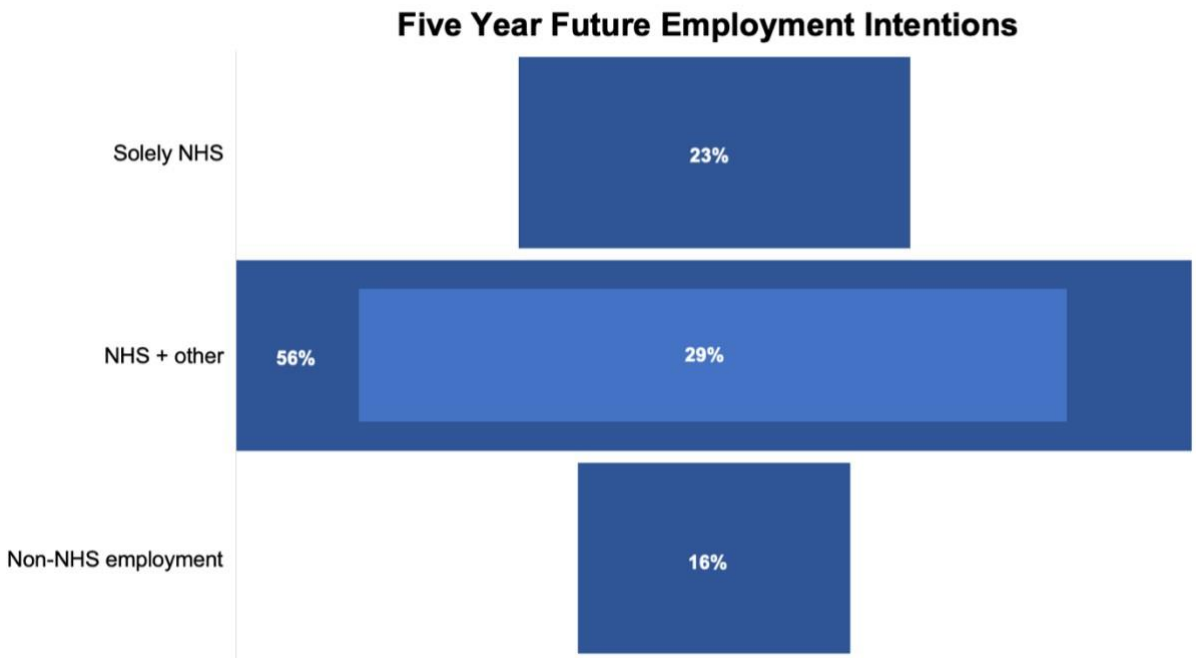


Future Employment Intentions

Participants contracted hours worked in their first NHS role ranged between 22.5 to 37.5 hours per week. Most participants (82%) reported maintaining these same hours in their current NHS role, whilst 18% reported reducing them to a range of 15 to 32 hours per week.

RQ6 explored the employment intentions of early-career CPs over the next five years. Descriptive statistics revealed that only 23% intend to remain working full-time and solely for the NHS. In contrast, 16% intend to work in non-NHS employment, and 56% intend to work part-time in the NHS alongside other employment. Of this latter group, about half (29% of all participants) intend to work in the NHS and private employment. See Figure 8 for employment intentions.

Figure 8



Note. 'NHS + other' refers to an employment intention of working part-time within the NHS and part-time within either/a combination of: research, academia, private, and third sector areas. The subgroup within this intention is that of 'NHS and private', given this being the most common 'NHS + other' employment intention.

Discussion

The present study sought to explore early-career CPs thoughts and decisions regarding their NHS employment, allowing valuable insight into the retention of this NHS workforce.

Asymmetries were revealed between the push factors associated with fleeting versus serious thoughts to leave NHS employment (RQ1). The factors associated with fleeting thoughts were underpinned by extrinsic motivators to one's professional self (e.g., wanting to maintain/develop skillset, having a wider vision to set up one's own private practice). Contrastingly, the factors associated with serious thoughts to leave were underpinned by organisational (e.g., poor/absent leadership/management), systemic (e.g., poor staffing/resources, inability to provide good quality care leading to moral injury), and individual-related (e.g., stress, burnout, negative impact on physical and mental health) factors. Such individual-related factors are particularly interesting due to their conceptually

similar yet differential distinctions. Whilst stress, burnout, and mental health are often misunderstood and referred to interchangeably, the findings highlight how they are in fact distinct and each hold important individual roles in influencing CPs serious thoughts to leave their NHS employment. They must therefore be considered as separate (e.g., not grouped under 'staff wellbeing') when understanding the employment thoughts and decisions of NHS CPs. Moreover, all such factors associated with fleeting and serious thoughts to leave mirror the factors associated with part-time NHS and non-NHS employment decisions, respectively. This is later discussed; however, their important role within early-career CPs cognitive processes around, and prior to, leaving is noted. This highlights the need for retention strategies to be targeted at the early cognitive stage.

Notably, participants with serious thoughts to leave their NHS employment engaged in more behavioural precursors prior to leaving (RQ2). This finding suggests increased thought intensity level drives increased active seeking of non-NHS employment, reflecting a higher overall intention to leave. The TPB [26] suggests that this higher intention would lead to the leaving of NHS employment; however, the results only partially support this. Indeed, serious thoughts led to increased leaving in comparison to fleeting thoughts, with more participants with serious thoughts fully leaving their NHS employment than solely reducing their NHS hours (RQ3). However, the comparable staying (51.60%) versus leaving (49.40%) rates noted for those with serious thoughts provide the theory's challenge. Some hypotheses are considered. First, the stable characteristics (or 'rewards') of the NHS could be protective against leaving, even for those with higher intentions. Second, early-career CPs could simply be 'pushing through', either as an avoidance-based coping strategy [33], or due to a felt commitment to the NHS driven by moral obligation [12]. This raises crucial questions regarding the implications to individuals' job satisfaction, levels of stress and burnout (and thus overall wellbeing due to the influence of stress and burnout upon this), and subsequent NHS retention. The need to further explore such rates is thus underscored.

As aforementioned, the factors most salient to non-NHS employment decisions (RQ4) mirrored those associated with serious thoughts to leave NHS employment. These were organisational (e.g., poor/absent leadership/management), systemic (e.g., poor

staffing/resources) and individual-related (e.g., stress, moral injury) factors, which align with wider NHS research [11, 22, 28]. Crucially, 'inability to provide good quality care' (e.g., moral injury) was one of the strongest predictors of serious thoughts to leave NHS employment and non-NHS employment decisions. Strikingly, Stinton's sister study [31] also found moral injury to be a present theme across all employment outcomes of UK early-career CPs. Williamson et al. attributes such a finding to the COVID-19 pandemic, where increasing demand yet limited resources led to staff's standard of work falling below their perception of 'good enough' [34]. Mounting evidence reports this becoming a familiar notion, where staff are increasingly required to perform work that challenges their values and morals, resulting in moral distress, moral injury, and poor mental health (e.g., stress and burnout) [1, 28, 31, 35]. Yet, this factor was also associated with participants decisions to solely work for the NHS. This underscores its power to either push or pull early-career CPs NHS employment decisions, as dependent on one's ability to work in alignment with their morals and values through the provision of their desired quality of care.

Arguably, an interplay between the aforementioned organisational, systemic, and individual factors may exist. Here, the presence of effective organisational leadership/management may serve to mitigate proceeding systemic and individual challenges. This is supported by literature that reports leadership/management structures to be a key determinant of mental health professionals' practice environments; specifically, in how professionals perceive their organisation's values, subsequently influencing NHS employment decisions regarding staying or leaving [28]. Indeed, the need for clear leadership and management structures comprising compassionate and collective approaches has been noted [36]. This is argued to be key in developing working relationships and trust at all levels [36], improve overall wellbeing and patient outcomes [37], and reduce intention to leave NHS employment [12]. Concerningly, increasing research has reported its absence, whereby a 'command and control' leadership/management style is being adopted, resulting in CPs feeling operationally led, having a quieter voice, and being expected to 'just get on with it' [37]. Kolar et al. further recognised a lack of understanding about the CP role by those in leadership/management roles, leading to feelings of

undervalue and frustration [38]. This is supported by Stinton [31] who reported subsequent job dissatisfaction and career disillusionment as a result. Whilst CPs are encouraged to take responsibility in taking up organisational leadership opportunities and roles early in their careers [39], organisational leadership/management structures that understand the CP profession and adopt a compassionate leadership style are crucially important to ensure organisational support. This may prevent proceeding systemic and individual challenges, and thus support subsequent retention.

Similarly, the factors most salient to part-time NHS employment decisions (push factors) largely mirrored those associated with fleeting thoughts to leave. These were predominantly extrinsic motivators for participants professional self (e.g., having a wider vision to set up one's own private practice, developing one's skillset, and pay). Indeed, pay is an NHS push factor that has been reported to become more salient since COVID-19, and a key reason for NHS staff leaving their NHS employment [11, 31]. Literature reports more (early-career) CPs committing to part-time NHS and part-time private work for financial rewards [10, 31, 40]. This may further be driven by funding challenges to CPs provision and access to Continued Professional Development (CPD), resulting in limited access to training and skill development [10] that is therefore being sought externally. Indeed, research into the Allied Health Professions (AHPs) reports this leading to thoughts of, and actual, leaving of NHS employment [12]. Taken together, these findings suggest a ceiling on early-career CPs financial and professional expectations, driving them to part-time NHS employment and seeking non-NHS employment to fill these expectations [12, 31]. Indeed, this is supported by the future employment Intentions findings, where an intention to work part-time in the NHS and part-time privately was reported at a minimum 6% higher likelihood in comparison to other employment intentions (RQ6). Whilst this positively reflects early-career CPs not wanting to fully leave the NHS, it also reflects their desire to reduce their NHS hours over the next five years. This raises questions regarding the duration to which an NHS footing remains, with a need to explore NHS employment patterns across career stages underscored.

Such part-time seeking of non-NHS employment may link to the factors associated with solely NHS and part-time (pull factors) NHS employment decisions. These were: 'job security', 'supervision, 'part-time/flexible working' and 'pension', as additionally found in Stinton's study [31]. Utilising the ERI model [16], these can be seen as 'rewards' when appropriately provided; an important element of the NHS People's Promise [29] and key to reducing intention to leave employment [41]. The findings of the current study support the latter, where such rewards seemingly increased the pull of NHS employment on a full-time or part-time basis. This is particularly interesting given only 12% of participants reporting the level of rewards received to completely match their level of effort (RQ5). This highlights an effort-reward imbalance within individuals NHS roles, which was particularly pertinent during COVID-19 [11] and, as revealed within this and Stinton's study [31], has never been regained. The findings of the current study may therefore speak to the pulling power of such rewards in keeping early-career CPs working for the NHS despite this imbalance [31]. Yet, given this reported imbalance and its noted influence on poor wellbeing (e.g., via stress, burnout, and mental health difficulties) [42], NHS commitment [40], and the leaving of NHS organisations and professions [17], its consideration within retention explorations is crucial.

Some final findings are noted. First, stress and burnout were most salient for participants' non-NHS employment decisions, supporting literature and media narratives, and highlighting their significant pushing power. Second, pay was only associated with part-time NHS employment (push factors). This challenges widespread narratives of pay being the key driver to non-NHS employment. Whilst not saying that it is not a contributor, the results highlight that organisational, systemic, and individual-related factors pose bigger influence. Third, supervision was noted salient for solely NHS and non-NHS employment decisions. Indeed, supervision is mandated by the BPS, is crucial for safe and effective practice, overall wellbeing, and CPD [43], and is highly important for CPs in this vulnerable career stage [44]. The findings therefore highlight its significant pulling and pushing power in its relative presence or absence. Finally, commitment to the NHS was rated particularly salient for full and part-time (pull factor) NHS employment decisions, yet not for non-NHS (full and part-time) employment decisions. This contrast may link to the aforementioned

notion of moral obligation [12], which may be felt by the NHS employment grouping; however, a deeper exploration of this is warranted.

Strengths and Clinical Implications

To the authors' knowledge, this is the first study to complete a comprehensive exploration of a nationwide sample of UK CPs NHS employment thoughts and decisions. Its inclusion of all aspects of CP decision-making, including thoughts, behavioural precursors, decisions, and effort-reward imbalance, allows for the thorough understanding of CPs NHS employment decisions.

The findings reveal that, at the early-career stage, many factors influence thoughts and decisions to leave NHS employment, with CPs intending to leave through gradual exit via mixed employment (e.g., NHS and private). This holds important clinical implications. For NHS organisations, an awareness of the factors that drive early-career CPs thoughts to leave one's NHS employment must be gained. Clear leadership and management structures, comprising compassionate and collective approaches [36], and provision of recognition and other rewards for efforts should be provided. Access to training and development will ensure the continual development of early-career CPs skillsets, and help to reduce professional gaps, which, in turn, prevents the pull of non-NHS employment. This could be further considered within recruitment, where specific outlining of rewards could be considered to enhance role attraction. Furthermore, organisations could also look to use feedback data to gain insight into employees and, particularly CPs, perceptions of areas of strengths and challenges within their role [44]. Here, effort and reward must be considered and balanced. Finally, protected space to discuss organisational and wellbeing challenges (e.g., stress, burnout, mental health difficulties, and the potential need for support from occupational health in light of such challenges) is recommended in alignment with previous research noting its importance in making staff feel heard and seen [33]. For early-career CPs, open conversations about individual, systemic, and organisational challenges must be had to ensure sufficient organisational insight and subsequent implementation of appropriate

support. The utility of peer support has been noted in nurses [45] and could be used for such conversations. Indeed, recognising the push factors as challenges, yet harnessing on the pull factors, is important to address NHS retention. Indeed, all the aforementioned hold important implications for service-users through increasing the equality of access to services via an increasing number of CPs within the NHS [15].

Limitations and Future Research

Some limitations are noted. First, recruitment was conducted predominantly via social media, which limited sampling to those with such access and engagement. Future research should therefore look to diversify recruitment from various employment areas (e.g., NHS and private practice), which would additionally likely solve the disproportionate representations of employment groups noted below.

Second, disproportionate sample sizes were present across employment outcomes, where most participants worked solely in the NHS. Despite the authors' attempts to proactively target early-career CPs from other employment areas (e.g., those in private practice), unequal samples ensued. This limited the scope of the analyses that could be conducted between these groups, underscoring the need for this to be addressed in future research to allow for direct comparisons and increasingly meaningful conclusions to be drawn. Similarly, few data were not obtained for some NHS employment outcome factors of the survey, resulting in disequilibrium of factors across outcomes. These were 'wider vision' for full-time NHS and part-time NHS (pull factors), 'workload' for part-time NHS (pull factors), and 'job security' for part-time NHS (push factors) and non-NHS employment. Caution must therefore be had interpreting these factors ratings given this disequilibrium.

Third, the survey methodology reduced the findings' reliability and validity due to the inherent bias within this subjective method. This was further driven by the survey being developed by the authors of the study, as drawing on and expanding upon previous research (e.g., Coombs et al., 2010; Derycke et al., 2010; Ge et al., 2021; Leary et al., 2024; Loan-Clarke et al., 2010; NHS England, 2023; Weyman et al, 2023). Whilst the survey was reviewed by the Patient and Public Involvement (PPI) panel for appropriateness, wording,

and length, it was not formally piloted. Future research could therefore consider developing a measure assessing CP employment decisions for a more systematic exploration of this topic, and piloting it to ensure its reliability and validity.

Fourth, the provision of multiple response options for the 'future intentions' survey section led to ambivalent participant responses that impacted analysis. Whilst this importantly highlights ambivalence present within many participants regarding their future employment intentions, it reduced the reliability of the data and subsequent findings of this area. Future research should consider limiting response options or tracking participants' future employment to overcome this.

Additionally, future research could further look to conduct a deeper exploration into fleeting versus serious thoughts to leave in relation to the TPB [26], as well as the hypothesised notion of 'pushing through' despite having an intention to leave. Moreover, it would be interesting to separate 'leaving' down further into full NHS exit versus internal leaving (e.g., moving Trusts) and associated predictors. Finally, exploring the predictors and outcomes of low and high NHS commitment would be of interest given its hypothesised role in staying versus leaving intentions and behaviours.

Conclusions

This study is the first to explore the factors key to early-career CPs NHS employment thoughts and decisions. Notably, organisational, systemic, and individual-related factors drive early-career CPs serious thoughts to leave their NHS employment, and subsequent leaving. Effort-reward imbalance plays a significant role, as well as external motivators for one's professional self. Whilst rewards of the NHS pull some to stay within their NHS employment on a part-time or full-time basis, the aforementioned are key drivers to mixed NHS and non-NHS employment; notably, an intention of NHS and private work over the next five years. This suggests that, at the early-career stage, the early signs of leaving are being seen through gradual NHS exit via mixed employment. NHS organisations must therefore address these factors to prevent full leaving of this NHS workforce over time.

Statements and declarations

Not applicable.

Ethical considerations

The study gained ethical approval from the University of East Anglia's (UEA) Faculty of Medicine and Health Research Committee in December, 2023 (ETH2324-1159).

Consent to participant

A participant information sheet was provided to all participants, followed by a consent form to obtain their voluntary written consent to participate.

Consent for publication

The participant information sheet outlined that the findings would be published in an academic journal, which participants provided consent for within the consent form.

Declaration of conflicting interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Chapter Four: General Discussion and Critical Evaluation

General Discussion and Critical Evaluation

This chapter summarises the findings from both the systematic review and empirical paper. The findings will be considered within the context of the wider literature in order to understand how they both compare and add to the current evidence-base. Strengths and limitations of the thesis portfolio (as a whole) are further provided, as well as the theoretical and clinical implications of the papers' findings, and areas for future research. The chapter closes with the portfolio's main conclusions.

Overview of the results

This thesis portfolio explored the wellbeing and employment decisions of the NHS psychological workforce, in a bid to understand its longevity and sustainability within the NHS. This was firstly completed through a systematic review and narrative synthesis of nine peer-reviewed papers, which explored levels of stress and burnout within trainee and qualified NHS psychological professions. This was then expanded upon through a proceeding empirical paper, which investigated the NHS employment thoughts and decisions of a national sample of early-career Clinical Psychologists (CPs) via an online survey.

Systematic review

The systematic review and narrative synthesis identified nine papers that met criteria for inclusion. The review revealed moderate levels of stress for trainees, where marginal differences in stress levels were revealed between trainee professions (notably, Trainee CPs and Trainee PWPs). No papers explored stress within qualified psychological professions, resulting in the non-establishment of stress levels for this sub-population. The review further revealed low-to-moderate levels of burnout for trainee and qualified psychological professionals, as dependent on the measure used to explore burnout within the study. Comparable levels of burnout between these career stages were reported, though Trainee CPs scored highest in 'emotional exhaustion' and qualified PWPs scored highest on burnout subscales within the Oldenburg Burnout Inventory (OLBI; Demerouti, 1999). Notably, the papers included in the review explored a selective 13 out of the total 18 NHS psychological professionals, of which are arguably the more commonly known, longer standing, and more spoken about professions (e.g., Clinical Psychologists, Counselling Psychologists, CBT

Therapists, Counsellors). Such limited exploration of all NHS psychological professions to date is stark, particularly given the continued investment into this workforce. Here, knowledge regarding how all psychological professions are faring is vital to ensure their longevity and sustainability within the NHS. Moreover, the included papers utilised a variety of different measures to explore levels of stress and burnout within the select psychological professions, and varied in how they reported such levels (e.g., in relation to subscale data, overall measure data, and cut-off threshold prevalence). The need for future research to address these limitations was emphasised.

Empirical paper

The empirical paper revealed a significant association between thoughts to leave NHS employment and subsequent decisions to leave. Fleeting thoughts to leave were associated with the extrinsic motivators of one's professional self, such as having a wider vision to set up one's own private practice and wanting to maintain/develop one's skillset, and resulted in increased staying within NHS employment. Notably, serious thoughts to leave were associated with increased engagement in more behavioural precursors to leaving, and were driven by organisational, systemic, and individual-related factors. Interestingly, they resulted in comparable rates of staying versus leaving in NHS employment. Moreover, asymmetries were revealed between the factors associated with each NHS employment outcome. Organisational, systemic, and individual-related factors were associated with non-NHS employment, extrinsic motivators of one's professional self were associated with part-time NHS employment (push factors), and stable characteristics (or 'rewards') of the NHS were associated with part-time NHS employment (pull factors) and full-time NHS employment. Finally, whilst many participants reported experiencing an effort-reward imbalance in their most recent NHS role, the majority intended to continue working for the NHS over the next five years. This was, however, predominantly desired via mixed NHS and non-NHS employment, leading to a reduction in NHS hours and an increase in non-NHS (private) hours, highlighting a gradual exit from NHS employment. Indeed, the explorational infancy of this area and noted limitations of the current study provides much scope for future research, which should be guided by the recommendations provided.

Interpretation of the findings in relation to theory and literature.

The stress findings revealed in the review are in alignment with early pioneering research by Cushway (1992; 1994; 1996), who also reported moderate (and very high) levels of stress within 75% of Trainee CP participants. Similarly, Lloyd (2017) also reported moderate levels of stress in Trainee CPs, as did Carter (2021) for Trainee Counselling Psychologists. Given the pioneering nature of Cushway's (1992) research into trainee stress levels, several factors were provided as an explanation to such moderate levels. These included: poor supervision, travelling requirements, deadlines, separation from one's partner, demands, finances, an uncertainty about one's own capabilities, fatigue from moving, and continuously changing placements. Later research has supported the early identification of these factors and understood them within the dual role of clinician and university student that trainees hold, of which has been reported to be a key contributor to their stress levels (Owen et al., 2021). Yet notably, Cushway (1992) also includes personal-related factors (e.g., finance, separation from partner), of which have been lesser acknowledged within research. The addition of these factors to the aforementioned is suggestive of a tripartite relationship between three trainee stressor domains; that is, of university-related stressors, clinician-related stressors, and personal-related stressors. These are indeed noted in existing research (Carter, 2021), and provide context to the moderate trainee stress levels revealed within the present portfolio's paper and previous research. They may further provide context to the comparable levels of burnout the paper revealed between trainee and qualified psychological professionals. Where burnout has been noted to develop from chronic exposure to stress (Khammissa et al., 2022), it could be argued that the chronic interplay of these stressor domains during the training period drives burnout in trainees to levels similar to qualified peers. Indeed, research reports 74.9% of trainees to have experienced burnout at some point in their training as a result of the stress and demand experienced (Swords & Ellis, 2017). Yet, Maslach (1982) attributes the development of burnout to be due to the clinical domain of the aforementioned tripartite relationship; specifically, face-to-face contact with clients. Where a multitude of stressors exist (Farber, 1983b; Hellman et al., 1986), of which are specific to an individual and their environment, the exact drivers of burnout are

difficult to precisely determine. However, what is crucial to note from these findings and supporting literature is the extent of the stress placed upon trainees that leads to burnout levels similar to those of qualified colleagues. This underscores the importance of stress and burnout strategies being implemented at the training stage to prevent later decline of professional wellbeing when qualified.

Interestingly, the levels of burnout revealed in the review for trainee and qualified psychological professionals were lower than initially anticipated. This is as compared to the high levels that have been reported for other healthcare professions of whom, arguably, hold similar job roles, stressors and demands (e.g., social workers, nurses, occupational therapists, and doctors; Johnson et al., 2012; Khatatbeh et al., 2021; Tonkin, 2022). Hypotheses for these lower levels were provided within the review's paper and are expanded upon within the current discussion in relation to further literature.

First, literature has consistently reported the importance of self-care for trainees, as implemented both by trainees themselves and by training courses (British Psychological Society [BPS], 2021; Carter, 2021). Indeed, the importance of self-care was first documented by Cushway (1992) within the original research, where several recommendations were provided for UK training courses. Since then, self-care has been a consistently recommended strategy to reduce stress, not only within the psychological professions, but within the helping professions as a whole (Carter, 2021; Posluns & Gall, 2020). Given this emphasis, it may just be that training courses are sufficiently promoting and implementing this, with trainees taking this on-board and implementing it within their daily life. In line with this, training courses retained budgets that trainees can use for their personal use. Although there is uncertainty whether such budgets will continue, research reports them having often been used for personal therapy, which holds important outcomes for trainees (Galvin & Smith, 2017) and for their patients' treatment outcomes (Eckhart, 2016). Coupled with this, trainee CPs have been reported to hold more protective factors (e.g., resources, social networks, and support) in comparison to other groups of healthcare professionals (Galvin & Smith, 2017). Together, this higher emphasis on self-care, provision and use of personal therapy budgets, and personal protective factors, may be serving as protective buffers

against the development of burnout and subsequential lower levels for trainee and qualified NHS psychological professionals.

Second, a core characteristic of being a psychological professional is being that of a 'reflective practitioner' (BPS, 2017; Schon, 1983). This is emphasised and practiced during training, as well as through clinical supervision during training placements and within qualified roles (Ooi et al., 2023). Indeed, regular clinical supervision is unique to the psychological professions and is reported to hold restorative and protective benefits for wellbeing (Proctor, 1987), particularly when coupled with reflection (Ooi et al., 2023). It can therefore be argued that this characteristic and associated skillset, which is supported through protected time of clinical supervision, reduces rising stress and burnout levels within the psychological professions, as compared to other healthcare professions.

Third, the empirical paper revealed the intention of early-career CPs to move towards part-time NHS employment, as supported by further literature noting such an occurrence (Rosairo & Tiplady, 2024; Tolland & Drysdale, 2022). It could therefore be argued that this move provides a buffer against continuous NHS stressors and demands for those who have already made the move, in turn, preventing stress and burnout levels from increasing. This hypothesis is supported by Summers et al.'s (2021) research reporting higher averages (above the overall mean) for psychological professionals working within the private sector on the Practitioner Workplace Well-being Measure. Notably, this differed from results reported within earlier research of participants predominantly employed by the NHS (Summers et al., 2021), and is supported by Stinton's (2025b) study that qualitatively reported early-career CPs' move to part-time NHS and private employment for wellbeing purposes. This therefore speaks to the protective role that part-time non-NHS employment plays upon psychological professionals' wellbeing.

Fourth, is the acknowledgement of other factors influencing stress and burnout levels. For example, research has reported the important influence of individual-related factors, such as personality and intrapersonal factors (Leger et al., 2017; Summers et al., 2021), and locus of control, self-esteem and coping styles (Maslach et al., 2001). Such factors speak to the 'individual-related' domain within the aforementioned tripartite relationship between

stressor domains. Moreover, the British Psychological Society (BPS) and New Savoy Partnership survey (2016) identified additional contributors to stress. These were: a lack of funding, increasing work-load pressure, misalignment between policy and directives, challenges in implementation plans, continuous commissioning cycles, and comprised service structures, organisational fear cultures, lack of respect and value and engagement of staff, lack of support, and limited career progression. All such factors can be underpinned by being linked to and a cause of the workplace, in turn, offering a further stressor domain by being that of one's workplace or organisation. Indeed, where such individual-related and environmental (e.g., workplace organisation) factors vary between individuals, stress and burnout levels will thus of course vary.

On a similar line to point four, is the role of different individual demographics upon levels of stress and burnout and leaving of NHS employment by the psychological professions. Notably, the demographics of the included participants in the empirical paper was very limited, with the majority of the participants being female, aged between 26-55 years old, and of White English, Welsh, Scottish or Northern Irish ethnicity. The limited demographic diversity of the sample reflects wider trends within the NHS psychological professions workforce, which remains predominantly White, female, and without representation proportionate to the communities they serve (Health & Social Care Information Centre, 2013; Rosairo & Tiplady, 2024; Smith, 2016). Indeed, the 2024 Psychological Professions National Workforce Census (NHS England, 2024) reported 81% of the NHS psychological professionals to be female, the majority to be aged between 20-49 years old, and only 10% to have disclosed a disability. Such limited demographic representation has been attributed to the many barriers to entering the psychological professions, particularly for those from minority ethnic backgrounds. This has been noted to include uncertain and low-paid career routes, sociocultural perceptions of the profession (e.g., as less prestigious than medicine), and reliance on voluntary experience that may be less accessible to those from disadvantaged backgrounds (Goodbody & Burns, 2011; Helm, 2002; Kinouani et al., 2015; Pulham et al., 2019). Additionally, admissions processes that prioritise academic attainment can also disadvantage applicants from underrepresented groups (Goodbody & Burns, 2011). Moreover, certain demographics have been associated with higher levels of stress and

burnout, and poorer retention. Simionato and Simpson (2018) reported the psychological professions younger, less experienced, and feminised workforce to be at greater risk. Here, younger clinicians have been reported to lack appropriate coping mechanisms, set unrealistically high expectations, and face heightened susceptibility to work-related stress (Cushway, 1992; Farber, 1990). Moreover, women have been reported to be more likely to report high burnout and exhaustion in comparison to men, partly due to additional domestic responsibilities and work-family conflict (Guendouzi, 2006; Rupert et al., 2009; Stevanovic & Rupert, 2009), and are more likely to reduce hours for childcare or caring responsibilities (Tolland & Drysdale, 2022). Disability is also a significant factor, with those reporting a disability demonstrating consistently lower wellbeing (Rao et al., 2023; BPS, 2024). Indeed, the 2024-2025 Alternative Handbook reports that 16% of trainee clinical psychologists held caring responsibilities, 32% disclosed a disability, and 85% were female. Taken together, all such demographics should be acknowledged when interpreting findings, as they form part of the systemic context influencing stress, burnout, and workforce sustainability within the NHS psychological professions workforce.

Fifth, is the recognition that not all stress is negative. This was highlighted by Sampson (1989), of whom drew recognition to Cushway's (1988) paper that stated that stress can indeed be positive through the way in which external demands are seen as challenges. Such a perception of challenge increases stress levels and leads to the stimulation and motivation of an individual to raise their performance levels, resulting in improved satisfaction and self-esteem. Selye (1974) termed this increasingly positive stress as 'eustress'; something that may have been experienced by the participants within the included studies of the review, resulting in the lesser impact of demands, and thus reduced (negative) stress and burnout levels. However, the measures used within the included studies do not explicitly differentiate between negative stress and eustress; therefore, this may be helpful to distinguish in future explorations of stress and burnout levels within this workforce.

Sixth, and particularly important for this population, is the professional stigma associated with reporting personal difficulties within the helping professions. Indeed,

research notes the culture of mental health to lead individuals to view such difficulties as a weakness, and placing pressure on themselves to be resilient enough to cope on their own (Doherty, 2023). Further literature reported higher levels of perceived stigma to be present for those with increased knowledge of, and contact with, individuals with mental health difficulties (Corrigan et al., 2012). Here, such stigma has been associated with shame and embarrassment, and a fear of being judged negatively by others when developing and reporting mental health challenges (Corrigan, 2004; Garcia & Crocker, 2008; Garelick, 2012). Moreover, a study of US CPs reported the idea of help seeking to be psychologically threatening and stigmatising (Walsh & Cormack, 1994), with a fear of being viewed as professionally incompetent by other professionals (Dearing et al., 2005; Walsh & Cormack, 1994). Taken together, such literature suggests a potential underreporting of stress and burnout in light of the stigma associated with mental health challenges and the fear of others finding out (Edwards & Crisp, 2017).

Finally, is the difficulty in using heterogeneous measures to explore stress and burnout levels. Where differing measures comprise differing definitions of these conditions, the variety in what constitutes stress and burnout varies per measure. This is exacerbated when new measures are continually developed, resulting in further heterogeneous measure use and differing definitions and clinical thresholds of stress and burnout adopted (BPS, 2021; Dyrbye et al., 2009; Sampson, 1989). Whilst these measure definitions and thresholds can be informed by established cut-offs, some measures do not retain these, such as the Perceived Stress Scale (PSS-10; Cohen et al., 1983). This results in the use of suggested cut-offs by previous research, of which are not formally validated by the developers of the measure, and subsequently reduce the findings' reliability and validity when used. Where burnout is frequently measured using the MBI (and its validated versions), Payne et al. (1982) noted the need for a consistent measure to be used for stress.

Indeed, the experience of stress and burnout by trainees during the training period may have influenced the empirical paper's findings of 41% of CPs experiencing thoughts to leave their NHS employment during clinical training, and 59% as a qualified professional. This is supported by the factor of 'stress' being rated joint highest for participants non-NHS

employment decisions, followed by burnout and overall mental health. The fact that such thoughts of leaving within one's qualified career predominantly arose during their first 9-12 months of being a qualified CP is concerning, and provides a timeframe to supporting literature also noting CPs having thoughts to leave their NHS employment early in their careers (Rosairo & Tiplady, 2024; Summers et al., 2021). A hypothesis for such findings is the potential discrepancy between CPs' expectations versus the reality of their qualified roles. Such expectation discrepancy is arguably supported by the factors associated with part-time NHS employment decisions (push factors), which hint towards perceived gaps in early-career CPs professional development by virtue of a ceiling being placed upon them (e.g., financially, in terms of their skillset, and in terms of their professional vision). Indeed, this may be driven by a discrepancy in what CPs are trained to do versus what the role allows them to do, or even what the service requires them to do. Strikingly, research has particularly noted the occurrence of the latter, particularly in relation to leadership and management. Here, Kolar et al. (2017) recognised a lack of understanding about the CP role by those in leadership/management roles, leading to CPs feeling undervalued and frustrated. Further research has noted that many CPs are placed in leadership roles as soon as they qualify, often without much prior formal preparation or training, nor such roles being formalised or authorised (Rao et al., 2021). Whilst CPs are expected to take on leadership roles, Rao et al. (2021) note that these roles and their associated demands are becoming increasingly managerial. Such a move to more managerial CP leadership directly contrasts the leadership skills CP develop during training, and thus their expectations of being a psychological leader within the NHS when qualified, as clearly noted by the Division of Clinical Psychology within their Clinical Psychology Leadership Development Framework (BPS, 2010). This is only one example of potential CP training versus qualified role discrepancy, and is likely not the only. Future research into the influence of CP role discrepancy upon intention and actual leaving is warranted.

The association between participants thoughts to leave their NHS employment and subsequent decisions to leave provides support for the Theory of Planned Behaviour (TPB; Ajzen, 1991) by confirming that intention (e.g., having thoughts to leave NHS employment)

does indeed lead to behaviour (e.g., of staying or leaving one's NHS employment). However, the fact that comparable leaving versus staying rates were reported for those with serious thoughts to leave, of whom also engaged in more behavioural precursors to leaving (indicating their higher intention of leaving), suggests that additional factors may have influenced their final NHS employment decision (e.g., of staying rather than leaving). Whilst intention did indeed drive the behaviour of active seeking of non-NHS employment, it did not drive the final behaviour of the leaving one's NHS employment for all participants. Two viewpoints for this finding are considered. First, relates to its surface-level impression, whereby it appears positive as no more participants left their NHS employment than stayed despite experiencing initial thoughts to. This therefore poses a positive influence upon retention and workforce numbers; on the surface, it suggests that individuals are actively wanting to stay, which provides further strength to the potential protective factors of the NHS that are later discussed. Yet, an alternative hypothesis is that these individuals stayed due to barriers around leaving, and therefore may not be wholly happy about doing so. This hypothesis is guided by literature reporting the emotionally avoidant coping strategies that psychological professionals adopt in order to just 'get on with it' (Carter, 2021). Such a culture of 'just getting on with it' is supported by further literature that notes it being created by organisational leaders, where little consideration of staff wellbeing and overall psychological safety is given (Rao et al., 2023). Together, this hints to the notion of psychological professionals pushing through; a notion that may link to Coombs et al.'s (2010) findings of Allied Health Professionals sense of moral obligation. Coombs et al. (2010) reported that this pulls such professionals to continue working for the NHS due to acting out of a sense of perceived moral duty, and does not necessarily make them feel good about doing so. Indeed, grey literature written by a CP who left their NHS employment for private practice speaks to this in relation to having to make a choice between the NHS (as driven by a felt sense of loyalty and obligation to it) or their mental health (Porter, 2022). Given, the implications of 'pushing through' upon wellbeing and subsequent retention, the need to explore the reasons for such comparable leaving versus staying rates within those with a higher initial intention to leave is essential.

What further feels pertinent to this notion of pushing through is that of the ‘NHS heroes’ narrative, which was developed for healthcare workers during the COVID-19 pandemic. Whilst holding positive intentions, the difficulty of it lay within its suggestion that NHS staff are not able to be sick or have days off, or more generally, experience challenges; something that has been noted to provide an image of self-sacrifice similar to that of veterans (Cox, 2023). Such difficulty is further seen within its provision of the image of a ‘perfect’ professional; one who does not falter, find challenge, or become ill, which was further enforced with the ‘clap for our NHS heroes’. Indeed, this message was largely incongruent to NHS staffs’ experiences during the COVID-19 pandemic, which was reported to be that of physical and mental exhaustion (The Lancet, 2020). However, due to the ‘hero’ narrative and clapping, it could be argued that professionals felt a need to push through regardless of how they were truly feeling. This may have contributed to the comparable staying versus leaving rates previously discussed, where professionals felt they had to continue within their NHS employment despite experiencing personal challenges. This would likely lead to stress and burnout, further providing context to the levels identified within the portfolio’s review, and stress and burnout being key factors associated with non-NHS employment decisions within the portfolio’s empirical paper. This is supported by the fact that NHS staff mental health and wellbeing hubs were set up during the COVID-19 pandemic in order to respond to the worsening mental wellbeing of the NHS workforce, and thus provide their rapid access to psychological support (NHS England, n.d.). Consequently, staff wellbeing became increasingly acknowledged during the COVID-19 pandemic, as supported by review with most included studies centering around the COVID-19 timeframe. Yet, Coombs et al. (2010) reported a widespread acceptance by Allied Health Professions of negative work pressures and challenges being ‘part and parcel’ of the job. Therefore, the extent to which comparable staying versus leaving rates are seen due to professionals pushing through (as driven by previous societal narratives), or due to accepting the challenges they face as part of their role, is under question. Future research should look to explore this further and thus expand upon Steel et al.’s (2002) finding being that the psychological processes within intention to leave and intention to stay are not necessarily

being the same.

Indeed, research into NHS Allied Health Professions found key differences in factors related to staying and leaving (Coombs et al., 2010; Loan-Clarke et al., 2010), as well as in the cognitive and behavioural effort with generalised thoughts of leaving and actual leaving (Fuller et al., 1996). The results of the empirical paper support this, whereby asymmetries were revealed between intensity levels of thoughts to leave NHS employment (e.g., fleeting versus serious thoughts), and between decisions to stay or leave NHS employment. Positively, the findings of the latter are supported by wider NHS workforce literature (e.g., Coombs et al., 2010; Leary et al., 2024; Weyman et al., 2023; Wintour & Joscelyne, 2024). As revealed within the empirical paper, Weyman et al. (2023) identified job security, NHS commitment, and an ability to provide good quality patient care to be key pull factors to individuals' decisions to stay working for the NHS. Contrastingly, stress, mental health, and leadership/management were noted to be key push factors to individuals' decisions to leave the NHS (Weyman et al., 2023). Although the push factors noted in Leary et al.'s (2024) research are related to frontline nurses, they too identified mental health and overwork (which can be linked to 'stress', a factor identified in the current portfolio's empirical paper) to be key reasons for leaving NHS employment. Leadership and management issues were further noted as key challenges to NHS staff engagement within Bailey et al.'s (2015) research, where further literature has noted it to be a consequence of a 'command and control' leadership/management style, resulting in CPs feeling operationally led, having a limited voice in comparison to other professions and, again, being expected to 'just get on with it' (Rao et al., 2021).

Moreover, Leary et al. (2024) and Weyman et al. (2023) also identified pay to be a key push factor salient to individuals' decisions to leave the NHS. The empirical paper indeed revealed pay to be a push factor, though notably solely for part-time working as opposed to full leaving. Research offers potential hypotheses for this difference, as linked to the increased range of options for CPs to receive private income (e.g., via private work, and locum and agency work), which has further been associated with the mixed-model of NHS and non-NHS employment that early-career CPs are increasingly moving towards (Rosairo

& Tiplady, 2024). Indeed, the push factors associated with part-time NHS employment were those of extrinsic motivators to individuals' professional selves. These factors are suggestive of a move to private work, of which are supported by the five-year employment intentions findings. Such a move is supported by literature that notes a growing number of CPs leaving their NHS roles, or reducing their contracted NHS hours, to work in independent private practice (Tolland & Drysdale, 2022), as termed the "pull of the private sector" (Rosairo & Tiplady, 2024, p.42). Grey literature (Bernard & Wang, 2021; Gilderthorp, 2021; Katie, 2023) and anecdotal murmurs further support this occurrence, being that of which this research was motivated to explore and understand.

Notably, an inability to provide good quality care (leading to moral injury) was associated with part-time NHS employment (push factors), and full-time NHS employment. Indeed, this factor was noted as particularly present during COVID-19, where staff were expected to do more work with less resources, resulting in a standard of work that fell below their perception of 'good enough' (Williamson et al., 2021). This resulted in NHS environments challenging professionals' sense of self-actualisation, leading to cognitive dissonance, moral injury, and their subsequent leaving of NHS employment (Leary et al., 2024). However, the presence of this factor in nearly all employment outcomes is striking as it underscores both its pulling and pushing power. Such contrasting power can be explained by its association with Allied Health Professionals attitudes towards working for the NHS (Coombs et al., 2010). Here, Coombs et al. (2010) reported an inability to provide good quality care to be a key driver for leavers of NHS employment due it to being associated with a negative attitude to working for the NHS (highlighting its pushing power). Contrastingly, Coombs et al. (2010) also noted it as a key pull factor in attracting Allied Health Professionals back to NHS employment due to it being associated with a positive attitude to work for the NHS when such care was able to be appropriately provided. Here, attitude is seemingly an important notion, and is an additional part of the TPB (Ajzen, 1991), which the current paper did not explore. Such influence upon one's attitude towards the NHS is understandable given 'quality care' being noted as a key commitment within the NHS Constitution for England (Department of Health & Social Care, 2023), and arguably therefore

underpins the core reasoning for individuals want to work within the NHS. Its power to either push or pull employment decisions is therefore likely dependent on an individual's ability to provide such care, and therefore must be strongly considered within the exploration of NHS workforce retention.

Finally, the ERI model (Siegrist, 1996) was applied to the understanding of the pertinence of these factors towards CPs' thoughts to leave their NHS employment, and subsequent employment decisions. Its application to cognitive processes involved in NHS employment decisions is supported by literature outlining its role within Belgian healthcare workers' intention to leave their organisation and profession (Derycke et al., 2010), to which the findings of the empirical paper provide support for the former, being that of leaving one's organisation (e.g., the NHS). Moreover, the felt ERI in participants' most recent NHS role provide support, and are supported, by literature noting the notions of inequity between the aforementioned push/pull factors leading to a perceived ERI (Weyman et al., 2023). This has been noted to result in a predictive association with individuals' intent and actual leaving of NHS employment (Hayes et al., 2012; Loan-Clarke et al., 2010), as found in in this portfolio's empirical paper. Indeed, the importance of rewards to ensure such a balance is noted in the NHS People's Promise (NHS England, 2020) and across further literature noting its influence on intention to leave, job satisfaction and intrinsic motivation (Herzberg et al., 1966; Jones et al., 2024; Leary et al., 2024). In agreement with widespread media narratives, the findings of the current study and wider literature suggest that pay is indeed an influencing factor, though not the only factor. Where there is such a complexity and multiplicity of factors influencing decisions to stay or leave NHS employment, and with differing levels of importance dependent on the NHS employment decision, such factors need to be jointly considered in terms of ERI (Leary et al., 2024). This is crucial given Leary et al.'s (2024) reporting of their links to intrinsic motivation, which influences subsequent NHS employment decisions, leading to either relief or guilt from leaving (Wintour & Joscelyne, 2024).

Strengths and Limitations

A key strength of this thesis portfolio is that it comprises two novel papers that provide crucial initial explorations into the sustainability of the NHS psychological workforce. The two

papers offer two original contributions to the existing evidence-base for this workforce within the UK NHS. In turn, they can be used to improve data quality around levels of stress and burnout within the psychological professionals, and around the complexity and multiplicity of factors that influence their NHS employment thoughts and decisions.

In specific relation to the review paper, to the author's knowledge, this is the first to complete a review of stress and burnout levels in all psychological professions within the NHS psychological workforce. This addresses a significant gap in the literature of such a review not previously existing, where those that do are non-UK-centric, only include either stress or burnout, and solely focus on qualified professionals. Its UK-centric focus, inclusion of both stress and burnout, exploration of both trainee and qualified career stages, and no limitation on publication date or stress and burnout measure used, allowed the completion of a comprehensive review into the existing evidence-base to widen current insight.

In relation to the empirical paper, to the author's knowledge, this is the first paper to explore NHS employment thoughts and decisions, and their associated factors, solely on the early-career CP population. Its inclusion of all aspects of NHS employment (e.g., thoughts, employment decisions, and associated factors), resulted in its highly comprehensive nature, allowing deep knowledge and insight to be gained.

A further strength of the empirical paper was its inclusion of free-text responses, which allowed participants to qualitatively develop upon their quantitative answers provided. This ensured that answers were not limited by the response options provided within the survey, allowing further data responses to be developed from additional qualitative answers. Furthermore, it ensured variability in answer response formats, which prevented bots from targeting the survey (Brainard et al., 2022). This confirmed that all answers were from reallife participants, in turn, increasing the reliability of the findings. Furthermore, the survey was further strengthened by being informed by wider NHS research, as cited within the paper. This guided the decisions regarding the inclusion of all aspects of NHS employment, with key insight being gained as to the most relevant factors for NHS staff as a whole, and for

CPs. Additionally, it is grounded within key theoretical frameworks (e.g., ERI [Siegrist, 1996], TPB [Ajzen, 1991]) and supporting associated literature, thus ensuring a strong theoretical and evidence-based underpinning.

Moreover, a panel of Patient and Public Involvement (PPI) members were involved and consulted from the outset of the study. Such members supported the study's development and ensured the accessibility of all documents used, such as of the forms and the survey developed. Continuous feedback from PPI members was gained throughout the research process to ensure that such PPI involvement was not done in a tokenistic manner, as noted as crucial within literature (Jackson et al., 2020), and was instead used to continuously develop the research as required.

Finally, a large sample size was obtained that comprised early-career CPs from across the UK. This not only ensured generalisability of the findings to all early-career UK CPs, but also highlights the high level of perceived importance of the research to those within the CP profession given such a widespread willingness to participate. This importance was indeed highlighted within anecdotal feedback gained from participants on their own accord, from others who heard about the research (e.g., during recruitment or via informal networks), and from key members of organisations (e.g., the BPS and Psychological Professions Network [PPN]) of whom expressed their support in the study and interest in its findings. Such support underscores the importance of the study, and the required need for it from those within the psychological field. The fact that it was completed alongside a joint qualitative sister study (Stinton, 2025b) allows the support of such qualitative data to the quantitative findings found within the current portfolio's papers. This ensures increasingly rich and deep insight into the findings, their contribution to the psychological field, and their expansion to the current evidence base.

Despite these key strengths, some limitations are noted. These must be both acknowledged and considered when drawing conclusions from the data. Limitations of the review are first provided, followed by limitations of the empirical paper.

First, the scope of the review was limited by the select psychological professions that were included in the studies. A comprehensive picture of stress and burnout levels within

trainee and qualified professionals of the NHS psychological workforce could therefore not be gained as had been initially hoped, in turn, reducing the addition of such comprehensive knowledge and insight into this area. This was noted within the paper as being a key area for future research to consider; that is, to ensure all psychological professions are explored within future empirical research, particularly given the continued investment into this workforce. Second, the quality of the studies was moderate, whereby most received a 'good' or 'satisfactory' rating, and one received an 'unsatisfactory' rating. Whilst these ratings were largely influenced by the methodology and data reporting of the studies, their quality must be considered when drawing conclusions from the review given the likelihood of increased bias as a result. Here, alternative methodology is recommended within the paper to overcome this limitation. Third, the nature of the review paper was the notion that psychological professions are stressed and burnt out. Therefore, it may have been the case that psychological professionals may have been too stressed or burnt out to complete the stress or burnout survey within the included study, or complete it to a true extent, as potentially exacerbated by the professional stigma associated with these conditions within the helping professions (Edwards & Crisp, 2017). Whilst this has been earlier discussed within the portfolio, emphasis is placed upon the need for this to be considered when interpreting the findings due to it acting as a potential confounder to the stress and burnout levels revealed, in turn, reducing the validity of the results.

In relation to the empirical paper, its sample solely included CPs within the early-career stage. Whilst this was indeed the intended target population and comprised a national sample of such CPs, the findings of the study cannot be generalised to CPs outside of this career stage. This is important to note given that the factors and their associated level of importance may differ depending on CPs career stages; therefore, caution should be had when relating these factors to CPs as a collective, as opposed to the specific career stage. The paper noted future research to explore the factors salient to CPs across career-stages, which would be particularly interesting to allow for differences to be noted. Second, the sample was particularly dominated by those working within the NHS. Whilst this may indeed be reflective of where early-career CPs are working, it may also reflect the lack of access to

those working in non-NHS employment, such as those within the private sector, resulting in these CPs under-representation within the research. Notably, whilst completing recruitment and proactively attempting to target private CPs, the author observed that many of those who were reached within the private field were those of senior CPs who were outside of the early-career stage, and thus could not be included. This provides further rationale to conduct this research into CPs across career-stages in order to formally explore these anecdotal observations, and further explore when and why they made their move to non-NHS (private) employment.

The proceeding limitations relate to the survey the empirical paper used. Although it was grounded in theory and informed by NHS literature, its development for the purpose of the study resulted in its reduced validity and reliability and, consequently, the findings. This, in turn, reduces the strength of the findings revealed, which must be considered when noting their conclusions. Such reduced strength may have further been influenced by the wording of the factors, where positive or negative terminology was used depending on the relative NHS employment outcome it related to. Whilst this was necessary for the operationalisation of the factors, and was supported by what previous literature has used, it may have been that such wording intricacies influenced participants' understanding or interpretation of the question or factor, as related to themselves and their experiences. Furthermore, an unequal number of factors were present across the NHS employment decisions. Indeed, this was informed by literature that noted the most salient factors for each employment decision; however, such disequilibrium prevented direct comparison of like-for-like, subsequently preventing the scope of statistical analyses that could be completed. Consequently, solely descriptives could be completed, as opposed to between-subjects ANOVAs, for example. Additionally, common-method bias may have been present within the self-reported predictor variables (e.g., push/pull factors) and dependent variables (e.g., thoughts to leave, subsequent leaving, and NHS employment decisions). Whilst research has noted that these influences are likely not as high as may be expected (Spector, 2006), they must still be acknowledged. Finally, the multiple response options that could be provided by participants within the 'future intentions' section of the survey resulted in multiple different, and often contrasting,

responses that muddied the data obtained. This impacted upon the analysis of this area, whereby descriptives of main employment areas could solely be obtained. It is therefore recommended that future research limits response options, or conducts longitudinal research that tracks participants employment areas over a specified time period, in order to obtain more reliable data. Despite this, it is indeed important to note that such muddied data is an important finding in and of itself, as it highlights a group of participants who are ambivalent about their future employment decisions. Indeed, such ambivalence could be driven by a range of different factors, which would be useful to be explore in order to understand decision-making processes regarding future employment.

Theoretical Implications

In addition to the aforementioned strengths of the review and empirical paper, both hold important theoretical implications. Indeed, both papers add to current knowledge regarding the wellbeing of the NHS psychological workforce and the NHS employment decisions of early-career CPs. This significantly adds to the current evidence-base, of which is notably limited, and improves the data quality around the push/pull factors relevant to this population of NHS professionals. Furthermore, the papers align with previously cited research exploring the wellbeing of psychological professions and the factors associated with their, and wider NHS workforce, respective employment decisions. They also advance upon governmental, BPS, and NHS England work into the wellbeing and retention of the NHS workforce and, specifically, the psychological professions workforce, in order to support their sustainability and longevity. Finally, the empirical paper extends upon the theoretical frameworks from which it was informed. Indeed, it highlights how action is indeed predicted by behaviour, as per the TPB (Ajzen, 1991); though, perhaps not to the extent that was first anticipated, with other factors playing a key part in helping to reduce such behaviour (e.g., rewards of the NHS preventing leaving of NHS employment). Despite this challenge, this study adds to the dearth of current literature applying the ERI model to work-related outcomes (e.g., intention to leave and employment decisions; Derycke et al., 2010; Hasselhorn et al., 2004; Kinnunen et al., 2008). Moreover, the research highlights how push/pull factors can be understood as ‘effort’ and ‘reward’ factors within the ERI Theory

(Siegrist, 1996), and how this can be applied to NHS roles to understand individuals' differing employment decisions. This is key in supporting the retention of the NHS workforce and should be further considered in recruitment strategies to support employment to perhaps more challenging or 'difficult to recruit to' roles (e.g., by clear advertising of rewards within the role).

Clinical Implications for Practice and Service Delivery

The review and empirical paper further hold important clinical implications that must be considered through a systemic approach by the system within which trainee and qualified psychological professions sit within. Notably, this includes the training programmes for the psychological professions, the workplaces of NHS psychological professions (e.g., NHS Trusts), professional bodies of the psychological professions (e.g., the BPS), and the government, of which are discussed below.

Firstly, UK training programmes of the psychological professions must acknowledge the varying contributors to stress and burnout; both visible and invisible. Indeed, self-care has been noted as important to be incorporated within training programmes in order to truly be able to practice what we preach as clinical professionals (Carter, 2021). This has been argued to be encouraged by both training courses and individuals themselves, and done so in a way that is less tokenistic and more integrative, as supported by professional bodies to ensure this proper implementation and role modelling by staff to trainees (Carter, 2021). Yet, training courses must be aware of causes of stress (and later burnout) that may not be as obvious, apparent, nor reported, and be flexible in offering adjustments to trainees to allow such needs and requirements to be catered for. Having an open narrative about stress experienced at this early stage would play an important role in recognising this and ensure realistic expectations are held to prevent high standards leading to burnout in pursuit of their obtainment. The stress and burnout data suggest that perhaps training programmes are getting this right, but this does not mean that all is ok and that the aforementioned should not be considered and implemented. Such consideration and implementation must continue regardless in order to ensure lower stress and burnout rates persist for the psychological professions, as identified to be in comparison to other healthcare professions.

Secondly, workplaces, such as NHS services and Trusts, must consider their approach through a systemic lens. This involves the individual psychological profession at the core, followed by the wider team, leaders and managers. A caring work culture has been noted as vital for both wellbeing and retention (Rao et al., 2023), and this can be fostered through the recognition of the factors that influence an individual's role (e.g., those included in the empirical paper for CPs and, arguably, the wider NHS workforce). Fostering a culture of wellbeing is vital, and this includes having open narratives about challenges and areas of strength, with the use of data to inform insight into the wellbeing of employees, such as via the Psychological Practitioner Workplace Wellbeing Measure developed by Summers et al. (2021). Indeed, collaborative working is vital to ensure support at both an individual employee and management level, and should be encouraged through a compassionate leadership approach. A key understanding of each individual profession within a team (both psychological and other), recognition of effort via the provision of reward, open narratives regarding experiences with the gaining of feedback for areas of improvement, the offer of flexible working though the identification of professional gaps required to be targeted, the absolute provision of CPD in order to ensure professional development, and the recognition of when more and/or targeted support may be required (e.g., during the early-career period), is vital. This does not fall to only one person, but instead requires a joint, collaborative, and evolving partnership within workplace systems.

Third, professional bodies hold a role in exploring the factors relevant to retention (Rosairo & Tiplady, 2024). Indeed, the BPS has worked hard in championing the need for further attention to the wellbeing and retention of the psychological professions, which has both prompted and supported empirical research into this area, allowing a strong voice for this workforce to be had. For this voice to remain, this work must continue alongside empirical research investigation. This may allow the importance of ringfenced money and wellbeing support (e.g., NHS Staff and Wellbeing Hubs) to be heard by the government and subsequently continued. A culture of wellbeing must be adopted, with compassionate leadership at all levels (Bailey & West, 2022), and the inclusion of all of the six domains identified by Rao et al. (2021) in relation to what a caring workplace should look like.

Future Research

Importantly, the review and the empirical paper noted key gaps within the existing evidence-base. These are noted as key areas for future research in order to expand upon the current portfolio's findings and provide increased insight into this area.

As previously noted, there is a significant need for increased empirical investigation of stress and burnout within all of the psychological professions that make up this NHS workforce, given the current sparsity identified by the review. Such future investigation must use the aforementioned recommendations of consistent measures and the reporting of all data. This will ensure that all reviews, such as the present, can be completed comprehensively, without their scope being limited, and with meaningful comparisons and conclusions being drawn.

The empirical paper offers several opportunities for the further extension of its findings. Future research could look to explore the contingent factors that stopped early-career CPs who experienced initial thoughts, and a high overall intention, to leave their NHS employment from subsequently leaving. Here, it would be interesting to explore key decision-making processes and other factors present and relevant to the protection of this population from leaving their NHS employment. It would further be of interest to explore the factors relevant to NHS employment decision making for CPs outside of the early-career phase in order to see if there are symmetries or asymmetries that are influenced by CPs particular career stages. Expanding upon this, future research could look to explore the extent to which service type predicts NHS employment decisions, given the reporting of differing demands within services (Wintour & Joscelyne, 2024). A further area of exploration could be that of 'internal leaving' (e.g., moving from one service to another within a Trust, or moving from one Trust to another), which may hold specific driving factors that are vital to establish given such internal leaving arguably being the precursor to full leaving of NHS employment. On a similar line, it would be interesting to break down 'intention to leave' to finer levels, including that of 'intention to leave the role', 'intention to leave the organisation', and 'intention to leave the profession', with use of the ERI questionnaire (Siegrist et al., 2004). This would expand upon Derycke et al.'s (2010) research, which is currently limited to Belgian healthcare workers.

Moreover, exploring the role of attitude within individuals' intentions to leave and subsequent employment decisions, particularly as associated to the prespecified factors of the current portfolio's study, would be key to gain insight into the potential cognitive underpinning to such factors and subsequent decisions. This would expand upon Coombs et al.'s (2010) exploration into Allied Health Professions and focus it specifically to CPs, providing further evidence to Ajzen's TPB (1991) within which 'attitude' is noted to be key. Finally, given the comprehensive nature of the current thesis and therefore substantial amount of data obtained, a secondary analysis could be completed using the unused data, with expansion via additional surveys as per the specific research questions.

Conclusions

NHS psychological professionals face numerous demands within their roles, both at the training and qualified career stages. The portfolio's review revealed that such demands may lead to moderate levels of stress during training, and low-to-moderate levels of burnout during training and once qualified. Importantly, the review highlighted that the training period likely poses a bigger influence towards such stress and burnout levels, over and above the distinct psychological profession. This was further emphasised through the comparable burnout levels between the trainee and qualified career stages, which highlights the extent of the demand trainees face during their training. This underscores the need for early interventive strategies to be targeted at this early point by UK training programmes to reduce such levels and prevent the later development of burnout as a trainee and once qualified; key to supporting staff wellbeing, improving patient outcomes, and ensuring the retention of this workforce. Extending this insight, the empirical paper identified further factors that provide threats to this workforce's retention at both the cognitive and behavioural levels. For early-career CPs, these were organisational, systemic, and individual-related factors, as well as extrinsic motivators. Indeed, the rewards of the NHS are seemingly protective against non-NHS employment decisions by increasing the NHS' pulling power when they are appropriately provided. However, the findings suggest that early-career CPs are gradually exiting NHS employment via a mixed-model of NHS and non-NHS employment, where private work is being sought to fill perceived professional gaps and role discrepancies. This

is vital for retention, and for the effective and safe practice of this key NHS workforce to, in turn, meet the needs of those who require their service.

Overall, this thesis portfolio is a key step in providing initial comprehensive insight into the current state of play for the wellbeing and retention of the NHS psychological workforce. It highlights the vital need to support their wellbeing from the very start of their careers, and address the numerous factors posing influence to their employment decisions within their qualified career. Indeed, there is no one size that fits all, and this is shown through the multiplicity and complexity of the factors identified to influence their NHS employment decisions. However, it is recommended that organisational and systemic factors are initially considered as a first step, given their presence and influence on both leaving cognitions and behaviour. Together, the findings of the papers should be used to inform understanding and intervention at an individual, organisational, and policy level, through a systemic approach of which is required.

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Appendix A

Author Guidelines for the Mental Health & Prevention Journal

ScienceDirect

Mental Health & Prevention

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Guide for authors

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. 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. 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
- 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

- Full-Length Research Papers (up to 5,000 words, excluding references and up to 6 tables/figures)
- Review papers are normally systematic reviews following the PRISMA statement of 4,000-5,000 words (Introduction through Discussion).
- 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)
- Short Communications (up to 2,000 words, 20 references, 2 tables/figures)
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Authorship

All authors should have made substantial contributions to all of the following:

1. The conception and design of the study, or acquisition of data, or analysis and interpretation of data.
2. Drafting the article or revising it critically for important intellectual content.

3. Final approval of the version to be submitted.

Authors should appoint a corresponding author to communicate with the journal during the editorial process. All authors should agree to be accountable for all aspects of the work to ensure that the questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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The editors of this journal generally will not consider changes to authorship once a manuscript has been submitted. It is important that authors carefully consider the authorship list and order of authors and provide a definitive author list at original submission.

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Declaration of interests

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence or bias their work. Examples of potential competing interests include:

- Employment
- Consultancies
- Stock ownership
- Honoraria

- Paid expert testimony
- Patent applications or registrations
- Grants or any other funding

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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.

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Authors must declare the use of generative AI in scientific writing upon submission of the paper. The following guidance refers only to the writing process, and not to the use of AI tools to analyse and draw insights from data as part of the research process:

- Generative AI and AI-assisted technologies should only be used in the writing process to improve the readability and language of the manuscript.
- The technology must be applied with human oversight and control and authors should carefully review and edit the result, as AI can generate authoritative-sounding output that can be incorrect, incomplete

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- Authors must not list or cite AI and AI-assisted technologies 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 generative AI and AI-assisted technologies in scientific writing 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 writing process.
- Statement: During the preparation of this work the author(s) used [NAME 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.

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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.

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

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- 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).

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Clinical trials must be registered in a public trials registry in accordance with International Committee of Medical Journal Editors (ICMJE) clinical trials guidelines and as a condition of publication in this journal.Purely observational studies, in which the assignment of the medical intervention is not at the discretion of the investigator, do not require registration.

Some key excerpts from the guidelines include:

- Trials must be registered at or before the onset of patient enrolment.

- The clinical trial registration number should be included 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, behavioural 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.

Reporting on clinical trials

You 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.

Clinical trial results

Authors must disclose all posting in registries of results of the same or closely related work.

We follow the International Committee of Medical Journal Editors (ICMJE) clinical trials guidelines. 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.

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

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- Lay out text in a single-column format.
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- 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.

Structured abstract

A structured abstract, by means of appropriate headings, should provide the context or background for your research. Some guidelines:

- State the purpose of your research.
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- Include your main findings, providing specific effect sizes and their statistical significance, if possible, and your principal conclusions.
- Emphasize new and important aspects of your study or observations.

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").

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

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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.

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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:

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You are **encouraged** to:

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- Use the numbering format when cross-referencing within your article. Do not just refer to "the text."
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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.

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- 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

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- 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."
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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/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/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/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/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.

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- data repository
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- year
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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.

Appendix B

Newcastle – Ottowa Quality Assessment Scale (adapted for cross sectional studies)

Selection: (maximum 5 stars)

1) **Representativeness of the sample:**
   a) Truly representative of the average in the target population. * (all subjects or random sampling)
   b) Somewhat representative of the average in the target population. * (non-random sampling)
   c) Selected group of users.
   d) No description of the sampling strategy.
2) **Sample size:**
   a) Justified and satisfactory. *
   b) Not justified.
3) **Non-respondents:**
   a) Comparability between respondents and non-respondents characteristics is established, and the response rate is satisfactory. *
   b) The response rate is unsatisfactory, or the comparability between respondents and non-respondents is unsatisfactory.
   c) No description of the response rate or the characteristics of the responders and the non-responders.
4) **Ascertainment of the exposure (stress and/or burnout):**
   a) Validated measurement tool. **
   b) Non-validated measurement tool, but the tool is available or described.*
   c) No description of the measurement tool.

Comparability: (maximum 2 stars)

5) The subjects in different outcome groups are comparable, based on the study design or analysis. Confounding factors are controlled.
   a) Data/results adjusted for relevant predictors/risk factors/confounders. **
   b) Data/results are not adjusted for all relevant predictors/risk factors/confounders, or no information regarding this is provided.

Outcome: (maximum 3 stars)

6) **Assessment of the outcome:**
   a) Independent blind assessment. **
   b) Record linkage. **
   c) Self report. *
   d) No description.
7) **Statistical test:**
   a) The statistical test used to analyse the data is clearly described and appropriate, and the measurement of the association is presented, including standard deviations and the probability level (p value). *
   b) The statistical test is not appropriate, not described, or incomplete.

Scoring for cross-sectional studies:
'Very good': 9-10 stars
'Good': 7-8 stars
'Satisfactory': 5-6 stars
'Unsatisfactory': 0-4 stars

Appendix C

PRISMA Abstract Checklist

Selection and topic	Item #	Checklist Item	
Title			
Title	1	Identify the report as a systematic review.	Yes
Background			
Objectives	2	Provide an explicit statement of the main objective(s) or question(s) the review addresses.	Yes
Methods			
Eligibility criteria	3	Specify the inclusion and exclusion criteria.	No
Information sources	4	Specify the information sources (e.g. databases, registers) used to identify studies and when each was last searched.	Yes, 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 synthesis results.	Yes
Results			
Included studies	7	Give the total number of included studies and participants and summarise relevant characteristics of studies.	Yes, No
Synthesis of results	8	Present results for main outcomes, preferably indicating the number of included studies and participants for each. If meta-analysis was done, repot the summary estimate and confidence/credible interval. If comparing groups, indicate the direction of the effect (i.e. which group is favoured).	Yes

Discussion			
Limitations of evidence	9	Provide a brief summary of the limitations of the evidence included in the review (e.g. study risk of bias, inconsistency and imprecision).	Yes
Interpretation	10	Provide a general interpretation of the results and important implications.	No
Other			
Funding	11	Specify the primary source of funding for the review.	No
Registration	12	Provide the register name and registration number.	No

Appendix D

PRISMA Checklist

Section and topic	Item #	Checklist item	Location where item is reported
Title			
Title	1	Identify the report as a systematic review.	20
Abstract			
Abstract	2	PRISMA 2020 Abstracts checklist.	Yes (Appendix C)
Introduction			
Rationale	3	Described the rationale for the review in the context of existing knowledge.	24
Objectives	4	Provide an explicit statement for the objective(s) or question(s) the review addresses.	24
Methods			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were groups for the syntheses.	25
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the data when each source was last searched or consulted.	24-25
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendix E

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.	25-26
Data collection process	9	Specify the methods used to collect data from all reports, including how many reviewers collected data from each report, whether the worked independently, any processes for obtaining or confirming data from study investigators and if applicable, details of any automation tools used in the process.	26
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	28-30
	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.	32
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of any automation tools used in the process.	26
Effect measures	12	Specify each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	28-30
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)).	N/A

	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling any missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results from individual studies and syntheses.	26
	13d	Describe any methods used to synthesis results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s), to identify the presence and extent of statistical heterogeneity, and software package(s) used.	28
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. sub-group analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesised results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	26
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.	27
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	27
Study characteristics	17	Cite each included study and present its characteristics.	28-30

Risk of bias in studies	18	Present assessment of risk of bias for each included study.	28-30
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.	28-30
Results of syntheses studies.	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing	31
	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.	
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesised	N/A
results.			
Reporting biases synthesis assessed.	21	Present assessment of risk of bias due to missing results (arising from reporting biases) for each	N/A
Certainty of evidence	22	Present assessment of certainty (or confidence) in the body of evidence for each outcome assessed.	26
Discussion			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	35

	23b	Discuss any limitations of the evidence included in the review.	38-39
	23c	Discuss any limitations of the review processes used.	39
	23d	Discuss implications of the results for practice, policy, and future research.	38
Other information			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state the review was note registered.	24
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	24
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	No
Support or sponsors in the review.	25	Describe sources of financial or non-financial support for the review, and the role of the funders	40
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

Appendix E

Search Strategy for Systematic Review

The following search terms were used for each database in combination with Boolean search strategies: (psychologist* OR counsellor OR psychotherapist OR "psychological wellbeing practitioner" OR IAPT OR "improving access to psychological therapies" OR PWP OR therapist* OR "wellbeing practitioner" OR "mental health practitioner" OR “clinical associate” OR “psychological practitioner” OR CAP) AND (burnout OR stress) AND (NHS or "national health service" or uk or "united kingdom" or england or scotland or wales or "northern ireland").

Appendix F

Author guidelines for the Health Services Management Research Journal

Preparing your manuscript for submission

Your article must be within the scope of the journal and be of sufficient quality. If not, it will not be reviewed. Please read the journal's Aims and Scope to see if your article is appropriate.

The manuscript must be your original work, you must have the rights to the work, and you must have obtained and be able to supply all necessary permissions for the reproduction of any copyright works not owned by you, including figures, illustrations, tables, lengthy quotations, or other material previously published elsewhere.

Article types

View our Special Collections currently accepting submissions.

The Sage Author Gateway has some general advice and on how to get published, plus links to further resources. Sage Author Services also offers authors a variety of ways to improve and enhance their article including English language editing, plagiarism detection, and video abstract and infographic preparation.

The journal encourages the submission of short, full-length, comparative and review articles from different backgrounds (health management, organizational psychology and sociology, applied economics, and others).

Health Services Management Research publishes seven main types of paper – reports of original primary research; reports of theoretical or methodological developments in health services, organisational or management research; evidence syntheses conducted rigorously and in accordance with accepted guidelines; theory-to-practice works; perspectives on emerging issues; and invited papers commissioned or solicited on important topics by the Editor and Editorial Board.

You will be asked which type of paper you are submitting when you submit a paper online, and will be able to choose from these seven types. Some editorial requirements of each type are outlined briefly below.

Original primary research

These papers present the findings from original empirical research using qualitative or quantitative methods. They should be up to 6000 words in length with up to six tables or figures and up to 30 references. They should be presented using conventional structured headings, and should contain a clear summary of the research findings and their implications for healthcare managers in one table or figure.

Theoretical or methodological developments

These papers present developments in theories, concepts or models in health services management research, or developments in research methods applied to health services. They should not simply contain reviews or reports on theory or methods, but should report a substantive advance or development. They should be up to 6000 words in length with up to four tables or figures and up to 30 references. They should be presented using structured headings though no particular structure is prescribed, and they should contain a clear summary of the key findings and conclusions from the paper in one table or figure.

Evidence *syntheses*

These papers present the results of secondary research – reviews of the existing research evidence conducted rigorously using recognised and accepted methods for review including (but not limited to) Cochrane systematic reviews, and realist or metanarrative reviews. They should be up to 6000 words in length with up to four tables or figures and up to 30 references. They should be presented using conventional structured headings including a clear explanation of the review methodology and process and they should contain a clear summary of the research findings and their implications for healthcare managers in one table or figure.

Theory-to-practice papers

These papers present the results of implementation of theoretical advances in managerial practices. They can report case studies, incidents, histories, interviews and all other forms of research that help to investigate heath management practices of organizations and systems, and their impacts and lessons. Papers submitted should ensure rigorous investigation of causal relationships and reliable assessment of the impacts, as well as highlight potentially generalizable interventions or practices.

They should be presented using structured headings though no particular structure is prescribed, and they should contain a clear summary of the key findings and conclusions from the paper in one table or figure. They should be up to 6000 words in length with up to six tables or figures and up to 30 references.

Perspectives papers

Papers that are short work that aim at highlighting, framing and discussing emerging health management issues in the agenda of organizations and systems. They are papers on cutting-edge topics, envisioning, provoking and providing brilliant “food-for-thought” for academics and practitioners. They should be presented using structured headings though no particular structure is

Ph.D breakthroughs

Papers that are directly derived from Ph.D works and dissertations. Tough sometimes they might be still immature and could be further developed in the current academic discourse, their rigorous and innovative methodological approaches and the new research questions they address make them of interest for the academics and practitioners community. They often anticipate new streams of research, or addresses old question with fresh and lateral views. They should be up to 6000 words in length with up to six tables or figures and up to 30 references. They should be presented using conventional structured headings, and should contain a clear summary of the research findings and their implications for healthcare managers in one table or figure. Given time issues of Ph.D candidates, a specific peer-review fast-track is designed for these submissions.

Invited or commissioned papers

These papers are invited or commissioned by the Editor and Editorial Board of the journal on important topics, and may present original empirical research, or theoretical or methodological developments, or evidence syntheses and in each case should follow the guidelines set out above. In inviting a contribution, the Editor may provide specific guidance on its intended purpose, audience and format. All invited or commissioned papers are subject to the same processes of peer review as other papers, please see Peer Review policy.

HSMR also promotes candidacy as guest editor for special issues.

To achieve the journal's objectives, authors are encouraged to write in a non-technical style, which is understandable to health management practitioners and specialists from other disciplines and in other countries.

Summary of article types:

Article Type	Abstract	Main Text	References	Figures/Tables
Original primary research	Up to 200	4,000 - 6,000 words	Up to 30	No more than 6
Theoretical or methodological developments	Up to 200	4,000 - 6,000 words	Up to 30	No more than 4
Evidence syntheses	Up to 200	4,000 - 6,000 words	Up to 30	No more than 4
Theory-to-practice	Up to 200	4,000 - 6,000 words	Up to 30	No more than 6
Perspectives	Up to 200	4,000 - 6,000 words	Up to 10	No more than 4
Ph.D Breakthroughs	Up to 200	4,000 - 6,000 words	Up to 30	No more than 6

Clinical trial registration

The journal conforms to the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first participant enrollment as a condition of consideration for publication. The trial registry name and URL, and registration number must be included at the end of the abstract.

Reporting guidelines

Your manuscript **must** follow the relevant EQUATOR Network reporting guidelines, depending on the type of study. The EQUATOR wizard can help identify the appropriate guideline. You will need to upload the appropriate checklist with your submission.

Other resources can be found at NLM's Research Reporting Guidelines and Initiatives.

If your research involves animals, you will be asked to confirm that you have carefully read and adhered to the ARRIVE guidelines.

Formatting your manuscript

Accepted file types

The preferred format for your manuscript is Word. You do not need to follow a template, but please ensure your heading levels are clear, and the sections clearly defined.

The LaTeX files are also accepted. A LaTeX template is available on the Sage Journal Author Gateway.

Your article title, keywords, and abstract all contribute to its position in search engine results, directly affecting the number of people who see your work. For details of what you can do to influence this, visit How to help readers find your article online.

Title

Your manuscript's title should be concise, descriptive, unambiguous, accurate, and reflect the precise contents of the manuscript. A descriptive title that includes the topic of the manuscript makes an article more findable in the major indexing services.

Abstract

Please include an unstructured abstract of 200 words between the title and main body of your manuscript that concisely states the purpose of the research, major findings, and conclusions. If your research includes clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract. Submissions that do not meet this requirement will not be considered.

For clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract.

Keywords

Please include a minimum of 4 keywords, listed after the abstract. Keywords should be as specific as possible to the research topic.

Artwork, figures, and other graphics

For guidance on the preparation of illustrations, pictures, and graphs in electronic format, please read Sage's artwork guidelines.

Figures supplied in color will appear in color online regardless of whether or not these illustrations are reproduced in color in the printed version. If you have requested color reproduction in the print version, we will advise you of the costs on receipt of your accepted article.

Please ensure that you have obtained any necessary permission from copyright holders for reproducing any illustrations, tables, figures, or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please see the Frequently Asked Questions page on the Sage Journal Author Gateway.

Acknowledgments

If you are including an Acknowledgements section, this will be published at the end of your article. The Acknowledgments section should include all contributors who do not meet the criteria for authorship. Per ICMJE recommendations, it is best practice to obtain consent from non-author contributors who you are acknowledging in your manuscript.

Writing assistance and third party submissions: if you have received any writing or editing assistance from a third-party, for example a specialist communications company, this must be clearly stated in the Acknowledgements section and in the covering letter. Please see the Sage Author Gateway for what information to include in your Acknowledgements section. If your submission is being made on your behalf by someone who is not listed as an author, for example the third-party who provided writing/editing assistance, you must state this in the Acknowledgements and also in your covering letter. **Please note that the journal editor reserves the right to not consider submissions made by a third party rather than by the author/s themselves.**

Author contributions

Papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.

The list of authors should include all those who can legitimately claim authorship. This is all those who:

1. Made a substantial contribution to the concept or design of the work; or acquisition, analysis or interpretation of data,
2. Drafted the article or revised it critically for important intellectual content,
3. Approved the version to be published,
4. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

Authors should meet the conditions of all of the points above. When a large, multicentre group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship.

Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship should be listed in the Acknowledgments section. Please refer to the International Committee of Medical Journal Editors (ICMJE) authorship guidelines for more information on authorship.

Please note that AI chatbots, for example ChatGPT, should not be listed as authors. For more information see the policy on Use of ChatGPT and generative AI tools.

You will be asked to list the contribution of each author as part of the submission process. Please include the Author Contributions heading within your submission after the Acknowledgements section. The information you give on submission will then show under the Author Contributions heading later at the proofing stage.

Statements and declarations

Please include a section with the heading 'Statements and Declarations' at the end of your submitted article, after the Acknowledgements section [and Author Contributions section if applicable] including each of the sub-headings listed below. If a declaration is not applicable to your submission, you must still include the heading and state 'Not applicable' underneath. Please note that you may be asked to justify why a declaration was not applicable to your submission by the Editorial Office.

Ethical considerations

Please include your ethics approval statements under this heading, even if you have already included ethics approval information in your methods section. If ethical approval was not required, you need to explicitly state this. You can find information on what to say in your ethical statements as well as example statements on our Publication ethics and research integrity policies page.

All papers reporting studies involving human participants, human data or human tissue must state that the relevant Ethics Committee or Institutional Review Board approved the study, or waived the requirement for approval, providing the full name and institution of the review committee in addition to the approval number. If applicable, please also include this information in the Methods section of your manuscript.

Consent to participate

Please include any participant consent information under this heading and state whether informed consent to participate was written or verbal. If the requirement for informed consent to participate has been waived by the relevant Ethics Committee or Institutional Review Board (i.e. where it has been deemed that consent would be impossible or impracticable to obtain), please state this. If this is not applicable to your manuscript, please state 'Not applicable' in this section. More information and example statements can be found on our Publication ethics and research integrity policies page.

Consent for publication

Submissions containing any data from an individual person (including individual details, images or videos) must include a statement confirming that informed consent for publication was provided by the participant(s) or a legally authorized representative. Non-essential identifying details should be omitted. Please do not submit the participant's actual written informed consent with your article, as this in itself breaches the patient's confidentiality. The Journal requests that you confirm to us, in writing, that you have obtained written informed consent to publish but the written consent itself should be held by the authors/investigators themselves, for example in a patient's hospital record. The confirmatory letter may be uploaded with your submission as a separate file in addition to the statement confirming that consent to publish was obtained within the manuscript text. If this is not applicable to your manuscript, please state 'Not applicable' in this section.

Declaration of conflicting interest

The journal requires a declaration of conflicting interests from all authors so that a statement can be included in your article. For guidance on conflict of interest statements, see our policy on conflicting interest declarations and the ICMJE recommendations.

If no conflict exists, your statement should read: 'The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article'.

Funding statement

All articles need to include a funding statement, under a separate heading, **even if you did not receive funding**. You'll find guidance and examples on our Funding page.

Data availability

The Journal is committed to facilitating openness, transparency and reproducibility of research, and has the following research data sharing policy. For more information, including FAQs please visit the Sage Research Data policy pages.

Subject to appropriate ethical and legal considerations, authors are encouraged to:

- Share your research data in a relevant public data repository
- Include a data availability statement linking to your data. If it is not possible to share your data, use the statement to confirm why it cannot be shared.
- Cite this data in your research

Reference style and citations

The journal follows the Sage Vancouver reference style. View the Sage Vancouver guidelines to ensure your manuscript conforms.

Every in-text citation must have a corresponding citation in the reference list and vice versa. Corresponding citations must have identical spelling and year.

Authors should update any references to preprints when a peer reviewed version is made available, to cite the published research. Citations to preprints are otherwise discouraged.

EndNote

If you use EndNote to manage references, you can download the Sage Vancouver EndNote output file.

Supplemental material

This Journal can host additional materials online (e.g. datasets, podcasts, videos, images etc.) alongside the full text of the article. Your supplemental material must be one of our accepted file types. For that list and more information please refer to our guidelines on submitting supplemental files.

English language editing services

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using Sage Author Services. Visit Sage Author Services for further information.

Appendix G

FMH Ethical Approval

University of East Anglia

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

Application ID: ETH2324-1159 (significant amendments)

Dear Annabel,

Your amendments to your study was considered on 13th December 2023 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

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

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

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

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,

Dr Paul Linsley

Ethics ETH2324-1159 (Significant amendments): Miss Annabel Harding

Appendix H

Patient & Public Involvement Expectations Sheet

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

Patient & Public Involvement (PPI) Expectations Information Sheet

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

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

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

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

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

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

PPI expectations:

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

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

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

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

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

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

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

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

Thank you.

Appendix I

Patient & Public Involvement Agreement Form

University of East Anglia

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

Patient & Public Involvement (PPI) Agreement Form

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

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

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

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

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

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

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

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

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

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

Name (BLOCK CAPITALS)	**Date**	**Signature**
_____	_____	_____

Appendix J

Participant Information Sheet

Early-Career Clinical Psychologist Sustainability Research

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

* Required

Participant Information Sheet

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

(1) What is this study about?
This study is looking to explore the employment decisions of early-career Clinical Psychologists (CPs), including the driving factors to stay working full-time within the NHS, working part-time within the NHS, or leaving NHS employment completely within this career period.

(2) Who is running the study?
This study is being carried out by researcher, Miss Annabel Harding (annabel.harding@uea.ac.uk), under the supervision of Dr Sheryl Parke (Sheryl.Parke@uea.ac.uk).

(3) What will the study involve for me?
Part 1: Completing the Demographic Form.
- This will ask questions related to your personal characteristics, your Doctorate in Clinical Psychology training, and your work as a qualified clinician.

Part 2: Completing the NHS Employment Decisions Questionnaire.
- This will ask questions related to your NHS employment decisions post-qualifying as a CP, and the factors that have influenced these.

You will then have the opportunity to participate in a parallel qualitative study, conducted by researcher, Megan Stinton (under the supervision of Dr Jinnie Ooi).
- This study involves completing a semi-structured interview via Microsoft Teams to further explore the early-career employment decisions of CP's.
- It will take approximately one hour to complete and is completely voluntary.
- You will be asked to provide your name and email address should you wish to opt-in to this separate study.

Participant Information Sheet Continued...

(4) How much of my time will the study take?
The study will take approximately 20 minutes to complete.

(5) Do I have to be in the study?
Participation is voluntary. Your decision to participate or not participate will not affect any current or future relations with the University of East Anglia.

(6) Can I withdraw from the study once I have started?
You can withdraw from the study whilst completing it by exiting the online survey window. However, once the online survey has been submitted, you cannot withdraw your data.

(6) Are there any risks or costs associated with being in the study?
The NHS Employment Questionnaire may evoke emotion or distress when reflecting on the challenges that you may have faced within your early career. Support agencies will be recommended at the end of the form if this is the case.

(7) Are there any benefits associated with being in the study?
Your participation will help us better understand the factors that are influencing early-career CP's employment decisions, in turn, helping to shape insight into, and the support offered within, the highly challenging early-career period.

(8) What will happen to information provided by me and data collected during the study?
The information you provide will be stored securely and your identity will be kept strictly confidential, except as required by law. Only Megan Stinton will have access to the identifiable information provided for participation in her study. Data management will follow the Data Protection Act 2018 (DPA 2018) and UK General Data Protection Regulation (UK GDPR), and the University of East Anglia's Research Data Management Policy.

The study's findings will be published as part of a doctoral thesis, which aims to be published in an academic journal and disseminated at relevant conferences.

The study's anonymised data may also be used within future research, as completed by other researchers.

Participant Information Sheet Continued...

(9) What if I would like further information about the study?
Please contact Annabel Harding (annabel.harding@uea.ac.uk) for further information.

(10) Will I be told the results of the study?
Due to anonymity, you are not able to be informed about the overall results of the study unless directly asked to be. Please contact Annabel Harding if you wish for this.

(11) What if I have a complaint or any concerns about the study?
If there is a problem, please contact Annabel Harding using the following address:
- annabel.harding@uea.ac.uk; Norwich Medical School, University of East Anglia, Norwich, NR4 7TJ

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the Head of the ClinPsy programme, Sian Coker (Programme Director): s.coker@uea.ac.uk or the Head of the Department of Clinical Psychology and Psychological Therapies, Niall Broomfield: n.broomfield@uea.ac.uk.

(12) How do I know that this study has been approved to take place?
To protect your safety, rights, wellbeing and dignity, all research in the University of East Anglia is reviewed by a Research Ethics Body. This research was approved by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

(13) What is the general data protection information I need to be informed about?
According to data protection legislation, we are required to inform you that the legal basis for processing your data as listed in Article 6(1) of the UK GDPR is because this allows us to process personal data when it is necessary to perform our public tasks as a University. Of further note to you;
- The data controller is the University of East Anglia.
- You can find out more about your data protection rights at the Information Commissioner's Office (ICO).
- For further information, or if you are unhappy with how your personal data is being used, please contact the University's Data Protection Officer at dataprotection@uea.ac.uk.

(14) OK, I want to take part - now what?
Please continue to the Participant Consent Form, should you wish to provide your consent to participate.

You will have the opportunity to download the entire form at the end of the survey once you have completed it. This will allow you to keep a copy of any part of the form, including this Participant Information Sheet and your Consent Form.

Appendix K

Participant Consent Form

Participant Consent Form

I am willing to participate in this study.

1. In giving my consent, I state that: *

	Please tick all if you agree to participate.
I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.	◯
I have read the Participant Information Sheet and have had the opportunity to discuss my involvement in the study with the researcher.	◯
I understand that participation is voluntary. My decision whether to participate will not affect my relationship with the researchers or anyone else at the University of East Anglia, now or in the future.	◯
I understand that I can withdraw my participation in the study by exiting the survey window at any point.	◯
I understand that I cannot withdraw my data after submitting the survey due to the data being anonymous.	◯
I understand that the results of the study may be used in the ways described in the Participant Information Sheet.	◯

I understand that the only personally identifiable information is my name and email address, should I decide to provide these due to wanting to participate in Megan Stinton's qualitative study.	○
I understand that the personal information will only be handled by Megan Stinton, will only be used for the purposes that I have agreed to (as outlined in the Participant Information Sheet), and will only be told to others with my permission (except as required by law).	○

Appendix L

Demographic Form

Demographic Form

Thank you for agreeing to complete this questionnaire. Your time and participation are so appreciated.

2. Please indicate your gender identity. *

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

3. Please indicate your age range. *

- ◯ <25
- ◯ 26-30
- ◯ 31-35
- ◯ 36-40
- ◯ 41-45
- ◯ 46-50
- ◯ 51-55
- ◯ 56-60
- ◯ 65+

4. Please indicate your ethnicity. *

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

5. What year did you qualify as a CP? *

- ◯ 2019
- ◯ 2020
- ◯ 2021
- ◯ 2022
- ◯ 2023

6. Did you take a break, or time off, after qualifying as a CP and before your **first** qualified job? *

- ◯ Yes
- ◯ No

7. If you took a break or time off, how many months after qualifying did you start your **first** qualified job?

Please state this as number of months e.g. 3 = 3 months.

The value must be a number

8. Which **county** was/is your **first** job as a qualified CP in?

If your first job was spread across more than one county, please state all the counties it was spread across. *

9. Was/is your **first** job as a qualified CP in the NHS?

Please note, if your first job was/is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

10. Was/is your **first** job as a qualified CP in academia?

Please note, if your first job was/is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

10. Was/is your **first** job as a qualified CP in academia?

Please note, if your first job was/is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

11. Was/is your **first** job as a qualified CP in research?

Please note, if your first job was/is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

12. Was/is your **first** job as a qualified CP in private practice?

Please note, if your first job was/is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

13. Was/is your **first** job as a qualified CP in a private company (e.g. Priory)?

Please note, if your first job was/is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

14. If your **first** job as a qualified CP was/is somewhere else, please state what employment area it was/is within.

15. Please indicate what type of contract your **first** job as a qualified CP in the NHS was/is.

If you worked in a split role and thus were on different contracts, please use the 'other' box to describe what these contracts were. *

- ◯ Permanent contract
- ◯ Fixed term / temporary contract

16. Please state the contracted number of working hours **(weekly)** your **first** job as a qualified CP in the NHS was/is.

If you worked a split role, please state the total number of contacted working hours (weekly) you worked across all your roles. *

The value must be a number

17. Please state the **number of days** that your contracted number of working hours as a qualified CP in the NHS was/is spread across. *

The value must be a number

18. Was/is your **first** job as a qualified CP in the **NHS** a split role? *

- ◯ Yes
- ◯ No

19. If your **first** job as a qualified CP in the NHS was/is a **split role**, what were/are your contracted number of working hours **(weekly)** in role 1?

Please state the total number of hours and the employment area this role was within. *

20. If your **first** job as a qualified CP in the NHS was/is a **split role**, what were/are your contracted number of working hours **(weekly)** in role 2?

Please state the total number of hours and the employment area this role was within. *

21. *Please ignore this question if your split role did not cover 3 areas.*

If your **first** job as a qualified CP in the NHS was/is a **split role**, what were/are your contracted number of working hours **(weekly)** in role 3?

Please state the total number of hours and the employment area this role was within. *

22. Please indicate whether you have changed from this **first** job since qualifying as a CP.

Please note that changing from your first job includes moving to/from/within a split role post. *

- ◯ No, I have not changed jobs since qualifying
- ◯ I have changed jobs **once**
- ◯ I have changed jobs **twice**
- ◯ I have changed jobs **three times**
- ◯ I have changed jobs **more than three times**

23. Why did you leave your **first** job? *

24. If you moved jobs **once**, how long were you in your **first** job before you left?

Please state this as number of months e.g. 3 = 3 months, 18 = 18 months. *

The value must be a number

25. If you moved jobs **twice**, how long were you in your **second** job before you left?

Please state this as number of months e.g. 3 = 3 months, 18 = 18 months.

If this question is not relevant, please state '0'. *

The value must be a number

26. If you moved jobs **three** times, how long were you in your **third** job before you left?

Please state this as number of months e.g. 3 = 3 months, 18 = 18 months.

If this question is not relevant, please state '0'.
*

The value must be a number

27. If you have moved jobs **more than three** times, how long were you in these jobs?

If this question is not relevant, please state '0'. *

28. When you left your **first** job, did you move to a different NHS Trust? *

- ◯ Yes
- ◯ No
- ◯ Not applicable

29. Which **county** is your **current** CP role in?

If your current job is spread across more than one county, please state all the counties it is spread across. *

30. Is your **current** CP role in the NHS?

Please note, if your first job is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

31. Is your **current** CP role in academia?

Please note, if your first job is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

32. Is your **current** CP role in research?

Please note, if your first job is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

33. Is your **current** CP role in private practice?

Please note, if your first job is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

34. Is your **current** CP role in a private company (e.g. Priory)?

Please note, if your first job is a split role and covers this employment area, please tick 'yes'. *

- ◯ Yes
- ◯ No

35. If your **current** CP role is somewhere else, please state the employment area that it is in. *

36. Please indicate what type of contract your **current** job as a qualified CP in the NHS is.

If you worked in a split role and thus were on different contracts, please use the 'other' box to describe what these contracts were. *

- ◯ Permanent contract
- ◯ Fixed term / temporary contract
- ◯

37. Please state the number of working hours (**weekly**) your **current** CP role in the NHS is.

If you work a split role, please state the total number of contracted working hours (weekly) you work across all your roles. *

38. If your **current** CP role is in the **NHS**, please state the **number of days** your previously number of contracted hours your current CP role is spread across. *

39. Is your **current** CP role in the **NHS** a split role? *

- ◯ Yes
- ◯ No

40. If your current CP role in the NHS is a **split role**, what is your total number of contracted working hours **(weekly)** across all your roles? *

The value must be a number

41. If your current CP role in the NHS is a **split role**, what are your contracted number of working hours **(weekly)** in role 1?

Please state the total number of hours and the employment area this role is within. *

42. If your current CP role in the NHS is a **split role**, what are your contracted number of working hours **(weekly)** in role 2?

Please state the total number of hours and the employment area this role is within. *

43. *Please ignore this question if your split role does not cover 3 areas.*

If your current CP role in the NHS is a **split role**, what are you contracted number of working hours **(weekly)** in role 3?

Please state the number of hours and the employment area this role is within. *

Thank you for completing the Demographic Form.

Please continue to the **NHS Employment Decisions Questionnaire**.

Appendix M

NHS Employment Decisions Questionnaire

NHS Employment Decisions Questionnaire

Intention to Leave NHS Employment

This part of the survey explores if you have ever had thoughts to leave your NHS employment at any point in your career thus far, **including during your time on DClinPsy training (e.g. whilst on placement) and/or as a qualified CP.**

Please note that if, as a qualified CP, you have transitioned from full-time to part-time NHS work, this would count as **having had thoughts to leave your NHS employment** (as you have transitioned out from full-time to part-time NHS employment). Therefore, please do complete this part of the survey.
Similarly, if you have already left your NHS employment, then you will have had an intention to leave your NHS employment that then led to you leaving it. Therefore, please do complete this part of the survey.

44. Have you ever had thoughts of leaving your **NHS** employment?

NHS employment can refer to during your time on clinical training (e.g. whilst on placement) or as a qualified CP. *

- ◯ No, I have never had any thoughts of leaving my NHS employment
- ◯ Yes, fleeting thoughts (e.g. in moments in frustration)
- ◯ Yes, serious thoughts (e.g. due to ongoing difficulties)

45. Did these thoughts of leaving your NHS employment arise during **clinical training** (e.g. whilst on placement)? *

- ◯ Yes
- ◯ No

46. How frequently did you have thoughts to leave your NHS employment during **clinical training**?

1 = never had thoughts to leave my NHS employment
5 = had thoughts to leave my NHS employment extremely frequently (e.g. everyday) *

1	2	3	4	5

47. How far into **clinical training** did you first have thoughts to leave your NHS employment? *

- ◯ Within the first year
- ◯ Within the second year
- ◯ Within the third year

48. Did these thoughts of leaving your NHS employment arise whilst you were working as a **qualified CP**? *

- ◯ Yes
- ◯ No

49. How frequently did you have/have you had thoughts to leave your NHS employment whilst a **qualified CP**?

1 = Never had/have thoughts
5 = Always had/have thoughts *

1	2	3	4	5

50. How far into **qualified life** as a CP did you first have thoughts to leave your NHS employment? *

- ◯ First 3 months
- ◯ 3-6 months
- ◯ 6-9 months
- ◯ 9-12 months
- ◯ 12-18 months
- ◯ 18 months-2 years
- ◯ 2-3 years
- ◯ 3-4 years
- ◯ 4-5 years

51. Rate how important each of the below factors were in influencing your thoughts of leaving your NHS employment.

Please note that this question solely relates to your **thoughts of leaving as a qualified CP**, not any action related to, or final decisions in, leaving.

You can rate **two or more** factors with the same rating (e.g. rating poor team climate and family commitments as '4').

Please make sure you scroll to see all 5 options on the scale. *

	Not important at all	Somewhat important	Moderately important	Very important	Extremely important
Poor/absent leadership/management	◯	◯	◯	◯	◯

Poor/absent supervision	◯	◯	◯	◯	◯
Negative impact on/non-support for mental health	◯	◯	◯	◯	◯
Excessive workload	◯	◯	◯	◯	◯
Limited opportunities for part-time/flexible working	◯	◯	◯	◯	◯
Limited opportunities for professional development (e.g. CPD)	◯	◯	◯	◯	◯
Poor pay (relative to other employment)	◯	◯	◯	◯	◯
Poor staffing levels	◯	◯	◯	◯	◯
Poor team climate	◯	◯	◯	◯	◯
Inability to provide good quality care to service users (moral injury)	◯	◯	◯	◯	◯
Limited opportunities for career progression	◯	◯	◯	◯	◯
Family commitments	◯	◯	◯	◯	◯
Wider vision (e.g. wanting to start up own private practice)	◯	◯	◯	◯	◯

Wanting to change professions entirely	○	○	○	○	○
Non-commitment to the NHS	○	○	○	○	○
Poor pension	○	○	○	○	○
Wanting to maintain/develop skillset that is not being practiced in job	○	○	○	○	○
High levels of stress	○	○	○	○	○
Negative impact on/non-support for physical health	○	○	○	○	○
Burnout	○	○	○	○	○

52. In relation to the factors that you have rated the **highest** (extremely important in influencing your thoughts of leaving your NHS employment), please explain why this is so. *

53. In relation to the factors that you have rated the **lowest** (not so important in influencing your thoughts of leaving your NHS employment), please explain why this is so. *

54. *Please use the space below to note down any other factors that were influential to prompting your intent to leave NHS employment, or any other comments you would like to make in regards to Q51.*

55. After having these initial thoughts of leaving, did you decide to leave your NHS employment? *

- ◯ Yes
- ◯ No

56. If you did decide to leave your NHS employment, what steps did you take, or have you taken, to leave? Tick all relevant. *

- ☐ Talked to colleagues/former colleagues about job opportunities outside of the NHS
- ☐ Actively looked for vacancies outside of the NHS
- ☐ Submitted job applications for jobs outside of the NHS
- ☐ Had interviews for jobs outside of the NHS
- ☐ Been offered a job outside of the NHS
- ☐ Requested details of jobs outside of the NHS but decided against applying
- ☐ Made plans to set up own private practice e.g. forming ideas in mind/visualising what this would be
- ☐ Made movements/actions regarding setting up own private practice e.g. speaking to relevant people, completing relevant paperwork
- ☐ Other

57. If you did decide to leave your NHS employment, did you decide to leave it partly (e.g. working part-time NHS) or fully (e.g. leaving the NHS completely)? *

- ◯ I decided to partly leave my NHS employment
- ◯ I decided to fully leave my NHS employment

58. If you decided not to leave your NHS employment, why did you decide not to? *

NHS Employment Decisions

Below are questions about your **current employment**.

59. Are you currently employed **solely** by the NHS? *

- ◯ Yes
- ◯ No

60. **Solely** employed by the NHS (the NHS is your sole employer):

Rate the importance of each factor towards your decision to only work for the NHS.

Please make sure you scroll to see all 5 options on the scale.
*

	Not important at all	Somewhat important	Moderately important	Very important	Extremely important
Effective leadership/ management	◯	◯	◯	◯	◯
Good quality/frequent supervision	◯	◯	◯	◯	◯
Support for mental health	◯	◯	◯	◯	◯
Manageable workload	◯	◯	◯	◯	◯
Opportunities for part-time/flexible working	◯	◯	◯	◯	◯
Opportunities for professional development (e.g. CPD)	◯	◯	◯	◯	◯
Good pay (relative to other employment)	◯	◯	◯	◯	◯
Good staffing levels	◯	◯	◯	◯	◯
Positive team climate	◯	◯	◯	◯	◯
Ability to provide good quality care to service users	◯	◯	◯	◯	◯
Opportunitiesfor career progression	◯	◯	◯	◯	◯

Flexibility around family commitments	○	○	○	○	○
Not wanting to change professions	○	○	○	○	○
Commitment to the NHS	○	○	○	○	○
Good pension	○	○	○	○	○
All skills being practiced sufficiently in job	○	○	○	○	○
Low/manageable levels of stress	○	○	○	○	○
Support for physical health	○	○	○	○	○
No experience/s of burnout	○	○	○	○	○
Job security	○	○	○	○	○

61. In relation to the factors that you have rated **highest** (extremely important in your decision to only work for the NHS), please explain why this is so. *

62. In relation to the factors that you have rated **lowest** (not so important in your decision to only work for the NHS), please explain why this is so. *

63. *Please use this space to note down any other factors that were influential towards your decision to continue working solely for the NHS, or any other comments you would like to make in regards to Q60.*

64. Do you work **both** in the NHS and elsewhere? *

- ◯ Yes
- ◯ No

65. Working **both** in the NHS and elsewhere:

Please rate the importance of each factor towards your decision to work both in the NHS and elsewhere:

It is recognised that some factors may have influenced your decision to continue working part-time within the NHS, and others may have influenced your decision to also work part-time outside of the NHS. Therefore, the factors have been separated into two corresponding lists. Take time to rate each factor in each list.

List 1: Factors influencing your decision to continue working part-time within the NHS:

Please make sure you scroll to see all 5 options on the scale. *

	Not important at all	Somewhat important	Moderately important	Very important	Extremely important
Effective leadership/management	◯	◯	◯	◯	◯
Good quality/frequent supervision	◯	◯	◯	◯	◯
Support for mental health	◯	◯	◯	◯	◯
Opportunities for part-time/flexible working	◯	◯	◯	◯	◯
Opportunities for professional development (e.g. CPD)	◯	◯	◯	◯	◯
Good pay (relative to other employment)	◯	◯	◯	◯	◯
Good staffing levels	◯	◯	◯	◯	◯
Positive team climate	◯	◯	◯	◯	◯

Ability to provide good quality care to service users	◯	◯	◯	◯	◯
Opportunities for career progression	◯	◯	◯	◯	◯
Flexibility around family commitments	◯	◯	◯	◯	◯
Not wanting to change professions	◯	◯	◯	◯	◯
Commitment to the NHS	◯	◯	◯	◯	◯
Good pension	◯	◯	◯	◯	◯
All skills being practiced sufficiently in job	◯	◯	◯	◯	◯
Low/manageable levels of stress	◯	◯	◯	◯	◯
Support for physical health	◯	◯	◯	◯	◯
No experience/s of burnout	◯	◯	◯	◯	◯
Job security	◯	◯	◯	◯	◯

66. In relation to the factors that you have rated **highest** (extremely important in your decision to continue working part-time within the NHS), please explain why this is so. *

67. In relation to the factors that you have rated **lowest** (not so important in your decision to continue working part-time within the NHS), please explain why this is so. *

68. *Please use this space to note down any other factors that were influential towards your decision to leave your NHS employment, or any other comments you would like to make in regards to Q65.*

69. List 2: Factors influencing your decision to also work part-time elsewhere outside of the NHS:

Please make sure you scroll to see all 5 options on the scale. *

	Not important at all	Somewhat important	Moderately important	Very important	Extremely important
Poor/absent leadership/ management	◯	◯	◯	◯	◯
Poor/absent supervision	◯	◯	◯	◯	◯
Negative impact on mental health	◯	◯	◯	◯	◯
Excessive workload	◯	◯	◯	◯	◯
Limited opportunities for part-time/flexible working	◯	◯	◯	◯	◯
Limited opportunities for professional development (e.g. CPD)	◯	◯	◯	◯	◯
Poor pay (relative to other employment)	◯	◯	◯	◯	◯
Poor staffing levels	◯	◯	◯	◯	◯
Poor team climate	◯	◯	◯	◯	◯
Inability to provide good quality care to service users (moral injury)	◯	◯	◯	◯	◯
Limited opportunities for career progression	◯	◯	◯	◯	◯

Inflexibility around family commitments	◯	◯	◯	◯	◯
Wider vision (e.g. starting up own private practice)	◯	◯	◯	◯	◯
Wanting to change professions	◯	◯	◯	◯	◯
Non-commitment to the NHS	◯	◯	◯	◯	◯
Poor pension	◯	◯	◯	◯	◯
Wanting to maintain/develop skillset not being practiced in job	◯	◯	◯	◯	◯
High levels of stress	◯	◯	◯	◯	◯
Negative impact on/non-support for physical health	◯	◯	◯	◯	◯
Burnout	◯	◯	◯	◯	◯

70. In relation to the factors that you have rated **highest** (extremely important in your decision to work part-time elsewhere outside of the NHS), please explain why this is so. *

71. In relation to the factors that you have rated **lowest** (not so important in your decision to work part-time elsewhere outside of the NHS), please explain why this is so. *

72. *Please use this space to note down any other factors that were influential towards your decision to work part-time for the NHS, or any other comments you would like to make in regards to Q69.*

73. Are you **not** currently employed by the NHS? *

- ◯ Yes, I am not currently employed by the NHS
- ◯ No, I am currently employed by the NHS

74. **Not employed** by the NHS:

Please rate the importance of each factor towards your decision to **leave** your NHS employment (either straight after qualifying e.g. as driven by experiences on placement during DClinPsy training, or after having worked within the NHS as a qualified CP).

Please make sure you scroll to see all 5 options on the scale. *

	Not important at all	Somewhat important	Moderately important	Very important	Extremely important
Poor/absent leadership/management	◯	◯	◯	◯	◯
Poor/absent supervision	◯	◯	◯	◯	◯
Negative impact on mental health	◯	◯	◯	◯	◯
Excessive workload	◯	◯	◯	◯	◯
Limited opportunities for part-time/flexible working	◯	◯	◯	◯	◯
Limited opportunities for professional development (e.g. CPD)	◯	◯	◯	◯	◯
Poor pay (relative to other employment)	◯	◯	◯	◯	◯
Poor staffing levels/resources	◯	◯	◯	◯	◯
Poor team climate	◯	◯	◯	◯	◯
Inability to provide good quality care to service users (moral injury)	◯	◯	◯	◯	◯

Limited opportunities for career progression	◯	◯	◯	◯	◯
Inflexibility around family commitments	◯	◯	◯	◯	◯
Wider vision e.g. starting up own private practice	◯	◯	◯	◯	◯
Wanting to change professions	◯	◯	◯	◯	◯
Non-commitment to the NHS	◯	◯	◯	◯	◯
Poor pension	◯	◯	◯	◯	◯
Wanting to maintain/develop skillset that was not being practiced in job	◯	◯	◯	◯	◯
High levels of stress	◯	◯	◯	◯	◯
Negative impact/non-support for physical health	◯	◯	◯	◯	◯
Burnout	◯	◯	◯	◯	◯

75. ıe factors that you have rated **highest** (extremely important in your decision to leave your NHS employment and work outside of the NHS), please explain why this is so. *

76. In relation to the factors that you have rated **lowest** (not so important in your decision to leave your NHS employment and work outside of the NHS), please explain why this is so. *

77. *Please use this space to note down any other factors that were influential towards your decision to leave your NHS employment, or any other comments you would like to make in regards to Q74.*

Effort VS Reward and Future Intentions

The following questions relate to your most recent NHS employment.

78. Please rate the level of effort that you feel that you put into your **most recent NHS** role.

1 = No effort at all
5 = Extremely high level of effort *

1	2	3	4	5

79. Please rate the level of recognition that you feel that you receive(d) within your workplace for the level of effort you put into your **most recent NHS** role.

1 = No recognition at all
5 = Extremely high level of recognition *

1	2	3	4	5

80. If you have receive(d) recognition, who did you receive(d) it from? *

81. Is receiving recognition for the level of effort you put into your work something that is important to you?

1 = Not at all important
5 = Extremely important *

1	2	3	4	5

82. Please rate how rewarding your workplace is within your **most recent** NHS role as a qualified CP.

1 = Not rewarding at all
5 = Extremely rewarding *

1	2	3	4	5

83. What are the rewards that you receive(d) in return for the level of effort you put into your **most recent** NHS role? *

84. Do you feel that the rewards you receive(d) match(ed) the level of effort you put into your **most recent NHS** role?

1 = Not at all matched
5 = Completely matched *

1	2	3	4	5

85. Please explain your answer to the question above. *

86. What are the qualities of your **current** employer that keeps you working for them? *

87. If you were to move jobs in the next few months or years (e.g. as a CP in a different service or employment area), what are the conditions that would be looking for? *

88. Which of the following best describes what you would like to be doing 5 years from now? *

- [ ] Continue working for the NHS
- [ ] Work for a private company e.g. Priory
- [ ] Work for self (e.g. own private practice)
- [ ] Work in research
- [ ] Work in academia
- [ ] Work within the voluntary sector
- [ ] Work in a different profession
- [ ] Not work at all

Thank you for completing the NHS Employment Decisions Questionnaire.

You now have the opportunity to participate in Megan Stinton's parallel qualitative study. Please continue to the next page and leave your name and email address if you wish to do so.

If you do not wish to participate in this, you may ignore these questions and submit the form.

Thank you.

Appendix N

Opt-In to Sister Study

Opportunity to participate in Megan Stinton's qualitative study:

As a reminder, this is:

- A semi structured interview, lasting approximately 1 hour, via Microsoft Teams.
- Led by researcher, Megan Stinton.
- To further explore the factors influencing CP's employment decision/s (through a qualitative approach).
- To enrich and complement the data obtained from the study you have just completed.

89. Name:

90. Email address:

Appendix O

Debrief Form

Your survey was submitted.

Thank you so much for taking part in this research study, which aims to explore the factors that influence early-career Clinical Psychologists to stay, leave or work part-time for the NHS.

Should you have experienced any distress or harm from the research, or the topics covered, please use the below support resources to access further support:

-Your clinical/managerial supervision within your role
-Your GP
-The Emotional Wellbeing Hub
-If you are an NHS professional: The NHS Staff Support Service in your service, or the Samaritan's NHS support line (free calls day and night on 116 123)

Please note that you can download the form now that you have completed it. Should you wish to keep any part of the form, then we recommend doing this.