# Staff experiences of working in the NHS: A systematic review of staff experiences of Schwartz Rounds in healthcare settings in the UK and a reflexive thematic analysis exploring the reasons and experiences of Clinical Psychologists leaving the NHS and working privately

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Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology

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(Excluding References and Appendices)

## THESIS PORTFOLIO: CANDIDATE DECLARATION

| | |
|---|---|
| **Title of degree programme** | **Professional Doctorate in Clinical Psychology** |
| **Candidate name** | **Klaudia Beata Cebula** |
| **Registration number** | **22042147** |
| **Initial date of registration** | **2022** |

**Declaration and signature of candidate**

I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.

I confirm that the decision to submit this thesis is my own.

I confirm that except where explicitly stated, the work has not been submitted for another academic award.

I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.

Signed:  Date: 25/04/2025

## Acknowledgments

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To my family, who have been on this crazy journey with me to become a Clinical Psychologist. Your support and belief in me have never wavered. Thank you for your words of encouragement, cheering me along on the more challenging days, celebrating the little wins and showing me love throughout it all. Special thanks go out to my amazing mum and sister. Do mojej wspaniałej mamy, bez Twojego poświęcenia, ciężkiej pracy, wyrzeczeń i bezwarunkowej miłości, nic z tego nie byłoby możliwe. Dziękuję za wszystko, co dla mnie zrobiłaś przez całe moje życie, i dziękuję za bycie moją opoką, szczególnie w ciągu ostatniego roku, który poddał mnie próbie na wszelkie możliwe sposoby. Kocham Cię. Do Oli, dziękuję za bycie moją najlepszą przyjaciółką, kibicką i powierniczką nie tylko podczas treningu, ale przez całe życie. Twoja spokojność, rozsądek i miłość pomogły bardziej, niż możesz sobie wyobrazić. Kocham Cię.

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## Word Counts

| | |
|---|---|
| Thesis Abstract | 386 |
| Literature review (includes abstract but excludes title, footnote, references and appendices) | 7,818 |
| Empirical paper (includes abstract but excludes title, references and appendices) | 7,974 |
| Executive summary (excluding references) | 2,487 |
| **Total:** | 18,665 |

## Contents

## Thesis Portfolio Abstract

The experiences of the healthcare workforce in the National Health Service (NHS) are a focus of many research studies. Difficulties with staff retention, burnout, stress and moral injury highlight a difficult climate in the organisation. This thesis aimed to understand how organisation wide staff interventions are experienced and shed light onto why a particular group of staff: Clinical Psychologists (CPs) are leaving the NHS to work in private practice. This thesis consists of a literature review, a research paper and an executive summary.

The literature review focused on understanding the experiences of Schwartz Rounds (SRs) in UK healthcare settings. SRs aim to support healthcare staff to deliver compassionate care and offer a protected space to reflect on their work. Ten peer reviewed studies were synthesised using a combination of thematic synthesis and a narrative synthesis. The studies were mixed method and were critically appraised using the Mixed Methods Appraisal Tool (MMAT). Overall, quantitative data showed positive responses to SRs however studies have used various versions of an evaluation questionnaire. Thematic synthesis identified three main themes: '*attention to safety is key'*; '*resonance, connection and time to recover'*; and '*relational and practical challenges'*. Findings suggest that care needs to be taken to create safety in each session to ensure staff feel comfortable. Ideas to address this included consideration of liminal spaces and utilising skills of CPs to lead the sessions to increase psychological safety. Furthermore, barriers like access to SRs across the organisation are considered. Further research routes are also explored.

The empirical paper highlights comments from the British Psychological Society (BPS) and the Association of Clinical Psychologists (ACP) which discuss large numbers of CPs leaving the NHS to work in private practice. Eight semi-structured

interviews were conducted and analysed using Reflexive Thematic Analysis. The analysis generated the following themes and subthemes: ‘Unreciprocated dedication’ with two subthemes: ‘Overwhelming expectations’ and ‘Power imbalance’; ‘Perfect storm’ with three subthemes: ‘Moral injury’, ‘Dawning realisation’ and ‘A drive for control and autonomy’. The results were contextualised using The Herzberg’s Motivation-Hygiene Theory. Implications and further research avenues were also discussed.

Finally, the executive summary is aimed at CPs, managers and stakeholders in NHS services. It aims to shed light on the experiences of CPs and highlights possible areas of focus to improve working conditions and retain greater number of CPs.

Paper One: Literature Review

# Staff experiences of Schwartz Rounds in healthcare settings in the UK: a systematic review of literature

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## Abstract

Increasing numbers of staff sickness in the NHS have resulted in a focus on staff wellbeing interventions. One proposed intervention is 'Schwartz Rounds' (SRs), which have been implemented in NHS Trusts across the UK. Little is known about staff experiences of this intervention. The current review aims to build a detailed understanding of experiences of SRs by healthcare staff in the UK to help further shape and improve the support offered to staff. A systematic search of SR literature identified ten peer-reviewed studies published between 2017-2024. These were critically appraised using the Mixed Methods Appraisal Tool (MMAT). Qualitative data was thematically synthesised, and quantitative data was described narratively. Quantitative data showed positive response to SRs. Thematic synthesis produced descriptive themes: '*attention to safety is key*'; '*resonance, connection and time to recover*'; and '*relational and practical challenges*'. Findings suggest that care needs to be taken to create safety in each session to ensure staff feel comfortable. Ideas to address this included consideration of liminal spaces and utilising skills of Clinical Psychologists to increase psychological safety in sessions. Furthermore, barriers like access to SRs across the organisation are considered. Further research routes are also explored.

Schwartz Rounds (SRs) are an organisation-wide intervention that has been gradually rolled out across healthcare settings in the UK since 2009. The intervention aims to support healthcare staff to deliver compassionate care and offer a protected space to reflect on their work. Current research on SRs is limited. A previous review by Taylor et al., (2018) focused on comparison of various interventions aimed at supporting healthcare staff with the emotional challenges of their work. To the author's knowledge there has been no literature review solely focusing on deepening the understanding of the experience of SRs by healthcare staff. Therefore, the present review focuses on synthesising available literature on SRs in the UK, to allow for an in-depth analysis of the experiences of SRs by healthcare staff.

The UK National Health Service (NHS) is among the largest employers in the country (Taylor et al., 2018). Latest figures show that the NHS workforce is made up of 1.5 million full-time equivalent staff, consisting of clinical and nonclinical staff (Nuffield Trust, 2024). Research suggests that the wellbeing of healthcare staff is compromised (Daniels et al., 2022). Healthcare staff experience higher rates of stress, burnout and mental health difficulties like depression, anxiety and suicidal ideation compared to the public (Leung et al., 2024). It is suggested that poor wellbeing of NHS staff costs the NHS around £12.1 billion a year. Research shows links between healthcare staff wellbeing and quality of patient care, safety, and staff turnover (De Hert, 2020; Murthy, 2022; Robson & Attart, 2019). Furthermore, the NHS experiences high rates of sickness absence which is attributed to anxiety, stress, depression and other mental health difficulties (Nuffield Trust, 2024). In 2022 this led to an average of over 500,000 sick days in a month (Nuffield Trust, 2024). This has a significant impact on individuals, families as well as patient care and experience (Sizmur & Raleigh, 2018). High rates of sickness absence can provide

less stability and continuity of care, increased waiting lists, inadequate staffing and high bed occupancy (Sizmur & Raleigh, 2018).

The NHS has been struggling with staff retention, filling vacancies and general staff wellbeing (Sizmur & Raleigh, 2018). Over the last two decades research, legislation and guidance has focused on improving staff wellbeing in hopes to employ and retain more staff as well as improve patient care (Daniels et al. 2022; Sizmur & Raleigh, 2018). The National Institute for Health and Care Excellence (NICE) has produced numerous guidelines to support mental wellbeing at work. In 2009, the focus was on tackling staff wellbeing by focusing interventions on individuals and organisation-wide approaches (NICE, 2009). In 2022, the guidelines suggest that workplaces should aim to ‘foster a positive, compassionate and inclusive workplace environment and culture to support psychological safety and mental wellbeing’ (NICE, 2022). Furthermore, organisations should ‘offer employees a private space and protected time to engage with interventions’ that support wellbeing.

The focus on interventions supporting staff wellbeing has been echoed in the recommendations by the British Psychological Society (BPS, 2022) and the Association of Clinical Psychologists (ACP UK, 2022). The BPS highlights that supporting healthcare staff’s mental health must take more of a precedence. This should not only include direct work with individuals and teams but also organisation-wide interventions. The ACP-UK advocates for systemic changes to improve working conditions and reduce burnout. This is done by providing peer support and networking spaces, resources and guidance and collaborations with employers. Individual NHS Trusts have also focused on utilising the knowledge and skills of

Clinical Psychologists (CPs) to support staff wellbeing through various interventions (Sherwood Forest Hospitals NHS, 2024).

Schwartz Rounds (SRs) were inspired by Kenneth Schwartz, a health-care lawyer who as a patient with terminal cancer observed diverse levels of compassion in staff members. He observed that high-paced environments ‘stifle the inherent compassion and humanity’ (Schwartz, 1995; Clancy et al., 2020). SRs are a structured group where clinical and non-clinical staff meet to discuss the social and emotional aspects of working in healthcare in a safe environment which aims to support staff to deliver compassionate care (Leung et al., 2024; Taylor et al., 2018). These are a one-hour meeting, starting with a panel of staff who present stories about a theme or experience of patient care, the audience then join the discussion. There are two facilitators encouraging focus on thoughts, feelings, and mutual understanding rather than problem solving (Clancy et al., 2020). Studies have found that SRs result in improved compassion for patients, better teamwork and interdisciplinary communication, reduced stress in staff and a positive impact on staff well-being (Taylor et al., 2018; Whitehead et al., 2021). At the organisational level SRs were seen to reduce hierarchy, help build shared values and influence culture by allowing dialogue that does not happen elsewhere (Taylor et al., 2018). Since then, there has been a few instances of SRs being trialled in universities for healthcare students in the UK (Abnett et al., 2022; Clancy et al., 2020; Gleeson et al, 2020; Smith et al., 2020). This hopes that by introducing SRs earlier there could be a positive influence on the next generation of workforce in healthcare settings.

The COVID-19 pandemic has brought about unprecedented times and change in the NHS (Willan et al., 2020). Many staff were redeployed, brought back from retirement and medical students were fast-tracked into clinical roles to support

the overstretched workforce (Boggon et al., 2022). Research suggests that the COVID-19 pandemic has caused significant distress for staff, resulting in increased rates of burnout, compassion fatigue, mental health difficulties and moral injury (Wong et al., 2021)[1]. As mentioned previously the focus on supporting staff via organisation wide interventions has been at the forefront of research for the last two decades. This has further intensified due to the impact of the pandemic on healthcare staff. SRs have become widely used within the NHS before the pandemic and continued to be utilised during and after the pandemic (Farrell et al., 2022).

## Rationale

SRs are an organisation wide intervention that has been gradually rolled out across the UK, in hospitals and universities. SRs have been trialled for several years however to the author's knowledge there has been no literature review deepening the understanding of the experience of SRs by healthcare staff. This review will include healthcare professionals and students who are enrolled on healthcare related courses as these students are on placements in healthcare settings and form part of the healthcare workforce. Investigating the experiences of staff who are in receipt of SRs can help build understanding on how these are received, and how they can be improved to further meet the needs of the workforce. Additionally, this helps to further develop the evidence base and gives grounding for further studies.

The current review will build on the review done by Taylor et al. (2018) which compared staff interventions. The current review focuses solely on SRs to perform

[1] Wong et al. (2021) uses the following definitions. Burnout is defined as a work related, stress-induced syndrome characterised by emotional exhaustion, depersonalisation and sense of reduced personal accomplishment. Compassion fatigue results from a prolonged exposure to the suffering of others, resulting in emotional and physical exhaustion. This leads to a diminished capacity to care for others. Moral injury refers to psychological distress arising from healthcare workers acting or witnessing actions contrary to their moral or ethical beliefs because of systemic constrain (e.g. resource shortages).

an in-depth analysis of the available literature since the review by Taylor et al. (2018). The date period helps to capture the use of the intervention before and after the pandemic as there was a focus on staff interventions before the pandemic due to the austerity in the UK health system. Additionally, the pandemic has put extra pressures on resources in the healthcare system and its staff. The review will include only UK based papers to understand the use of SRs in this healthcare system during this time period. Therefore, the current literature review has the following aims:

- To synthesise and review literature examining healthcare staff and students experience of SRs in UK healthcare settings

The literature review question:

*What is the experience of SRs by healthcare professionals in the UK?*

## Methods

The current review was conducted in three stages: systematic search of literature about SRs, critical appraisal using an appraisal tool and synthesis of findings.

### Scoping searches

Scoping searches on SRs were conducted in June 2024 on Google Scholar and Staffordshire University Library. This highlighted the review by Taylor et al., (2018). There has been no recent review that focused purely on staff experiences of this intervention.

### Searching

A systematic literature search was conducted between 7th – 15th June 2024 utilising the following electronic databases: CINAHL, PsychInfo, Web of Science,

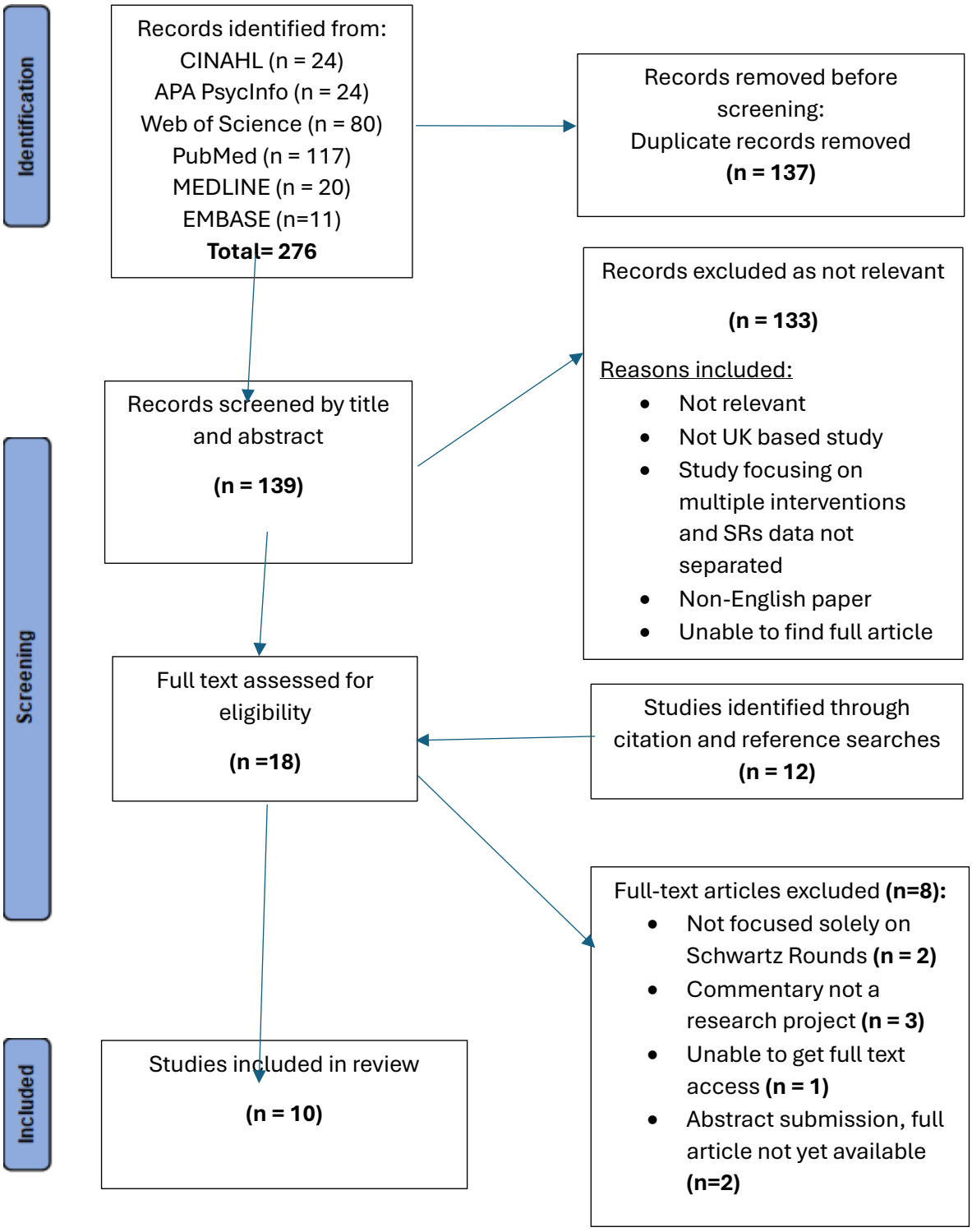
PubMed, MEDLINE and EMBASE. These were used to replicate the search process by Taylor et al. (2018). To replicate Taylor et al., (2018) the only search term that was used was “Schwartz Round”. This kept the search wide to ensure all relevant papers were found. Papers were then screened again to ensure they map onto the review aims and question. The following inclusion and exclusion criteria were used:

Table 1. Inclusion and exclusion criteria

| **Inclusion** | **Exclusion** |
|---|---|
| Papers published from 2017 onwards (Taylor et al. 2018 included papers until 2017) | Papers published before 2017 |
| English language | Non-English papers |
| Peer reviewed journal articles/empirical research examining healthcare professionals experience of SRs | Not peer reviewed/ grey literature/theses/ commentaries |
| Healthcare professionals (qualified or trainee/student) involved in SRs | Non-healthcare professionals, Healthcare professionals involved in other staff interventions |
| Studies conducted in UK settings | Studies conducted outside of UK settings |

After initial searches Web of Science and PubMed were also included to ensure that all relevant literature was included. Following this the articles were then screened by title and abstract; Figure 1 of PRISMA diagram (Page et al., 2021) shows this process. Following this, citation searches of articles accepted at full text level were completed using Web of Science and Google Scholar. A hand search of all reference lists from the included articles was also conducted to ensure all relevant papers were included.

Figure 1. Flow diagram demonstrating screening process following PRISMA guidelines (Page et al., 2021)



### Selection

The initial search produced 276 articles comprising of 137 duplicates. Papers were then screened by title and abstract and 133 were removed as not relevant. Following full text review and completion of citation and reference list searches, 8 articles were removed due to: not solely focusing on SR and SR data not being able to be separated from other interventions used, no access to full article. This resulted in 10 papers being selected for the review.

### Data extraction and appraisal tool

Eligible studies were reviewed. Key information including authors, year of publication, aim, study design and analysis, main findings, and quality score are included in Table 2 in the Results section and in Appendix 1 and 2.

Articles included in the review comprised of mixed methods studies, qualitative and quantitative studies. The Mixed Methods Appraisal Tool (MMAT) was used as it enables evaluation and comparison of different methodologies (Hong et al., 2018). Details of this are presented in Appendix 1 and Appendix 2. As suggested by the authors of MMAT, each criterion is scored as ‘Yes’, ‘No’ and ‘Can’t tell’ (Hong et al., 2018). Each paper design is rated out of 5* or 100%. For the mixed methods studies there are 15 criteria, however, the authors highlight that ‘the overall quality of a combination cannot exceed the quality of its weakest component’.

### Publication bias

Publication bias occurs when studies are published due to their significant results (Song et al., 2013). This can skew our understanding of interventions. The current literature review aimed to appraise studies of high quality, hence the search only included peer-reviewed articles. Grey literature, theses, commentaries and non-

peer reviewed papers were excluded. ProQuest was used to search for relevant theses and studies not in the English language, this showed no results. Therefore, although using peer reviewed papers may increase the risk of publication bias, the lack of available relevant grey literature suggests the review was still inclusive of the question this aimed to address.

### Data synthesis

The current review aimed to understand experiences of healthcare staff participating in SRs. As most of the studies have included qualitative components to deepen our understanding of the experience, the decision was made to use thematic synthesis to integrate findings of multiple studies (Thomas & Harden, 2008). Quantitative data from studies was synthesised separately using elements of narrative synthesis (Popay et al., 2006). This included developing a preliminary synthesis of findings of included studies and exploring relationships in the data.

To carry out the thematic synthesis three stages were completed: ‘coding of text “line-by-line"; development of ‘descriptive themes’, and the generation of ‘analytical themes’ (Thomas & Harden, 2008). Nine papers included a qualitative component. Findings, discussion and conclusions of 4 papers were analysed line-by-line. This is in line with previous systematic reviews of qualitative studies (Campbell et al., 2016). This resulted in 49 different codes. These codes were organised into 3 descriptive themes based on their content. These were then used to conduct line-by-line coding of the remaining papers. Thomas and Harden (2008) highlight that to ‘go beyond’ the content of the original studies and develop analytical themes the reviewer should apply the review questions to their descriptive themes. The reviewer is then encouraged to consider the implications of participant’s views for intervention development. The reviewer then continuously revisits and refines themes to ensure

that the analytical themes adequately explain all the descriptive themes and address the review questions.

# Results

## Overview

Studies included in this review were evaluations of SRs conducted in a variety of services, including hospice, acute, mental health, community services and university healthcare courses (medicine, nursing and psychology). SRs included a variety of professionals including clinical and non-clinical staff. Studies used mixed methods, quantitative and qualitative designs. These focused on evaluating feedback forms, conducting interviews and focus groups with attendees, panellists and facilitators, as well as observations of SRs. Studies in this review had a range of outcomes from evaluating student experiences of SRs, to evaluating if SRs are an adequate emotional support for healthcare staff, and to understanding storytelling within rounds. Studies have ranged from small group evaluations to national scale evaluations. See Table 2 for details of studies.

Table 2. Data extraction table

| Authors and Date | Aim | Design and Analysis | Main findings | Quality score |
|---|---|---|---|---|
| **Abnett, et al., (2022)** | To compare medical students experience of a single-discipline and a multi-discipline SR. | Mixed methods, Point of Care Foundation (POCF) 8-item questionnaire and focus groups, thematic analysis | Positive response to single-discipline and multidisciplinary SRs, higher feedback scores for single-discipline SRs, large groups, structure and scripted panellists were frustrations | ***** (100%) |
| **Allen, et al., (2020)** | Evaluate mental health professionals' experience of SRs. | Mixed methods, Kings Fund 9-item questionnaire and focus groups, thematic analysis | SRs viewed as a good forum to express emotions, share experiences and feel validated and supported by colleagues, positive application in mental health settings | *** (60%) |
| **Atkins et al. (2023)** | Explore how the content of the talk in SRs creates beneficial effects on those attending SRs | Qualitative, recording 5 SRs sessions, conversation analysis | Interactions in SRs seen to foster sense of social solidarity, endorsements for both emotions the panellists expressed as well as metapragmatic endorsements of the act of talking about emotions were present in all rounds, generalisations were used in linking panellists' contributions to wider experiences and second stories designed to connect to the panellists first stories were used to build a shared experience. | ***** (100%) |
| **Clancy, et al., (2020)** | To develop understanding of how healthcare students experience SRs in a university context | Qualitative, semi-structured interviews, Interpretative Phenomenological Analysis | SRs promote connectedness, however safety to share in SRs is limited by fear of judgement, SRs are applicable to educational context | ***** (100%) |

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| **Farr & Barker (2017)** | To analyse the implementation of SRs in three community and mental health services | Qualitative, realist evaluation, interviews, observations and evaluation forms | Where rounds were successfully implemented, they enabled emotional resonance across colleagues, participants appreciated attending the rounds and saw improved communications, trust and openness with colleagues and more compassionate care with patients.<br><br>Work pressures and geographical dispersal of staff were the main challenges to attending SRs. | ***** (100%) |
| **Flannagan et al., (2020)** | Explore self-reported experiences of the Rounds, and differences between the proportions of professional staff groups attending. | Quantitative, POCF 7-item questionnaire, calculating mean responses for each question, correlations to investigate relationship between staff groups and total mean scores, factor analysis to determine whether questions could be seen as loading onto a single factor | The experience of attending SRs was positive across all settings. Staff reported that SRs helped them gain insight into the working lives of colleagues. No differences between the responses of clinical and non-clinical staff were seen. | **** (80%) |
| **Gleeson, et al., (2020)** | To explore the use of student-specific SRs as a medium for reflective practice among medical students | Mixed methods, POCF 12-item questionnaire, thematic analysis | Students rated SRs highly, students rated SRs higher than written reflection | ** (40%) |
| **Maben et al., (2021)** | Identify how SRs work, for whom and in what contexts. | Qualitative, interviews, realist evaluation | Preliminary frameworks describe how, why and for whom SRs work. These include trust, safety and containment; group interaction; counter-cultural/3rd space for staff; self-disclosure; storytelling; role modelling vulnerability; | ***** (100%) |

| | | | | |
|---|---|---|---|---|
| | | | contextualising patients and staff; shining a spotlight on hidden stories and roles; and reflection and resonance. There was variability in the way Rounds were run across organisations. Attendance for some staff was difficult | |
| **McCarthy, et al., (2021)** | Explore the role of discourse and reflection through storytelling, exploring panellists' motivations, experiences and reported impacts associated with panel participation. | Qualitative, interviews, thematic analysis | SR impact on panellists included increased emotional resilience and acceptance of experiences, reduced negative assumptions about colleagues, increased tolerance and compassion | ***** (100%) |
| **Smith, et al., (2020)** | Investigate if SR provides the same benefits to medical students as it does to other healthcare professionals | Mixed methods examining data from evaluation surveys, thematic analysis | SRs fostered empathy and understanding towards patients and colleagues, but in future SRs function needs to be more explicit | ***** (100%) |

## Recruitment and participants

The sample sizes of studies are difficult to ascertain as some studies report exact number of SR attendees however others report number of evaluation forms received, noting that more participants could have been present and not completed the evaluation forms. This ranges from reported number of participants as n=8 to 13,452 evaluation forms received.

Participants included clinical and non-clinical staff across various disciplines as well as healthcare students. Not all studies have reported participant characteristics like gender. However, those who did, reported higher rates of female participants across all the research designs (Abnett et al. 2022; Allen et al., 2020; Clancy et al., 2020; Farr & Barker, 2017; Smith et al., 2020). Females accounted for 65.25% of the pooled sample across these studies (92 females and 49 males). Although at first this might appear skewed it is worth noting that figures from NHS (2018) research suggest that the NHS workforce is made up of 77% females and 23% males. Thus, the high representation of females in these studies may reflect the workforce in the healthcare settings.

Abnett et al. (2022) highlight potential biases in their sample. The authors highlight that panellists were purposely chosen by the researchers, and they have been provided with SR topics in advance. Although providing topics in advance is standard procedure so that panellists can prepare their stories, usually panellists are volunteers. Selecting panellists may have influenced the direction and authenticity of the reflections. The remaining studies comprised of opportunity samples of staff members or purposeful recruitment of healthcare students.

Samples included various clinical and non-clinical disciplines: healthcare students, medical students, psychiatry, occupational therapy, psychologists, nurses, midwives, social workers, physiotherapists, speech therapists; and catering staff, domestic support staff, administration, building estates, managers, porters and security respectively. The samples have covered a wide array of disciplines thus making the data more credible and generalisable across healthcare settings.

### Research design and analysis

The quantitative studies report the mean scores of responses gathered on various evaluation forms allowing for preliminary conclusions on the average ratings of SRs. However, reporting mean scores does not provide information about the variability in the data. Furthermore, the studies do not mention any outliers or skewness in the data, which mean scores can be distorted by. Thus, we do not know if the mean scores are representative of a typical data point. Additionally, studies do not report confidence intervals which would offer more precision and reliability of the mean as it will give ranges in which the mean is likely to fall (Visentin et al., 2020). Finally, the studies do not report any pre- and post- measures and there was no randomisation to conditions.

Two studies attempted to consider variables that could impact SRs (Flanagan et al., 2020; Abnett et al., 2022). Flanagan et al. (2020) aimed to explore if different professions appraise SRs differently by comparing scores and the proportions of different staff groups attending. Abnett et al (2022) aimed to examine the impact of varying the range of disciplines in SRs attendance. Both studies aimed to further analyse which staff groups find the intervention useful.

High MMAT scores on qualitative analysis was attributed to careful data analysis and interpretation. To make this more rigorous authors used independent data coders, separate data coding by two researchers before reaching consensus, supervisions and journals to maintain reflexivity and used consultative groups to cross-check data codes and ensure credibility. The data was then presented sufficiently to back up themes and conclusions. However, the study by Gleeson et al., (2020) had the lowest quality score on the MMAT as the authors do not explain the process used to thematically analyse the data and did not show consistent links between the qualitative data sources, collection, analysis and interpretation. Quotes from data were either not interpreted or not used as evidence to support themes produced. Abnett at al., (2022) did not report the analysis of free-text boxes of the questionnaire and instead focused their qualitative analysis on focus groups that they also conducted. Smith et al., (2020) increased the quality of their study by clearly explaining their analysis process of the free-text boxes. The authors employed data analysis triangulation. They showcased a high level of inter-rater reliability (Kappa coefficient 0.84) and used quotes to evidence their themes.

### Measures

The use of a feedback questionnaire designed by the Point of Care Foundation (POCF) was common among the studies. The questionnaire was used by 3 mixed methods studies (Abnett et al., 2022; Gleeson et al., 2020; Smith et al., 2020) and 1 quantitative study (Flanagan et al.,2020). However, each study used a different version of this questionnaire- see Appendix 3. This questionnaire asks participants to rate statements relating to the value of attending the SR on a Likert scale as well as providing free text boxes for qualitative feedback. The versions of this questionnaire vary from a 7-item to 12-item questionnaire. Most of the questions

overlap with each other however there are some additional questions especially in the paper by Gleeson et al. (2020). Utilising the same measure of feedback builds on the evidence base, ensures validity, reliability and reproducibility as well as increases our ability to generalise the findings. The use of additional questions allows for richer data gathering.

Contrastingly to other studies, Allen et al. (2020) used a different evaluation form. This is a standardised evaluation form designed by the Kings Fund (Cornwell & Goodrich, 2010) which helped to evaluate SRs when they were first piloted in the UK. The work has then been continued by the POCF who have then developed the questionnaire further. Thus, although the use of questionnaires is different, the questions map onto the updated versions of the questionnaire by POCF (See Appendix 3). All versions of the questionnaire allow data gathering on the evaluation of the intervention however they are not specific enough to gather accurate data on what way SRs are impacting on staff and students doing their jobs or their wellbeing.

## Quality appraisal

The characteristics and overall quality appraisal of included studies are shown in Table 2. Appendix 1 shows scores on individual methodologies and then a combined overall score for mixed methods studies. The overall quality ratings in the included studies vary from 40%, obtained by one study to 100% obtained by 7 studies. The average MMAT score was 88%. There is no official guidance on characterising the quality of studies as low, medium or high, however the higher scores indicate better quality and rigour of the studies.

Strengths

Overall, purely qualitative studies have shown the highest ratings on the quality appraisal. These showed adequate data collection methods to address the research question, their findings were adequately derived from and substantiated by the data. High rigour in qualitative analysis was demonstrated by having independent researchers analysing data or researchers coding data independently before coming together to reach consensus. On the other hand, one of the main strengths of quantitative components of the studies used were high feedback response rates on questionnaires. High rates were demonstrated by Smith et al. (2020), Gleeson et al. (2020) and Abnett et al. (2022), with feedback rates ranging from 86%-100%.

### Limitations

The main limitation of these evaluation studies was the risk of nonresponse bias, which can be defined as a ‘failure to collect data from a sample unit in the target population’ (Okafor, 2010). This can mean that participants who respond to questionnaires can potentially be those with strong opinions (for or against) the intervention. This can skew results in favour or against the proposed intervention. In the current studies it is unclear what proportion of participants did not respond therefore we cannot be certain if the current results are skewed. Secondly, longitudinal data was not available in most studies, thus we cannot make conclusions about the experiences of SRs over time. Allen et al. (2020) is the only study mentioning longitudinal data, however, it is only mentioned that SRs are still being scored highly on the evaluation forms, with no other conclusions made about the data.

## Quantitative data synthesis

Abnett et al. (2022) set out to compare single-discipline and multi-discipline student SRs, thus examining if discipline had an impact on SR scores. Although both were rated highly, single-discipline SRs received higher feedback scores. Abnett et al. (2022) reported that participants' responses ranged from 'Agree Somewhat' to 'Completely Agree' on all 8 statements on the questionnaire. However, before making generalisations about single-discipline and multi-discipline student SRs, it is important to highlight that large group sizes and scripted panellists were highlighted by participants as hindering open reflection. More research is needed to highlight possible variables affecting SRs. Furthermore, research is also needed to explore impact of attending SRs on variables like staff wellbeing.

Flanagan et al. (2020) aimed to explore if different professions appraise SRs differently by comparing scores and the proportions of different staff groups attending. The findings showed no significant differences in responses from clinical and non-clinical staff. Mean ratings from 6 out of 7 questions were above 4 on a scale of 1-5 indicating that participants generally agreed with positive statements.

Gleeson et al. (2020) compared medical student SRs to written reflection preferences. Results highlight that that there was a significant difference in preference between the two conditions; 90% students highlighted that they preferred SRs over written reflection. Furthermore, the authors compared results on the evaluation of student SRs to data across the local NHS Trust. Findings were similar for both groups, with 80-100% of participants rating the statements as 'Completely Agree' or 'Agree' on almost all questions. The only difference was in the final question: 'Overall rating of SRs', where 90% of students rated these as 'excellent' or 'exceptional' compared to 78% in the NHS Trust wide sample. This shows a

difference; however, the authors do not calculate if this difference is statistically significant.

Lastly, Smith et al. (2020) aimed to investigate whether providing SRs for second year medical students has the same benefits as it does to healthcare professionals. Results suggest that participants rated SRs highly. Mode answers to 9 out of the 10 statements were ‘Somewhat Agree’. The final question: ‘Today's round has given me a greater understanding of the importance of empathy with patients as people’ had a mode answer of ‘Completely Agree’.

## Thematic synthesis

The thematic synthesis generated 3 descriptive themes. The review question was then used as a framework to generate and define the analytical theme. Table 3 shows the analytical theme, descriptive themes and studies in which they appeared. See Appendix 4 for detailed evidence of each theme.

Table 3. Analytical and descriptive themes

| Analytical theme and definition | Descriptive theme | Studies |
|---|---|---|
| **Practical and emotional experiences- this includes the environment created by SRs, content of SRs and challenges in attending or engaging in SRs** | *Attention to safety is key* | Abnett et al. 2022, Allen at al., 2020, Clancy et al., 2020, Farr & Barker, 2017, Gleeson et al., 2020, Maben et al., 2021, McCarthy et al., 2021, Smith et al., 2020 |
| | *Resonance, connection and time to recover* | Abnett et al. 2022, Allen at al., 2020, Atkins et al., 2023, Clancy et al., 2020, Gleeson et al., 2020, Maben et al., 2021, McCarthy et al., 2021, Smith et al., 2020 |
| | *Relational and practical challenges* | Abnett et al., 2022, Allen at al., 2020, Clancy et al., 2020, Farr & Barker, 2017, Gleeson et al., 2020, McCarthy et al., 2021 |

## Attention to safety is key

Experiences of SRs were highly impacted by the ability to create a safe environment for staff to reflect in. This was reflected in 8 out of the 10 included studies. Maben et al. (2021) highlighted key aspects of creating safety included *"pre-Round safety checks like checking panellists understand the potential consequences of publicly telling their story"*. Whereas *"an 'unsafe' Round would include panellists and audience members experiencing embarrassment, rejection, reprisal or blame, or experience bullying and punishment for speaking out*" (Maben et al., 2021). When a

safe space is created participants felt more able to be open and vulnerable in front of their colleagues. One participant explained:

> *"It feels safe and feels okay to talk about something that perhaps you haven't wanted to admit..." (McCarthy et al. 2021)*

However, this may not be a universal experience of all rounds as some participants expressed ambiguities if the SRs were really a safe space, especially when senior colleagues or management were involved in the SR. Participants expressed worries about being judged or their reflections being used against them outside of the SR. This was particularly a concern for staff in training and/or at the start of their career ladder.

> *"Although it is confidential and it stays in that Schwartz round that if you've said something that they don't agree with [..] would that affect how they view you during your training" (Clancy et al., 2020)*

> *"There is that sort of feeling will you get judged, what are other people thinking about your experiences?" (Abnett et al. 2022)*

Safety was seen as something that can be developed using smaller groups, maintaining a structure to rounds as well as having facilitators that were psychologically minded helping guide reflection away from problem solving and into discussions around emotions.

### Resonance, connection and time to recover

Content of SRs played an important part in how healthcare professionals experienced SRs. This was highlighted in 8 out of the 10 studies included in this review.

Sharing specific stories and thoughts that resonated with people were seen as important in fostering a sense of connection and validation.

> *“I liked the fact that the session felt genuinely supportive and insightful. Good to hear the acceptance of other’s thoughts, feelings and emotions evoked by distressing experiences.” (Allen et al., 2020)*

> *"It highlighted that I am not alone and that I have people to talk to.” (Gleeson et al., 2020)*

However, when this is not reciprocated by members of the group it can leave participants feeling potential shame and regret. This could have an impact on how SRs are experienced and viewed by participants.

> *“… people didn’t respond to me, I didn’t know why that was, and maybe it was too difficult for other people, as well […] I kind of regretted doing it afterwards.” Atkins et al. (2023)*

Maben et all (2021) explained that *“timing of stories was important, some stories were deemed ‘too soon’ or ‘too raw’”.* The authors highlight that facilitators played an important role in thinking about content and discussing if specific patient stories are appropriate or should be held off for future SRs.

Apart from validation and connection, participants also expressed experiencing strong emotions due to the content of SRs.

> *“During [the Round] I was so angry. I was gripping the chair and my heart was flooding with misery because of the injustice of it all. And so I felt very tense and upset. And then, immediately afterwards, I felt a bit better.” (McCarthy et al., 2021)*

Expressing big emotions has been seen as normalising, giving permission to feel negative emotions about the culture of the organisation and patients. This was seen in a context of healthcare professionals feeling like they were not able to express emotions at work. However, content of SRs can be highly emotive meaning staff can find it hard to return to work straight after. This was especially highlighted by Allen at al. (2020) who stated that *"time to process the emotive content of the Rounds before returning to work"* is needed.

### Relational and practical challenges

Six studies suggested that there were challenges that impacted the SR experience or ability to join in the SRs. This included authority figures believing that SRs were a waste of time when other work needed to be done (Farr and Barker, 2017), fear of judgement from others (Abnett et al., 2022), sharing emotions being seen as uncomfortable (Gleeson et al., 2020), unfamiliarity with reflection (McCarthy et al, 2021), size of rounds (Allen et al., 2020), timing and scheduling of SRs (Clancy et al., 2020) and the use of virtual rounds (Abnett et al., 2022). SRs were seen as beneficial, however often these were set up as small pilot studies or across sites or times that meant it was difficult for staff to attend. The need to carefully consider the set-up of SR and their context was highlighted across studies.

> *"it's very difficult when you're on a shift pattern to get everybody because it's not ideal" (Allen et al., 2020)*

> *"In journey times, 2 hours potentially, more or less, from one side of [the area] to the other…. Trying to get staff to a location for the Schwartz Round and it be accessible to everybody has been hugely challenging." (Farr and Barker, 2017)*

## Discussion

The current review aimed to synthesise literature on experiences of SRs by healthcare professionals. The review aimed to answer the question: '*What is the experience of SRs by healthcare professionals in the UK?'.* The review synthesised qualitative, quantitative and mixed methodology studies to broaden our understanding of this.

Overall quantitative studies suggest that SRs have been rated highly by participants. The papers have used different versions of an evaluation questionnaire, but the items do overlap significantly thus allowing us to draw conclusions on the experience. Items across questionnaires have enquired about building self-awareness, awareness of colleagues' and patients' thoughts and feelings, as well as an overall experience of the rounds. The results across these studies have been consistently high. This is in line with findings from other countries like Australia, Canada and USA (Adamson et al., 2018; Leung et al., 2024; Lown & Manning, 2010). Furthermore, findings from qualitative studies support this. Findings suggest that SRs mostly feel safe, allow for validation and connection with colleagues as well as processing and sharing strong emotions. This is further supported by previous literature (Deppoliti et al. 2015; Goodrich, 2012).

Qualitative studies have allowed for a deeper understanding of staff experiences. This has allowed for staff to comment on the environment that is created in SRs, the content of SRs and barriers they have encountered with this intervention.

A main factor that has been highlighted in the environment created by SRs was the feeling of safety. Psychological safety has been defined as a 'shared belief

that the team is safe for interpersonal risk-taking' (Edmondson, 1999). This had an impact on whether people felt safe to share their thoughts and join discussions. When this has worked well participants reported feeling connected to and validated by colleagues. However, when this was not established participants held back from interacting due to fear of judgement or felt regret for sharing with the group. A Four Stages of Psychological Safety model by Clark (2020) highlights stages teams move through to establish psychological safety. This includes inclusion safety, learner safety, contributor safety and challenger safety. Inclusion safety talks about members of the team feeling welcome regardless of their personal characteristics or professional role. Secondly, the environment encourages members to ask questions, make mistakes, give and receive feedback. Thirdly, team members should feel empowered to contribute ideas and suggestions, as well as raise concerns without interpersonal fear. Finally, members should feel able to challenge the way the team works and come up with new ideas of working. Critique of the model highlights that building psychological safety may not be a linear process and highlights that context is an important factor which can be impacting psychological safety. More research is also needed as measuring psychological safety and progression through the stages is difficult. The model also focuses on a team, however in the context of SRs as attendance is voluntary it may be hard to establish rapport and safety as SRs may be made up of different people each time. However, the model highlights important aspects of psychological safety which could be useful when thinking about implementing SRs. These were seen throughout the studies that reported a good level of psychological safety. Participants highlighted the broad range of disciplines and professional hierarchies and commented on this being a positive aspect: "*there's also something about flattening hierarchies, so we've had the most senior manager*

*in our locality on a panel with a receptionist and with, I think, a nurse[...] struggling with similar dilemmas brings everybody down to the same human level" (Maben et al., 2021).* Participants felt able to ask questions, feedback and share their ideas: "*Enjoyed reflecting on emotions and hearing different professions very similar viewpoints. Sharing experiences, validating emotions, talking openly"* (Allen et al., 2020). Finally, some studies have questioned current ways of working: "*I feel like in the medical culture in general we don't talk about mistakes well, [...] going back and reflecting on it helped me and helped me to try and think of learning from errors as a beneficial thing as opposed to a culture of blame"* (Clancy et al., 2020). Thus, it can be suggested that the model should be considered when implementing SRs.

The findings highlight that when SRs work well there is a resonance and connection between staff members. This can be seen as solidarity in the group, which can be defined as sharing of goals, collective sentiment, where parties strive to achieve goals together (Sangiovanni, 2015). In SRs the goal is to create an environment where it is safe to share thoughts and feelings and allow for reflection and processing of work situations. However, this may not always be successful, as attendance in SRs can change it can be difficult to establish if the group has a shared goal of sharing and reflection. One way to increase the likelihood of solidarity in the group is to consider contact theory which suggests that 'positive interactions between group members can reduce prejudice and increase social harmony' (Sengupta et al., 2023). The theory highlights that it is important to set up spaces where group members should have equal status within the interaction, work towards shared objectives, have support from higher authorities and have opportunities for personal interaction outside of the settings to build deeper connections. Thus, highlighting the need for SRs boundaries to be established at the start of each

session clearly. It may also be worth considering setting up spaces before or after the SRs where staff can get to know each other more to allow for deeper connections. Findings from this literature review also suggest that there is a need for consideration of liminal spaces. Liminal spaces are transitional spaces where individuals are between two phases or states, often characterised by ambiguity and uncertainty (Scaratti et al., 2021). Staff have highlighted that SRs can bring about big emotions which may make it hard to return to their duties straight away. Therefore, it may be important to consider establishing some time following SRs that allows staff to process the emotional content of the rounds before returning to work.

The challenges highlighted by participants like geographical spread of workforce, workload pressures, fear of judgement, reflection being uncomfortable are not uncommon. These have also been seen in studies around the world (Gallagher 2018; Ng et el., 2023; Wilkins et al., 2021; 2024). In fact, this is a common theme amongst organisation wide approaches which might not be unique just to SRs (Brand et al., 2017; Keyworth et al., 2022; Williams et al., 2015). Literature suggests that several things could minimise the impact of these barriers to allow healthcare staff to engage in staff interventions. These included managers being aware of staff interventions, encouraging staff to take part in these and sharing their own experiences of using these interventions or support systems, open discussions around mental health, staff support and interventions (Keyworth et al., 2022).

### Strengths and Limitations

The current literature review considered mixed methods, quantitative and qualitative studies allowing for detailed examination of available research. This helped to summarise and draw conclusions on a wider and deeper scale. The use of the MMAT allows for a comprehensive assessment of different study designs.

Furthermore, the MMAT has been shown to have good reliability and validity thus ensures a consistent and accurate assessment of included studies (Souto et al., 2015).

Articles included in the review are recent and build on a previous review (Taylor et al. 2018). Using the latest research helps to make conclusions on the current organisational climate, highlights gaps in the literature as well as current experiences of interventions which can bring about reflections and change.

This review is not without its limitations. Firstly, the studies used in this review mostly comprised of small samples and there is a lack of longitudinal data. Current studies have mostly focused on gathering feedback on SRs; however, little is yet known about the immediate and long-term impacts of attending SRs on staff wellbeing and organisational culture. The COVID-19 pandemic has impacted any further research as the focus in healthcare settings shifted to dealing with unprecedented times.

The quality of studies has varied across the included articles. The major factor in studies lower quality scores were the lack of information on analysis and limited interpretation and evidence of qualitative data.

Lastly it is important to consider that this review has been conducted by a single reviewer, meaning there is a lack of second rating of the quality appraisal and of paper selection. A second reviewer is needed to improve overall rigor.

### Implications for research and practice

Overall, the studies included in this literature review make a strong case to further explore the use of SRs. Further research should focus on improving quality of studies and the use of pre- and post- measures to explore immediate effects of SRs

on variables like staff wellbeing and stress levels. Furthermore, longitudinal studies would allow us to assess for potential benefits of SRs over time. To draw conclusions about effectiveness of SRs over other staff interventions randomised control trials could also be implemented.

Future SRs need to be considered in the context they will be set up in. Facilitators need to consider logistical and practical implications and how to overcome these barriers. Participants from studies in this literature review highlighted that working various shift patterns may impact their ability to join SRs. Furthermore, group sizes were also commented on and may need to be considered in future set up.

Lastly, the safety of rounds was questioned. Although many felt safe to share their emotional experiences of work, others were uncertain. As suggested by the BPS (2022) and ACP-UK (2022), clinical psychologists' skills to run staff interventions may be beneficial to overcome this challenge.

## Conclusions

Overall, the review synthesised and discussed latest literature exploring staff experiences of SRs. Staff highlighted key components that impacted their experiences like the safety in sessions, resonance, connection and time to recover as well as relational and practical challenges. This is in line with previous literature on SRs and other staff interventions. Further research avenues have also been suggested.

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# Appendices

## Appendix 1. Quality appraisal

### Mixed methods appraisal ratings

The table below represents all studies used in this review. The studies varied in design and included quantitative, qualitative and mixed methods design. As none of the studies included in this review were randomised control trials, this MMAT criteria was omitted in this table. To represent all studies in one table the components that were not applicable to the study design were greyed out. Table A includes the questions from the MMAT to provide further details on the criteria. The answers range from ‘Yes’, ‘No’ and ‘Can’t tell’, to represent this visually ratings of ‘Yes’ were assigned the value of ‘*’, ratings of ‘No’ and ‘Can’t tell’ were assigned a numerical score of ‘0’. The scores were then added to create an overall rating score for the study. To calculate the rating score of mixed method studies the guidance proposed by Hong et al., (2020) was used; see figure A below.

| Studies | **Mixed methods appraisal** | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **1.1** | **1.2** | **1.3** | **1.4** | **1.5** | **3.1** | **3.2** | **3.3** | **3.4** | **3.5** | **4.1** | **4.2** | **4.3** | **4.4** | **4.5** | **5.1** | **5.2** | **5.3** | **5.4** | **5.5** | Total for qualitative design | Total for quantitative design | Total for mixed methods design | Overall rating score |
| Farr & Barker (2017) | * | * | * | * | * | | | | | | | | | | | | | | | | ***** | | | ***** (100%) |
| Flanagan et al., (2020) | | | | | | | | | | | * | * | * | 0 | * | | | | | | | **** | | **** (80%) |
| Maben et al (2021) | * | * | * | * | * | | | | | | | | | | | | | | | | ***** | | | ***** (100%) |
| Atkins et al. (2023) | * | * | * | * | * | | | | | | | | | | | | | | | | ***** | | | ***** (100%) |
| Clancy et al., 2020 | * | * | * | * | * | | | | | | | | | | | | | | | | ***** | | | ***** (100%) |
| Abnett et al., 2022 | * | * | * | * | * | * | * | * | * | * | | | | | | * | * | * | * | * | ***** | ***** | ***** | ***** (100%) |
| Gleeson et al., 2020 | * | * | 0 | 0 | 0 | * | * | * | * | * | | | | | | * | * | 0 | * | 0 | ** | ***** | *** | ** (40%) |
| Allen et al., 2020 | * | * | * | * | * | | | | | | * | * | * | 0 | 0 | * | * | * | * | 0 | ***** | *** | **** | *** (60%) |
| McCarthy et al., 2021 | * | * | * | * | * | | | | | | | | | | | | | | | | ***** | | | ***** (100%) |
| Smith et al., 2020 | * | * | * | * | * | | | | | | * | * | * | * | * | * | * | * | * | * | ***** | | ***** | ***** (100%) |

**Table A- details of appraisal items**

| **1. Qualitative Studies** | **3. Quantitative non-randomised studies** | **4. Quantitative descriptive studies** | **5. Mixed Methods** |
|---|---|---|---|
| **1.1** Is the qualitative approach appropriate to answer the research question? | **3.1** Are the participants representative of the target population? | **4.1** Is the sampling strategy relevant to address the research question? | **5.1** Is there an adequate rationale for using a mixed methods design to address the research question? |
| **1.2** Are the qualitative data collection methods adequate to address the research question? | **3.2** Are measurements appropriate regarding both the outcome and intervention (or exposure)? | **4.2** Is the sample representative of the target population? | **5.2** Are the different components of the study effectively integrated to answer the research question? |
| **1.3** Are the findings adequately derived from the data? | **3.3** Are there complete outcome data? | **4.3** Are the measurements appropriate? | **5.3** Are the outputs of the integration of qualitative and quantitative components adequately interpreted? |
| **1.4** Is the interpretation of results sufficiently substantiated by data? | **3.4** Are the confounders accounted for in the design and analysis? | **4.4** Is the risk of nonresponse bias low? | **5.4** Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? |
| **1.5** Is there coherence between qualitative data sources, collection, analysis and interpretation? | **3.5 D**uring the study period, is the intervention administered (or exposure occurred) as intended? | **4.5** Is the statistical analysis appropriate to answer the research question? | **5.5** Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? |

## Figure A- Rating of Mixed methods Studies (Hong et al., 2020)

For each retained study, an overall quality score may not be informative (in comparison to a descriptive summary using MMAT criteria), but might be calculated using the MMAT. Since there are only a few criteria for each domain, the score can be presented using descriptors such as stars (*) or %:

5***** or 100% quality criteria met
4 **** or 80% quality criteria met
3 *** or 60% quality criteria met
2 ** or 40% quality criteria met
1 * or 20% quality criteria met

For mixed methods studies, since there are 15 criteria to rate (instead of 5), the premise is that the overall quality of a combination cannot exceed the quality of its weakest component. Thus, the overall quality score is the lowest score of the study components. The score is 20% (*) when QUAL=1 or QUAN=1 or MM=1; it is 40% (**) when QUAL=2 or QUAN=2 or MM=2; it is 60% (***) when QUAL=3 or QUAN=3 or MM=3; it is 80% (****) when QUAL=4 and QUAN=4 and MM=4, and it is 100% (*****) when QUAL=5 or QUAN=5 or MM=5; (QUAL being the score of the qualitative component; QUAN the score of the quantitative component; and MM the score of the mixed methods component).

## Appendix 2. Expanded characteristics and quality table

| Authors and Date | Setting | Sample | Strengths | Limitations |
|---|---|---|---|---|
| **Abnett, et al., (2022),** | Harlow, Queen Mary University of London medical students on placement in the Trust | 26 (n=19 for first SR- 12 females and 7 males, 8 medical students for second SR (7 of which were present in the first SR) in addition students from radiography (n=3), nursing (n=2), midwifery (n=1) and operating department practitioners (n=1). Focus group 1 N=10 medical students, Focus group 2 N=5 medical students | High feedback response in both SRs (94.7-100%), good use of evidence from transcripts to highlight themes | Unintentional selection bias in choice of panellists, |
| **Allen, et al., (2020),** | Derby, Mental health services | 150 staff employed within the service were invited, 93 (62%) attended at least one SR and completed evaluation forms, of these 33 (35%) attended more than one SRs. Nurses represented the largest professional group (n=40, 43%), medical professionals (n=12, 13%) and occupational therapists (n=11, 12%)<br><br>Those who attended multiple rounds were invited to participate in the focus group, 9 attended (27% of those eligible to attend) | Six-year follow-up using standardised feedback questionnaire, good use of evidence to support themes, themes were coded by two researchers independently to increase validity, facilitator notes from SRs were also double-coded | Only 62% of those invited participated in SRs, low attendance to focus group (27% of those eligible) |

| | | | | |
|---|---|---|---|---|
| **Atkins et al. (2023),** | Birmingham, Data consists of five one-hour long SRs from three UK hospitals | 5 separate SRs across 3 UK hospital Trusts, no information on participant characteristics | Demonstration of a lot of thought into ethical considerations resulting in several steps of gaining consent, detailed content analysis, different types of SRs recorded (case-based and thematic), analysis cross checked between researchers and external analysts resulting in high rigour analysis | Small sample- only 5 one-hour long SRs were used, no information on participant characteristics |
| **Clancy, et al., (2020),** | Plymouth University | 8 participants (7 females and 1 male, aged between 23-41 (mean= 30.5, SD= 6.48), students enrolled in Mental Health Nursing (n=2), Adult Nursing (n=3), Clinical Psychology (n=1), Medicine (n=2), Five participants attended 1 SR, Two participants attended 2 SRs, and one participant attended 3 or 4 SRs | Questions informed by evaluation forms, good reflexivity and credibility- use of reflective journal and transcripts independently coded and checked by multiple researchers, further cross checking of analysis in a consultative IPA group | Sample contained only one male, small sample size, potential for self-selection bias of those who attended the SR |
| **Farr & Barker (2017)** | Research approved by University of Bath, 3 case studies from different NHS Trusts. Case A was a large Foundation Trust, delivering mental health, community and specialist services to adults | 22 participants (steering group, n=4, facilitator n=7, panellists n=4, attendees n=7), this included 3 males and 19 females. Participants were in the following roles: clinical (n=15), senior manager role (n=6) and non-clinical (n=1). The research also included 5 observations of SRs (85 participants across all rounds) | Structured observation forms to ensure that same information is collected across all observations. Use of 3 foundation trusts covering large geographical area allowing for wider generalisation of findings, use of evaluation sheets to triangulate the findings from | Incomplete data as one Trust withdrew from running rounds during data collection therefore observations were not conducted in that area |

| | | | | |
|---|---|---|---|---|
| | and children, Case B was a large and complex community Foundation Trust covering a wide, rural geographical area, delivering services through doctors, community nurses, physiotherapists, 6 dietitians and other healthcare professionals. Case C was a Foundation Trust that provided mental health services. It had a mixed rural and urban geography | | qualitative interviews, findings derived from the data and backed up well by qualitative data from interviews | |
| **Flannagan et al., (2020)** | London, data from POCF from organisations in England and Wales between February 2011 and July 2015 | 13,452 evaluation forms from 402 SRs across a total of 47 organisations were represented, of which one had three sites, resulting in 49 locations in total comprising of 28 acute trusts, 3 community trusts, 5 mental health trusts and 11 hospices.<br>Sample included: doctors (11%), nursing (nurses, midwives, ward sisters, ward managers) 18%; healthcare assistants 2%; other clinical (social workers, | Use of evaluation form from POCF which has satisfactory psychometric properties, items on the scale highly correlated and loading onto a single factor (Cronbach's alpha = 0.86, item loading ranged from 0.54-.0.78), | Data included the use of mean scores from all participants per round, therefore findings may be less precise than if using raw scores. 38% of respondents did not specify their profession thus making it difficult to ascertain if there is a correlation between the types of professionals attending SRs, data |

| | | | | |
|---|---|---|---|---|
| | | psychologists, chaplains, physiotherapists, speech therapists, OTs, pharmacists, radiographers) 11%; board members and management 3%; non-clinical (administration staff, porters, security, domestic) 4%; other (fundraiser, volunteer, other) 13%; 38% did not specify or were missing. | | used from feedback received across total of 47 organisations risk of nonresponse bias not considered. |
| **Gleeson, et al., (2020)** | London, major UK teaching hospital | Year 3 medical students on rotation through a major UK teaching hospital, 45/84 attended SRs (53%), however, feedback received from 42/45 participants (93%). | High feedback rates (93% of all participants), qualitative data independently analysed and cross-correlated after to increase reliability and validity | Little evidence to support themes, SRs not explicitly explained to participants at the start so there may have been different expectations at the start although this was rectified, no baseline data collected |
| **Maben et al., (2021)** | Guildford, 45 sites across UK, sites included hospice, acute, mental health/community | 97 interviews of 49 telephone interviews and 48 case study interviews. Telephone interviews included 28 facilitators/clinical leads and 21 in the steering group. In the case study interviews there were 27 facilitators/clinical leads and 21 in the steering group | Large sample, evidence-informed programme theory and use of formal theories to examine the impact of SRs, findings derived from the data and backed up well by qualitative data from interviews, coding consensus reached across researchers | Self-reported data, no concrete data about changes in practice although this was one of the aims. |

| | | | | |
|---|---|---|---|---|
| **McCarthy, et al., (2021)** | Birmingham, 9 case-study sites including acute, community, mental health NHS trusts and hospices | 50 semi-structured interviews with SR panellists (clinical n=39, non-clinical =11) | Good sample size, good use of evidence to support themes, detailed demographic data collected | Some panellists interviewed soon after their SRs therefore impacts post SRs may not have yet been analysed |
| **Smith, et al., (2020)** | Buckingham University, entire cohort on a second year MBChB programme | 83 participants in SRs (36 males and 47 females, age range 18 to over 40 years olds), with 82 returning questionnaires (71 participants answered all questions and 21 gave additional written feedback) | 86% completion rates of standardised questionnaire, data triangulation- two independent researchers coded thematic data, dependability and confirmability ensured by external audit by a researcher outside of the project, Kappa coefficient for interrater reliability of coding was 0.84 | Only 25% provided written feedback- nonresponse, sampling or selection bias, SR not repeated, little generalisability |

## Appendix 3. Different versions of the POCF and Evaluation form (Cronwell & Goodrich, 2010)

| **Abnett et al. 2022 (PCOF)** | **Flannagan et al., 2020 (PCOF)** | **Gleeson et al., 2020 (PCOF)** | **Smith et al., 2020 (PCOF)** |
|---|---|---|---|
| The stories presented by the panel were relevant to my daily work | The stories presented by the panel were relevant to my daily work | The stories presented by the panel were relevant to my daily work | Today's round will help me work better with my colleagues |
| I gained knowledge that will help me to meet the needs of patients | I gained knowledge that will help me to meet the needs of patients | I gained knowledge that will help me to meet the needs of patients | In today's round I have gained knowledge that will help me care for patients |
| Today’s Round will help me work better with my colleagues | Today’s Round will help me work better with my colleagues | Today’s Round will help me work better with my colleagues | Today's round has given me confidence in handling non-clinical aspects of care |
| The group discussion was helpful to me | The group discussion was well facilitated | The group discussion was helpful to me | Today's round has given me greater awareness in handling sensitive issues |
| The group discussion was well facilitated | I have gained insight into how others care for patients | The group discussion was well facilitated | Today's round has given me greater understanding of how expressing thoughts, questions and feelings would help me |
| I have gained insight into how others care for patients | I plan to attend Schwartz Rounds again | I have a better understanding how my colleagues feel about their work | Today's round has given me greater understanding how giving and receiving support is beneficial and helps us feel valued |
| I plan to attend Schwartz Rounds again | Overall rating on today’s Round | I have a better understanding of how I feel about my work | Today's round has given me greater awareness of improving teamwork, connectedness and communication |

| | | | |
|---|---|---|---|
| I would recommend Schwartz Rounds to colleagues | | Today's Round has added to my insight and self-awareness | Today's round has given me greater awareness of the importance of attentiveness to social and emotional aspects of patient care |
| | | I feel more connected to my colleagues due to today's round | Today's round has given me an awareness of increased feelings of compassion towards patients |
| | | I plan to attend Schwartz Rounds again | Today's round has given me a greater understanding of the importance of empathy with patients as people |
| | | I would recommend Schwartz Rounds to colleagues | |
| | | Overall rating | |

Evaluation form from Cronwell and Goodrich (2010)

| Allen et al., 2020 |
| --- |
| The case discussed was relevant to my daily clinical work |
| I gained knowledge that will help me in caring for my patients |
| Today's Round will help me work better with my colleagues |
| The overview and presentation of the case today was helpful to me |
| The facilitator helped the discussion today |
| I have gained insight into how others think/ feel in caring for patients |
| I plan to attend Schwartz Centre Rounds again |

## Appendix 4. Qualitative evidence

| | | |
|---|---|---|
| **Attention to safety is key** | **Abnett et al. (2022)** | “I think going into a room with so many people that I’ve never met before and talking about these things very, very difficult” ; “There is that sort of feeling will you get judged, what are other people thinking about your experiences?” “I can at times really be quite negative about medicine. And I feel in the group like that it’s quite hard to put that across without being worried about getting judged for it” |
| | **Allen et al. (2020)** | “think it’d give you chance to vent in a safe environment” |
| | **Clancy et al. (2020)** | “Rounds providing a space to help put “things in perspective” (Eliza) where “people reveal their own sense of erm, struggle or inadequacy is quite new” and “not something that’s normally discussed at work, there’s not normally any erm … space given to that” (Sam), suggesting Rounds are a unique space”; “Participants described a sense of comfort which appeared to contribute to feeling safe, " I wasn't asked to do anything ... I just listened and reflected and quietly acknowledge people “; “although it is confidential and it stays in that Schwartz round that if you've said something that they don't agree with would they then keep that, erm, and would that affect how they view you during your training” |
| | **Farr & Barker (2017)** | “The way in which Schwartz Rounds were facilitated was important to create a safe space where people could “dare to share” (Female interviewee), where “vulnerabilities are exposed” (Female interviewee) and “people feel able to speak quite openly about difficult things in a very contained way” |
| | **Gleeson et al., (2020)** | "safe space to reflect" |
| | **Maben et al. (2021)** | “I always check about safety, about whether they feel safe enough to tell it.”; “I’ve been really impressed (...) the facilitators have managed to keep it to time, keep it controlled”; Safety and trust were identified by facilitators as cumulative, influencing whether people shared and which stories are offered. Participants’ feelings of trust, safety and containment develop through repeated exposure to safe Rounds”; “It’s how you set it up at the beginning, providing, setting the ground rules.”; “issues of feeling shame (…) you don’t necessarily feel comfortable in sharing with your colleagues (..)(shame) is almost brought to light and almost solved”; “It’s set up to be a safe, confidential forum (…) a place for people to express their feelings, some ‘containment’ both from the panel and other people in the audience” |

| | | |
|---|---|---|
| | **McCarthy et al. (2021)** | ‘It feels safe and feels okay to talk about something that perhaps you haven’t wanted to admit’ |
| | **Smith et al. (2020)** | “positive comments regarded the SR as a forum not only to “learn experientially” but to so in a “safe environment” |
| Resonance, connection and time to recover | **Abnett et al. (2022)** | ““normalise emotion” and “promote connectedness” with colleagues”; “but for me, it was very reassuring to also know how normal that is”; ““To see so many people go “ I don’t enjoy this, I want to see it diferent”—Is it a really positive thing? I think yes” “I don’t know what any medical student now who doesn’t feel the same way the people in this group feel personally. So that gives me hope because we are the future of the hospital force within the medical teams”; I think [SRs] could really benefit the communication issues between specialties as well, which was a topic that kind of arose in that discussion” |
| | **Allen et al. (2020)** | “A few of the participants commented on how their attendance at the Rounds had left them feeling emotional and how they had struggled to process the content of the Rounds, due to the need to return to work after the Round.”; I think Schwartz somehow just allows ventilation so there’s no closure’; ‘We can all have an input and go away and it feels like there’s closure to it, rather than us all just coming in, listening and then it’s all emotions that we all feel as well and then we just go off again’. |
| | **Atkins et al., (2023)** | “I think it strengthens the connections and the relationships with other people”; “I’m really grateful to you for that because it was just so poignant” |
| | **Clancy et al. (2020)** | “I wasn't asked to do anything ... I just listened and reflected and quietly acknowledge people "; “everyone was able to connect with themes that were being discussed”; “, I don't think the chairs moved but it felt towards the end like we were almost sat in a circle. I don't know if people, if the panel moved their chairs out, it felt, it felt like we ended up in a circle, umm, very much on a level very much as equals, especially as everybody had spoken, umm, and I, I came out of that feeling better”; " removed the barriers between the different health professions, and erm different seniorities ... "; “on the things you have in common"; “take away like the symbol of the role and it's actually you know, we're all individual and we all have feelings” |
| | **Gleeson et al., (2020)** | “Really insightful way to think about how you feel”; “It was really comforting to know that other groups have similar experiences to us”; “It highlighted that I am not alone and that I have people to talk to”; |

| | | |
|---|---|---|
| | **Maben et al. (2021)** | "It's just about having a broader view or whether it's about reconnecting to their values"' "issues of feeling shame (…) you don't necessarily feel comfortable in sharing with your colleagues"' "it allows you just to be vulnerable, to share about a time or an experience in your life and I just think that really just maybe energises others to feel safe"; "seeing people participate and share comments about their personal experiences has altered the way I think about some people. And I've been able to see more of them as a person (…) (and) feel more positive about them general" |
| | **McCarthy et al. (2021)** | "After the panel had spoken, the audience go into this terrible silence ... You can almost hear people thinking, 'Shall I say something? I'd really like to say something, but I'm not brave enough.' But then once someone gives their opinion, then other people start to put their hand up and speak."; "The first person ...stopped to say, 'It was a massively complicated case and I think you dealt with it really well', and that was really nice to hear"; "I feel this pressure to always be nice, and sometimes – being human – sometimes you don't have nice thoughts or feelings, sometimes people irritate you, push your buttons and push boundaries that make you feel uncomfortable. ... Rounds are good at drawing that out."; "Because there were different topics, people responded to one more than the other, and actually nobody responded to my story. I actually found that quite difficult because I couldn't work out why that was, and I felt I'd made myself really quite vulnerable"; "During [the Round] I was so angry. I was gripping the chair and my heart was flooding with misery because of the injustice of it all. And so I felt very tense and upset. And then, immediately afterwards, I felt a bit better"; "I think it does encourage you to share your problems a little bit more, be more willing to perhaps talk problems through. And I think at a team level that is beneficial – to feel that not only you should be talking about how you're feeling, but also encouraging members of your team to do that as well" |
| | **Smith et al. (2020)** | "I have learned to empathise better with my colleagues … I learned what might go on in other peoples"; "understood that others feel similar to me"; "people wanted to talk about themselves and it sort of turned into a complaints session … people just try to come up with more extreme stories and how they were victimised" (student 10) or "Forced group reflection is just another opportunity for those who are unlikely to have self-insight, or self-aggrandisement from telling their side of the story. Facilitated whinging session" (student 8)" |
| | **Abnett et al. (2022)** | "I think it actually sets you up to feel self-conscious about not having a particularly good structure to what you're saying"; "I think there's quite a few people in there which can be |

| | | |
|---|---|---|
| Relational and practical challenges | | quite intimidating to be raw and emotional"; "I'm not sure I would be able to articulate what I want to say … And be able to admit those sorts of things in such a big group with so many people"; "Especially online, if you can't see people's faces, it's really disconcerting, kind of spilling your heart out"; "I think definitely it being on Teams and not being able to see everyone will take away the personal aspect of it where you might feel more comfortable to share" |
| | **Allen et al. (2020)** | "participants highlighted how they had struggled to get the time to attend the Rounds regularly because of their shift system making it difficult to take a full lunch break"; "It's very difficult when you're on a shift pattern to get everybody because it's not ideal. We all have to go back for two o'clock, so you don't see the end of them... I've only managed to be here for half an hour of it, you know, or fifteen minutes and then I've had to go back to my ward so I've got the gist of it'."; "Smaller group of people with whom you could build up trust over a period of time might make it easier for me to contribute with my own experiences'; "there's never the same set of people there, there's never a chance to develop cohesion, a sense of group, a sense of support" |
| | **Clancy et al. (2020)** | "participants emphasized the importance of addressing barriers to attendance, such as use of practice hours, ease of access when on placement in the hospital, and course and personal commitments. There was a sense that prioritizing attendance was difficult, perhaps reflecting a culture which prioritizes getting things done rather than discussing experiences."; ""I think they'd just be like there's useful work to be done here so why would you want to go to this?" Neena's seniors not promoting Rounds represented a barrier to attendance"; ""after attending a larger Round Vicky described how it was "not quite so easy to speak up … the conversation moves so quickly so every time you think of something to say … it's kind of moved on" |
| | **Farr & Barker (2017)** | "It's that commitment, is it relevant to me, is it my area? So I think it is selling it to people, that it's relevant to them, even if it's not specifically in their patch."; "In journey times, 2 hours potentially, more or less, from one side of [the area] to the other…. Trying to get staff to a location for the Schwartz Round and it be accessible to everybody has been hugely challenging." |
| | **Gleeson et al. (2020)** | "Sometimes harder to share thoughts in larger groups"; "It can feel intimidating to speak" |

| | | |
|---|---|---|
| | **McCarthy et al. (2021)** | “I was thinking about the experience in terms of my professional viewpoint, but actually when I met with the facilitator it was more how you felt about things. So it made the prep actually quite challenging in a way because you’ve got to think about your own personal perception of things and how you feel. We don’t always talk about how we feel very easily do we?” |

## Paper Two: Empirical Paper

# ‘If we're not doing a good enough job […] I don't want to be a part of that anymore’: a qualitative study exploring reasons and experiences of Clinical Psychologists leaving the NHS and working privately

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Word Count: 7,974

## Abstract

The British Psychological Society and the Association of Clinical Psychologists highlight that increased numbers of Clinical Psychologists (CPs) are leaving the NHS for private practice. There has been limited research on the reasons for this. Semi-structured interviews were conducted with eight CPs and analysed using Reflexive Thematic Analysis (RTA). The analysis generated the following themes and sub-themes: 'Unreciprocated dedication' with two sub-themes: 'Overwhelming expectations' and 'Power imbalance'; 'Perfect storm' with three sub-themes: 'Moral injury', 'Dawning realisation' and 'A drive for control and autonomy'. CPs discussed pressures and demands on them whilst being unsupported by their managers and organisation. No singular cause finalised their decision to leave. CPs experienced moral injury, stress and burnout. Lack of control, autonomy and career progression, family needs, and salary were also contributing factors to their decision. Services should consider compassionate leadership initiatives, improving CPs' autonomy and focus on offering training and career progression. Lastly, services should explore CPs' skills and consider those in service and job planning. Further research avenues were also discussed.



*Key words*

*Clinical Psychology, NHS, retention, private practice*

The Association of Clinical Psychologists (ACP-UK) and the British Psychological Society (BPS) made statements regarding the current climate in the psychology profession. They observed that ‘more junior psychologists are leaving the NHS to work in the private sector than at any other time’ (ACP-UK, 2018) and saw a ‘greater number of practitioners leaving the NHS’ (BPS, 2023). There has been a paucity of research on this. This study explores experiences of Clinical Psychologists (CPs) and aims to elucidate reasons behind CPs’ decision to leave.

The National Health Service (NHS) has highlighted challenges with the sustainability of its workforce in the NHS Long Term Workforce Plan (NHS England, 2023). This Plan hopes to almost double the workforce by 2036/37 and retrain and retain current talent. The Plan has highlighted a need to focus on the psychological professions due to increased demands for psychological services from the public; current workforce shortages; lack of integrated care; lack of focus on prevention and early interventions; and the need to improve outcomes for those accessing services. The Psychological Professions Workforce Plan (PPWP) for England (Health Education England, 2021) outlined a strategy to expand and develop the psychological workforce by 2024 to support the delivery of the NHS Long Term Plan. The PPWP focuses on growth and diversification of the profession; development of career opportunities; building local, regional and national leadership in the profession; and transformation by embracing new ways of working.

Expansion in clinical training places and development opportunities is a long-term strategy (Health Education England, 2021). As training new CPs to enable them to join the current workforce takes years, increasing current retention is vital. High turnover rates are associated with poorer quality of care and higher costs for

employers to train and recruit new staff (Health Education England, 2021). The Plans also aim to address the working conditions to retain staff.

Concerns about retention rates vary. The BPS has noted that ‘we are seeing a greater number of practitioners leaving the NHS for development and promotion opportunities once they are further on in their careers’ (BPS, 2023). The BPS released guidance on ‘Best Practice in Psychology Recruitment’ in January 2021, as they highlight that there is ‘a significant expansion of psychology posts but difficulty in recruiting with one in seven posts unfilled.’ The ACP-UK have responded to this by stating that difficulties in recruitment are caused by a lack of career progression opportunities (ACP, 2021), which could contribute to CPs leaving the NHS for the private sector. More recently, the BPS suggested that retention of CPs may not be as critical of an issue as originally thought (BPS, 2023). It suggested that ‘although larger absolute numbers of psychologists will be leaving NHS (as there are larger numbers overall), the rate of leaving has decreased in comparison to the rate before or immediately after the pandemic’ (BPS, 2023). However, retaining staff remains an important consideration in workforce planning and development of the profession.

### Organisational culture

Recently the NHS suffered significant strain due to austerity and cuts (Stuckler et al., 2017). The COVID-19 pandemic has placed greater demands on the NHS and its staff (Boggon et al., 2022; Willan et al., 2020). Studies found increase in referral rates of approximately 77% to children and young people mental health services compared to prior to the pandemic (NHS Confederation, 2022). A recent report highlighted that the NHS has ‘insufficient institutional capacity to meet the demand for care’ (Weyman et al., 2024). Healthcare staff have been working under extended high levels of pressure during the pandemic, raising concerns about staff

retention and health and wellbeing (Thorlby et al., 2020). Healthcare staff are facing significant challenges, including work-related stress, frustration over patient care standards, and concerns over the future of institutional and individual capacity to cope (Weyman et al., 2024). This has resulted in high rates of sickness leave and contributed to healthcare staff leaving the NHS (NHS Staff Survey, 2021; Rimmer, 2018; Weyman et al., 2024). CPs are also affected by these issues. Current research on CPs suggests that they face excessive workloads, professional self-doubt and poor management (Bell et al., 2024; Hannigan et al, 2004). These factors contributed to burnout, high workforce turnover and absenteeism, thus sharing similarities with other staff groups.

### Personal and professional context

A recent study on CPs' experience of working in and leaving Child and Adolescent Mental Health Services (CAMHS) to work independently has brought up challenges faced by CPs in the NHS (Wintour & Joscelyne, 2024). The study highlights the negative changes, which the services have undergone over time. Participants have experienced increased caseloads, more administrative work, reduced staffing levels, changes in their clinical roles and clinical work becoming more complex. CPs described feeling like they were 'firefighting' by responding to crises rather than providing interventions to facilitate any change. CPs were unable to use their skills and help young people and their families due to organisational pressures. CPs described CAMHS work as traumatic and damaging to their emotional wellbeing. Furthermore, CPs have mentioned difficult relationships with management, often feeling unsupported and undervalued. Some CPs reported being targeted and bullied by managers. The participants in this study resorted to leaving the NHS to work privately. This was accompanied by feelings of guilt, loss and grief

regarding their departure. For others, although the decision to leave was difficult it brought relief and participants felt this was the only option.

## Theory and framework

Several frameworks can be used to explain decisions to leave. The Herzberg's Motivation-Hygiene Theory, which previously has been applied to healthcare staff leaving the NHS can assist considerations why CPs are quitting (Leary at el., 2024). Herzberg (2015) suggests that there are two factors that explain job satisfaction and dissatisfaction. Motivators, or intrinsic factors that lead to job satisfaction, are related to the nature of the work itself, enhancing motivation and satisfaction. These include: a sense of achievement in one's work, receiving acknowledgement for efforts, performing engaging and challenging tasks, having responsibility or autonomy, opportunities for career development and learning new skills. In the study by Wintour and Joscelyne (2024), there is a clear absence of intrinsic factors. CPs described increased caseloads and changes in their role and responsibilities. They were unable to use their unique skills, crises instead. Bullying and targeting from management would suggest that CPs were not valued or acknowledged for their efforts. Herzberg (2015) also describes hygiene factors, or extrinsic factors which prevent job dissatisfaction, but do not lead to job satisfaction. These include salary, company policy, quality of management, working conditions, relationships with colleagues or supervisors and job security. CPs mention strained relationships with management and disagreeing on policies, like the waiting-list initiatives. CPs mention difficult relationships with colleagues and feeling that it was easier to work alone (Wintour and Joscelyne, 2024). The Motivation-Hygiene Theory highlights that organisations should focus on improving motivators to increase employee satisfaction whilst also addressing the extrinsic factors to prevent

dissatisfaction to keep their staff happy (Herzberg, 2015). Leary et al. (2024) highlight that staff leaving the NHS show a link between intrinsic and extrinsic factors, suggesting that the theory may be relevant in explaining leaving decisions.

Another framework that has focused on understanding the leaving decisions of CPs is the model proposed by Saddington (2021). The model highlighted three categories relating to organisational factors, which included shifting organisational valuing, cycle of imposed change and trying to achieve the impossible. Shifting organisational valuing suggested that changes in the organisation's values can lead to a disconnect between CPs and the workplace. CPs in the study by Saddington (2021) highlighted a shift towards numerical targets, increasing power of operational management and declining value of psychology. The Cycle of imposed change discussed that instability, and frustration can be created by frequent and poorly managed changes in the organisation. CPs described repeated top-down changes that lacked transparency or collaboration which have led them to feel disempowered. Finally, achieving the impossible related to CPs facing unrealistic workloads due to competitive commissioning and senior management placing unachievable targets to retain contracts. CPs felt that management saw them as inefficient and blamed them for not being able to achieve targets. These factors were seen as influencing CPs to resign.

## Rationale

There is currently limited research into experiences and reasons for CPs leaving the NHS for private practice. Policies and guidelines highlight staff shortages and the need for better recruitment and retention. Previous studies have focused on organisational factors or specific service experiences leading to resignation. Furthermore, the COVID-19 pandemic has changed the way CPs work, increasing

therapy conducted remotely (Saxon et al., 2023) which has created more opportunities in private practice. However, little is known about CPs transitioning to work privately as opposed to other forms of employment.

This study aims to provide a general (not service-specific) focus on CPs leaving the NHS to work privately and considers a range of potential influences on this decision-making process.

### Aims

The current study aims to:

- Explore the experience of CPs who left the NHS for private practice.

### Research Question

How do Clinical Psychologists describe and explain their reasons to leave the NHS for private practice?

## Method

### Ethics

The study was approved by the University of Staffordshire ethics committee (ID: SU_23_020) (Appendix 1). All participants provided written and verbal consent. Participants were made aware that they may experience discomfort or distress when asked to recall their experiences. Participants were debriefed after taking part and signposted to sources of support (Appendix 2).

### Design

The aim of the current research is to explore and interpret the experiences of CPs. To encompass this, a qualitative paradigm was used. This approach does not

attempt to test a hypothesis, rather explore how individuals feel and make sense of their experiences (Braun & Clarke, 2013). Thus, semi-structured interviews were used to obtain rich, deep accounts of perspectives and experiences. The interview schedule was developed based on topics of interest, gaps in the literature and with input from research supervisors (Appendix 3). The schedule was refined following feedback from the research supervisor on the first participant interview.

The current study focused on identifying themes and patterns in relation to the research question and shared participant experiences. This area is relatively under-researched thus requires an exploratory and inductive process. It was important to focus on participants' own accounts and experiences versus a more deductive approach. One qualitative method that allows for this whilst also emphasising the role of the researcher in shaping of the analysis and reflecting on own influences is Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2022). Other approaches like Interpretative Phenomenological Analysis (IPA) were unsuitable as this focuses on idiographic approaches rather than collective group experiences.

### Researcher position and reflexivity

The current study is based on a relativist ontology which highlights that there is no single reality and how we see the world is shaped by our social and cultural context (Braun & Clarke, 2022). The study takes on an interpretivist epistemological stance suggesting that reality is constructed through social interactions and interpretations. This combination allows for knowledge to be co-constructed between the participants and the researcher. This suits the current research as it allows for deep exploration of CPs' experiences and how they make sense of their leaving decision as well as considers the researcher's stance.

I am a trainee CP in my final year on the Professional Doctorate in Clinical Psychology at the University of Staffordshire. I am a psychological professional who has worked in NHS services both during and pre-training, making me an insider researcher. I have been exposed to the stresses and pressures of working in the NHS and have observed CPs struggling with these daily. I have witnessed CPs going on sick leave or leaving the services due to this. This then had a knock-on effect on teams by increasing workload and pressures on other professionals, further impacting their well-being and reducing the service capacity to provide psychological support to clients. This has led me to assume that working in the NHS following qualification may be a stressful experience. The research idea arose from wanting to influence and improve working conditions for all CPs in the NHS. My knowledge and experience are invaluable in understanding the nuanced experiences of participants in the study and help to inform the analytic process.

Following the completion of the first interview, I requested that this be reviewed by the study supervisor to reflect on how my positionality can affect the data collection and interpretation. I have noticed that due to my assumptions of NHS work being stressful, I did not explore the participants' experience in enough detail which could have led to the first interview being 15 minutes. I used supervision to reflect on my own responses and how they contributed to this. Furthermore, I reflected on my position as an inside researcher and how this could shape interview dynamics. Participants stated that they did not want to put me off working in the NHS. I took time to reassure participants that providing their real experiences could help improve working conditions not just for me but for other future psychologists. Following these reflections, the interview schedule questions were further developed to be more open-ended to allow the participants to express themselves fully.

I utilised the reflexive exercises in the book by Braun and Clarke (2021) to consider my position as a researcher in the interviews and data analysis. Furthermore, I used a reflexive diary throughout the process of this study to facilitate insight and critical engagement with participants and the material. When strong feelings arose, I utilised research supervision to reflect on why I might be having this response and how this might matter for my research, a process encouraged by Braun and Clarke (2021).

## Sample and data collection

Recruitment used purposive sampling, which is often used in qualitative research to ensure that individuals are well-informed of a phenomenon of interest and share specific characteristics, in this case being a qualified CP who has recently left the NHS for private practice (Etikan et al., 2016). Using this sampling strategy ensures that participants can answer the research question. Inclusion and exclusion criteria are seen in Table 1.

Table 1. Inclusion and exclusion criteria

| Inclusion | Exclusion |
|---|---|
| Qualified Clinical Psychologist-HCPC UK registered | Resigned from the NHS post due to ill health and/or retirement |
| Up to 3 years since leaving NHS and solely in private practice | Resigned to work in another sector than private (e.g. voluntary sector, local authority, academia) |

Initially the inclusion criteria only included CPs who have left the NHS in the last 12 months; however, it was expanded to include those who have left the NHS in the last 3 years. This was to promote recruitment whilst also considering potential recall bias and ensuring timeframe did not reflect too many changes within the NHS.

Previous guidelines by Braun and Clarke (2013) suggest that small-scale research projects should aim to include around 6-10 participants. Recent recommendations on sample sizes in RTA highlight that the aim is for ‘information power’, suggesting that the more information a sample holds relevant to the study, the fewer participants are needed (Malterud et al., 2021). Therefore, the target sample size for this project was between 6-10 individuals as it was anticipated that this would generate rich data about this complex issue.

Participants were recruited using Facebook, X and LinkedIn. Study advert was shared with relevant professional groups on these platforms to target eligible participants (Appendix 4). Snowball sampling, i.e. reposts, were also used to further recruitment. The study was actively advertised between March and April 2024 and October to December 2024. Participants were invited to contact the researcher via email. Those who contacted the researcher were provided with a participant information sheet and consent form (Appendix 5 and 6). Fifteen individuals expressed interest in the study. Once participants had signed and returned the consent form to the researcher, a mutually convenient time was arranged to conduct an interview. The final sample consisted of 8 individuals. Reasons for non-inclusion included: being employed in the NHS to some capacity (n=3), leaving the NHS but not working in private practice (n=1) and not responding to the researcher following initial expression of interest (n=3). Demographic data on time since qualification, years working in the NHS, date of leaving the NHS and predominant area of psychology practised etc., were collected (Table 2).

Table 2. Demographic data of participants

| *Participant* | *Year of qualifying as a CP* | *First post in the NHS post qualifying* | *Length of employment in the NHS since qualification* | *Main area of practice* | *When did the participant leave the NHS?* | *Nature of current role in private practice* |
|---|---|---|---|---|---|---|
| ***Samantha*** | 2018 | Children and adolescent mental health (CAMHS) | 5 years | CAMHS | 2023 | Data not collected |
| ***Megan*** | 2006 | CAMHS | 16 years | CAMHS | 2023 | Associate Psychologist |
| ***Tom*** | 2017 | Adult Mental Health | 7 years | Adults | 2023 | Own a private practice company |
| ***Ellie*** | 2009 | CAMHS | 14 years | CAMHS | 2023 | Own a private practice company |
| ***Tamara*** | 2003 | Children's services | 11 years | Children's services | 2023 | Sole trader, Associate Psychologist |
| ***Molly*** | 2019 | CAMHS | 5 years | CAMHS | 2024 | Associate Psychologist |
| ***Mark*** | 2014 | CAMHS | 7 years | Adult mental health | 2022 | Own a private practice company |
| ***Kate*** | 2016 | CAMHS | 8 years | CAMHS | 2024 | Associate Psychologist |

All interviews were conducted via Microsoft Teams and lasted between 15 minutes to 1 hour 16 minutes (mean duration 61 minutes). Verbal and written consent was obtained prior to each interview. Each interview was transcribed automatically by Microsoft Teams and checked and corrected by the researcher. Following the interview, participants were debriefed and provided with a debrief poster (Appendix 2).

## Data analysis

The research explored the experiences of CPs leaving the NHS for private practice through questioning the experience prior, during and after the resignation. Reflexive Thematic Analysis (RTA) was used to analyse the data. RTA's flexibility offered a possibility of using inductive and deductive analysis (Byrne, 2022). A predominantly inductive approach was used to best represent meaning as communicated by the participants (Braun and Clarke, 2013; Byrne, 2022). A degree

of deductive analysis was used to ensure that open coding contributed to producing themes that were relevant and meaningful to the research questions (Byrne, 2022). Both semantic and latent coding were used when meaningful information was interpreted. As Byrne (2022) suggests, this reflects the theoretical assumptions of the analysis, where both the meaning making is constructed and communicated by the participant and the interpretation of the meaning by the researcher is described. The data was analysed using the 6 steps outlined by Braun and Clarke (2022): familiarisation with the dataset, coding, generating initial themes, developing and reviewing themes, refining, defining and naming themes and writing the report. Braun and Clarke (2022) also highlight that the researcher will move back and forth between the stages until themes are finalised.

In the current study the researcher checked the transcripts of the data against the videos of the interviews and read the interviews repeatedly to become familiar with the data. The researcher noted the content of the interviews. The researcher then used NVivo to conduct data analysis. Initial codes were made on all transcripts and data was sorted into these in NVivo. Initial codes were checked against the data, these were sorted into initial themes and brought to individual supervision and an RTA workshop group to discuss. Then, the researcher returned to the original data and revised codes and themes. Themes were then reviewed, reorganised, collapsed, defined and finally named. Lastly, during the report write up the researcher reviewed the research question, coding extracts and themes whilst making connections between the data and available literature.

## Rigour

To enhance rigour of the study, the researcher adhered to the six steps outlined by Braun and Clarke (2022). To ensure data accuracy, transcripts were

checked with original recordings of interviews. Regular meetings with supervisor and RTA workshop groups were utilised to explore codes. Excerpts directly from participant material were used to evidence themes. A clear audit trail of the analytic process was maintained to show how themes were developed (Appendix 7).

## Results

Two main themes and 5 sub-themes were developed (Table 3). Further examples of evidence for each theme are provided in Appendix 8.

Table 3. Themes and sub-themes

| Theme | Definition | Sub-theme | Participants |
|---|---|---|---|
| **Unreciprocated dedication** | Efforts given to the organisation by CPs is not matched by the loyalty and commitment from the organisation | *Overwhelming expectations* | *Samantha, Megan, Tom, Ellie, Tamara, Molly, Mark, Kate* |
| | | *Power imbalance* | *Samantha, Megan, Tom, Ellie, Tamara, Molly, Mark, Kate* |
| **Perfect storm** | Combination of unfavourable circumstances that acted as a catalyst for the decision to leave | *Moral injury* | *Samantha, Megan, Tom, Ellie, Tamara, Molly, Mark, Kate* |
| | | *Dawning realisation* | *Samantha, Megan, Tom, Tamara, Molly, Kate* |
| | | *A drive for control and autonomy* | *Samantha, Megan, Tom, Ellie, Tamara, Molly, Mark, Kate* |

## Context

All the CPs in the current study were simultaneously working in private practice and their NHS role before leaving. Therefore, participants were aware of private practice and how to transition into it, which could have swayed their decision to leave. Most participants highlighted that they requested to increase their working hours privately or used their current ways of finding private work to transition to private practice fully. When talking about private practice participants highlighted themes of good supervision, flexibility in working hours and variability of work. Participants also highlighted disadvantages like not seeing the most deprived client groups, having to organise their own equipment, resources, accounting and insurance. Participants mentioned how they overcame these disadvantages and continued working in private practice.

## Theme 1: Unreciprocated dedication

This theme describes the pressures felt by CPs working in the NHS. It encapsulated how much CPs give of themselves but do not feel that this is reciprocated by the system, thus highlighting a stark discrepancy. CPs felt like they were ‘drowning’ and that at times they did not ‘see eye to eye’ with clinical leads (Samantha).

### Overwhelming expectations

Participants described ‘increased expectations on staff’ whilst ‘the level of risk’ and ‘waits were increasing’ (Samantha). Ellie noted that there were ‘staff changes’ and ‘people going off sick’. Molly explained that over time ‘there were three times as many referrals, or four times as many referrals’, whilst what staff and services ‘could provide was decreasing’ (Samantha). Community services that were previously

providing ‘the early help had just disappeared’ (Ellie), meaning that individuals now had to access NHS services for support. Services tried to cope with this by repeated ‘redesign’ and ‘just trying to keep making a new bag out of less material’ (Ellie). Megan went on to describe that ‘the resources in the NHS just got more and more scarce’ and ‘I was either burnt out or very close to burning out when I left’. This demonstrates the impact the lack of resources and increased demands had on CPs which could have contributed to them leaving.

All participants talked about how pressure built over time and how this became ‘very, very stressful, very, very high pressures’ (Tom). Interventions were limited to a number of sessions to cope with the demand which unsurprisingly placed ‘pressure upon clients and clinicians’ (Mark). Furthermore, the type of work and job role changed over time, ‘the risk, the complexity and what I actually felt like I could do as a psychologist or bring as a psychologist. That wasn't really there anymore’ (Samantha). Ellie felt that ‘you would only be seen by CAMHS […] if you were threatening to kill yourself or self-harm’. It appears that CPs were not able to utilise their unique skills to make meaningful changes and instead were firefighting and managing risk. Molly went on to say that she ‘heard the most horrific stories of child abuse, several times per day and […] there was no space to make sense of it, to process it. It was so incredibly fast-paced’. CPs did not have time to process the trauma they were exposed to which could have impacted their emotional wellbeing.

### Power imbalance

This sub-theme describes CPs feeling powerless against the organisation and feeling unsupported and scrutinised by the system and managers. Megan described that some management decisions were ‘slightly odd’ and could be seen as a ‘grievance or bullying’. These decisions ‘involved the whole team’, but ‘the team

wasn't consulted on it' suggesting a divide between management and clinical staff, as their opinion was not considered. Tom highlights that 'the head of service calling us [...] shop floor workers' felt 'very [...] demeaning'. This statement suggested a power imbalance between how management sees themselves compared to clinical staff.

Tamara noticed that the team wasted time managing 'power [...] dynamics', 'which got in the way of doing useful work'. When considering solutions for this, she said 'it was fixable but not whilst people were frightened'. She stated that raising issues in the organisation did not feel like they 'will be managed in […] a safe way that would make me feel all right'. This was echoed by Mark feeling like upper and middle management 'closed ranks' leaving him feeling scrutinised and unsupported when he whistle blew about his predecessor. Mark was 'a bit scared to take some of this to my supervision space because… […] my supervisor is in the senior management ranks…' highlighting that he has lost trust in getting support from individuals in leadership roles. This highlights a one-sided relationship, where CPs were forced to pour a lot of effort to meet expectations but were mistreated and unsupported in return by the system.

Kate described a 'high level of complaints [...] about nothing to do with what the staff have done', instead the complaints would be about 'the process' or disagreements with 'the outcomes' of assessments. Thus, staff felt attacked about things that were outside of their control and were, in fact, issues of the wider system. She states this had 'a real impact', suggesting that CPs were feeling deflated after receiving complaints when they have worked hard. Megan said CPs were 'kind of pressured to give in to complaints rather than not, rather than feeling like the manager, managers had our back'. This suggests a level of betrayal was felt by CPs,

as they have not received the backup they expected from their managers, leaving them feeling powerless.

### Theme 2. Perfect storm

This theme encompasses a combination of factors occurring at a similar time which acted as a catalyst for the decision to leave. This is further broken down into three sub-themes: ‘Moral injury’, ‘Dawning realisation’ and ‘A drive for control and autonomy’.

### Moral injury

Moral injury can be defined as psychological, social and spiritual distress arising from action which violates one’s beliefs and values (Wong et al., 2021). Participants in the current study described a discrepancy in what the service was providing and what the psychologists thought was needed.

Tom stated: ‘in terms of values, yeah, they kind of really deteriorated in terms of what you were initially there for, which was the care and to show compassion’. He also says CPs were limited in what they were able to offer, and felt like at times he was doing the clients a ‘disservice’ as he had to discharge them before they were ready or face explaining himself to the managers and supervisors. This was echoed by Ellie who thought that ‘12 sessions of CBT isn't going to solve intergenerational trauma’. She described needing to ‘survive the generic [CAMHS] team’ and this as ‘really demoralising’ thus suggesting she was acting against what she believed was needed due to service pressures.

Tamara goes on to say ‘as long as I'm not doing harm and I'm doing my best to do something useful, I'm happy. And it got to the point in the NHS where I wasn't sure about that anymore’. She ‘felt so ineffectual’ and that her work became ‘all

about numbers, less about human beings'. This highlights CPs felt unable to exercise care and compassion and feel like they are doing harm to their clients, thus acting against their own values and morals.

This brought up complicated feelings for Samantha who states she was 'angry and feeling like quite a lot of injustice for our service users and for what we were doing'. She also said: 'I wouldn't tell anyone to go here. I wouldn't want my family to go here. I wouldn't want my friends to go here'. Molly put herself in the client's shoes and said she would 'absolutely not' want to be seen by her team. She explained that she 'would be blamed as a mother and […] would not be helped'. Once she has realised this, she knew she 'couldn't stay'. This highlights that CPs were providing a service that they were not proud of which led them to consider leaving. Samantha expressed that 'if we're not doing a good enough job and I don't want to be a part of that anymore', thus highlighting this explicitly.

### Dawning realisation

This theme demonstrated that many CPs had time away from their roles for variety of reasons including maternity leave, sick leave and bereavement; which allowed them to gain a different perspective and lead them to consider leaving the NHS.

The time away highlighted the significant impact, which their work was having on their health and wellbeing. Samantha noticed how her body felt when she was on leave compared to when she returned by saying: 'I guess having that time off had allowed me to be like, oh shit, this is how I feel like at work'. Samantha further explained that 'it was the jump from like not feeling fight or flight all day, despite having a baby to, God now I have to go and […] feel like this and it's going to be

really, really intense and I'm going to feel really unwell’. CPs described being in a state of fight or flight and not having time to notice and reflect on the way they were feeling daily. Having the time away allowed them to come out of this threat state and notice how different they feel.

Whilst on leave CPs realised that the issue lay in the system and was not something that can be easily fixed. Tamara stated ‘I went off sick initially just for a couple of weeks. And then while I was off, I just thought this isn't going to be fixable in a couple of weeks and actually life's too short.’ Whilst Tom reflected that during his personal therapy, he had a conversation with his therapist that highlighted that this is a never-ending battle: ‘the environment that you're in is obviously causing this and […] we can't change everything you've discussed’. This highlighted that the issue and pressure felt by CPs was not going anywhere and thus contributed to them thinking how to protect themselves from feelings of stress and burnout.

### A drive for control and autonomy

This theme represented the final factors that led to the decision to leave. This included family duties, a lack of flexibility, financial reasons, distance to work and career progression. Kate summed this up by stating that she ‘wanted to live more than I wanted to work, rather than, work to live maximum like two days a week […] [at] weekends’. This suggested that CPs’ lives were on hold whilst working in the NHS and they felt unable to experience life as they desired until they were in private practice.

Ellie highlighted ‘part of the reason why I left the NHS is because I have probably a neuro diverse child who was not coping with all the breakfast clubs, the

after school clubs and holiday clubs […] which is why I left so that I could just fit around that'. Working in the NHS felt inflexible to fit around family needs.

However, it was not just the family needs that were neglected. In their NHS roles, CPs felt like their career progression was at a standstill. The lack of progression was demonstrated by: "what between? 15 years […] I don't think I got any training in therapy" (Megan); "that stagnation, like, that's why I jumped because I, I wanted to be a consultant, I wanted sort of to move up and I felt like there was no opportunity to do that" (Tamara). Tom highlighted that he 'fought tooth and nail' for training and it took two and a half years for it to be approved.

All CPs were working in private practice before ending their employment in the NHS. They were therefore exposed to advantages of private work which likely influenced their decision to leave the NHS. Molly left the NHS to gain autonomy over her hours, caseload and clients: 'I determine my hours. I determine my caseload. I determine who I see', something that was impossible in her NHS role. Furthermore, the financial compensation in private practice could influence leaving the NHS: 'you could be earning a 6-figure salary, and that's higher than obviously the head of service gets within the NHS' (Tom).

## Discussion

The current study aimed to understand why CPs are leaving the NHS for private practice. Previous research has focused on organisational factors influencing CP's decision to leave the NHS (Saddington, 2021). The current research aimed to build on the findings and understand the personal experiences of CPs working in the NHS and their reasons for leaving. Two overarching themes were developed: 'Unreciprocated dedication' and 'Perfect storm'. There were 5 sub-themes in total:

‘Overwhelming expectations’, ‘Power imbalance’, ‘Moral injury’, ‘Dawning realisation’ and ‘A drive for control and autonomy’.

The ‘Unreciprocated dedication’ theme discussed the efforts CPs were giving to the organisation and the perception that this loyalty and commitment was not reciprocated. In the ‘Overwhelming expectations’ sub-theme, participants described increased expectation and demands on staff, with increased levels of risk and longer waiting lists. CPs have also mentioned not being able to offer what they normally would have as a psychologist and instead they were firefighting due to increased risk. CPs have mentioned feeling pressure, burnt out and not having time to process highly traumatic stories. This was previously seen in prior research which highlighted that CPs were facing unrealistic workloads and felt that their work was traumatic (Wintour & Joscelyne, 2024; Saddington, 2021).

Participants mentioned a divide between leadership and staff in the ‘Power imbalance’ sub-theme which could have further contributed to increased feelings of burnout and their decision to leave. Previous literature suggests a link between leadership and burnout, suggesting that improved leadership practices could mitigate burnout among mental health clinicians (Gavestock, 2023). Difficult relationships with management were also highlighted in previous research with CPs in CAMHS settings (Wintour & Joscelyne, 2024).

The theme of ‘Perfect storm’ highlighted that there was no single cause which led to CPs leaving the NHS and instead it was a collection of unfavourable circumstances. From this, three sub-themes were developed: ‘Moral injury’, ‘Dawning realisation’ and ‘A drive for control and autonomy’. Moral injury has been defined as a type of trauma characterised by feelings of guilt, shame, existential and

spiritual conflict arising from actions and experiences that violate one's moral beliefs and values (Jinkerson, 2016). CPs have highlighted that they were unhappy with their NHS work and did not want to be a part of the services they were providing, highlighting that it is going against what they believe in. Wider literature suggests that moral injury is prevalent in healthcare workers, and it is seen as a deep violation of their moral beliefs (Dean et al., 2019). The authors highlight that this may be due to clinicians not being able to provide high-quality care due to systemic constraints, resulting in feelings of guilt, shame and betrayal to their professional values. Moral injury was associated with staff wanting to leave their jobs (Colville et al., 2019). Thus, it can be seen as a contributing factor for CPs leaving their NHS jobs.

Most of the CPs in this study have had a period of leave from their roles which was highlighted in the 'Dawning realisation' sub-theme. For some, this included maternity leave or compassionate leave for bereavement, however others took time off as sick leave. Studies have suggested that high job demands, and low job control increase the need for recovery increasing the likelihood of sickness leave (Schaufeli et al., 2009; Sonnentag & Zijlstra, 2006). CPs have highlighted that the time away from their roles allowed them to recover from possible burnout or gave them time to realise that the NHS role is no longer right for them. The disparity between how CPs felt when away from work or once they were back at work was seen as a contributing factor in them deciding to leave.

In the 'A Drive for control and autonomy' sub-theme the final reasons contributing to the decision to leave were childcare, financial issues, lack of training and career progression. Previous literature suggests that lack of training and career progression is an important factor in staff retention (Gaffney, 2005; Hassan et al., 2013). These issues are in line with what is reported by the ACP-UK (2018) and BPS

(2023) which suggested that CPs are leaving their roles due to the lack of opportunities for promotion and progression. Furthermore, the financial implications of working in private practice also drew CPs out of the NHS. Research has shown that salary satisfaction was an important component in staff retention (Iqbal et at., 2017). Although reasons for CPs to ultimately make the decision to leave varied, there are organisational aspects that must be considered to increase retention rates. This includes training, career progression and salary.

The Herzberg's Motivation-Hygiene Theory (Herzberg, 2015) can be applied to findings from this study. The theory suggests that motivation factors which lead to job satisfaction include a sense of achievement in one's work, receiving acknowledgement for efforts and having autonomy and opportunities for career development. The motivation factors which enhance job satisfaction were not present in CPs' roles. CPs mention working against their values, and lack of support from the organisation, lack of autonomy and lack of career development or training. The theory suggests that hygiene factors that prevent job dissatisfaction can include salary, quality of management, working conditions, relationships with colleagues or supervisors. CPs mention difficult working conditions, poor relationships with management and supervisors, and lower salary, suggesting lack of hygiene factors in their NHS roles. Leary et al. (2024) suggested motivation and hygiene factors contributed to healthcare professionals leaving the NHS. The present study supports those findings and indicates CPs have similar reasons to leave the NHS.

### Strengths and limitations

The current study attempted to explore CPs' experiences of the NHS and their reasons to leave in an open manner. This was a novel study with important implications for considering workforce planning of CPs in the NHS. The participants

in this study were from various geographical areas in the UK and at different points in their career, thus allowing for rich information gathering.

However, no study is without its limitations. The current research is of an exploratory qualitative nature thus making it hard to draw generalisable conclusions. However, as there is currently a lack of research in this area it makes a strong foundation for further research.

The sample was predominantly female (6 females, 2 males). Although this is not an equal divide, it is representative of the CP workforce which is reported to be 80% female (Johnson et al., 2020). Further demographic data regarding diversity was not routinely collected. Further research should ensure that additional demographic data is collected as factors around diversity and intersectionality may contribute towards CPs' experiences and motivations to leave the NHS.

The recruitment of participants happened across various online platforms, so it can be speculated that those reaching out to partake in the study have felt strongly regarding their decision to leave and wanting to share their accounts of the process. However, as with most studies this is an opportunity sample relying on self-report. Although this may be seen as a potential source of bias, the themes included in this report have been supported by most of the participants, thus suggesting commonalities across experiences.

Finally, as this is a reflexive thematic approach the researcher's stance as an insider researcher must be considered. To increase rigour, the researcher kept a reflexive diary, utilised research supervision and RTA workshops.

## Further research

There is currently limited research into the retention of CPs in the NHS. Further research can consider CPs from a wide range of services to see if there are any relationships between type of service CPs work in and their retention rates. The CPs in this study have worked across CAMHS and adult mental health services however there is a lack of representation from Learning Disabilities, Older Adult or specialised services e.g. physical health or neuropsychology services. Additionally, there is a lack of understanding as to why CPs may choose to remain in the NHS and their experiences which warrants further exploration as it can be utilised to improve work conditions and culture.

The current research is a qualitative study making it hard to generalise the findings. Large scale survey designs on reasons why CPs leave could be the next direction in this area.

Future research could focus on comparing CPs' reasons to leave the NHS with other professionals to see if there are any factors specific to the clinical psychology profession. This can then be used to inform working practices and help increase retention.

Further research could focus on the loss of qualified clinicians whose training is paid for by public funds. This can not only consider the economic issues but the impact on service provision, waiting lists, client experiences and impact on the staff that do remain in the NHS. For example, CPs in private practice may not be in the position to work with the most complex or high-risk clients due to lack of provision of 24-hour shared care. This may impact the client populations that present to NHS

care and those who may potentially be missed by services due to the need to prioritise risk management.

Another potential area of research may be to investigate how and to what extent trainees on the Clinical Psychology doctorate programmes are prepared by their training to work within present day NHS with all its challenges.

### Clinical implications

The first theme of ‘Unreciprocated Dedication’ shows an overwhelmed psychology workforce which feels unsupported by management. CPs face trauma which they have no time to process and are constantly firefighting due to service pressures. One way to help manage CPs’ feelings of overwhelm and allow them to process trauma they are exposed to is the use of reflective and thoughtful spaces. These allow staff to reflect on the emotional toll of caring for others, working under constant pressure and service and team issues. Leaders need to place value on reflectiveness and support initiatives like supervision sessions and Schwartz Rounds (SRs) (Schwartz, 1995). Studies have found that SRs result in improved compassion for patients, better teamwork and interdisciplinary communication, reduced stress in staff and a positive impact on staff well-being (Taylor et al., 2018; Whitehead et al., 2021). At the organisational level SRs were seen to reduce hierarchy, help build shared values and influence culture by allowing dialogue that does not happen elsewhere (Taylor et al., 2018). Thus, they can be used to address several issues raised by CPs in this study.

CPs also highlighted difficult relationships with management, thus stronger relationships need to be fostered, so that staff feel supported and valued. One way to do this is to introduce Compassionate Leadership training for managers.

Compassionate leadership (West & Chowla, 2017) is based on empathy, openness and communication, considering physical and mental health, inclusiveness, integrity, respect and dignity (Ramachandran et al., 2024). It helps staff members feel heard, understood and valued, whilst helping them to perform at optimal levels. Research has suggested that compassionate leadership reduces burnout among staff, fosters psychological safety and leads to better patient experiences (Lown et al., 2016; Maben et al., 2012; West & Chowla, 2017). CPs in the current study felt that it was not safe to raise concerns. Compassionate leadership strategies have been shown to create psychological safety, reducing fear of speaking up and increase willingness to voice concerns (Krause et al., 2023; Lilius et al., 2008).

However, an important factor to consider is the position of the NHS leaders. The service capacity, resources and risk are unlikely to change soon, yet the pressures on management to meet targets whilst managing this is ongoing. There is a push to be reactive to new challenges which can lead to difficult team dynamics and blame projection. Leaders themselves may be lacking support and compassion hence may struggle to offer support and compassion for their teams. Thus, focus on compassion initiatives towards leaders is important as impact of these will disseminate downstream (Banker & Bhal, 2020; Lanaj et al., 2022; Paakkanen et al., 2021).

The ‘Perfect storm’ theme highlighted different reasons to why CPs leave including need for control, autonomy, better working conditions and career development. Service changes and interventions to address these issues need to be carefully considered. As part of the clinical psychology doctorate, CPs are taught to assess, formulate, design, deliver and review interventions. The training also develops their leadership skills. Therefore, the skills of a CP can be crucial in tacking

these issues. Involving CPs from the conception all the way through delivery and review of interventions or service changes could provide a person-centred approach in resolving issues. Moreover, career progression and training options need to be routinely reviewed and offered to not only upskill the workforce but to keep up with latest research trends and clinical guidance. In the current economic climate with budget cuts, this may be difficult to achieve. One way to address this could be the use of internal training and establishing specialist interest groups within services to support training costs. Furthermore, the use of service evaluation skills of CPs might contribute to cost effectiveness of services.

Moreover, CPs in this study have expressed that their role became about firefighting, and they were unable to bring other skills of a CP. Therefore, the understanding of clinical psychology in teams needs further exploration. Allowing CPs to utilise various skills may not only be beneficial to the service but also allow them to have variability in their role, which could in turn improve their job satisfaction.

## Conclusions

The findings suggest that there is no single reason that leads to CPs leaving the NHS for private practice. Themes were indicative of ‘Unreciprocated Dedication’ from CPs to the service and a ‘Perfect Storm’ of factors that contributed to a final decision to leave. This was viewed through the Motivation-Hygiene theory (Herzberg, 2015) lens. Services should consider implementing compassionate leadership initiatives, improving CPs autonomy and focus on offering additional training and career progression. Lastly, services need to build an understanding of CPs’ competencies and consider those in service and job planning. Further research avenues were also discussed.

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# Appendix

## Appendix 1- Ethics approval

University of Staffordshire

**School of Health, Education, Policing and Sciences**

**ETHICAL APPROVAL FEEDBACK**

| | |
|---|---|
| **Researcher name:** | **Klaudia Cebula** |
| **Title of Study:** | **Why are clinical psychologists leaving the NHS?** |
| **Status of approval:** | **Amendment approved** |

Thank you for your correspondence requesting approval of minor amendments to your ethics application to:

1. inclusion criteria for participants: previously the project was only including participants who have left the NHS in the last 12 months however this has now been extended to the last 3 years to ensure that data covers wider sample of individuals and reflects changes in the profession.
2. Participant information sheet and study advert inclusion changed from 12 months to 3 years.

Your amended application is approved. We wish you well with your research.

**Action now needed:**

Your amendment has now been approved by the Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

**Signed:**

**Date: 04.11.2024**

Sarah Rose

Dr. Sarah Rose

Ethics Co-ordinator - HEPS

## Appendix 2- Debrief

**THANK YOU FOR TAKING PART IN THIS RESEARCH!**

**Why are Clinical Psychologists leaving the NHS?**

**Aims of the research:**
The current study aimed to investigate the experiences of clinical psychologists leaving the NHS. Previous literature on clinical staff resigning from the NHS has heavily focused on mental health nurses and allied healthcare professionals. No previous studies have considered the experiences of clinical psychologists when resigning from the NHS. The current study aims to highlight current issues in the profession and hopes to inform further research and organisational change.

**Data storage:**
Data from the interviews will be anonymised and transcribed. In line with Staffordshire University regulations, transcriptions of the interviews will be stored for 10 years after the end of the project, after which it will be destroyed. The data will be kept secure Staffordshire University Network Drive. Data will only be shared within the research team and will not be shared with any third parties. You are able to withdraw your data from the study within 6 weeks of the initial interview, after which withdrawal of your data will no longer be possible due to data being anonymised and included in final thesis.

If you choose to withdraw from the study, we will not retain any information that you have provided us as a part of this study.

If you have any questions or require more information about this study, please contact me using the following contact details:

Researcher:
Klaudia Cebula
Trainee Clinical Psychologist
c042147m@student.staffs.ac.uk

Supervised by:
Dr Yvonne Melia
Research Supervisor
yvonne.melia@staffs.ac.uk

We understand that this research might potentially bring up some strong emotions. Please see the below options for support:


Wellbeing Support | Activities & ideas | British Red Cross


Together: A leading UK mental health charity (together-uk.org)


Mental wellbeing - Mind


Contact Us | Samaritans


How Shout 85258 works | Shout 85258 (giveusashout.org)

## Appendix 3- Interview Schedule

*Background information for context*

- What year did you qualify as a Clinical Psychologist?

- Was your first post after qualifying in the NHS?

- How long have you worked in the NHS in total?

- Did you consistently work in the NHS prior to moving into private practice?

- What was your main area of practice whilst working in the NHS e.g. Adult Mental Health/CAMHS/Older Adults etc?

- Have you previously moved areas or remained consistently in one speciality? If you have moved, please specify what other specialties you have worked in?

- When did you formally leave the NHS?

- How soon after leaving did you move into private practice?

- What is the nature of your current role in private practice (e.g., own company, associate role, employed outside NHS), please specify?

- Have you previously done private work alongside your NHS role? If so, please specify the nature of this.

1. What were the factors that drove you to work in the NHS?

- Personal values

- Organisational culture and NHS values

- Professional identity as a Clinical Psychologist

2. Can you tell me about your experience of working in the NHS? I would also be interested in hearing about how these experiences changed over time, if relevant

- Fit with your personal and professional values

- Organisational culture and NHS values (capacity and resources/demands, bullying or harassment)

- Professional identity as a Clinical Psychologist

- Management

- Supervision

- Autonomy and control in your role

- Opportunities for personal and professional development

- Your well-being

3. Tell me a bit about what motivated you to start thinking about leaving the NHS?

- Personal and professional values

- Organisational culture and NHS values (management, supervision, capacity and resources/demands, bullying or harassment)

- Relationships with the team and service

- Well-being

- Autonomy and control in your role

- Professional identity

- Opportunities for personal and professional development

4. What were your thoughts and feelings about considering leaving?

5. What were the factors involved in you making the final decision to leave the NHS? (use prompts in 2 and 3 as necessary) What efforts did you make to address the factors that were making you consider leaving the NHS?

6. What has been your experience since leaving the NHS? What would you say are the main advantages to practising as a Clinical Psychologist since leaving the NHS and working privately? And disadvantages? (use prompts in 2 and 3 as necessary)

7. When you look back now, how do you think and feel about your decision to leave the NHS?

8. Is there anything that could have been done to make you stay working in the NHS?

9. Is there anything that I haven’t asked about that is important in helping me understand your experiences and reasons for leaving the NHS?

## Appendix 4- Study advert

# ARE YOU A CLINICAL PSYCHOLOGIST WHO HAS LEFT THE NHS?

**If you are a Clinical Psychologist who has left the NHS for private practice in the last 3 years, we want to hear from you.**

### About the research?

Latest information from the ACP and the BPS has highlighted that an increasing number of psychologists are leaving the NHS for private practice. It is suggested that one reason why psychologists are leaving due to 'lack of opportunities for promotion and progression' in the NHS. We want to hear your story!

### Why should I take part?

This research gives you a chance to share your experience and help other psychologists. We hope that this research will help inform the working practices to ensure higher staff retention and staff well-being.

### What does it involve?

One 60-minute online interview focusing on your experience of leaving the NHS.

### How do I sign up?

Please contact Klaudia Cebula at c042147m@student.staffs.ac.uk if you have any questions about the study or would like to take part.

## Appendix 5- Participant information sheet

**INFORMATION SHEET FOR PARTICIPANTS**

*Project Reference Number: [insert once provided by the university ethics committee]*

**Why do clinical psychologists leave the NHS for private practice?**

I would like to invite you to participate in this research project which forms part of my Professional Doctorate in Clinical Psychology research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

**What is the purpose of the study?**

Recent information published by the British Psychological Society (BPS) and the Association of Clinical Psychologists- UK (ACP-UK) has highlighted that more psychologists are leaving the NHS for private practice than at any other time. Previous research relating to reasons and experiences of practitioners leaving the NHS has focused on mental health nurses and other allied healthcare professionals. There has been no research into why clinical psychologists may be leaving the NHS and their experiences of this process. The current research aims to shed light onto this.

**Why have I been invited to take part?**

You have been invited to take part in this research as you are a qualified Clinical Psychologist who has left the NHS for private practice in the last 3 years.

**What will happen if I take part?**

This is a qualitative research. You will be asked to participate in one semi structured online interview over MS Teams. Interview questions will focus on exploring your experience of leaving the NHS. An example of questions you may be asked is: *'Can you tell me when you started to think about leaving the NHS for private practice?'*

Please note that consenting to participate in this research means you consent to the interview to be recorded. The researcher will inform you when the recording will start. Interview data will then be transcribed and analysed using thematic analysis. The interview may take around 30-60 minutes. Effort will be made to anonymise any identifiable data.

**Do I have to take part?**

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have

any questions that will help you make a decision about taking part. If you decide to take part we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

**What are the possible risks of taking part?**

Although care has been taken to minimise any risks during this study, some individuals may experience distress when discussing their memories and experiences on the topic. Please talk with the researcher if you require support following participation, please note that other support services will be available following the study should you require further support.

**What are the possible benefits of taking part?**

Although there is no direct or immediate benefits to you following participation in the study, we hope that the research will help to provide more insight into why clinical psychologists are leaving the NHS. We hope that in time this informs further research and may inform organisational change.

**Data handling and confidentiality**

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

Interview recordings will be kept on a password secure device and will further be protected by a password individually. The data will then be transcribed and recordings of interviews will be deleted. Transcriptions will be password protected. Care will be taken to anonymise any identifiable data, however please bear in mind that characteristics like being a clinical psychologist who has resigned from the NHS in the last 3 years will be part of the write up and dissemination of this research. You will not be asked to share identifiable information on your previous employment e.g. the names/addresses of the NHS Trust and specific service information. Should this information be mentioned as part of your answers to the interview questions, this will be removed in the transcription and analysis.

In line with Staffordshire University regulations, transcriptions of the interviews will be stored for 10 years after the end of the project, after which it will be destroyed. The data will be kept secure on a Staffordshire University Network Drive. Data will only be shared within the research team and will not be shared with any third parties.

**Data Protection Statement**

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

**What if I change my mind about taking part?**

You are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study within 6 weeks of the initial interview, after which withdrawal of your data will no longer be possible due to data being anonymised and included in final thesis.

If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study.

**What will happen to the results of the study?**

The study is part of the requirements to complete the Professional Doctorate in Clinical Psychology with the intention to be published in peer reviewed journals.

You have the choice if you would like to be contacted after the research project is completed, and if you would like to provide feedback on the research project, or receive a summary of the research report itself. You can select either opt in or opt out on the Consent Form to indicate your choice. If you opt in, your contact details will be kept securely on the University Network Drive for 3 months following the study completion in December 2025. Following this period your personal data will be erased.

**Who should I contact for further information?**

If you have any questions or require more information about this study, please contact me using the following contact details:

Klaudia Cebula
Trainee Clinical Psychologist
c042147m@student.staffs.ac.uk

**What if I have further questions, or if something goes wrong?**

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

**Dr Yvonne Melia**
**Thesis Supervisor**
**yvonne.melia@staffs.ac.uk**

**University Ethics Committee**
**Prof Sarahjane Jones**
**sarahjane.jones@staffs.ac.uk**

**Thank you for reading this information sheet and for considering taking part in this research.**

# Appendix 6- Consent Form

**Appendix 2. Research consent form**

**CONSENT FORM**

*Title of the study: Why are clinical psychologists leaving the NHS?*
*Name of the researcher: Klaudia Cebula*

Please read and complete this form carefully. If you are unsure about anything, please speak to the researcher. If you consent to participate in the study, please mark the appropriate responses and sign and date this declaration form.

| | YES | NO |
|---|---|---|
| The research study has been satisfactorily explained to me by the researcher verbally and/or in a written format. | ☐ | ☐ |
| I understand what the research will involve: A 30–60-minute online interview regarding the experience of leaving the NHS. This will be recorded and transcribed for analysis. | ☐ | ☐ |
| I understand that I may withdraw from this study at anytime, without giving an explanation. | ☐ | ☐ |
| I understand that I can withdraw my date up until 6 weeks from interview date, after which withdrawal of data will no longer be possible due to data being anonymised and included in final thesis. | ☐ | ☐ |
| I understand that all information about me will be treated in confidence and that any identifiable data will be removed. | ☐ | ☐ |
| I understand that any audio recording material will be stored securely and in line with the university regulations. | ☐ | ☐ |
| I understand that the researcher may discuss progress of research with the research supervisor at Staffordshire University. | ☐ | ☐ |
| I understand that anonymised data will be used as part of doctoral work and any subsequent publications. | ☐ | ☐ |
| I would like to be contacted after the research is completed. | ☐ | ☐ |

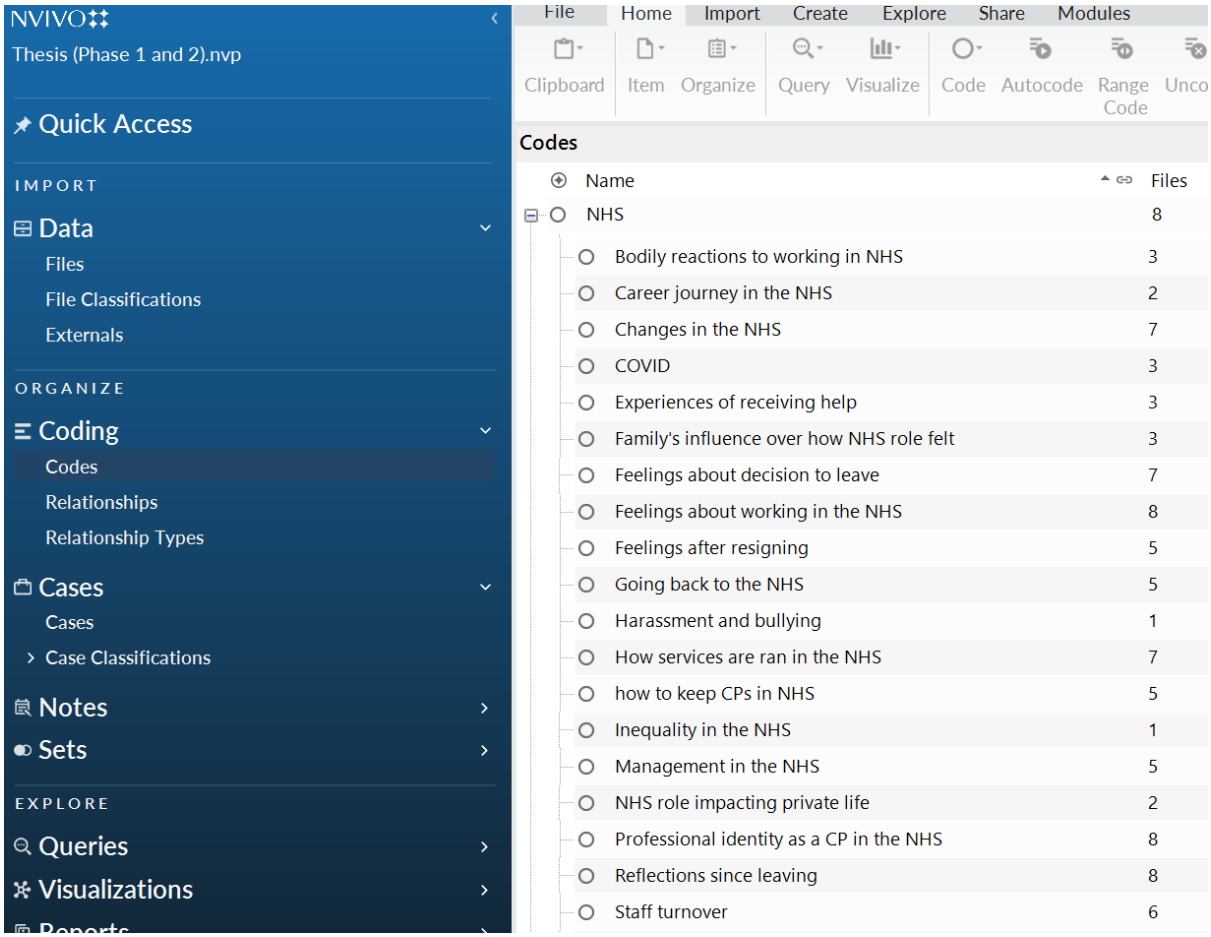
I freely give my consent to participate in this research study.

Signature: _____ Date: _____

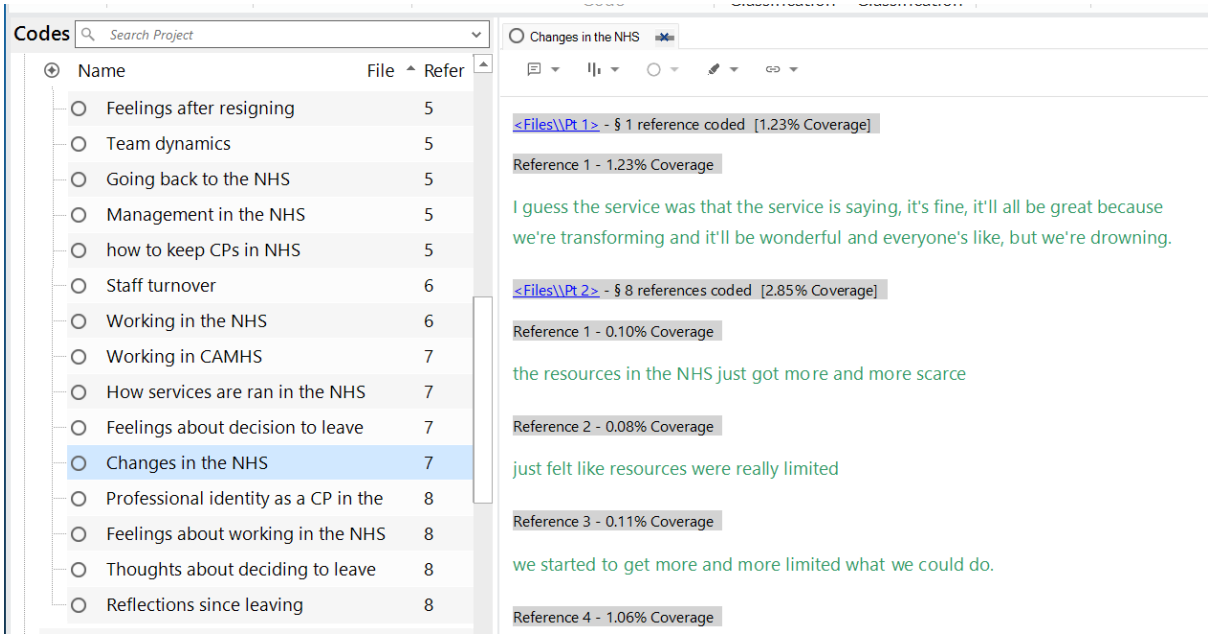
# Appendix 7- Audit of analytic process

## Familiarisation with data and generating initial codes

This is an example of the initial codes that were generated in the first two stages of data analysis (familiarisation and generating initial codes). This is not a complete list, but a selection to demonstrate the process. Each transcript was read, and new codes were created. If the same code could be used in a different transcript the data was coded under the same code. The number under 'Files' shows how many different participant transcripts used this code.



To further demonstrate this the following picture shows one of the codes in more details. The code of ‘Changes in the NHS’ has been opened. On the right-hand side, the raw data that went into this code is shown. This is data from interview with Samantha (Pt 1) and Megan (Pt 2).



### Generating themes

Codes were clustered into potential themes by sorting them into tables. After reviewing these, those with similar attributes were colour coded to form initial themes.

How do Clinical Psychologists describe and explain their reason to leave the NHS? **NHS experience**

| Cluster 1- Being a CP in the NHS | Cluster 2- NHS functioning | Cluster 3- 'This can't continue' | Cluster 4- Looking back |
|---|---|---|---|
| • Career journey though the NHS<br>• Professional identity as a CP | • Changes in the NHS<br>• How services are run in the NHS<br>• Management in the NHS<br>• Staff turnover | • Feelings about decision to leave<br>• Thoughts about deciding to leave | • Reflections since leaving<br>• Feelings after resigning |

| Cluster 5- Working in the NHS | Cluster 6- Private life | Cluster 7- When things go wrong | Cluster 8- We need help | Cluster 9- Not the end |
|---|---|---|---|---|
| • Supervision in the NHS<br>• Working in CAMHS<br>• Working in the NHS<br>• COVID<br>• Work aspects that didn't feel good<br>• NHS Values<br>• Team dynamics<br>• Feelings about working in the NHS | • Bodily reactions to working in the NHS<br>• Family's influence over how NHS role felt<br>• NHS role impacting private life<br>• Time off from the NHS | • Harassment and bullying<br>• Inequality in the NHS<br>• Whistleblowing | • Experiences of receiving help<br>• How to keep CPs in the NHS/what needs to change? | • Going back to the NHS |

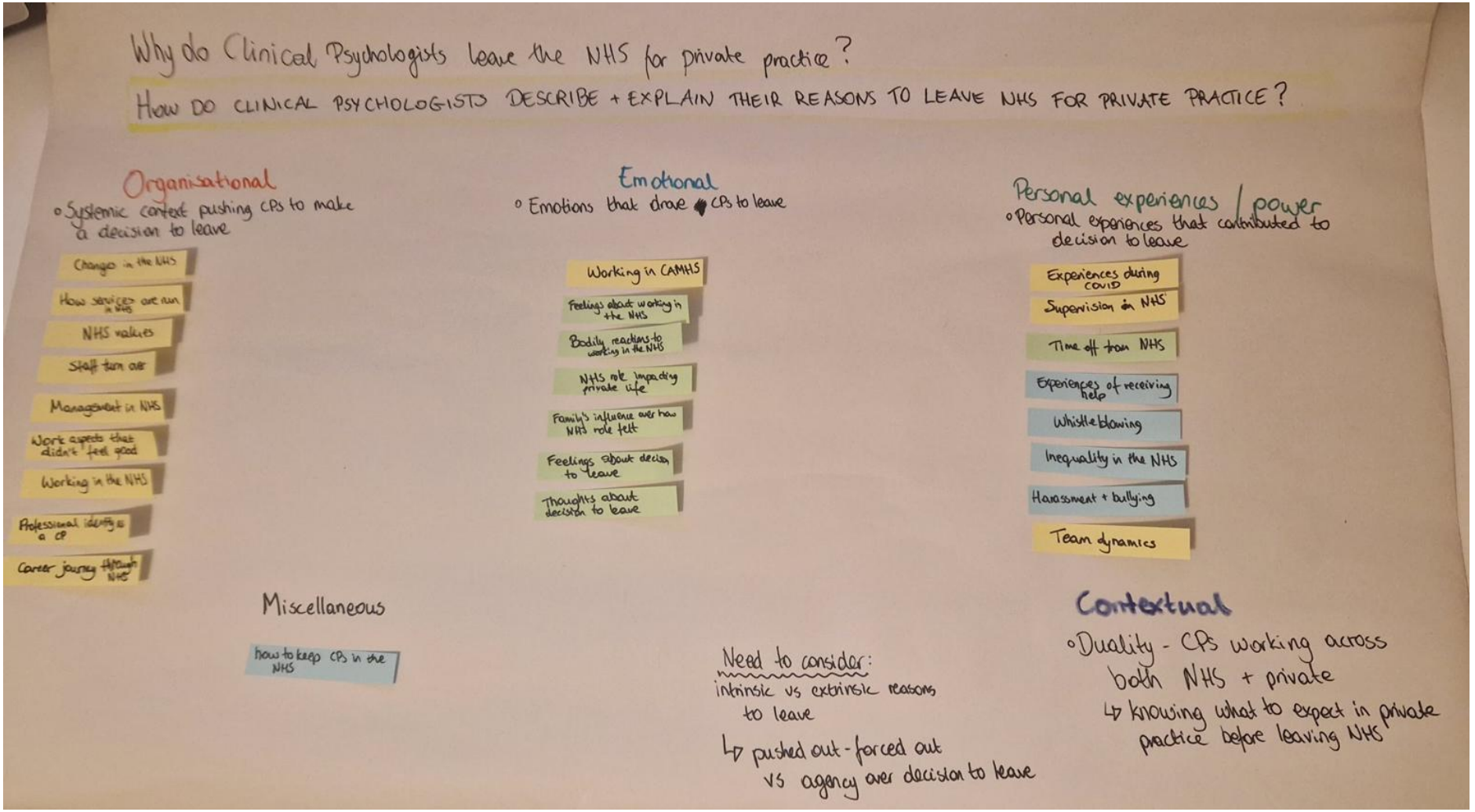
These were then clustered together into initial themes and sub-themes:

| **Cluster 1: System context** | |
|---|---|
| Organisational factors | • Changes in the NHS<br>• How services are run in the NHS<br>• Working in the NHS<br>• Working in CAMHS<br>• NHS Values<br>• Work aspects that didn't feel good<br>• Staff turnover<br>• Management in the NHS<br>• Team dynamics<br>• COVID |
| Being a psychologist in the NHS | • Professional identity as a CP<br>• Career journey in the NHS<br>• Supervision in the NHS |

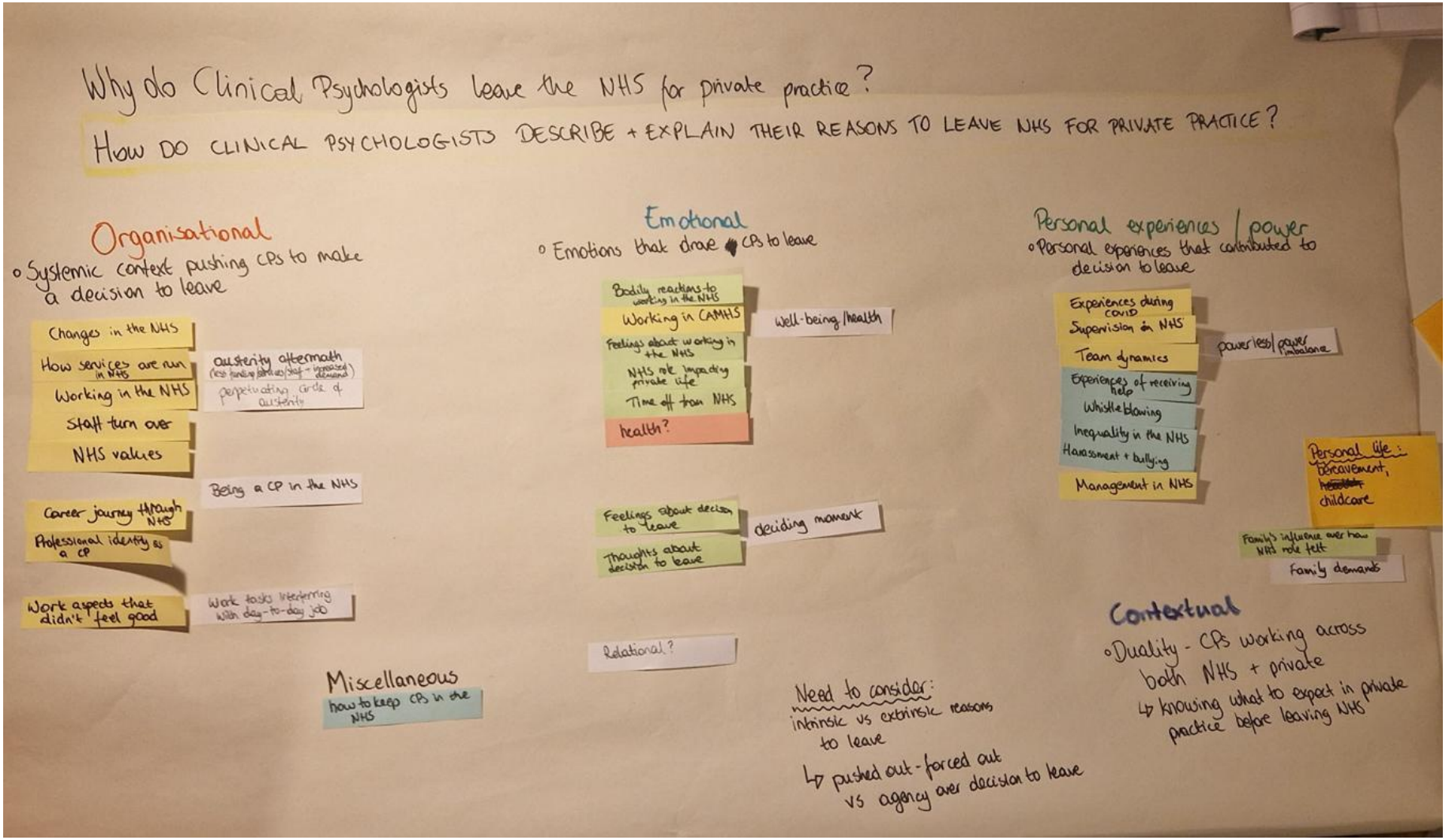
| **Cluster 2: Emotional experience** | |
|---|---|
| Emotions whilst working in the NHS | • Feelings about working in the NHS<br>• Time off from the NHS<br>• Bodily reactions to working in the NHS<br>• NHS role impacting private life |
| Emotions when deciding to leave | • Feelings about decision to leave<br>• Thoughts about deciding to leave |

| **Cluster 3: Personal experiences** | |
|---|---|
| • | • How to keep CPs in the NHS/what needs to change?<br>• Experiences of receiving help<br>• Whistleblowing<br>• Inequality in the NHS<br>• Harassment and bullying |

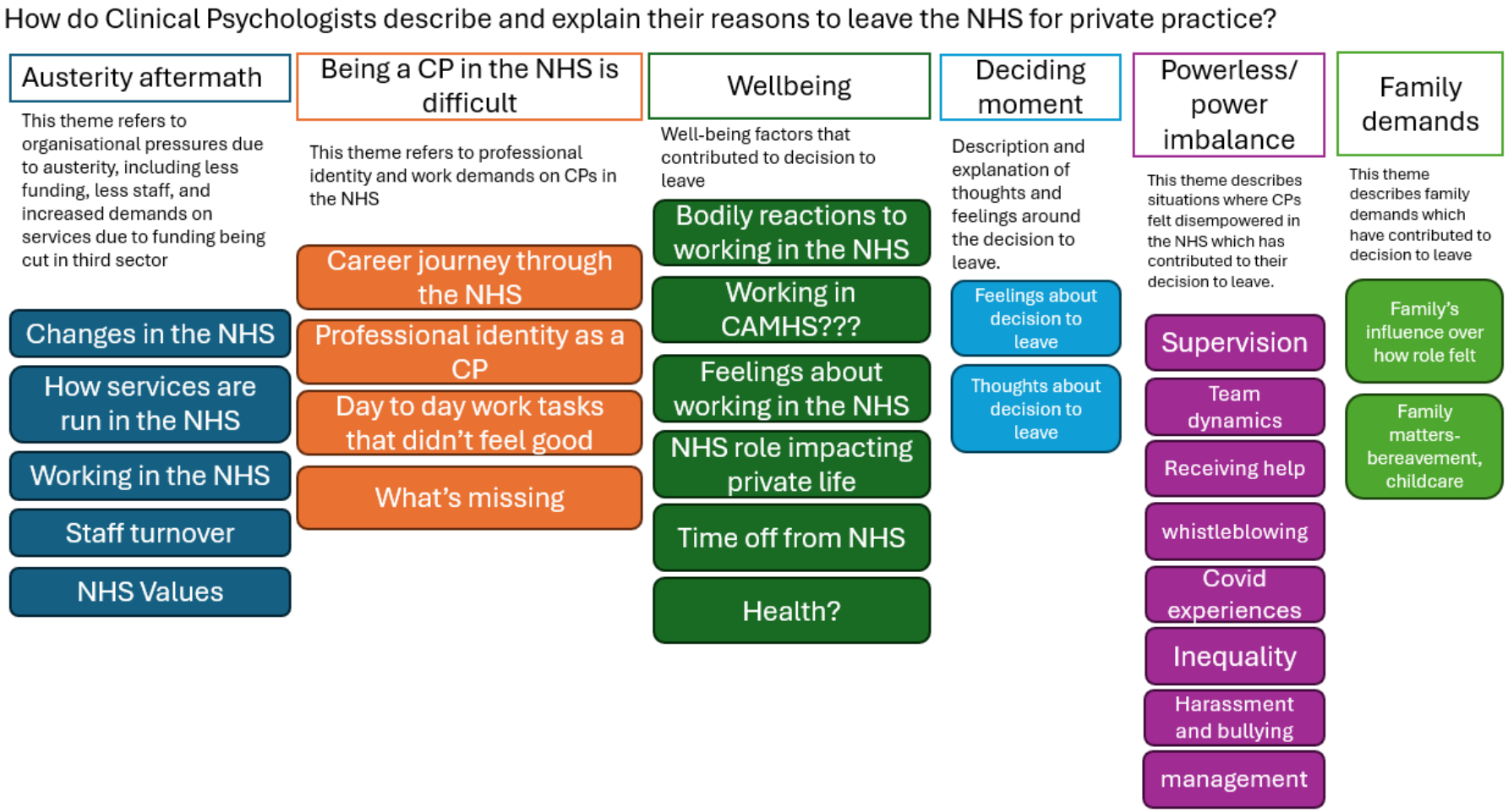
This was then handwritten out to get a better visual representation of this. Additional ideas like ‘contextual information’ or ‘need to consider’ were added to the bottom of the page to keep in mind through the analysis process.



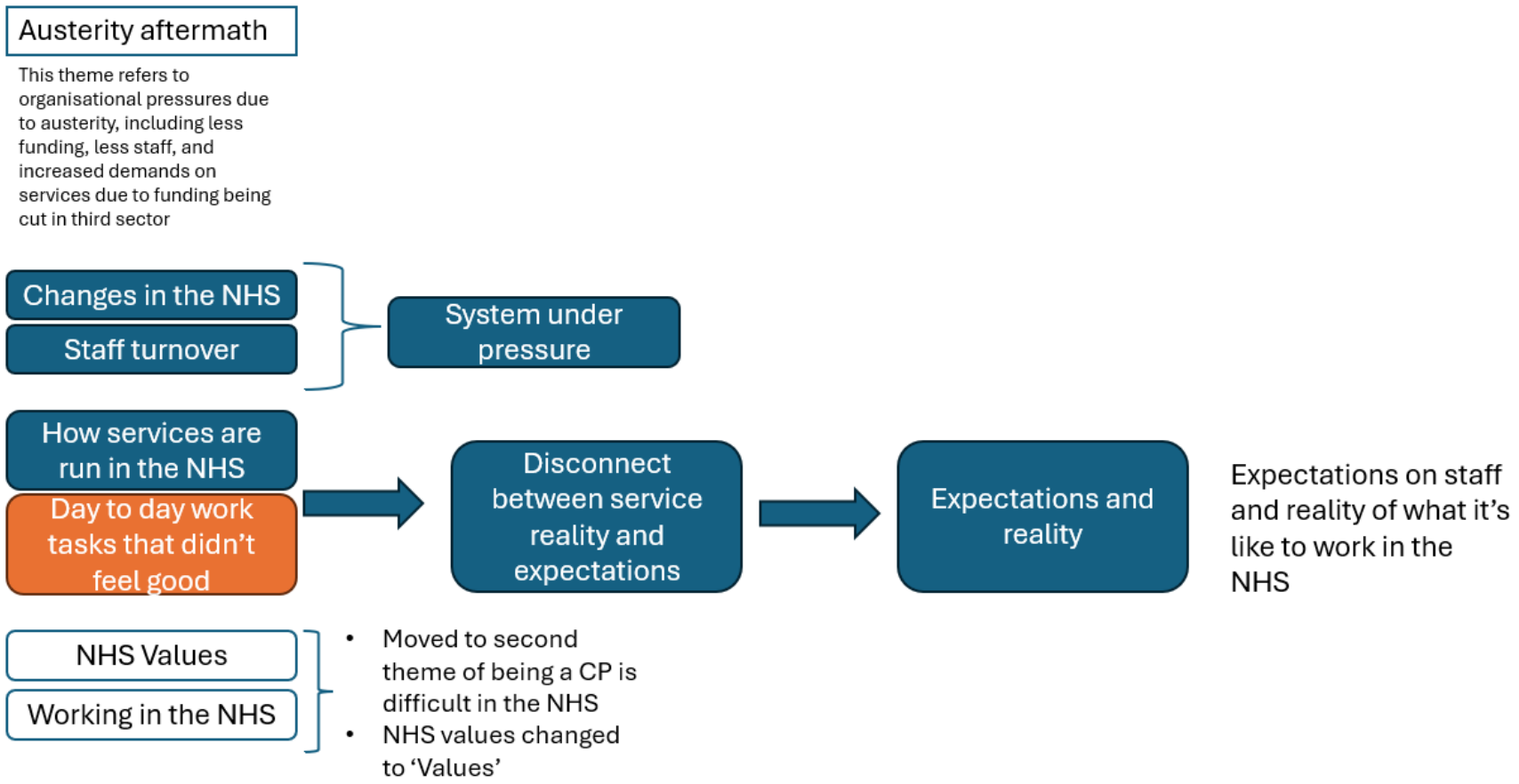
Themes were revisited and re-worked. New theme names and clusters were produced (white tags).



This was then transferred to the computer to make the process easier to read.

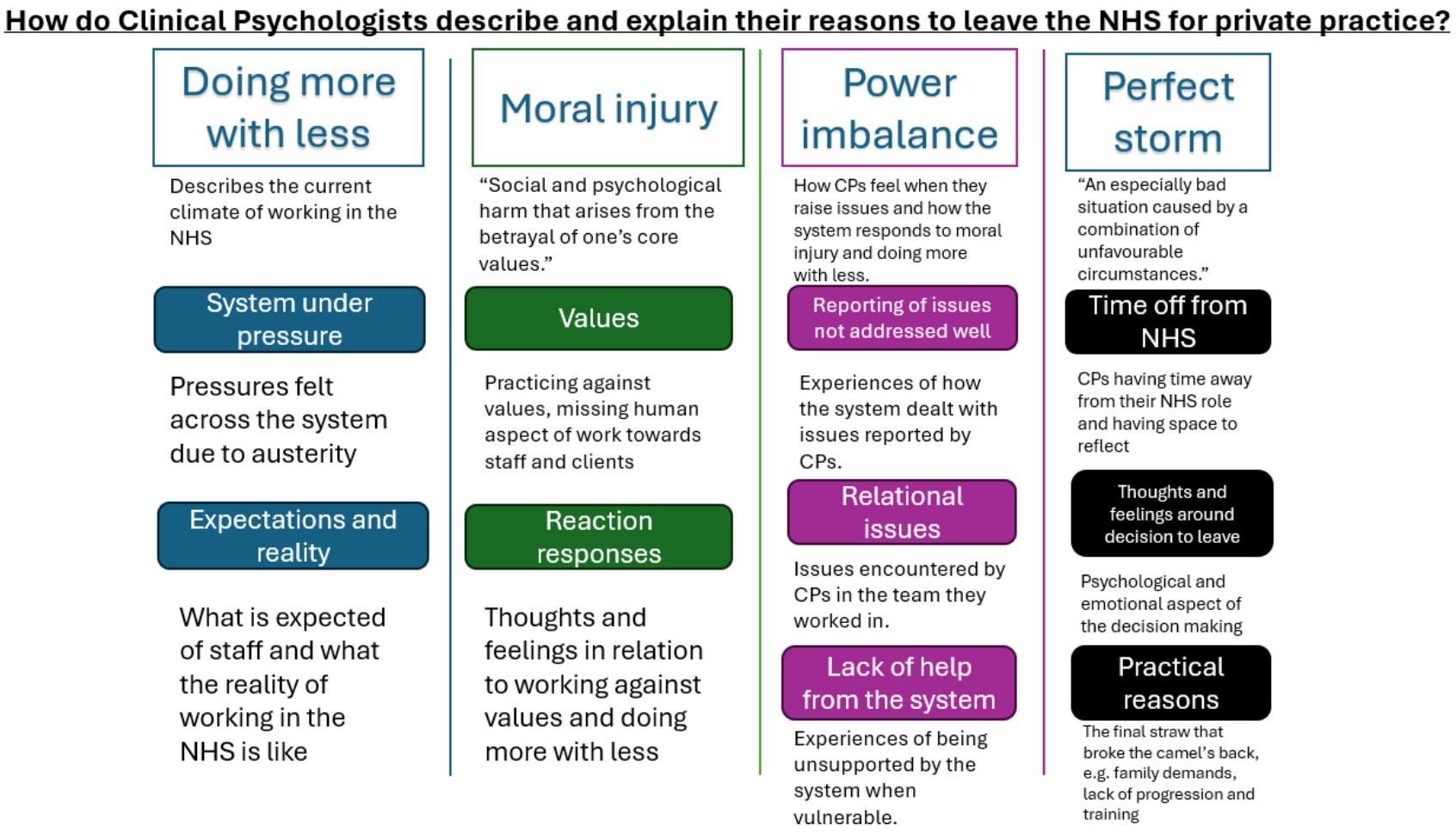


Each theme was considered separately. Some codes from other themes were moved across to different themes. The following picture shows the ‘Austerity aftermath’ theme and how this was re-worked as an example of the process that was undertaken with all themes. Here we can see that the first two codes of ‘changes in the NHS’ and ‘staff turnover’ were collapsed into ‘system under pressure’. ‘Day to day work didn’t feel good’ was brought in from the initial theme of ‘Being a CP in the NHS is difficult’. ‘How services are run in the NHS’ and ‘Day to day work didn’t feel good’ were collapsed into ‘Disconnect between service reality and expectations’, which was later reworked to be ‘Expectations and reality’. The rest of the codes were moved to the theme of ‘Being a CP in the NHS is difficult’. The rest of the themes and codes were reviewed and redefined, moved and collapsed where necessary.

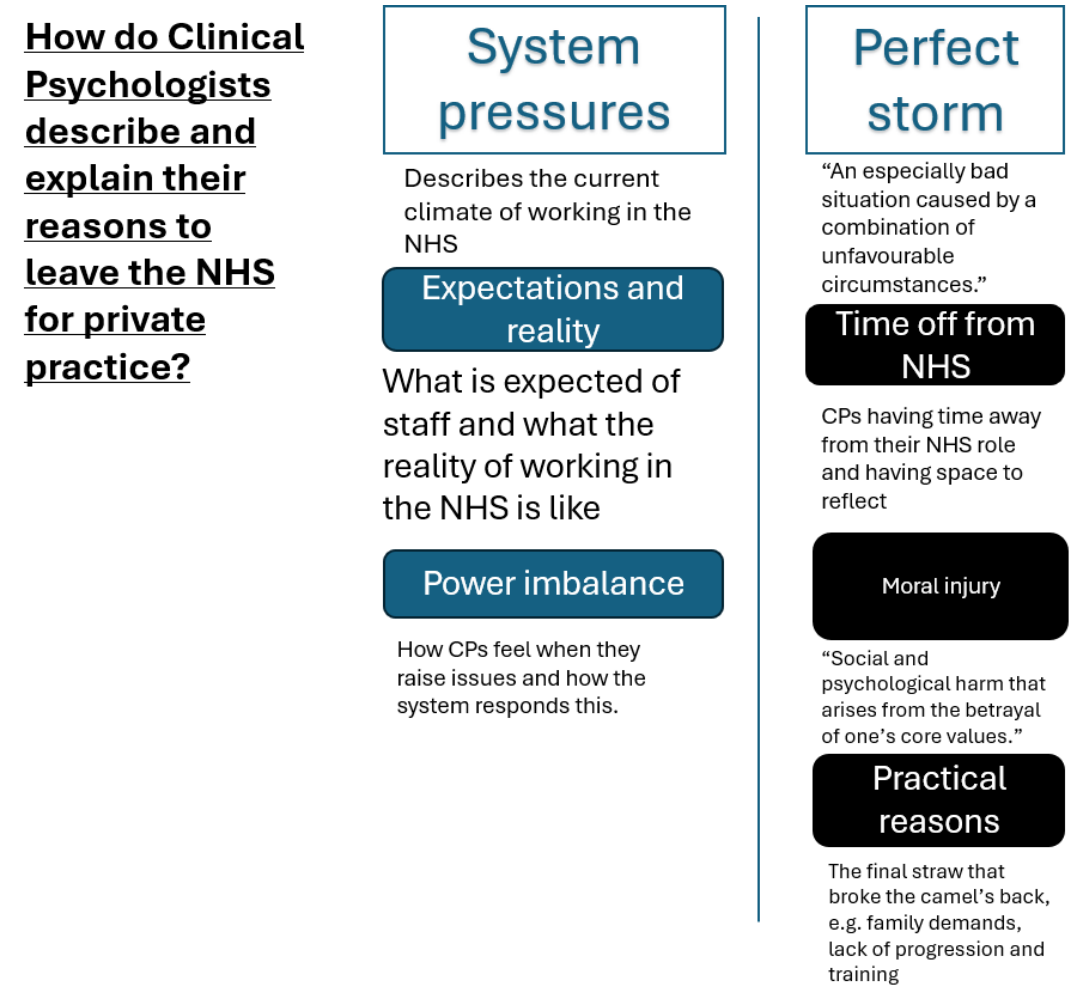

Austerity aftermath
This theme refers to organisational pressures due to austerity, including less funding, less staff, and increased demands on services due to funding being cut in third sector
Changes in the NHS
Staff turnover
System under pressure
How services are run in the NHS
Day to day work tasks that didn't feel good
Disconnect between service reality and expectations
Expectations and reality
Expectations on staff and reality of what it's like to work in the NHS
NHS Values
Working in the NHS
Moved to second theme of being a CP is difficult in the NHS
NHS values changed to 'Values'

## Reviewing potential themes

Following the above process the following picture shows what the result of the reviewing, re-defining, re-named, moving and collapsing of themes resulted in.



These were further reviewed by going back to the data and refining. This resulted in two themes and 5 subthemes.



## Defining and naming themes

Themes were defined and renamed, producing two themes and 5 sub-themes:

Table 2. Themes and sub-themes

| Theme | Definition | Sub-theme |
|---|---|---|
| **Unreciprocated dedication** | Efforts given to the organisation by CPs is not matched by the loyalty and commitment from the organisation | *Overwhelming expectations* |
| | | *Power imbalance* |
| **Perfect storm** | Combination of unfavourable circumstances that acted as a catalyst for the decision to leave | *Moral injury* |
| | | *Dawning realisation* |
| | | *A drive for control and autonomy* |

## Appendix 8- Further evidence for themes

| Main theme | Sub- themes | Participants | Further evidence for themes |
|---|---|---|---|
| **Unreciprocated dedication** | **Overwhelming Expectations** | Samantha | ‘The waits were increasing’<br>‘the risk, the complexity and what I actually felt like I could do as a psychologist or bring as a psychologist. That wasn't really there anymore.’<br>‘the team changed quite often and everyone was very stressed’<br>‘everyone was just really up against it’<br>‘the service is saying, it's fine, it'll all be great because we're transforming and it'll be wonderful and everyone's like, but we're drowning. So I think there was just this disconnect between service and what was actually happening’<br>‘lots of people are always leaving’<br>‘18 members of staff had left in the last year’<br>‘when I first left, they just lost six’; ‘there is a high turnover’ |
| | | Megan | ‘as years go on, you know, the resources in the NHS just got more and more scarce and it just… I, I would say I was either burn out or very close to burning out when I left’<br>‘in the NHS it just felt like resources were really limited’<br>‘we started to get more and more limited what we could do’<br>‘earlier on my career I could, you know, in terms of trying to get to know young people and trying to like, get spend time with them, I could just give them an appointment and just have an hour of not doing very much, just making them feel comfortable.’<br>‘the last 2-3 years, couldn't do that really. You just didn't have the time to do, ‘I'll see you for an hour’’<br>‘you just didn't have enough time to do things, very, very busy.’<br>‘when I was in my last post, you know, we… People came for therapy… People….You know, we could do long term therapy.’ |

‘I guess like the last year, you know, we're really encouraged not to let things drift to discharge if that was practical. I guess there was more pressure and awareness of that’

‘the culture of CAMHS it became more like we saw people that were at risk, there wasn't like, we'll see somebody for therapy because they, they've had a trauma’

‘the priority was people that were self-harming and risky. You're keeping people out of hospital.’

‘toward the last two years, three-years, keeping people out of hospital, those people got seen, keeping people in the area stopping out of area placement.’

‘if you just had a run of a mill of OCD that didn't put you at risk… They weren't prioritised because there's obviously people that would need to be seen because we were just so limited’

‘people left and weren’t replaced with right… Well with the same level of qualification’; ‘you were just rushed’

‘how am I going to fit that in when I've got like five other people to see that day’; ‘You just never got on top of your To Do List really.’

‘just always trying to justify getting money for my team and it's just … that just felt like draining. Just felt like I'm begging for money all the time. It just felt draining. It just felt like we'd never got enough money.’

‘I'm just exhausted. I think in terms of how I felt, you're just really never ending always, you know it quite easy to stay on your laptop. So when you're on hybrid, it's quite easy to know you finish at 4:00 but not finishing until to half five because you had things to finish off or somebody called you on Teams and needed some support.’

‘it just felt really like hard to switch off the laptop 'cause people need you, yeah, like your to do list never ending’

‘I'll do all this in my weekend to try and write a bid for more money or whatever, and actually it get nowhere or it could go back to, you know, the same, the same meetings.’

‘People always asking for more, including the family, but then I also knew the family only ask because they, they need it.’

| | | |
|---|---|---|
| | Tom | ‘I was working with very complex families, so, you know, it didn't feel like we're ever discharging anymore with a good outcome.’<br>‘I do remember having a strong word in my supervisor, like I'm not doing this thing. I'm not going to write another bid on a Saturday anymore, because I've got kids and I want to spend time with them and stuff like that. Well, they would never say it, they was also an expectation that you do work outside your hours and she kind of did make it very plain on that occasion, that well who else was going to do it’<br>‘there was kind of unsaid expectation that you do work outside if, if there is a deadline’<br>‘going to meeting because you have to rather than you- even if we got nothing to contribute’<br>‘there’s endless amounts of meetings with the NHS’<br>‘you get send to meetings from the off really, I suppose, but they're just pretty repetitive with no outcomes very often.’<br>‘it just felt never ending’<br>‘it's just how stressful it is. It's just the amount of work’<br>‘the NHS, is very stressful’<br>‘Very kind of like they demand on your all time’<br>‘there was that expectation that that was very much drilled into you that you would continue to work in the NHS partly because the NHS obviously paid for the entire five years, which was a lot of money, but I guess partly because you as one of these specialists, you've been working within your local health board for five years minimum, so by that point, there was a kind of a reputation or a relationship with the staff that worked there and they kind of held you a little bit higher.’<br>‘during my training in, in my opinion that's when things deteriorated. So there was no longer a name badge given to you. There was no longer your own room, but they actually, you know, started to in invent this concept of hot desking so no personal private space to do anything’<br>‘access to your own desk, your own laptop resources, etcetera. All of that became very, very limited, and it did become a struggle’ |

‘our particular health board went into special measures. So what that meant was we were expected to report to the government on a weekly basis in terms of our clinical contacts. And if we didn't meet those contacts, why?’
‘it went from a very sort of relaxed, you know, clinical psychologist had a had a good reputation to, you know, not really being valued and also almost the opposite.’
‘People were now asking you why you haven't met, you know, the minimum criteria, clinical contacts, etcetera. So it became very, very different, very, very stressful, very, very high pressures.’
‘always being told you've only got 12 sessions. Why are you seeing this person for 13? It was very, very difficult to work’
‘the waiting list got longer, I was had like a 2 1/2 year waiting list. You know the person would come and see you and you would be the first person that that person could see within the service understandably, so the first session was really listening to the clients understandably be very angry and very frustrated about having to wait and their conditions have got significantly worse repeatedly having to apologise for that and then also say and by the way, whereas I would have had flexibility to see you for 20 sessions a couple of years ago, we've actually only got 12 and we're really, excuse me, we're really encouraged to review people after six actually to check whether you do need those extra six to make, it became very as if you were almost managing clients expectations unfairly and because of the budget cuts and what was coming down, so I guess in terms of your therapeutic relationship with clients, it had a huge impact on that’
‘I always noticed myself trying to problem solve ways in, in terms of making this work. So in terms of the effort, it was almost doubled because I would be going around saying, well, could this person be transferred onto, let's say, a CPN, community psychiatric nurse or, you know, could they be reviewed regularly by psychiatry and still stay in the team? Could they do a psychologically informed group by one of the nurses? And it was almost like it's almost like haggling with the client. You know, I can't see you, but would you do this in order to keep you safe in order to prevent risk from deteriorating?’

| | |
|---|---|
| Ellie | ‘it kind of did feel you were almost trying to kind of manage that disappointment with them.’<br>‘there's that kind of buzzword, isn't there, of revolving door patients but I think what happened was people weren't getting better and so they were coming back into the service, you know, they were utilising that kind of six month period of of wait and then almost writing in their diaries as soon as six months was over. Let me come back and get a top up, which is what they needed from the from the start.’<br>‘there would be a lot of not necessarily physical violence. I I once had sort of shoes thrown at me, but more kind of the the verbal aggression, the verbal violence, you know, I’m not well, you're you're a shit therapist, how dare you discharge me. And then the tears and the self-harm. So it you know it did feel quite detrimental to some clients at least.’<br>‘the reason why I could manage very, very difficult and demanding clients in the CMHT was because that wasn't just my role at the start, I had other things that I could go to like doing bits of service development or you know, I love to teach and I used to teach all the the nurses different sort of psychologically informed strategies, all that kind of stuff. And again, part of the reason for leaving was that was all taken away from me.’<br>‘when you're seeing clients, a lot of them obviously in the cmht have experienced horrific trauma, to kind of have to hear that as a therapist, hour after hour after hour, it's not sustainable. If you're not kind of, you know, balancing that with other things, you could pay attention to.’<br>‘It was literally seeing clients back-to-back’<br>‘You all have to do this. You all have to do this amount of people. We're all different and we all have different skills. And it just wasn't recognised or utilised’<br>‘it's just the same old shit in a different kind of clothing.’<br>‘it was just causing people to burn out sitting there every Monday for 4 hours trying to go through all the referrals and knowing that every single one of them would have to wait so long’ |

‘all the Tier 2 voluntary sector stuff had lost all of their funding. So all the other services that would do the early help had just disappeared so suddenly it was almost as if you could, you would only be seen by CAMHS if you, if you were threatening to kill yourself or self harm’
‘I survived it by moving to a different team’
‘the service that I was working in decided to redesign again because it's just trying to keep making a new bag out of less material’
‘I think generic CAMHS is pretty brutal’
‘staff changes and people going off sick’
‘We had capacity for, we had enough staff to have capacity for like 5 assessments a month, but we were getting 5 referrals a week’
‘there was always a debate about whether we should be working with parents or not. And I feel really strongly we should. That should be the first port of intervention. But you're not. You're only allowed to work with parents if it's with regard to if you're doing parenting interventions or you're doing parent child work, you can't... ‘
‘you're kind of just stuck a lot of the time’
‘12 sessions CBT isn't going to solve the housing crisis or… Unemployment, so social stuff that maintains mental health problems.’
‘feeling like I had to say yes to everything and drowning in the work’
‘I'm thinking I can do this. I could do that or I could kill myself and I remember being like that wasn't my thought because I didn't... I wasn't suicidal. I didn't want to die. I was very certain about that. But it was definitely somebody else's thought that got into my head and gone into my body.’
‘it's the trauma of the work kind of sits in you’
‘you just sit in these in this, in this fish bowl of that work and it just it can't help but kind of into your head and your body’
‘you have an entire organisation that's run by people in the helping profession, majority female. A lot of whom will have additional caring duties because we continue to have stark inequality when it comes to… women tend to take on much more of the helping professions to and the caregiving duties, whereas men don't. And so

| | |
|---|---|
| Tamara | therefore, the women who are really good at the job will get burnt out quicker and will not be able to stay in working.’<br>‘it was exhausting trying to get all the all the admin done. It was never. It always took longer than actually… actually was’<br>‘managing risk one at the expense of anything else’<br>‘you couldn't really pinpoint where your job ended and what, what were your responsibilities were and who did what.’<br>‘I think we spent a lot of time managing dynamics of people being threatened or, or, or power kind of dynamics. Which got in the way of doing useful work.’<br>‘we were ending up managing people to make sure that the professionals felt included and listened to and valued to such an extent that you couldn’t say, well actually I disagree and I think you know, this is what this family needs.’<br>‘seeing families in massive distress where you couldn't offer them support’<br>‘eats away at you over time that you can do it and you can begin to be resilient. But it does affect your resilience after a while.’<br>‘There were difficult dynamics in teams personalities. Yeah. Things that I couldn't find a way to make better because they were very historical. And even if you change some people in the service, somehow the same patterns of behaviour got picked up and replayed.’<br>‘even taking half an hour for lunch, if somebody rang me in that half an hour, I'd feel terrible, like I wasn't where I was supposed to be’<br>‘when I did get a consultant post I jumped into what I'd been waiting for, for years and I found massive more stress masses, more responsibility for exactly the same amount of money that I've been on for the previous ten years, and the prospect of being on that for five more years before I got an increase in salary was really not very attractive’<br>‘I've got to sit through this for five years before there's a there's a gain for my family, you know, like it was a gain for me because I got a challenge and I got some career progression, but actually there's nothing in it for anyone else except me being more stressed, more tired and working more hours for nothing.’ |

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| Molly | ‘I think in the NHS it was that it was the unfairness of, you know, what it felt, like I was being used I think, so that the desperation to get a consultant posts that meant that they would then pile on so much more and yet they haven't lost anything and I still the on the same amount’<br>‘a lack of trust, so much pressure and stress. People couldn't possibly do what they're being asked to do anymore, and the more people that left, the more likely it was that everyone else would go, because you know, there's, there's even fewer people to do all of the work and the demands never changed.’<br>‘This this is what you said we needed to do if we were at capacity, if we had all our staff vacancies filled at half capacity, we can surely, all you can expect is half the work. But that isn't how it was received. Still have to do all the work with half the people and then the other people went off sick and because they were so stressed’<br>‘it's got something to do with how money, resources, contracts are managed and who manages them. Everything is so ring fenced, tightly held on to. As I said, self-serving the organisation or the government or whatever, wherever this, you know, lands, you keep pushing it further and further out.’<br>‘It's all about numbers, less about human beings’<br>‘It's very hard to hire people. So, I think lots of people don't have to be as good to be hired’<br>‘There was no time to process anything. I, I heard the most horrific stories of child abuse, several times per day and there was… there was no space to make sense of it, to process it. It was so incredibly fast-paced.’<br>‘no time to process the horrific stories that I heard. I remember I used to go home and just cry. Just… not for me, but more kind of… I cried for the kids whose stories that I heard that I was deeply impacted by.’<br>‘in CAMHS I felt really alone with all the risk, which was that was quite terrifying.’<br>‘that was a massive issue in CAMHS that we were in one room and I think it was quite a small room and at one point I counted 20 people there. You know, I had had somebody call me distressed matter saying, ‘Oh my, my daughter put the ligature around her neck. What do I do? What do I do? I'm like, I don't know, you know, call |

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| Mark | ambulance or call the police, I don't know'. And then the person next to me, I could hear their conversation. You know, there's some next to me I could hear… And I just couldn't focus. I couldn't process things, so I used to go home after whole day of work and then do all of my admin. This is working ridiculous hours because I couldn't get my admin, my letters and my notes done in the office'<br>'my psychological health was really poor when I was in CAMHS, I used to cry. Every Tuesday I cried because that's what my assessment clinic. So I would see between two and four young people have been horrifically abused, you know, sexually, physically, just had horrible experiences and I was... I had an hour and a half assessment, then I was supposed to do notes, but it couldn't do notes because the phones were ringing and everything. And then I went into another assessment, and then that finished. And then we were supposed to have an MDT'<br>'there were four assessments booked and then we had an MDT, which was one hour long and we were supposed to within this one hour. We're supposed to decide, you know, treatment pathway for all of these highly complex kids. That's 15 minutes, you know for each child'<br>'I just remember I used to leave the office at 5:00 or, like, 5:15 and just cry while I was going home. And I, I felt horrible. I felt like what did I sign, sign myself up to? Why did I even qualify?'<br>'I think after a few months I didn't even want to be psychologist anymore. I just thought I don't want to do this.'<br>'our caseloads went up like threefold, like there were three times as many referrals, or four times as many referrals'<br>'I didn't have an opportunity to do it much in my job and that I was actually quite underutilised in my role. And I only realised that after I started doing therapy in private practise.'<br>'business managers who, who weren't clinicians leaning on me to discharge clients.'<br>'And I felt like I was having to juggle certain things because I'm practical in knowing that there are big waiting lists and we have to ensure that people are seen in a timely way and that we can't have, you know, open-ended psychotherapy' |

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| Kate | ‘The system is too much about putting pressure upon people, putting pressure upon clients and clinicians and, and about boxing everyone and, and meeting targets and things not being human and relational enough.’<br>‘there weren't enough therapy rooms to provide psychotherapy and, and you know, when you when you hear about tales about them having spent 300 million on some new build. And I'm just thinking can you just spend 10 grand on you know? Refurbishing some therapy rooms or extending the building a little bit, you know, and again it goes back to my point about sort of medical model. How it historical stuff in that all the psychiatrists had their own rooms. You know, and we'll be scrimping around, you know, like, oh, right, oh, can I get a room at that time for an hour or we've got, like, you know, 2 rooms between the whole clinical psychology team. All the psychiatrists have got a room each, and they lock it when they're not there.’<br>‘By the time we were back, we're at 200 and then a year after that, we're at 500. So again, there's just that general that's changed in terms of waiting list, waiting times, referral numbers has been a big difference.’<br>‘Our waiting times are still about a year for ASD. In some places it's seven years, but it still wasn't kind of what I wanted to be able to provide.’<br>‘massively increasing demands.’<br>‘It never matched what we, what we needed’<br>‘Parents just weren't happy with we're not assessing, we're not diagnosing. So again, that's a bit of a knock when you think I've done such, absolutely pulled out all the stops there and so on formally complained or I know that my team member, we've done XY and we've done everything and they've complained.’<br>‘we just finished off 1 complaint and then the next one would land in the inbox and then we'll deal with that one and then the next ones in the inbox. So again, that sense of it doesn't quite fit with working so, so hard to then just get complaint, complaint, complaint. It didn't quite fit with, and what I want it to be to be doing.’<br>‘just general NHS bureaucracy like, I remember I'd made, I pretty much made my decision, but we're in the managers meeting, we have a risk register of the risks in the, in the service we're going over and I was like, I'm sure we'd finish that and we'd |

done that one last month. It was finished and one of the my colleagues said, ‘Oh yeah, no, but what has to happen? So we have to put it from this spreadsheet onto a different spreadsheet before we can take it off this spreadsheet’. And I was just like: ‘really? OK, so it's got to go from that spreadsheet to another spreadsheet to go from this meeting to another meeting to come back to this meeting to go off that spreadsheet. And I was like, oh, right, this doesn't, this isn't helping those kids on that waiting list, is it doing all this sort of stuff?’’

‘I had done a huge piece of work to make a new referral form. I've worked with parent/carer forum. I've got two SENCO focus groups. I'd worked with a young autistic person. I've been to other forums to… such a lovely co-produced referral. And we're ready to launch this new service. We're ready to go. And then the form had to go to some other sort of policy meeting in the, the whatever to get signed off, and that again, most of things which are massively delayed it. Or they have some questions about it that we'd already like given them all the answers to. So like that, you're the one thing holding us up now and I joined a meeting to ask a few questions, to answer a few questions. Was meant to go on like at the beginning, they didn't realise that we'd appeared in this meeting, left us in two hours. I sat through that very boring policy meeting for at the end. Then to be like, oh, we just have this one question. Yeah, that's all fine. But that could that, that delayed us maybe about 3 months for it to go to that one meeting.’

‘I become more and more aware of that are holding me back, us back, from actually I'm here to help these kids. And doing all these bits and pieces isn't doing anything to help little Billy. He's been waiting two years for his ADHD assessment and just go sort of all that red tape, those steps and things that you just think this isn't… I understand some of it that needs to happen but it was just getting a bit much in terms of all that NHS bureaucracy.’

‘it's things like even just like the systems the amount of time it takes to record an e-mail trail, a telephone call and a quick teams meeting on SystmOne takes longer than doing the actual piece of work’

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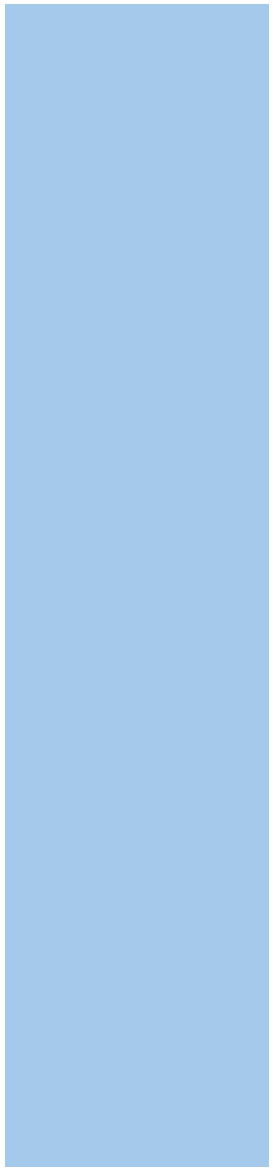
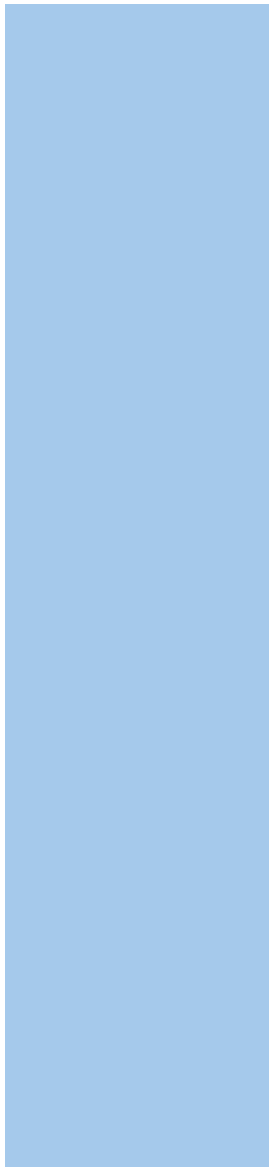
| | | ‘clinical systems are taking too much time, that I could be doing other things or the, the time it takes versus the value that it adds’ |
| **Power Imbalance** | Samantha | ‘wider service clinical leads, we didn't necessarily see eye to eye with at times’<br>‘me and that other colleague did end up whistle blowing on the way out’<br>‘fear around that as well and like repercussions’ |
| | Megan | ‘we were kind of pressured to give in to complain rather than not, rather than feeling like the manager, managers had our back’<br>‘some people felt very supported’<br>‘Some people know, almost felt bullied’<br>‘slightly odd kind of management decision that seems like it could be a grievence or bullying or very like, yeah just some kind of questionable management decisions’<br>‘questionable decisions that you know? Where that involved the whole team, but the team, the whole team, wasn’t consulted on it.’<br>‘there were a lot of training and lots of supervision to do when no one was really taking ownership of that’<br>‘some people were employed and actually it wasn't really thought through who was going to supervise them and who can take ownership of their induction and their training’<br>‘a few new people that came and that they felt quite lost because they weren't really contained’<br>‘when you've employed by a big, a bigger team that actually then didn't really think through your supervision and your training and how much induction you need that, you know I guess, I didn't really work out for anyone, like for the team and for the person.’ |
| | Tom | ‘it was just client after client after client back-to-back and I said where is the the time for research, self-reflection, all that kind of stuff and I remember very specifically, she said times have changed, Tom, this is a purely clinical role and this was an 8A not a seven. It's a purely clinical role if you want to do research go work for the university’ |



‘during meetings they they implemented what they had to, they were, there was all this always this kind of narrative: I'm really sorry, but it's just what we have to do and I'm not sure how much they did stand up for us.’
‘the head of service calling us kind of shop floor workers, you know us on the shop floor and it just felt very kind of demeaning’
‘it got to the point where management was rated so low that we we actually had to invent these staff well-being groups and get external agencies to come and facilitate them because it was just rock bottom in terms of how we felt about managers kind of caring for us and giving us what we need. It was all kind of tick box exercises I when the well-being groups were made three years later, I hadn't seen a single change. It was a complete waste of time and money, but I guess if you're reporting to the government it looks very good, doesn't it? If you've got these staff well-being groups, they they didn't change a thing.’
‘the onus was on us to to tell them what we wanted and then they very much came back and says, well, we don't have the budget for that or this is not, this is the job, not a holiday’
‘I was sexually harassed by a member of staff, not, not a client’
‘this individual was stacked on the spot for another offence, so she kind of left the service, but in terms of what I had experienced, that certainly wasn't resolved’
‘it wasn't dealt with partly because she'd left, it did feel a bit kind of unresolved.’
‘there was other sort of bits of bullying as well’
‘my manager, who was fairly new to the service kind of asked for a meeting and she basically said to me, I think the comments that you're saying n our team meetings go a little bit deeper than just what you should be saying. I think it's a personal attack on me basically, so what the manager was saying and I said to her, I'm I'm really sorry, I mean, if if there's if there are issues in the service which there were, I am going to speak my mind and tell you but I really don't think I've said anything that was a personal attack and you know I said to I'm really sorry if I have, would you be able to give me some examples and she thought for quite a long time, actually. And she turned around and said, Tom, I'm really sorry, but I can't, I can't give you any and I



said, well, if if you're kind of going to bring me up for personally attacking you and you can't give me one single example, I think that's really unfair and she said it's it's just, it's just the way it comes across. So I said, OK, that's fine. I'll, I'll go away and I'm, I won't say what you said, but I'm going to speak to my colleagues and and just ask for their opinion on how I am in, in kind of meetings and all of them said absolutely not, they said, if anything, I think you're quite tame given what we're going through, I mean, I had another meeting with her and again I said, have you thought of any examples, because I really can't think about what you're talking about, and again, she said no.'

'I wouldn't say it was bullying, but I've I've never been spoken to like that and if they were valid reasons, absolutely fine, I would take that on the shoulders, but it was just that sense of you're attacking me, but I can't tell you why and again, that really distorted the kind of the relationship with with management.'

'Managers weren't really interested in your personal development.'

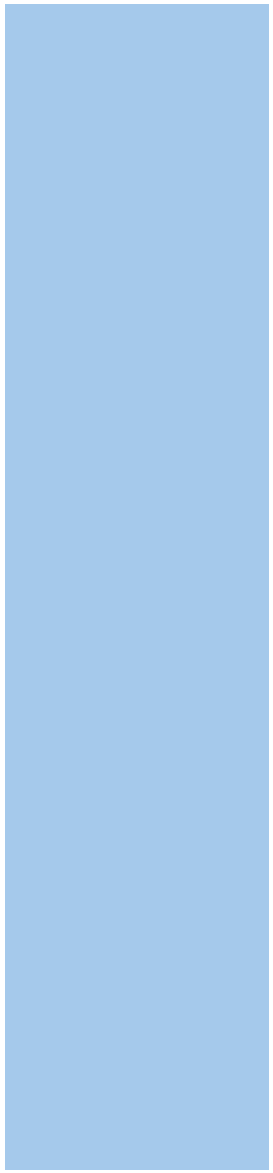
'I spoke to management and said I can't be in an environment where I'm working with, you know, chaotic people. No disrespect, but chaotic people.'

'That are taking inappropriate risks and probably are more likely to come in with COVID because they're not listening to the rules. You know, again, perfectly understandable. It wasn't supported at the time'

'We were breathing in all sorts and I took the decision to actually walk out. I said I can't be here, I'm more than happy to work from home. I'm more than happy to ring clients from home, but I can't be in a hospital environment. I'm really glad I did because I'm I was told by management, there was nothing that they could do to support this and they would have to report it to HR and there was a chance that I would be disciplined or sacked or whatever.'

'a couple of weeks later, everybody was told to to lock down so they they did apologise for that. Again, I just felt very unsupported. Two people in my team died.'

'just that lack of individual difference and understanding that, you know, some people are going to be more resilient, but if you've got a recognised health condition that makes you extremely vulnerable. And that really wasn't listened to'



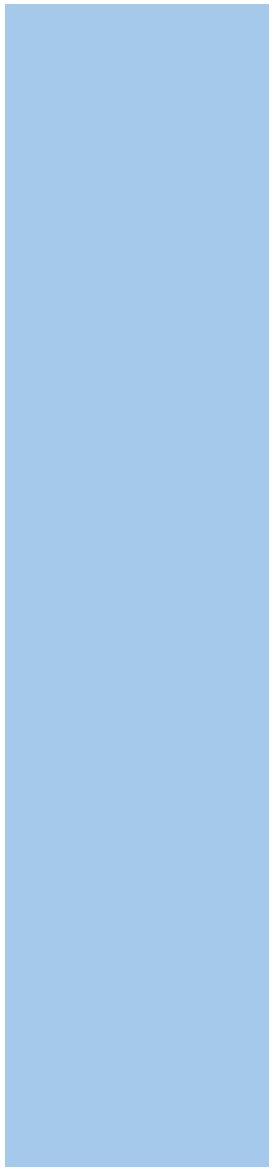
‘every month I sent an e-mail to my manager saying I can't cope. I'm literally doing the job of two people here’
‘I sent these emails repeatedly for about 6 months and all I got back was we are recruiting, nobody's applying or nobody's suitable, you know, but there's nothing else we can do. So I I suggested things like, you know, bringing in someone from the other team or getting temporary bank psychologists like loads and loads of suggestions. None of them will listen to. And again, I just felt like I couldn't continue to do the job of three people a year later I was just burnt out basically.’
‘there was absolutely nothing that management came came back with.’
‘It was. It was very much. This is all we can kind of offer you in that role’
‘I had that job planning meeting and my manager literally just filled it with clients and says you can't do anything else for the next year.’
all the the training and the skills we've got to just be a therapist and not utilise all our skills.’
‘my head of service. I never once saw her. Like she never came down and I mean, she works in the same hospital for the same department. She never once came down to the office and just said hi.’
‘more senior management never saw them, but we would only see them if a we'd done something wrong,’
‘No communication. And then feeling very much like you were on the shop floor and you didn't have permission to seek sort of higher advice.’

Ellie

‘my very first my locum post was not well supervised’
‘I started to have ideas about how I think wanted things run, but I wasn't necessarily allowed to do those.’
‘8B post and that was a bit of a baptism, baptism of fire’
‘I also knew from being in leadership that anything that people really needed we couldn't offer because we're understaffed’

Tamara

‘I think we spent a lot of time managing dynamics of people being threatened or, or, or power kind of dynamics. Which got in the way of doing useful work. I'm being able to be honest about what we thought about what helps and what doesn't help. Which



became hard and tiring and actually took me away, took the focus away from what we were supposed to be doing. So we were ending up managing people to make sure that the professionals felt included and listened to and valued to such an extent that you couldn't say, well actually I disagree and I think you know, this is what this family needs.'

'supervision sometimes it didn't happen or somebody forgot, or it kept changing because staff retention was so low that roles people kept moving in and out of different roles, and you'd be well, who's my supervisor now?'

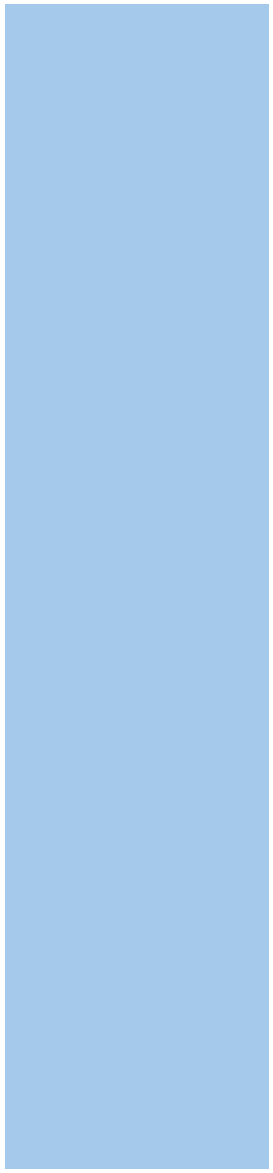
'Sometimes I had a lot of autonomy, but no power, so I might have lots of ideas about what I thought needed to happen, but couldn't make them happen, so you know, so sort of independence to think about them. But when you get need resources or you need a system process to change there was no capacity for the wider service to think about that'

'If you've got such, you know, you need to prove that this week you've done so many numbers as a team and you've seen so many people and you've discharged this many. If you take a couple of days out of that then, yeah, somebody else has got to make up for it, and that's feels also like, didn't I feel a bit guilty about taking that time out…'

'I think there was a lack of transparency, lack of honesty about that, so people were so threatened within the organisation that you couldn't speak of it.'

'it was fixable, but not whilst people were frightened and nobody dare say that.'

'It felt like…. the organisation, what people within the organisation were so threated themselves that they pushed blame around to other people. And so it didn't feel safe because as soon as you push a point that might trigger someone to be threatened. There was a risk that that would come back to you and that would almost become like a threat that, that people would be criticising you or turning like back on what you weren't doing very well or almost, you know, I don't even know whether this is true, but there was a feeling, a sinister feeling that people might actually set you up for, to for things to go wrong. So it was, so it was a lack of trust, isn't it? I didn't trust that if I raised them, it will be managed in a in a safe way that would make me feel all right.'



Molly

‘So even from the team members up to me felt like that. And then from yeah, top down as well’
‘I started perimenopause at the same time and I then realised, I think I've probably got ADHD and I think at that point, like, yeah, I don't know if I can do this anymore. So, all the things I've done for years brilliantly masking, juggling and, you know, looking like I was incredibly efficient all those things came together in a not very supportive organisation and then I felt like I can't do this anymore.’
‘I've got to sit through this for five years before there's a there's a gain for my family, you know, like it was a gain for me because I got a challenge and I got some career progression, but actually there's nothing in it for anyone else except me being more stressed, more tired and working more hours for nothing.’
‘So no, no, no, not enough support to understand and help with that’
‘I had to raise concerns about another trainee during my training. I, who I thought was behaving inappropriately and I wasn't supported very well’
‘my manager at that point she, she had this view that if you work from home you don't work. So she was not willing to allow me to kind of work from home.’
‘my line manager was quite unhelpful and quite unresponsive. She… Yes, she was just not really kind of interested in me as a person. It was just about numbers.’
‘She had that kind of style of management when you're just told what to do, so she would, for example, she would, I, I would block out a space in my diary to do some admin and she would go into my diary and book me a meeting for highly, highly complex case with psychiatrists and multidisciplinary meeting for the next day.’
‘it was a very one sided relationship like you're here to do this. You're going to do that.’
‘I was sent to occupational health, which was horrible experience because the guy kept on asking me where I am from and how long I've been in this country. Which was quite upsetting actually, and that, you know, and put Brexit into the, you know, whole equation. And then… then he told me during my Occupational Health interview, then he told me how many emails he received while he was talking to me and he kept on asking me, what's your output, what's your output? I'm like, I don't

know what you're talking about. He was talking at me in a really patronising way and then he just wrote this report saying, oh, she needs to take time off or she needs to reduce her hours.'

'I took time off, my GP signed me off, my GP was lovely and… but after that they started kind of rushing me back in, which I thought was quite confusing because it was my managers were kind of, they were saying just take time off take, you know, take time off and once you're off you'll recover and it will all be fine. And when I was off then I started getting these phone calls. So when are you coming back'

'I went back, but they didn't tell me, and I kept on asking, but they didn't tell me much about what my return to work will look like. So I think at that point you had like phased return, which you could take for three months. But they didn't tell me that, it was kind of when I was sick, they were kind of just saying, oh, it will just make it work, whatever, whatever it takes. They didn't… Yeah. And then, then at one point, they just said, well, you know the phase return is only three months. So in 10 days, this was like a week, week and a half. You either have to cut your hours or, you know, you have to return to full, full time work. And I was like, 'well, 10 days, you're giving me 10 days to make this decision?' I was really, really upset. The guy from HR was really patronising. So that was a horrible experience.'

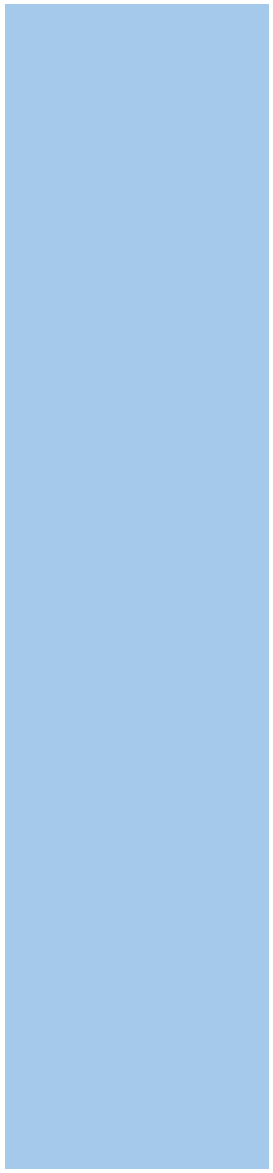
'I started taking my annual leave as my sick leave, which feels really uncomfortable. But that's how I maintained my salary.'

'they never planned to reduce my caseload. They were happy to reduce my salary'

'I carried the same caseload with the same responsibilities, but on half the days and half the salary'

'I started closing people and I was hoping that I'm going to have reduced caseload now finally. And I started getting more referrals and kind of being told that I have to take on more clients. And that's when I realised that they fully intended to pay me two days a week. But give me caseload for four days per week. And that's when I decided to leave.'

'I didn't have holidays for like 9 months because all of my annual leave was used for my sick leave, and I was completely burned out. And I went to him and I cried. And



Mark

that was, I think that was the only time that I cried in my supervision. But I cried about how exhausted I was and how burnt out I was. And he just said I'm sorry you feel this way I sounded really hollow. It sounded really hollow to me. And then he, next day, or the day after he asked me if I can take on another client. And I was just thinking, did you not just hear and see me?'

'Like… So… At that point, I stopped trusting him and I stopped seeking him out for advice'

'I thought that my Trust was unkind and uncaring, that I didn't care about people, that they were cold.'

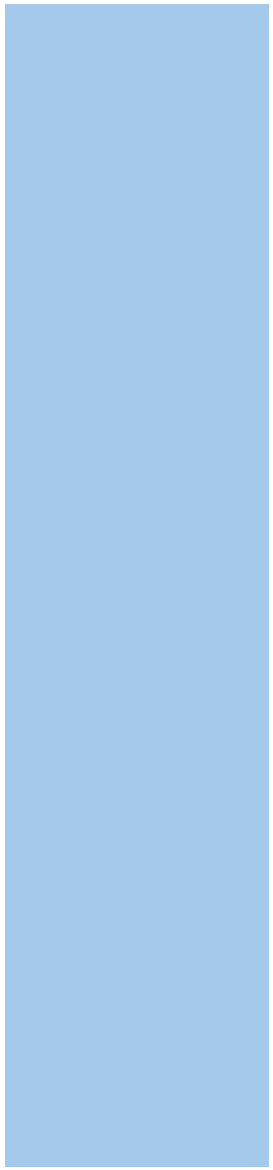
'You told me that I can't work, you know, you told me that this is a full time post. Then you told me that these adjusted hours contract expires end of September.'

'then all of a sudden, they said that I can stay on 2 1/2 days per week. So you know, it went from, 'no, you can't do this' to 'we want you to full time, stay full time' to actually 'you can do half time'.'

'I think they were surprised by how much I insisted on my caseload reducing.'

'I suppose, use my skills as a clinical psychologist to understand systems and people and dynamics, but you were often pushed, pushed, pushed, pushed, push, push, push, push, push'

'I submitted a major whistle blowing. So, it was about my predecessor where I discovered, I uncovered multiple, multiple, multiple examples of, of poor care which was leading to dangerous things happening. And so, you know, initially if you uncover something, it's fine. I'll sort that out. OK, I'll fix that, you know. But it, it was so widespread and she'd moved into sort of senior management ranks. And, and yeah, so I did this major whistle blowing, which was investigated by a consultant, clinical psychologist from a different part of the Trust. And not only did she say yes, you know, Mark was right to raise all of this. There were multiple examples of poor care, things need to change. But whilst carrying out the investigation she sort of found examples of poor systemic practise across the whole of psychology. So there was a, a huge report and a big action plan for certain senior managers and directors. And so I think it'd be safe to say that it annoyed a lot of people.'



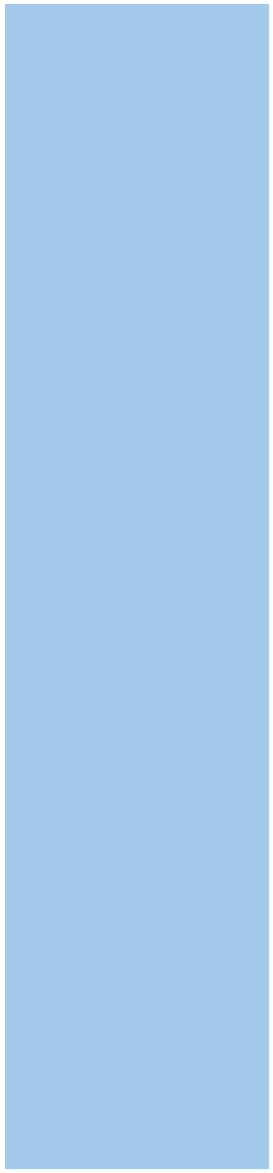
‘I just started getting treated extremely badly, and you were very panickety over a lot of different things. You know, there was skulduggery at play.’

‘I was starting seeing where they were making things up about me and forging documents. So it was just like and wherever I went. So I'd go to HR and say, hey, look, this has happened I'd you know this is inappropriate or that's wrong or so and so said this to me so and so's done this I'm having a problem with this, everybody closed ranks. Everybody closed ranks, ranks and even, you know, I was almost a bit scared to take some of this to my supervision space because… You think? OK, well, my supervisors in the senior management ranks…’

‘you've got all these difficult paradigm of where can you take it. OK, I'll take it to HR or HR because you know, maybe they took it to the HR director and the HR director sits with two other directors that I've been clashing with directors that previously I didn't even know who they were.’

‘due to past bad experiences, sort of traumatic experiences, I just could not sit with wearing a mask. And you know, I thought, well, I'll do it properly. You know, I went to my GP. We discussed it. My GP knew me well. At all documented and he said, I do agree that you should be exempt from wearing a mask and initially. You know, told my line manager, it was all fine. OK, we accept this. We accept your explanation, and you got documentation from your GP. But they knew about some of the boundaries and around it anyway. My line manager did. So… But that just ended it becoming this enormous battle where they were basically changed their mind and decided I had to wear a mask or go and work from home. They're basically, I'd sort of see is they were forcing me to wear a mask.’

‘I'm juggling the effects of the whistle blowing and I'm juggling the impact of, of like all of this, right? And I started to see sort of… might kind of seems strong language, but you know it's my narrative. So I think I can explain it how it is. I started to see from people above, particularly around the whistleblowing and, and all the COVID stuff, they were really pushing down on me like a fascist like approach which really sat with me really, really badly where it was about control and about people getting their own way’



Kate

‘Whistleblowing, I think because basically I just become disliked. I think I'd become a bit of a pain in the backside. I just became disliked. The fact that I was good at my job was of no interest to them. All became about a power, power dynamic battle.’
‘the pressure became so great it was impacting upon my physical and mental health. I think I was treated so badly and for personal professional development, I've been going to psychotherapy for like, weekly for 10 years. So at the time I had to use every minute of that space every week. All down to how I was being treated in work. I had no space to discuss anything else.’
‘it was a traumatic and very bad experience and it got to the extent where I thought I have to leave.’
‘they were going down on my professional identity. So I don't know like whenever there was certain opportunities coming up like I, you know, you get an e-mail from the head of psychology and she, she was one of these people who had to action this, whistle blowing kind of list, you know, and oh, oh, can we have a volunteer for, you know, to do this, to do that? All that sounds interesting. I didn't get considered for a single thing.’
‘Try to use supervision to an extent. Like I said, I didn't feel like I was able to tell the full narrative 'cause there was that slight anxiety about ‘she’s within their circle’’
‘the lack of proper support for staff members under pressure because I had to go and seek that myself.’
‘the level of complaints we’d get about nothing to do with what the staff have done, the processes it was purely the we disagree with the, the outcome that can have a real impact or the amount of verbal abuse that my staff would, would get from parents, carers, less professionals, but sometimes.’
‘It's just that sense of we're working so hard in a, in a system that is not always working with us and then the abuse that you're getting for just doing your job or just saying unfortunately we have got a year, two year wait. We are doing the best that we can for that and just how awful some people can be to staff in the NHS, I think that's, that's probably a huge part that leads to either people leaving or that burn out to that general stress’

| | | | |
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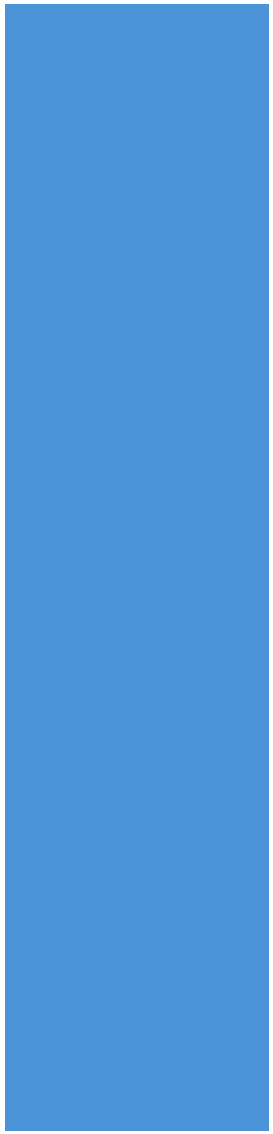
| Perfect Storm | Moral Injury | Samantha | ‘the jarring bit for me was going back into a service that didn't really work properly. Having to do those things again on purpose’<br>‘there's a drip, drip, drip before and you end up where you end up thinking like this. OK, this is the service we're providing and going back in and being like, this is not OK.’<br>‘I don't want to do these things anymore, but I have to pick them up on purpose because there's no drip, drip anymore because I'm just coming in, like, cold. That felt a bit too…Yeah… too uncomfortable.’<br>‘I often come back to that kind of like moral injury kind of thing, of I don't want to be a part of this.’<br>‘I wouldn't tell anyone to go here. I wouldn't want my family to go here. I wouldn't want my friends to go here’<br>‘if we're not doing a good enough job and I don't want to be a part of that anymore.’<br>‘I can't do this’<br>‘bit of anger towards like the service and what they're providing.’<br>‘I was angry and feeling like quite a lot of injustice for our service users and for what we were doing and a sense of trying to protect the team’<br>‘cry on the way to work’<br>‘cry on the way home’ |
| | | Megan | ‘employment of a colleague who was a trainee psychotherapist and then she was employed as the qualified psychotherapist, like, without the post going to advert.’<br>‘I thought the whole ethos of the NHS was fair and equitable opportunities…’ |
| | | Tom | ‘if somebody wasn't ready at the end of therapy, you felt like you were almost doing them a disservice because if you continue to see them, you would have to explain to your manager and supervisor as to why.’<br>‘in terms of values, yeah, they kind of really deteriorated in terms of what you were initially there for, which was the care and show compassion and and appreciate obviously that mental health isn't as prescribed as going into surgery for two hours. You know, things change, things happen. So yeah, that flexibility is really important to me and that's the thing that they, they, the NHS took away.’ |



Ellie

‘we were almost forced to see people face to face unless there was a genuine clinical reason. And again, I just didn't agree with that. I didn't understand the the rationale for having to put people through that when they were still very scared.’

‘I just felt that our health board could be that centre of excellence. It went the other way, unfortunately, so it's sad. It's sad that it couldn't have become what it should have been’

‘lot of people pretty unhappy then and then, you know, obviously that was hugely demoralising’

‘it was phrased was, CAMHS was failing our children when I was felt like, well, no, we've continued to work incredibly hard. Resource that you've given us is failing’

‘It's just the same old shit every time’

‘We will work with people until they get to this point and then they all get. Now you can leave the adolescent team. So in some ways like there was nowhere to go from the generic team.’

‘the sort of surviving the generic team is just really demoralising because 12 sessions of CBT isn't going to solve intergenerational trauma. Isn't going to change….You know the housing status of the family…’

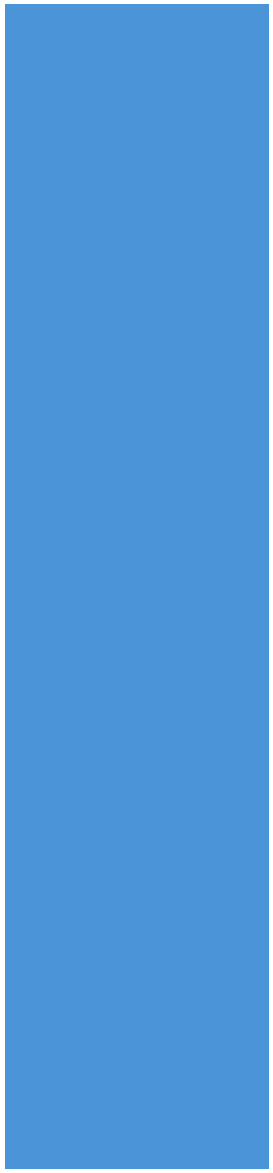
‘I think it's really hard because you'd get daily phone calls from parents saying things like if my child kills themselves, it's going to be your fault and, and you know, and trying to stay compassionate to the parents, which I still very much am, who are feeling so powerless and helpless.’

‘When all the staff are being powers and helpless, it's just just really shitty.’

Tamara

‘managing risk one at the expense of anything else’

‘it was very hard to know how much of this was managing risks of families and children and how much of it was managing risk to the organisation and which one was the priority. So it became felt more and more to me like I was managing, protecting the organisation rather than thinking about thinking about what families children needed… which is, yeah... So, it's so… and, and actually the reasons I went into it became less and less possible.’



Molly

‘Ended up not working with most vulnerable families, working with hard to engage families because as soon as somebody wasn't readily at the door waiting, you'd close them anyway. So, so I was like, well, that's pointless, might as well not bother.’
‘we were ending up managing people to make sure that the professionals felt included and listened to and valued to such an extent that you couldn’t say, well actually I disagree and I think you know, this is what this family needs.’
‘It was just what I said earlier about that clash of wanting to do good work and not being able to, and that that's the kind of moral injury stuff I think’
‘as long as I'm not doing harm and I'm doing my best to do something useful, I'm happy. And it got to the point in the NHS where I wasn't sure about that anymore.’
‘I felt so ineffectual’
‘every morning having to face another crisis with another set of horrible decisions to make when none of them were OK. But you have to choose between the least, you know the least harmful, least horrible decision.’
‘It's all about numbers, less about human beings’
‘the culture was changing and I didn't quite like how people were behaving and I thought we were starting to be quite client blaming and parent blaming. The narrative how… The issues were discussed and formulated in no longer kind of sat well with me and I, I thought we were placing a lot of blame on the parents who were struggling.’
‘I felt more and more distant from them. And I remember we did this... We did this exercise in one of the meetings or something. You know, when you're supposed to, like, choose your values and then think about, like, what does it look like when you act those values and what does it look like when you’re slipping away and I realised that my values were very different than my teams. There was there was a massive difference and I don't know whether there was any overlap or any shared values.’
‘I think there was one point when I thought if I had a child with a disability, would I want them to be seen by my team and the answer was absolutely not, because I would be blamed as a mother and I would not be helped. And once, once I realised that this was my thinking, I knew I couldn't stay…’

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| | Mark | ‘there wasn't always enough room to for me to say well actually I think that that could impact upon patient safety and therefore isn't a good idea, so I'm not going to do that.’ |
| | | ‘the directors are obsessed with corporate image and that in my experience corporate image is more important to them than patient safety and staff welfare.’ |
| | Kate | ‘It was a ‘I think this process is really silly, but that you have to do it and you are going to do it. But I don't want to do that anymore’.’ |
| | | ‘I just knew for me I… to be the best clinician that I want to be. I felt that I couldn't do that working in the NHS, which is sad.’ |
| | | ‘it's hard to work to the values of the NHS in the NHS because it's so overstretched and because the capacity isn't there.’ |
| Dawning realisation | Samantha | ‘it was very, very hard to be in that service and to be in that position and that role but I think coming back from such a long period of time of being away’ |
| | | ‘I came back in kind of early 2023. It was really jarring.’ |
| | | ‘I found was I felt sick. I felt unwell. I was just in fight or flight all day. And I guess having that time off had allowed me to be like, oh ****, this is how I feel like at work.’ |
| | | ‘I genuinely felt like that the whole time I was there, and I knew I felt like that. But then almost going back and being like, OK, so I'm going to feel like this again. Great. Yeah, if it didn't feel OK now that I have a child.’ |
| | | ‘it was the jump from like not feeling and fight or flight all day, despite having a baby to God now I have to go and like, feel like this and it's going to be really, really intense and I'm going to feel really unwell.’ |
| | | ‘I'm probably not going to sleep because, you know, it definitely impacted my sleep, like throughout my career’ |
| | | ‘I wouldn't be able to get back to sleep because I'd be thinking about work. So I think that was the jarring kind of bit.’ |
| | | ‘When I came back, it was a lot of worry and stress and burnout. And then...’ |
| | | ‘Got burned out quite quickly.’ |
| | Megan | ‘I had ten months off when I was in the NHS. So after my husband died, so completely grateful for that time but even throughout that time it was just like do I, do |

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| | I, do I go, do I and I kind of, I guess logistically, I've always kind of thought no, I do have to go.’ |
| | ‘I suppose you on the other vein could be what part of that 10 month was not just for bereavement but actually that burnout as well, possibly. You know, the thought of going back to all that while I was still grieving as well, just like no chance really.’ |
| Tom | ‘I was so burnt out last Christmas I had to take sick leave’ |
| | ‘I was, you know, saying can I can I just take two weeks off. And he was like, no, you you need months, Tom, this is this is really bad. He did try me on medication, so antidepressants, which didn't really react well with me. I don't know whether that's because I wasn't depressed. It was more stress and burnout.’ |
| | ‘We got to the point where the the therapist was really honest and open with me. And she said basically I don't think there's anything you can do to change, Tom. I think the environment that you're in is obviously causing this and and we can't change everything you've discussed. We can't change that. This is not the new problem’ |
| Tamara | ‘I don't think it helped me get better. Being in an organisation that wasn't as supportive and was very chaotic and stressful’ |
| | ‘I went off sick initially just for a couple of weeks. And then while I was off, I just thought this isn't going to be fixable in a couple of weeks and actually life's too short.’ |
| | ‘well, talk to my supervisors and managers. I went back part time, started HRT. Yeah. I did all those things over, over three or four month period.’ |
| | ‘But I was really once I've made the decision, I was really clear that even if those things kind of helped, it was never, it was not going to be enough and that time off just gave me space to reflect.’ |
| | ‘what that I had not had for years, so having a couple of months not working, suddenly you get much such a different perspective on what's important and what you've been through’ |
| Molly | ‘I had health difficulties. I have long COVID. So I was unwell and I had to take some time off.’ |
| | ‘It was quite badly handled.’ |

| | | |
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| | Kate | ‘I was kind of, I felt quite pressurised to take time off, but I thought, OK, well, I'm just going to take time off.’<br>‘I used my annual leave for my sick leave, I couldn't actually take holidays, so I burned out really quickly after that’<br>‘I will never recover under this pressure’<br>‘shingles, high blood pressure scare. That's odd. And then the next month, I've got a really bad flu. And I was off work for maybe like a week and 1/2 or something, or maybe not quite that much, but I was. I was off for a working week’ |
| A drive for control and autonomy | Samantha | ‘being a new mum and having an impact on the kind of parent I wanted to be. My lack availability with my little girl.’<br>‘Going home and not having any head space for her wasn't OK. So that I think just a level of like burnout was just having impact on my family.’ |
| | Megan | ‘I don't feel like there were equitable opportunities to receive different types of training’<br>‘What between? 15 years. I didn't get... I'm just trying to think... I don't think I got any training in therapy in specific, you know, therapy’<br>‘a personal thing, so my husband died very suddenly’<br>‘I can't be 90 minutes away if my kids are at home at school and they need me’<br>‘it was that really that gave me the the the push in the end. But I think leading up to it was the like the burnout feeling of and yeah, feeling like disheartened and not really appreciated…’<br>‘the commute was just too much’<br>‘I wanna earn a decent amount of money with the least amount of time at work and private, going private is the only way to do that.’<br>‘I just want to work at least amount of time for the money’ |
| | Tom | ‘part of me says I could be doing this exact same job, i.e. you seeing patients back-to-back if that's all that kind of private practise was, you know, a couple of years ago, I could be doing that for literally 10 times more, not that it's about the money, but if you're not going to have all those extra things at the NHS used to give you, then why?’ |

‘I asked for some training and it wasn't like EMDR, which is like 2 1/2, three grand that I would get that it was something, it was an online act course for about £300 and I thought tooth and nail for why I needed this, why it was really helpful, nobody else in the service was trained, it was a service need and I think it took me about 2 1/2 years for them to actually say yes’

‘just comparing that to private practise. You know, if I ask, you know, one of my private practise insurers for a training, I mean it would be signed and sealed the next day.’

‘I can do that in private practise, and again, I would I would get paid like literally 10 times more per session.’

‘there wasn't any development’

‘I just didn't have an option. I used to work 8 till four and I remember sat in the car park outside the hospital at that kind of 7:45 first person always in because everyone else started at 9:00 and just saying to myself, I cannot go in. I cannot sit there for 8 hours knowing that I'm, you know, getting paid poorly, treated poorly, hot desking, you know, there's no well-being. Nobody even knows I exist. Unless something goes wrong, you know? And I just felt I can't live like that. My quality of life is at, it was literally at its lowest, and I think that's what made me sort of say, you know, even though I'm not quite sure what I'm getting myself into, I can't stay here any longer.’

‘it's not my wife that has to take the boys to school. I can take them. I can get them ready for school, get them dressed, take them, drop them off’

‘I can pick them both up from school’

‘in the NHS we take the next person off the waiting list and there's no negotiations on that, whereas in private practise I can read a referral and decide to accept or reject it and that's really helpful because I I feel like I'm helping people better because I've got specific skill set’

‘I did more training in my first year than I did in my entire existence within the NHS’

‘The pay is ridiculously higher than within the NHS’

‘you could be earning  a 6 figure salary, and that's higher than obviously the head of service gets within the NHS.’

Ellie

‘you're definitely working less for more’
‘I do it every day, sort of around kids’
‘I remember my accountant saying to me. You seem to be making your money in private practise. You think about growing your business’
‘I've left because of my children’
‘part of the reason why I left the NHS is because I have probably a neuro diverse child who was not coping with all the breakfast clubs, the after school clubs and holiday clubs, mostly the holiday clubs. Which is why I left so that I could just fit around that.’
‘I'm fairly certain I've probably got ADHD. Like real skills, learning for stuff about how to manage their caseload and how to might work their time’
‘the kids don't have to go to after school club. My eldest goes to secondary school now and I can be home when he gets home as well which is good.’

Tamara

‘in my time the budgets and resources for training has diminished massively’
‘there was less about personal development, I don't really think, I don't think that was really ever considered’
‘CPD was… There's not enough of it. And the pressures to it, if you, if you choose to be away for a day, somebody else has to cover you and they don't get to go. And so it became such a tricky thing to negotiate.’
‘It was more about managing my stress, wanting freedom to make decisions about the bits of work I think are useful and say no to bits of work I don't think are useful.’
‘I don't want to be tired and miserable and feel bad all the time. I want to be happy and enjoy my life’
‘I can just pick what bits are easy for me, nice for me.’
‘choosing the bits of work I enjoy, I'm saying no to the things I either, that make me stressed or I think it's stupid and a waste of time or a harmful. I can just say no and walk away’
‘flexibility of working whenever I want to’
‘I was waiting for a consultant post to come up anywhere in the [location of UK] with children and in 10 years there wasn't one within driving distance of my home.’

‘that stagnation, like, that's why I jumped because I, I wanted to be a consultant, I wanted sort of to move up and I felt like there was no opportunity to do that or whatsoever’

‘when I did get a consultant post I jumped into what I'd been waiting for, for years and I found massive more stress masses, more responsibility for exactly the same amount of money that I've been on for the previous ten years, and the prospect of being on that for five more years before I got an increase in salary was really not very attractive’

‘I don't think I earn anything more, maybe marginally more than I did, but for so much less hours’

Molly

‘while I was ill, I was constantly told why don't you just reduce your hours, reduce your hours, you know? But I couldn't just reduce my hours because I've got a mortgage, I've got bills, you know, I couldn't just drop my salary, but once I realised that I can make private work work and the private work just picked up so fast,’

‘I trusted her more and I felt more comfortable around her than I felt around, my NHS manager, my Clinical Psychology manager. I found, I find clinical psychologist who work in private practise to be way kinder, way more compassionate, or fun as well.’

‘I determine my hours. I determine my caseload. I determine who I see’

‘I actually found way more support in private practise than I had in the NHS’

‘The fact I could have my, I can have training that I want. I don't have to spend, you know, hours and hours on completely useless mandatory training.’

‘I decide how I want my week to look like so you know, I decide and it really works with my health, because if I have more energy, I can book a busier week, but then if at the end of the week I feel a bit tired, I can kind of think, OK, so maybe I won't book just as much next week or for the week after. So you know, I can manage and monitor my, my health.’

Mark

‘I can work privately and I will not have to put up with senior management directors treating me, like excuse the language, shit. You know and...’

‘I suppose as well I started to think it might give me more variety as well.’

Kate

‘Not having to do mandatory training. Not up to take unfair orders from team managing directors. Not to worry about getting treated badly.’
‘Variety of work and maybe flexibility’
‘having a stress induced virus, high blood pressure, knocked out by flu, you need to, your body is telling you something here. What is that? So that was a… So I've been thinking a bit about I'm, I'm not quite sure the current way I'm working is working. And then I had a few illnesses all in one go. And I was like this. You're on the track. You're on a nice pathway to burn out, I think here. And I tried to make the conscious decision to not allow myself to get to the point of burning out before doing something about it.’
‘I wanted to live more than I wanted to work, rather than, work to live maximum like two days a week. You know that sort of weekends.’
‘It's my life here. We only get, get the one? And I've got to prioritise myself over a service or other people having a bit of a tricky time while they transition.’
‘I wanted to be and still be financially safe and secure with the hours I wanted, wanted to be.’
‘It's really nice being able to be flexible with my, with my time.’
‘the flexibility’
‘I'll do a lot more CPD. One, because again, the, the time to be able to, to, to do that. But also I don't, I've only got my budget to work from if that makes sense. So I don't have to… you want to do a piece of training in the NHS you’ve got to fill out a form, you know, telling people why I need that training, why it fits the service, when it's going to happen and you've only got this many hours or days, CPD in a year.’

## Appendix 9- Journal of Occupational and Organizational Psychology guidelines

### AIMS AND SCOPE

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

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

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

### Free Format Submission

*Journal of Occupational and Organizational Psychology* now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

**Parts of the Manuscript**

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

**Title Page**

You may like to use this template for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

**Author Contributions**

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

**Abstract**

Please provide an abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article. The abstract should not include any sub-headings.

**Keywords**

Please provide appropriate keywords.

**Acknowledgments**

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

**Practitioner Points**

Authors will need to provide no more than 2-4 ‘key points’, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article.

**Main Text File**

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the LaTex Main Document should be uploaded as a “LaTeX Supplementary File.”

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract without any subheadings;
- Up to seven keywords;
- Practitioner Points: Authors will need to provide no more than 2-4 ‘key points’, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article.;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below)
- Statement of Contribution.

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

**References**

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

**Tables**

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

**Figures**

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

**Supporting Information**

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

**General Style Points**

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

## Paper Three: Executive Summary

# ‘If we're not doing a good enough job […] I don't want to be a part of that anymore’: a qualitative study exploring reasons and experiences of Clinical Psychologists leaving the NHS and working privately

**Klaudia Beata Cebula**

**Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology**

**April 2025**

Word Count: 2,4587

## Target audience

This research summary may be of interest to:

Clinical Psychologists

Professionals working in services seeking to understand the experiences of Clinial Psychologists in the NHS

Stakeholders and management of NHS services

## Background

In recent years the NHS has struggled with staffing levels and meeting the demands of the public for mental health services (CQC, 2023). Staffing level difficulties have been seen in the psychological workforce. The British Psychological Society (BPS) and the Association of Clinical Psychologists (ACP-UK) have spoken about difficulties in recruitment due to lack of career progression opportunities and the fact that more Clinical Psychologists (CPs) are leaving the NHS for private practice (ACP-UK, 2018; BPS, 2023). However, there has been a limited number of studies considering why CPs are leaving the NHS for private practice. Therefore, the current research aimed to explore the experiences of CPs who have left the NHS.

### *Organisational context*

The National Health Service (NHS) has highlighted challenges with the sustainability of their workforce in the NHS Long Term Workforce Plan (NHS England, 2023). The Plan hopes to almost double the workforce by 2036/37 and retrain and retain current talent. The Plan has highlighted that there is a need to focus on the psychological professions due to increased demands for psychological services from the public; current workforce shortages; lack of integrated care; lack of focus on prevention and early interventions; and the need to improve outcomes for those accessing services. The Psychological Professions Workforce Plan (PPWP) for England (Health Education England, 2021) outlined a strategy to expand and develop the psychological workforce by 2024 to support the delivery of the NHS Long Term Plan (NHS England, 2019). The PPWP focuses on growth of the profession; development of career opportunities; diversification of the profession; developing local, regional and national leadership for the profession; and transformation by embracing new ways of working.

Increasing clinical training places and offering development opportunities is a long-term strategy (Health Education England, 2021). It may be years before new psychological staff are trained and joining the current workforce. Therefore, current retention is important as high turnover rates are associated with poorer quality of care and higher costs for employers to train and employ new staff (Health Education England, 2024). The Plans also aim to address the working conditions to help retain staff.

### *Understanding why healthcare staff are leaving the NHS*

Research suggests that there may be two factors that contribute to healthcare staff leaving the NHS: intrinsic and extrinsic factors (Herzberg, 2015). Intrinsic factors

that lead to job satisfaction are related to the nature of the work itself and can enhance motivation and satisfaction. These include: a sense of achievement in one's work, receiving acknowledgement for efforts, performing tasks that are engaging and challenging, having responsibility or autonomy, opportunities for career development and learning and developing new skills. Extrinsic factors prevent job dissatisfaction, but do not lead to job satisfaction. These include salary, company policy, quality of management, working conditions, relationships with colleagues or supervisors and job security. Research suggests that a combination of intrinsic and extrinsic factors may lead to leaving decisions (Leary at el., 2024).

### *What we know about CPs so far*

Previous research has focused on organisational factors or factors within a particular context that have led CPs to leave the NHS. However, our knowledge is still limited on general factors influencing CPs' decisions to leave.

Saddington (2021) has highlighted three categories relating to organisational factors that may have contributed to CPs leaving. This included: shifting organisational valuing, cycle of imposed change and trying to achieve the impossible. Shifting organisational valuing to numerical targets, increasing power of operational management and declining power and value of psychology led to disconnect between CPs and the workplace. Cycle of imposed change described repeated top-down changes that lacked transparency or collaboration which have led CPs to feel disempowered. Finally, achieving the impossible related to CPs facing unrealistic workloads due to competitive commissioning and senior management placing unachievable targets to retain contracts. These factors were seen as influencing a push towards leaving the NHS.

Similarly, in a recent study on CPs' experience of working in and leaving Child and Adolescent Mental Health Services (CAMHS) to work independently has brought up challenges faced by CPs in the NHS (Wintour & Joscelyne, 2024). CPs have experienced increased caseloads, more administrative work, difficulties with staffing levels, changes in their clinical roles and clinical work getting more complex. CPs described feeling like they were 'firefighting' by responding to crises rather than providing interventions to facilitate any change. Furthermore, CPs described CAMHS work as traumatic and as damaging to their emotional wellbeing. CPs have also mentioned difficult relationships with management, often feeling unsupported and undervalued.

***Rationale***

There is currently a limited number of studies that have investigated the experiences and reasons for CPs leaving the NHS for private practice. Policies and guidelines highlight staff shortages and need for better recruitment and retention. Previous studies have focused on organisational factors or specific service experiences that lead to CPs leaving. The current study aims to provide a general, not service-specific focus on CPs leaving the NHS. It is an exploratory study to consider the range of potential influences on this decision-making process.

***Aims of the research:***

To explore the experience of CPs who have chosen to leave the NHS for private practice.

## What did we do?


Step 1
•Ethics- Ethical approval from the University of Staffordshire.
Step 2
•Recruitment- An advert was placed on social media platforms looking for HCPC registered CPs who have left the NHS to work in private practice in the last 3 years.
•Those who expressed interest were provided with information about the study and consent forms. CPs who consented to participate were then invited for an online interview at a time convenient to them.
Step 3
•Interviews- Interview questions were based around current limitations in the literature and questions that help answer the research question and aims.
•At the start of the interview participants and researcher discussed consent again and all participants provided verbal consent to carry out the interview.
•Eight interviews were carried out and recorded on MS Teams.
•Interviews lasted on average 61 minutes.
Step 4
•Analysis- Interview transcripts were analysed using 'Reflexive Thematic Analysis' (RTA, Braun & Clarke, 2022). RTA has six main steps: familiarisation with data, generating initial codes, generating themes, reviewing themes, defining and naming themes and producing a report. The researcher followed this protocol in this study.
•RTA is exploratory and allows for identifying themes and patterns in CP's experiences.
Step 5
•Write up of report and executive summary.

## What did we find?

Through the analysis two overarching themes were developed, each had sub-themes which are more specific aspects of the theme.

### Theme 1: Unreciprocated dedication

This theme highlighted the efforts given to the organisation by CPs is not matched by the loyalty and commitment from the organisation.

CPs have mentioned that working in the NHS changed over time into being very stressful and pressured. They felt like they could not use their unique skills as a CP to make meaningful changes and instead were firefighting and managing risk. Furthermore, CPs had no time to process the trauma they were exposed to due to service pressures.

> 'the risk, the complexity and what I actually felt like I could do as a psychologist or bring as a psychologist. That wasn't really there anymore' (Samantha).
>
> 'I heard the most horrific stories of child abuse, several times per day and [...] there was no space to make sense of it, to process it. It was so incredibly fast-paced' (Molly)

‘the head of service calling us […] shop floor workers’ felt ‘very […] demeaning’ (Tom)

‘power […] dynamics […] which got in the way of doing useful work’ (Tamara)

‘a bit scared to take some of this to my supervision space because… […] my supervisor is in the senior management ranks…’ (Mark)

CPs felt powerless against the organisation and felt unsupported and scrutinised by the system and managers. Across services there was an obvious power imbalance between how management sees themselves compared to clinical staff.

There was a one-sided relationship, where CPs were forced to pour a lot of effort to meet expectations but were mistreated and unsupported in return by the system.

**Theme 2: Perfect storm**

This theme showed a combination of unfavourable circumstances that acted as a catalyst for the decision to leave.

‘in terms of values, yeah, they kind of really deteriorated in terms of what you were initially there for, which was the care and to show compassion’ (Tom)

‘as long as I'm not doing harm and I'm doing my best to do something useful, I'm happy. And it got to the point in the NHS where I wasn't sure about that anymore’ (Tamara)

‘all about numbers, less about human beings’ (Tamara)

Participants in the current study described a discrepancy in what the service was providing and what the psychologists thought was needed. The values of the service and CPs were no longer aligned which resulted in moral injury. Moral injury can be defined as psychological, social and spiritual distress arising from action which violates one’s beliefs and values (Wong et al., 2021).

Many CPs had time away from their roles which allowed them to gain a different perspective on their roles and lead them to consider leaving the NHS. CPs had time away from their roles for a variety of reasons including maternity leave, sick leave and bereavement. Whilst being away CPs have realised that the issue lies in the system, and it is not something that can be easily fixed.

> 'I went off sick initially just for a couple of weeks. And then while I was off, I just thought this isn't going to be fixable in a couple of weeks and actually life's too short.' (Tamara)
>
> 'it was the jump from like not feeling fight or flight all day, despite having a baby to, God now I have to go and [...] feel like this and it's going to be really, really intense and I'm going to feel really unwell' (Samantha)

> 'I wanted to live more than I wanted to work, rather than, work to live maximum like two days a week. You know that sort of weekends' (Kate)
>
> "what between? 15 years [...] I don't think I got any training in therapy" (Megan)
>
> "that stagnation, like, that's why I jumped because I, I wanted to be a consultant, I wanted sort of to move up and I felt like there was no opportunity to do that" (Tamara)

CPs' lives were on hold whilst working in the NHS and they felt unable to live life until they were in private practice. Furthermore, NHS work did not allow for flexibility around family needs. CPs were also frustrated at the lack of career progression and training. Furthermore, the financial implications of working in private practice were also seen as potentially drawing CPs out of the NHS.

*Further context*

All the CPs in the current sample were simultaneously working in private practice and their NHS role before leaving. Therefore, participants were aware of

private practice and how to transition into it, which could have swayed their decision to leave.

## Making sense of findings

This study offered insight into CPs' experiences of working in the NHS and suggests reasons for why they have left. Working in the NHS has been shown to be challenging and pressured. CPs felt unsupported in this high paced and traumatising environment. CPs experienced unrealistic workloads, difficult relationships with management and working against their values.

Like the previously mentioned research on healthcare professionals leaving the NHS, CPs experienced similar intrinsic and extrinsic factors influencing their decision. The intrinsic factors which enhance job satisfaction were not present in CPs' roles. CPs mention working against their values, and lack of support from the organisation, lack of autonomy, lack of career development or training. The extrinsic factors that prevent job dissatisfaction were also not present. CPs mention difficult working conditions, poor relationships with management and supervisors, and their salary being better privately. Thus, it can be suggested that CPs face similar difficulties to other healthcare professionals which may be contributing to their leaving decision.

## Recommendations

- **Use of reflective spaces-** these allow staff to reflect on the emotional toll of caring for others, working under constant pressure and reflect

on service and team issues. Leaders play a key part in encouraging reflective spaces like supervision groups or Schwartz Rounds (Schwartz, 1995). Research has shown that these staff interventions improved compassion for patients, better teamwork and interdisciplinary communication, influenced organisational culture and had a positive impact on staff well-being (Taylor et al., 2018; Whitehead et al., 2021).

- **Fostering better relationships with management-** Introduction of Compassionate Leadership training for managers. Compassionate leadership (West & Chowla, 2017) is based on empathy, openness and communication and considering physical and mental health (Ramachandran et al., 2024). It helps staff feel heard, understood and valued, whilst helping them to perform at optimal levels. Research suggested that compassionate leadership reduces burnout among staff, fosters psychological safety and leads to better patient experiences (Lown et al., 2016; Maben et al., 2012).

- **Supporting leaders and managers-** The service capacity, resources and risk are unlikely to change soon yet the pressures on management to meet targets whilst managing this is ongoing. Leaders themselves may be lacking support and compassion hence may struggle to offer support and compassion for their teams. Thus, focus on compassion initiatives towards leaders is important as impact of these will trickle downstream (Banker & Bhal, 2020; Lanaj et al., 2022; Paakkanen et al., 2021).

- **Improving autonomy and career progression-** CPs need to be involved and consulted on service changes. Through clinical training CPs

develop leadership skills which can be used to help design and bring about changes in teams. This can help CPs feel listened to rather than feeling like changes are driven top-down. Furthermore, career progression and training options need to be routinely reviewed and offered to not only upskill the workforce but to keep up with latest research trends and clinical guidance.

- **Developing understanding of psychology in teams-** The understanding of clinical psychology in teams needs further exploration. Allowing CPs to utilise various skills may not only be beneficial to the service but also allow them to have variability in their role, which could in turn improve .

## Dissemination

- The findings of this study will be submitted for publication in an academic journal.
- The results will also be shared with the participants of this study who have given consent to be contacted.
- The findings of this study will also be shared with a local NHS Trust to aid with thinking about service development.

## Limitations

- The current research is of an exploratory qualitative nature thus making it hard to draw generalisable conclusions. However, as there is currently a lack of research in this area it makes a strong foundation for further research.

- The sample was predominantly female (6 females, 2 males) which although is not an equal divide, it is representative of the CP workforce which is reported to be 80% female (Johnson et al., 2020).

- Finally, as this is a reflexive thematic approach the researcher's stance as an insider researcher must be considered. To increase rigour the researcher kept a reflexive diary, utilised research supervision and RTA workshops.

## Further research

- Consideration of CPs from a wide range of services to see if there are any relationships between type of service CPs work in and their retention rates.

- Large scale survey designs on reasons why CPs leave could be the next research direction in this area.

- Comparison of CPs' reasons to leave the NHS with other professionals to see if there are any factors specific to the clinical psychology profession.

- Research into the loss of highly qualified clinicians whose training is paid for by public funds, considering economic issues, the impact on service provision, waiting lists, client experiences and the staff that do remain in the NHS.

- Investigations into how and to what extent trainees on the Clinical Psychology doctorate programmes are well enough prepared by their training to work within present day NHS with all its challenges.


Thank you for taking your time to read this summary and thank you to all the Clinical Psychologists who made the time to participate in this research.

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