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Doctoral Thesis:

Burnout and retention among psychological practitioners: a qualitative investigation into the influence of organisational factors

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Word Counts

	Main Text	**Appendices (including tables, figures, and references)**	**Total**
Thesis Abstract	300	0	**300**
Literature Review	7,572	6,022	**13,594**
Research Paper	7,998	5,549	**13,547**
Critical Appraisal	3,944	852	**4,796**
Ethics Section	3,715	1,851	**5,566**
Total	**23,529**	**14,274**	**37,803**

Abstract

The wellbeing of the mental health workforce both internationally and within the NHS is an area of concern. Problems with staff burnout and retention are of particular concern, and research has highlighted how organisational issues can play a role. This thesis comprises a literature review, research paper, and critical appraisal. In the literature review, a meta-ethnography reviewing eight qualitative studies of mental health practitioners' experiences of burnout was conducted following methodology outlined by Noblit and Hare (1988). A line of argument was developed which suggested that burnout experience can compromise practitioners' physical and mental wellbeing, and sense of self-efficacy; that mental health practitioner self-knowledge and boundaries can contribute to or protect against burnout, and; that organisational culture and values can create a workplace that can be protective against practitioner burnout or contribute to it.

The research paper explores how organisational factors can influence clinical psychologists' decisions to leave the NHS. Seven participants were interviewed, and grounded theory methodology was used to identify organisational processes perceived to influence decisions to leave the NHS consisting of: trying to achieve the impossible, cycle of imposed change, and shifting organisational valuing. Psychologist categories were also identified, describing participant experience and coping in relation to organisational processes with impacts contributing to decisions to leave. These consisted of: striving for autonomy and integrity, valuing people, trying to make things better, seeking sustainability and growth, and a push to leave / pull to return. The findings highlight how organisational factors influenced participant decisions to leave the NHS, and a tentative conceptual model was presented.

The critical appraisal extends the discussion of the research strengths and limitations and expands the discussion of opportunities for further research and implications. Reflections

are offered around reflexivity and the personal journey as a new meta-ethnographer and grounded theorist through the research.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University between September 2019 and May 2021. The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: David Saddington

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Date:

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Section One: Literature Review

Mental health practitioners' experience of burnout: a qualitative meta-ethnography

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Abstract

Purpose: Research indicates that mental health practitioner burnout is a major problem with significant personal, client care, and workforce implications. Despite this, there is relatively little published research illuminating practitioners' burnout experiences. Understanding more about these may help improve efforts to reduce burnout and support practitioner wellbeing, organisational sustainability, and client care. *Methodology*: A meta-ethnography reviewing eight qualitative studies was conducted following methodology outlined by Noblit and Hare (1988). *Findings*: A line of argument was developed which suggested that burnout experience can compromise practitioners' physical and mental wellbeing, and sense of self-efficacy; that mental health practitioner self-knowledge and boundaries can contribute to or protect against burnout, and; that organisational culture and values can create a workplace that can be protective against practitioner burnout or contribute to it. *Originality*: The meta-ethnography represents an extended interpretation of the original qualitative papers and thus represents a novel addition to the burnout literature.

Keywords

Practitioner experiences; burnout; meta-synthesis

Since ‘burnout’ was first proposed by Freudenberger (1974), awareness and concern about the impact of burnout on mental health staff, services, and clients has grown. The most common characterisation of burnout was proposed by Maslach et al. (1981), consisting of emotional exhaustion, depersonalisation, and reduced personal accomplishment. Emotional exhaustion is the main feature and leads to practitioners feeling overwhelmed and depleted, while depersonalisation leads to practitioners developing negative attitudes and distant relationships with their work and clients. Emotional exhaustion and depersonalisation are hypothesised to lead to negative self-appraisal and reduced feelings of accomplishment (Maslach et al., 1981; Maslach & Leiter, 1997).

Burnout itself is not a binary concept, and practitioners may experience differing levels of emotional exhaustion, depersonalisation, and reduced personal accomplishment at any given time (Maslach & Leiter, 1997). Burnout is conceptualised as occupying one end of a continuum, at the opposite end to ‘flourishing’, which includes aspects like a general sense of well-being and positive emotions (Jankowski et al., 2020). Research suggests burnout is a distinct concept from other phenomena like anxiety, depression, general stress reactions, and job satisfaction (Awa et al., 2010; Maslach et al., 2001). While some initial symptoms can overlap, burnout is also considered distinctly different to vicarious traumatisation, and secondary traumatisation or compassion fatigue considered to derive from emotional labour with clients (Canfield, 2005; Dunkley & Whelan, 2006; Figley, 1995). Vicarious traumatisation is considered unique to trauma work and is defined as the transformation considered to take place in a therapist through their work with trauma clients’ difficult experiences, which can produce defensive reactions including numbing, denial, and distancing, seen as a ‘normal’ reaction to trauma work (Dunkley & Whelan, 2006; McCann & Pearlman, 1990). Secondary traumatisation, also known as compassion fatigue, is an overlapping but broader concept, defined as a reaction arising from a therapist’s exposure to client experiences

and their empathy for the client that can include symptoms such as reexperiencing, avoidance and numbing, and persistent arousal (Figley, 1995; O'Halloran & Linton, 2000).

Burnout has been classified as an official diagnosis, a 'state of vital exhaustion', by the International Classification of Diseases (World Health Organisation, 2019), and healthcare practitioner burnout is considered a major public health problem with serious personal, client care, and workforce implications. Burnout rates within the mental health workforce are amongst the highest of any health speciality; mental health jobs are perceived to have become more demanding and stressful over time (Paris & Hoge, 2010). Morse et al. (2012) found between 21 to 67 percent of mental health workers may be experiencing high levels of burnout. Research by Westwood et al. (2017) within the UK's flagship 'Improving Access to Psychological Therapies' (IAPT) programme, found burnout rates of 68.6 percent among psychological wellbeing practitioners and 50 percent among high-intensity therapists, underlining the extent of the problem.

Burnout is linked to practitioner turnover, absenteeism, and costs relating to recruitment and training (Rollins et al., 2010; Schaufeli et al., 2009), with ramifications for staff retention, and performance of mental health services (Paris & Hoge, 2010). Staffing gaps due to burnout have knock-on effects as continuing workloads fall on remaining staff, potentially increasing pressure and stress. Burnout has also been linked with lower quality care, lower expectations about client recovery, and negative feelings about clients (Holmqvist & Jeanneau, 2006; Salyers et al., 2017) and is therefore a major issue of concern given that burnout undermines sustainability of services and may negatively impact care.

Our current understanding of burnout predominantly derives from the quantitative research conducted over past decades. While a number of different burnout measures exist, the Maslach Burnout Inventory (MBI) (Maslach et al., 1981) is most widely used, due to its 'gold

standard' reputation given high reliability and validity (Schutte et al., 2000). However, though widely used Paris and Hoge (2010) urge caution in drawing hasty conclusions from research given inconsistency in how many researchers have scored and analysed MBI data, with imprecise definitions and measurements of other variables analysed alongside burnout in many studies.

In a review of recent empirical burnout research Yang and Hayes (2020) found that work factors, psychotherapist factors, psychotherapist demographic factors, and client factors are all thought to influence burnout. Work factors encompass job control, work setting, work environment, job demands, and support. Job control is defined as the degree to which employees can exercise autonomy in performing their roles (Sargent & Terry, 1998). Independent practice work settings are associated with lower self-reported burnout than inpatient, outpatient, and community settings (Craig & Sprang, 2010; Warren et al., 2012). Work environment refers to perceptions of work conditions and organisational climate (Thompson et al., 2014). Job demands encompass practical and psychological aspects of roles (Hamaideh, 2011), and support includes co-worker, administrative, and clinical support and supervision (Jovanović et al., 2016; Vilardaga et al., 2011). Psychotherapist factors encompass psychotherapist mental health history, countertransference emotions in clinical practice, psychological distress from work or other areas of life, therapist self-efficacy or confidence in professional abilities, mindfulness, coping strategies, and personality factors (Choi et al., 2014; Warren et al., 2012). Psychotherapist demographic factors encompass gender, race, age, education level, and parental status (Thompson et al., 2014). Finally, client factors encompass the nature of the client difficulties, and other client characteristics, such as 'difficult' personality characteristics or ambivalence about change (Warren et al., 2012; Yang & Hayes, 2020).

Negative impacts on therapists have also been found including on physical wellbeing (Acker, 2009; Kaeding et al., 2017) and psychological wellbeing (Fong et al., 2016; Papadomarkaki & Lewis, 2008; Shoji et al., 2015; Tzeletopoulou et al., 2018). However, despite the importance and urgency of the subject, the current burnout knowledge base heavily relies on correlational studies, making conclusions about causal relationships difficult. Relatively little qualitative research has been done to illuminate our understanding of burnout, and Yang and Hayes (2020) caution that the burnout literature remains 'sparse'.

Given the negative impacts of burnout and pressing need to broaden the current knowledge base, there is a need to review the qualitative research exploring practitioners' experiences of burnout that has emerged. Accordingly, the aim of the current research is to systematically identify and critically appraise the relevant studies and use meta-ethnography to understand how practitioners experience burnout.

Method

The meta-ethnographic method outlined by (Noblit & Hare, 1988) was chosen as it enables the generation of new concepts from existing studies, and provides clear guidance for conducting the process. Meta-ethnography is concerned with interpretation, with the aim of identifying relationships between different qualitative studies and generating new knowledge via mutual translation and synthesis. Noblit and Hare (1988) outline seven phases of a meta-ethnographic approach: Phase 1: Getting started; Phase 2: Deciding what is relevant to the initial interest; Phase 3: Reading the studies; Phase 4: Determining how the studies are related; Phase 5: Translating the studies into one another; Phase 6: Synthesising Translations; Phase 7: Expressing the synthesis.

Epistemology

A critical realist epistemological stance was adopted, holding that pre-existing structures and mechanisms underlie human action, and that these structures and mechanisms have an independent ontological status regardless of whether or not they are observed by human actors. Such underlying generative mechanisms may or may not be directly observed by human actors, but can be observed and experienced by their effects (Danermark et al., 2019). Critical realism is considered an appropriate and robust philosophical grounding for ethnographic enquiry (Edwards et al., 2014).

Phase 1: Getting started

The area of interest suitable for qualitative investigation chosen was mental health professionals' experience of burnout, and review question 'How do mental health practitioners experience burnout?' chosen. Search terms were identified from terms used in existing literature and consultation with the PsycINFO thesauruses, with input from my research supervisor and a university librarian. The literature search detailed below was then conducted to identify relevant qualitative papers.

Searching for studies

The search was conducted by combining searches of electronic databases and hand searching the reference lists of identified papers. A highly sensitive search strategy was chosen given the high retrieval effectiveness for qualitative studies (McKibbon et al., 2006). The PsycINFO, CINAHL, Medline, and Academic Search Ultimate databases were searched in January 2021 to cover different mental health professional fields, including all dates and restricted to published academic papers. A university librarian was consulted to develop a Boolean search combining the following search terms contained in Table 1.

---Table 1 here---

Phase 2: Deciding what is relevant

The initial search identified 458 papers. The title and abstract of each paper was reviewed to check relevance to the synthesis aims. Fifty-three papers remained and were included if they passed the inclusion and exclusion criteria (Table 2).

---Table 2 here---

After applying these criteria eight papers remained. Reference lists of these papers were checked, and no additional studies were identified, therefore eight papers were included in the meta-synthesis (Figure 1).

---Figure 1 here---

Phase 3: Reading the studies

Papers were each read several times to become conversant with the content. The papers incorporated perspectives from different professional backgrounds including psychiatrists, counselling psychologists, counsellors, clinical psychologists, behavioural health and substance use workers, and psychoeducators. Perspectives from different countries included Canada, New Zealand, USA, and Australia. The studies also represented a range of different workplace settings. Table 3: Study characteristics, summarises included papers.

---Table 3 here---

Each paper was quality appraised using the Critical Appraisal Skills Programme qualitative checklist (CASP, 2018), chosen to provide a structured process to appraise each paper. A score was given for each question based on a three-point scale following Duggleby et al. (2010): 1 little or no justification or explanation; 2 some evidence issue addressed but not

fully elaborated on; 3 extensively justified and explained. All were considered to be good quality papers with total scores ranging from 25 to 30. No paper was excluded given that journal word limits may have led to information being excluded; it is also unclear what minimum score would merit inclusion versus exclusion. Several CASP appraisals were independently reviewed by a peer to provide additional rigour to the quality appraisal process and ensure consistency between researchers. CASP scores are provided in Appendix 1-A.

Phases 4: Determining how the studies are related

To determine how studies are related Noblit and Hare (1988) propose making lists of themes or metaphors and comparing these to determine how they are related to one another. This phase involved capturing frequent or salient concepts from each paper in lists on separate post-it notes. Using post-it notes enabled items within each list to be moved around and be compared with those in other lists, with determination of relationships between concepts in other studies highlighted by lines and arrows. In order to make clear how concepts relate to one another, a grid was created into which related concepts from each paper were placed (Table 4). Schutz's (1962) typology was utilised whereby first order constructs incorporate descriptive summaries of participants' own interpretations, while second order constructs incorporate author interpretations.

---Table 4---

Phase 5: Translating the studies into one another

Table 4 illustrates how the studies were translated into one another. Each cell in each row represents a related concept from the relevant study. Empty cells signify no data contributed, meaning the concept was not present in that study. Related concepts from each row were translated into the first order constructs, which encompasses the related concepts

from each paper. Thus on the first row, content from six studies apart from Sim et al. (2016) and Eliacin et al. (2018) went into the first order construct ‘idealised carer expectations’.

Phase 6: Synthesising the translations

By reading the first order constructs and second order constructs off the grid relationships between the studies could be established, from which third order interpretations and a line of argument was synthesised. This process is illustrated in Table 5. Noting the inherent subjectivity of interpretation, supervision discussions were used to review appropriateness and fit of the third-order interpretations. Phases 1-6 did not proceed in a linear fashion and there was much iteration and refining through the process. The final phase 7: expressing the synthesis, is represented in this paper.

---Table5---

Results

The synthesis produced a line of argument with three themes:

1. Burnout can impact on practitioner physical and mental wellbeing, and sense of self-efficacy.
2. Practitioner self-knowledge and boundaries can contribute to or protect against burnout.
3. Organisational culture and values can create a workplace that can be protective against practitioner burnout or contribute to it.

Theme 1: Burnout can impact on practitioner physical and mental wellbeing and sense of self-efficacy

This theme highlighted the impact on practitioners experiencing burnout encompassing fatigue, sleep difficulties, mood disruption and irritability, reduced confidence and self-efficacy, reduced motivation and productivity, avoidance, withdrawal, and isolation.

The experience of burnout took a heavy physical toll, with common descriptions of feeling physically drained and exhausted. Onset of physical fatigue varied, with some practitioners noticing a gradual onset and others experiencing sudden onset akin to 'hitting a wall': "It was like a shadow coming over me, I felt like a switch had gone off" (Turnbull & Rhodes, 2019, p.4). Difficulties with sleep and insomnia were commonly experienced with negative impacts on physical health and a heavy toll on mood: "…There came a time when I could hardly sleep, was constantly preoccupied, filled with… maybe not suicidal, but very depressive feelings…" (Bernier, 1998, p.56). Disrupted sleep was associated with negatively impacted day to day functioning: "…I hadn't been sleeping well… I think it was probably 12/18 months. We all know the difficulties that occur when we're not sleeping right, you know, mood and concentration…" (Hammond et al., 2018, p.7). The emotional experience of burnout was characterised as feelings of being overwhelmed in most studies with a sense of 'helplessness' and 'feeling like a failure' (Turnbull & Rhodes, 2019). Negative impacts on practitioner mood and mental wellbeing were also experienced. Practitioners commonly found themselves less tolerant and more irritable: "when you're burned out, sometimes your frontal lobe stops working and stuff comes out" (Eliacin et al., 2018, p.390), negatively impacting relationships with colleagues. The process of physical and mental impact also contributed towards an undermining of confidence and sense of self-efficacy, with a sense that practitioners felt they were letting clients down: "I lost confidence and would be questioning a lot more, 'Am I really making a difference?'" (Turnbull & Rhodes, 2019, p.5), in turn fuelling a sense of failure in a vicious cycle: "It felt like a perfect storm, I was feeling like a failure in the three big aspects of my life, as a mum, as a wife, as a psychologist" (Turnbull & Rhodes, 2019, p.5).

Practitioners also perceived negative impacts on their motivation and productivity, with a number of studies highlighting reduced job performance and failing to get work done. As work became associated with feelings of dread, avoidance or 'pulling away' thoughts and

behaviours emerged: "… One of the main things I remember is driving to work… just wishing I felt sick that day or, you know, that I get a flat tyre or something so I didn't have to go" (Hammond et al., 2018, p.7). Mental distancing or 'checking out' in work was also highlighted, though this theme was not contributed to by all studies: "I was feeling that I cared less. During sessions I would be sitting, staring off into space" (Turnbull & Rhodes, 2019, p.5). This distancing and withdrawal process appears to have contributed to feelings of loneliness and isolation for many practitioners, with reduced engagement with colleagues and a drive towards 'escaping': "If I had a break I would just drop everything… maybe surf the internet, look at the news, or do something completely unrelated to work" (Hammond et al., 2018, p.7). Several studies highlighted how this process led to practitioners physically distancing from work, with sickness absence, resignation, or retirement: "I turned in my resignation. I needed to burn the bridges. I came back later, but during my leave I needed to say to myself 'I don't want to hear from them, that type of work is not for me'" (Bernier, 1998, p.56). Withdrawal and isolation outside work was also in evidence in several studies, with negative impacts on social engagement and interpersonal relationships: "Outside [work], I am really isolated. I had a friend probably not even six weeks ago call me on that and said, what's going on? You have been in a shell for a long time. [I am] so very isolated. I just want to shut everything off when I get home." (Eliacin et al., 2018, p.391).

Theme 2: Practitioner self-knowledge and boundaries can contribute to or protect against burnout

This theme highlighted individual factors contributing towards or protecting against burnout, including practitioner internal expectations and beliefs, acceptance or denial of burnout symptoms, professional culture and stigma, practitioner knowledge about burnout, personal development and self-knowledge, boundaries and work-life balance, and personal growth from previous burnout.

The majority of studies reflected high practitioner internal expectations and implicit beliefs about being able to cope and putting clients' needs first, suggesting an idealised or self-sacrificing view of how a caring professional ought to be. Many practitioners articulated high expectations of themselves: "an inability to perform at less than 100%" (Fischer et al., 2007, p.419), which, when coupled with heavy workloads, fuelled a culture of minimising personal needs and 'keeping going'; "I experience [being] tired, a little tired… it's the pace of our job; we keep going" (Beitel et al., 2018, p.213). Many studies found acknowledging or accepting burnout symptoms was difficult for practitioners: "I think there was soft burnout early on, but I didn't pay attention to the signs, I did some self-care, took a holiday, and kept going" (Turnbull & Rhodes, 2019, p.5). Denial meant practitioners often pushed themselves to keep going until burnout symptoms became impossible to ignore:

> In spite of my wife's advice, I refused to see the forewarning signals. There came a time when I could hardly sleep, was constantly preoccupied, filled with… maybe not suicidal but very depressive feelings. I felt as if I was nailed to the floor… empty, undecided. I was forced to recognise that I was suffering from a mental rather than a physical illness. I didn't have a heart condition, nor cancer, nor any 'honourable' disease. Once this fact was admitted, it was much easier to accept to rest (Bernier, 1998, p.56).

Barriers related to professional culture getting in the way of acknowledging personal difficulties were also highlighted: "I would be quite hesitant to talk about the support I have sought. There is a kind of stigma that as a psychologist you should be coping yourself" (Turnbull & Rhodes, 2019, p.5). Many practitioners articulated a need to be seen by peers as 'professional', bound up with an idealised image of being able to keep going: "I didn't want people to know I was experiencing difficulties, that I was professionally diminished. Often, I was incapable of working, but I persisted in going to the office just to maintain my image." (Bernier, 1998, p.59).

Variable practitioner knowledge about burnout emerged, again pointing to cultural issues within professional training and development. Practitioners frequently commented on the lack of attention to self-care and burnout awareness in professional training and development: “They didn’t tell us anything about burnout… so I didn’t even think it was something that happened…” (Hammond et al., 2018, p.6), with some training modelling unsustainable behaviours: “There is something wrong with the [psychology training] system when so many students are really struggling with the pressure and with the stress” (Turnbull & Rhodes, 2019, p.5). Willingness to acknowledge difficulties was highlighted by a number of practitioners in terms of a cultural challenge within the caring professions: “As a profession there is not enough talking about when therapists are struggling” (Turnbull & Rhodes, 2019, p.5).

Within the narratives, the protective effect of personal development and practitioner self-knowledge and awareness emerged: “Knowing your own stuff is hugely important” (Turnbull & Rhodes, 2019, p.6). Undertaking personal counselling and therapy were considered valuable for building self-awareness and resilience: “Having your own therapy is helpful, just for understanding your own relationship patterns, and how you deal with stress and self-care” (Turnbull & Rhodes, 2019, p.6), as well as helping to manage the early onset of burnout symptoms: “I was getting off track, so what I’ve done now is I’ve found my own therapist, which has been helping greatly” (Sim et al., 2016, p.393). Learning to value own needs was perceived as an important part of developing resilience to burnout as part of the personal development process:

> I always try to do the same things I recommend to clients, so, if I’m telling someone to go for a walk, or find a hobby, or reach out to others, those are the same things I kind of have to force myself to practice as well. (Beitel et al., 2018, p.214).

Related to self-knowledge and awareness, practitioners across a number of studies identified the importance of meaning in their work in resisting burnout: "Finding ways that your everyday work is valuable or important" (Turnbull & Rhodes, 2019, p.6). A commitment to clients was shared by practitioners across studies and this primary motivation and focus was perceived as protective: "the sense that I might be helping people… I might occasionally make a difference, that's a help" (Fischer et al., 2007, p.419), and conversely, contributing towards burnout when practitioners perceived they were unable to support clients effectively.

Boundaries and work-life balance also emerged as important themes protecting against burnout, with this narrative contributed to across all studies. Within the workplace, professional variety, time and space to think, time to take breaks, or time to train were emphasised: "I've learned at least a few times a day to shut my office door and just kind of take a breather… some music" (Beitel et al., 2018, p.214), as well as taking physical breaks from work and holidays. By contrast, blurred boundaries between work and home life were perceived as contributing to burnout: "I don't mean literally take [the patients] home with me, but they're in my head. I'm thinking about them at night-time" (Beitel et al., 2018, p.213). Having a distinct life outside work separate from the caring role was perceived by practitioners in most studies as protective:

> Just like any good counsellor, I try to have balance in my life too. Having outlets where I don't have to think about this stuff, having friends, and spending time with people where I know I'm supported, and safe, and can have fun and relax. Having that balance where you can know that life goes on regardless of some of these bigger things that are happening is helpful. (Viehl et al., 2018, p.62)

Practitioners highlighted a wide variety of hobbies, interests, and physical activities including volunteering (Sim et al., 2016), yoga, kayaking, baking, pets (Beitel et al., 2018), reading fiction, gardening (Fischer et al., 2007) that they perceived to help protect against

burnout: “Doing new things keeps you interested, keeps you stimulated” (Fischer et al., 2007, p.419).

A theme of personal growth from practitioners’ burnout experience also emerged from many studies, with a process of questioning leading to enhanced self-awareness and improved attentiveness to boundaries and self-care. Being forced to confront individual limitations imposed by burnout symptoms helped practitioners re-evaluate expectations: “I thought I couldn’t go away, then I had to for my health and everyone was really fine” (Hammond et al., 2018, p.6) and expand self-knowledge: “When going through burnout I realised I didn’t have hobbies. I wasn’t a person outside my caring role” (Turnbull & Rhodes, 2019, p.6). It also enabled some practitioners to re-evaluate their role and boundaries with clients: “I get a sense of feeling like I am helping people help themselves. I help them stay afloat; but I don’t swim for them, I help them find strength to swim” (Turnbull & Rhodes, 2019, p.6), emerging with more realistic and sustainable expectations of themselves: “I’m only human and it’s ridiculous to be thinking that you are totally bulletproof” (Turnbull & Rhodes, 2019, p.6).

Theme 3: Organisational culture and values create a workplace that can be protective against practitioner burnout or contribute to it.

This theme highlighted the important role that organisational culture and values play in influencing the workplace environment, policies, and relationships that contribute to practitioner burnout or support resilience. It encompasses organisational ‘productivity’ culture and emphasis on administrative tasks, perceived conflict between organisational versus clinical priorities, availability of structured support and supervision, quality of relationships and collaboration, and organisational support for protective practices.

This theme interlinks with other themes by creating the policies, culture, and constraints within which practitioners can take individual action to mitigate burnout, and within which the

individual undergoes their burnout experience. This theme is considered particularly important: "Many things contributed to burnout, but organisational factors were first" (Turnbull & Rhodes, 2019, p.5).

Organisational value and priority placed on 'productivity' was perceived by practitioners as a major source of pressure. Excessive workflow expectations meant many practitioners felt they were not able to do their work to an appropriate standard: "There is so much to do and not enough time, or not enough to do it well" (Fischer et al., 2007, p.419), generating a gap between their internal perceptions of acceptable quality care and what they were able to deliver: "It's usually just feeling like there's too much to do and I'm not doing any of it as well as I like" (Sim et al., 2016, p.392). Many practitioners perceived that administrative tasks imposed by the organisation took up excessive time and added to pressures while adding little value and diverting practitioners away from patient care:

> There is so much paperwork to be done; you are accountable to persons above, who are accountable to other persons above… Such a pyramid is crazy. This complexity is supposed to increase therapeutic efficiency! As clinicians, we feel like simple executants. We feel so removed from the reasons that compelled us to work in the field. We no longer have real human contact with clients. I find it quite alienating. (Bernier, 1998, p.60).

Time taken up by tasks associated with organisational rather than clinical priorities left many practitioners struggling to provide 'good enough' care to fulfil their own values, leaving them more vulnerable to burnout:

> I felt like I was so distracted trying to get everything else done that my clients weren't getting the attention that they needed. I think that bothered me more than anything. Those

> were the factors that really contributed, I think, to that overwhelming burnout feeling. (Viehl et al., 2018, p.62).

Structured support and protected space for reflection emerged as a protective factor against burnout, with supervision and the quality of supervisory relationships emphasised across many studies: "Reflective supervision is how you cope; you need to have this reflective space" (Turnbull & Rhodes, 2019, p.7). Structured peer support was considered a further important buffer against burnout: "My peer support group has been particularly valuable, it gives one an opportunity to talk about how one's feeling and how one's struggling." (Fischer et al., 2007, p.419). Informal support through social relationships with colleagues, characterised as 'team spirit', were also seen as valuable and protective, providing an outlet for daily stresses: "[At lunchtime I] go into the staff lounge because there's a good mix of people in there… we jokingly refer to it as the no empathy zone… we laugh at ourselves… it's restorative" (Sim et al., 2016, p.392). Regular informal interaction with peers helped practitioners feel supported and grounded: "I seek the companionship of my co-workers and colleagues, I really like them. I feel very comfortable with [them]" (Beitel et al., 2018, p.214), as well as fulfilling a containing function that helped them cope with stress:

> Our team is pretty close so that really helps burnout when I can just vent about either a client issue or administrative or family issues. I can go to them and vent for ten, fifteen minutes, feel better, and then get back concentrating on what I was doing. (Eliacin et al., 2018, p.319)

The quality of relationships between practitioners and managers was also seen as either a protective or contributing factor towards burnout. Managers' approach to practitioners was considered to derive from organisational priorities and values. Open communication and a sense of collaboration helped practitioners feel engaged and valued: "My boss has an open-door policy. Our Associate Director's good at staying involved." (Eliacin et al., 2018, p.319);

positive relationships with managers helped practitioners feel supported, and protected against burnout. In contrast, management focus on 'productivity' was felt to influence an "aggressive administrative environment" (Fischer et al., 2007, p.420) where practitioners felt less control over their workloads and more fearful of blame and punishment for not meeting targets, increasing the feelings of pressure they experienced: "People are just walking right by you, trying to hurry and get stuff done because they know they are being scrutinised. It becomes an unfriendly place to be." (Eliacin et al., 2018, p.390).

Practitioners' ability to take care of themselves was also influenced by the extent to which organisations appeared to understand and value protective practices. Some practitioners highlighted appropriate organisational policies being in place but either not followed or not engaged with effectively: "Conversations around yourself or self-care were given lip service" (Turnbull & Rhodes, 2019, p.5). Organisational policies also influenced practitioners' ability to boost their resilience; examples highlighted by practitioners include feeling supported to take breaks and holidays, access to training and development opportunities, and access to professional networking. Policies within the workplace also influenced practitioners' ability to maintain boundaries: "[The patients] have access to us all the time. Even in here [counsellors' office] on the phone… they're at your door looking for you. That can [lead to] high burnout because of the constant stimulation" (Beitel et al., 2018, p.213), and policy changes can have unintended consequences for workplace social mixing: "When we had the hour lunch, a lot of us would sit in the break room. It would be nice to chat with each other and have a laugh. Now, if I go in there [lunch room] sometimes there's nobody there. I'm not socialising as much as I used to" (Eliacin et al., 2018, p.391).

Discussion

This meta-ethnography aimed to explore the burnout experiences of mental health practitioners and contribute to the burnout literature, generating richer detail about how

practitioners could be better supported, and how resilience and sustainability within the mental health workforce could be positively influenced. The resultant line of argument; that burnout experience can compromise a practitioner's physical and mental wellbeing, and sense of self-efficacy; that mental health practitioner self-knowledge and boundaries can contribute to or protect against burnout, and; that organisational culture and values create a workplace that can be protective against practitioner burnout or contribute to it, represents an extended interpretation of the original papers (Noblit & Hare, 1988). As such, this meta-ethnography represents a novel addition to the burnout literature.

The findings offer insights into practitioners' experiences of burnout. The impact on practitioners found within the review is broadly consistent with themes of emotional exhaustion, depersonalisation, and reduced feelings of personal accomplishment articulated by Maslach et al. (1981), where emotional exhaustion and depersonalisation can influence reduced feelings of self-efficacy and personal accomplishment (Maslach et al., 2001). The characterisations of the physical impacts of burnout reported by participants within the review studies, including sleep difficulties, insomnia and other physical health symptoms, are consistent with those reported by social workers in Acker (2009) and by trainee counselling and clinical psychologists in Kaeding et al. (2017).

The impacts of burnout on mental well-being highlighted by the review are consistent with recent quantitative research indicating that mental health practitioners experiencing burnout are at greater risk of anxiety and depression, as well as secondary traumatic stress and general psychological distress (Fong et al., 2016; Shoji et al., 2015; Tzeletopoulou et al., 2018). The review highlights the impact of burnout on self-efficacy, experienced by practitioners within the review as a vicious cycle of feeling they were letting clients down which fuelled their sense of failure. This is consistent with the inverse relationship between psychotherapist emotional exhaustion and self-efficacy found by Kim et al. (2018) in a quantitative study with

community mental health practitioners, as well as the findings of a meta-analysis of 57 quantitative studies encompassing health care providers, teachers, and other professionals across a range of countries, which found a 'significant' relationship between self-efficacy and burnout (Shoji et al., 2016). Findings within the review about practitioner distancing from work, encompassing attempts to psychologically distance from the workplace including practitioners making themselves physically unavailable within the workplace (Fischer et al., 2007), avoiding work (Hammond et al., 2018), or physically distancing via resignation, unpaid leave, part time work, or sickness absence (Bernier, 1998), align with quantitative research that indicates burnout can undermine therapist job satisfaction and influence decisions to leave work (Delgadillo et al., 2018; Salyers et al., 2015; Scanlan & Still, 2013).

The line of argument that self-knowledge and boundaries can contribute to or protect against burnout has potential implications for policy and practice. The line of argument findings suggest that it may be helpful to encourage and empower practitioners within the workplace to monitor signs of burnout and utilise protective strategies. Examples of such protective practices highlighted within the review included prioritising self-care (Beitel et al., 2018; Sim et al., 2016; Turnbull & Rhodes, 2019; Viehl et al., 2018), utilising emotional support from supervision, co-workers, friends and family (Beitel et al., 2018; Bernier, 1998; Eliacin et al., 2018; Hammond et al., 2018; Sim et al., 2016; Turnbull & Rhodes, 2019; Viehl et al., 2018), boundary setting within the workday and maintaining work-life balance (Beitel et al., 2018; Sim et al., 2016; Turnbull & Rhodes, 2019), and potentially engaging in personal therapy (Fischer et al., 2007; Sim et al., 2016; Turnbull & Rhodes, 2019).

Within the line of argument about self-knowledge and boundaries contributing to or protecting against burnout, the meta-ethnography findings highlight the role of cultural beliefs informing practitioner expectations about self-care and boundaries. Within the review, many practitioners had difficulty acknowledging burnout symptoms and appeared to prioritise

'keeping going' over their own well-being, with difficulty asserting boundaries within work (Beitel et al., 2018; Bernier, 1998; Fischer et al., 2007; Hammond et al., 2018; Turnbull & Rhodes, 2019). While limited research into workplace interventions to reduce practitioner burnout exists, many interventions tend to be individually orientated focused on improving practitioner awareness and skills (Awa et al., 2010). The review finding about keeping going may imply that workplace interventions relying on the individual to monitor themselves for signs of burnout and make use of protective and self-caring practices may also require changes in professional cultural expectations that enable practitioners to acknowledge they are struggling and seek help without feeling they are 'letting the side down'. Within the review, professional cultural discomfort with acknowledging vulnerability appeared to play an important role in shaping such 'self-sacrificing' beliefs and behaviour that contribute to burnout. This is also reflected in Tay et al.'s (2018) study of clinical psychologists' experiences of seeking help for mental health difficulties, which found that concerns about negative personal and professional consequences as well as shame were barriers to help-seeking.

These findings from the review about cultural beliefs potentially impeding help-seeking may also have potential implications for clinical training as well as continuous professional development, suggesting an explicit focus on self-care and boundaries may be helpful. They also highlight an area of potential opportunity for mental health professions' representative organisations to promote a culture of openness around practitioner mental health where talking about practitioner vulnerability becomes normalised, enabling a cultural shift that de-stigmatises acknowledging personal struggles. These implication from the review findings are reflected in recent guidance by the British Psychological Society on 'supporting and valuing lived experience of mental health difficulties in clinical psychology training' (British Psychological Society, 2020), and the recent emergence of peer-network organisations such as

‘in2gr8mental health’ (n.d) in the UK which seeks to de-stigmatise and support lived experiences of mental health among mental health professionals.

The meta-synthesis produced a line of argument that organisational culture and values can create a workplace that can be protective against practitioner burnout or contribute to it. Within the review, practitioners’ burnout experiences of feeling out of control and overwhelmed by workloads aligns with quantitative studies by Gibson et al. (2009) and Steel et al. (2015) which found job demands (including workload, hours of work, and psychological labour) significantly predicted emotional exhaustion, which precedes depersonalisation and reduced personal accomplishment in the development of burnout (Maslach, 1999). Practitioners within the review also highlighted the role of reduced autonomy in burnout experience, in particular in relation to ‘productivity’ workplace cultures, and environments where the expected throughput of work was perceived as too high to feel manageable or to be able to do as well as they would like (Beitel et al., 2018; Eliacin et al., 2018; Fischer et al., 2007; Sim et al., 2016; Turnbull & Rhodes, 2019; Viehl et al., 2018). This aligns with quantitative research that has found increased autonomy or job control may reduce or prevent burnout, with the converse contributing to burnout (Lasalvia et al., 2009; Rupert et al., 2009; Steel et al., 2015; Vilardaga et al., 2011). Within the review, practitioners highlighted the value of supervision and co-worker support in managing and mitigating burnout (Beitel et al., 2018; Bernier, 1998; Eliacin et al., 2018; Hammond et al., 2018; Sim et al., 2016; Turnbull & Rhodes, 2019; Viehl et al., 2018), and this finding aligns with quantitative studies that found supervisor support predicted burnout in among mental health therapists (Gibson et al., 2009) and trainee psychiatrists (Jovanović et al., 2016), while supervisor and co-worker support both predicted burnout among addiction counsellors (Vilardaga et al., 2011).

The meta-synthesis line of argument that organisational culture and values create a workplace that can be protective against practitioner burnout or contribute to it draws attention

to factors influencing burnout lying outside individual practitioner control. The review findings about practitioner job control, autonomy, supervision and support in participant burnout experiences, which in turn influence the extent to which an individual is able to self-care and maintain boundaries at work, are influenced by organisational and managerial priorities, values and culture. This suggests that some burnout contributors may be systemic. If so, this may have implications for the way mental health services are designed and managed, particularly for services where practitioner autonomy is low and productivity expectations are high.

Within the meta-ethnography, practitioners predominantly highlighted the depersonalisation attribute of burnout in relation to workplace and personal relationships rather than clients. Negative or distant attitudes towards clients as part of practitioner burnout experience were only highlighted in a minority of studies. A quantitative study with mental health therapists found therapist burnout negatively impacted client treatment outcomes, with the attribute of therapist disengagement, analogous to depersonalisation, associated with treatment outcomes and hypothesised to negatively affect empathy and alliance-building (Delgadillo et al., 2018). This finding from the meta-ethnography may represent a limitation of the original studies, or may highlight an area of further study in relation to how far practitioners experiencing burnout perceive their empathy and alliance building is impacted by their burnout. As the therapeutic relationship is the strongest predictor of successful therapy outcome (Norcross & Lambert, 2019), this may represent an important area of future research to further the understanding of how burnout may impact therapy quality and client outcomes. Given the findings within the meta-ethnography that many practitioners had difficulty acknowledging they were experiencing burnout and tried to keep going, this also raises a potential question about how aware practitioners experiencing burnout are that their therapy quality may be compromised. A potential study in this area could explicitly explore the relationship between burnout and strength of therapeutic relationship and perceived quality of client care utilising a

mixed-method approach with practitioners and their clients. The practitioner group could undertake a quantitative measure of burnout (e.g. with the MBI (Maslach et al., 1981)), and therapeutic alliance (e.g. Working Alliance Inventory (Horvath & Greenberg, 1989)) and qualitative interview about their perception of burnout impact on therapeutic relationship and quality of client care. The client group could also complete the WAI (Horvath & Greenberg, 1989), with follow-up interview about their perception of the therapeutic relationship and quality of care.

Strengths and Limitations

The strength of this review is that it contributes a novel interpretation of the experience of burnout among mental health practitioners from an international perspective. No other qualitative review of burnout experience has been found, which highlights the need for this research.

Within the studies included in the review, staff who had left services because of burnout were not included so their experiences could not be captured by the meta-ethnography, thus included studies may be considered to exhibit survivorship bias. This could be considered a limitation, and burnout experiences of staff who left mental health work due to burnout is an under-researched area for further study.

The included studies were all concerned with the burnout experiences of staff working within diverse mental health settings in the public and private sectors in Canada, New Zealand, USA, and Australia. Data representing findings from different countries and continents can be synthesised if relevance and applicability are considered (Soilemezi & Linceviciute, 2018), and these countries were considered relevant and applicable for data synthesis given all countries are considered ‘core’ anglosphere countries, defined as a group of countries (including the UK) with a similar level of economic development sharing extensive historical, cultural, and

political affinity (Legrand, 2015). The study countries also all adopted the same New Public Management (NPM) governance reforms to their public healthcare systems from the 1980s onwards, constituting marketisation of services within the public sector and a stronger emphasis on performance management and managerialism (Ferlie, 2017), which means health services are likely to be organised and managed more similarly to both each other, and to private sector services compared to non-NPM countries such as Germany and France. However, the included countries all represent countries with a similar level of economic development and extensive historical, cultural, and political affinity (Legrand, 2015), therefore a limitation is that other more dissimilar economic or cultural settings were not represented. The included countries themselves also retain substantial cultural differences which may have influenced variation in the way the already diverse services in the study operated, as well as potentially influencing the different ways participants in the studies experienced burnout, and the researchers interpreted and reported the findings.

Study settings were also broad, including drug rehabilitation settings, social service settings, and solo practice settings, and this diversity and mix of public and private contexts may limit the translatability of findings between settings. Taken together, the diversity of the studies may be considered a strength given similar themes emerged from diverse contexts, but may also be considered a weakness that may limit the generalisability of the findings. Additionally, while services were diverse, they still only represented a subset of mental health settings which may be also considered a limitation.

Within the meta-ethnography the search term, ‘counsellor/counselor’ was omitted in preference to broadly defining variations of therapist and other relevant terms. The search strategy did pick up two studies with different types of counsellors as participants and both were included in the review. However, omission of the term from the original search could

have led to incomplete retrieval of identified research, so this omission should be considered a limitation.

The researcher is a Trainee Clinical Psychologist working within NHS services in the UK and holds views favouring publicly provided health services, and sceptical towards the appropriateness and efficacy of competition and marketisation in relation to service quality and practitioner wellbeing. It is conceivable the review exhibits reporting bias reflecting the researcher position, which could be considered a limitation.

Conclusion

The findings presented in this study provide rich insights into the burnout experiences of mental health practitioners with potential implications for policy and practice. The key findings of the meta-ethnography are that burnout can impact practitioner physical and mental wellbeing and sense of self-efficacy, and that practitioner self-knowledge and boundaries, and organisational culture and values can contribute to or protect against burnout. The findings highlight the importance of factors contributing to burnout that lie outside practitioner control. The role played by professional culture in promoting and maintaining 'self-sacrificing' beliefs and behaviour, and the role played by organisational culture and values are highlighted. The potential gap in understanding of the impact of burnout on therapy quality is also highlighted as an area for further research.

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Table 1: *Search strategy for PsycINFO database (performed 15 January 2021)*

Main search areas	Search terms
Burnout	DE “burnout” OR DE "Compassion Fatigue" OR DE "Emotional Exhaustion" OR DE "Occupational Stress") OR TI (burnout OR burn-out OR "burn out" OR "occupational stress" OR "compassion fatigue") OR AB (burnout OR burn-out OR "burn out" OR "occupational stress" OR "compassion fatigue") AND
Discipline	DE "Mental Health Personnel" OR DE "Clinical Psychologists" OR DE “support workers” OR DE “occupational therapists” OR DE "Psychiatric Hospital Staff" OR DE "Psychiatric Nurses" OR DE "Psychiatric Social Workers" OR DE "Psychiatrists" OR DE "Psychotherapists" OR DE "School Psychologists" OR DE "Psychiatric Hospital Staff" OR DE "Attendants (Institutions)" OR DE "Psychiatric Aides" OR DE "Psychotherapists" OR DE "Hypnotherapists" OR DE "Psychoanalysts" OR “high intensity therapists” OR “low intensity therapists” OR “IAPT”) OR TI (psychiatrist* OR psychologist* OR psychotherapist* OR occupational therapist* OR ("psych* (doctor* OR nurse* OR aide OR aides OR attendant*")) OR AB (psychiatrist* OR psychologist* OR psychotherapist* OR occupational therapist* OR ("psych* (doctor* OR nurse* OR aide OR aides OR attendant*") OR (“mental health (staff OR support worker* OR nurse* OR worker*”)) AND
Methodology	(DE "Qualitative" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Interview" OR DE "Thematic Analysis") OR TI ((qualitative N5 (research OR study OR method*) OR interview* OR interpret* OR narrative OR phenomenolog* OR "grounded theory" OR "mixed method*" OR mixed-method*) OR AB ((qualitative N5 (research OR study OR method*)) OR interview* OR interpret* OR narrative OR phenomenolog* OR "grounded theory" OR "mixed method*" OR mixed-method*)

Table 2. *Study Inclusion and Exclusion Criteria*

Inclusion	**Exclusion**
Published in English	Used quantitative methodology
Used qualitative methodology	Primary focus concerned with related but different concept to burnout (e.g. compassion fatigue, workplace stress etc.)
Participants are staff working in mental health services delivering talking therapies	
Concerned with staff experience of burnout	

Table 3

Study Characteristics

Study	Researcher discipline	Country	Methodology	Sample	Study Aims
Bernier (1998)	Social Work	Canada	Grounded Theory	20 human service workers: psychologists, psychoeducators, social workers, criminologists	To explore the situational determinants of coping with severe reactions to work-related stress, including burnout
Fischer, Kumar, & Hatcher (2007)	Psychiatry	New Zealand	Grounded Theory	12 psychiatrists	To explore causative and protective facts associated with burnout in New Zealand psychiatrists
Sim, Zanardelli, Loughran, Mannarino & Hill (2016)	Psychology	USA	Consensual Qualitative Research	14 counselling psychologists	To examine thriving, burnout, and coping strategies of early and later career counselling psychologists
Beitel, Oberleitner, Muthuligam, Oberleitner, Madden, Marcus, Eller, Bono, & Barry (2018)	Psychology, Psychiatry	USA	Grounded Theory	31 counsellors	To examine experiences of burnout and approaches for managing and/or preventing burnout
Eliacin, Flanagan, Monroe-DeVita, Wasmuth, Salyers, & Rollins (2018)	Psychology, Psychiatry, Occupational Health	USA	Thematic Analysis	40 mental healthcare providers (behavioural health, substance use, and psychiatric rehabilitation; profession job groups not identified)	To explore how workplace social environment can impact burnout
Hammond, Crowther, & Drummond (2018)	Nursing, Midwifery and Indigenous Health	Australia	Thematic Analysis	6 clinical psychologists	To explore clinical psychologists' different experiences of burnout

Viehl, Dispenza, Smith, Varney, Guvensel, Suttles, McCullough, Chang, Brack, & Kaufmann (2018)	Human Growth & Development, Psychology & Counselling, Education	USA	Constructivist Grounded Theory	21 mental health practitioners	To examine the experiences of burnout among sexual minority identified male mental health practitioners
Turnbull & Rhodes (2019)	Psychology	Australia	Narrative Inquiry	17 clinical psychologists	To explore the lived experiences of Australian psychologists in relation to burnout, recovery, and broader wellbeing

Table 4

Translating studies into one another

	Study concepts							
First order constructs	**Bernier (1998)**	**Fischer et al. (2007)**	**Sim et al. (2016)**	**Beitel et al. (2018)**	**Eliacin et al. (2018)**	**Hammond et al. (2018)**	**Viehl et al. (2018)**	**Turnbull & Rhodes (2019)**
Idealised carer expectations	Desire for perfection	High expectations of self	-	Importance of keeping going	-	Client needs valued above clinicians'/ pressure of peer expectations	Personal priority on helping clients	Idealised image of profession and expectations of self
Burnout awareness / difficulty acknowledging vulnerability	Reluctance to acknowledge problems	Personality traits towards perfectionistic / obsessive	Gaining self awareness	Denial of burnout	Attitudes influenced by leadership	Lack of understanding about burnout	Self-care deemphasised	Overlooking early warnings / stigma around admitting difficulties
Boundaries and personal balance	Limitless involvement in work / balance	Boundaries and balance	Setting boundaries and self-care	Work life boundaries	Asserting boundaries to meet goals	Difficulties maintaining boundaries / life stresses	Boundaries and work life balance	Work life boundaries and identity outside work
Self-knowledge and awareness	Lack of self awareness / need for external confirmation	Knowing what supports you	Self awareness / adjusting perspective	Knowing what helps you cope	-	Inadequate education of self-care	Recognising and valuing own needs	Knowing your own stuff / accepting own vulnerability

Impact on self & perceived quality of care	Threat to identity	Importance of feeling as though helping people	Defeated / loneliness and isolation	Ruminating about patients	Impacted relationships with clients	Decreased personal accomplishment	Letting clients down / lack of fulfilment and self-doubt	Loss of confidence and feeling failure / reduced efficacy
Physical impact of burnout	Physical symptoms	Worn down and fatigued	Drained and exhausted	Physiological / tiredness	-	Fatigue	Declining health and physical symptoms	Onset of physical impact
Emotional impact of burnout	Impacted moods and feelings / distancing	Changes in mood / irritability	Emotional stress, fantasies about leaving	Emotional fatigue / overwhelm / irritability	Decreased empathy / irritable and impatient	Emotional exhaustion and mood impact / avoidance	Emotional impact affecting relationships in and out of work / leaving work	Emotional exhaustion and mentally checking out
Supported / unsupported carer	Lack of support from colleagues & managers	Supportive relationships	Interpersonal support	Peer support	Unfriendly and isolating atmosphere	Trusting long-term relationships	Responsibility for boundaries and self-care on the individual	Support from managers and policies
Team spirit	-	Feeling backed up	Co-workers relationships / support	Companionship with co-workers	Team buffering stress / social capital	-	Feeling unsafe among colleagues	-
Value of supervision	Conflict in values with supervisors	Professional support	Relationships with supervisors	Importance of supervision	Supportive supervision	Importance of supervisor relationship	Values disconnect with supervisors	Importance of quality supervision
Workload	Overwork & heavy bureaucracy	Excessive work and admin	Challenges with workload	Job demands	Productivity demands	Excessive workload / work hours and lack of control	Pressure to see clients	Unreasonable workloads
Workplace culture	Organisational mission and structure / values	Responsibility without control	Climate of workplace	Staffwide encounters and communication	Organisational context /values influencing workplace / social isolation	Financial considerations influencing workload	Administrative responsibilities over client care, productivity over self-care	Workplace culture

Second order constructs								
(a) Individual awareness and ability to seek support influences burnout experience	*Individuals have difficulty admitting there is a problem*	*Personality traits (perfectionism and obsessiveness), could contribute burnout*	*Maintaining self-awareness seems especially important for healthcare workers*	-	*Higher level staff set the tone for a workplace supportive norms*	*Fallacy of client expectations and needs being more important is a contributor to burnout*	-	*Internal expectations and professional culture contributed to need to meet high expectations*
(b) Personal development and boundaries can protect against burnout and lead to growth	*Burnout experience influencing, boundaries and growth*	*Paying attention to boundaries and personal life is protective against burnout*	*Boundaries and self-care help to manage burnout*	*Maintaining work-life boundaries enabled protective practices*	-	*Being well-informed about burnout and self care would enable adaptation of work styles and coping strategies*	*Maintaining balance and own needs used as a buffer to burnout*	*Attending to self-care and boundaries enables restoration of balance*
(c) Individuals experience physical symptoms, emotional pressure, and self-doubt	*Burnout experience can involve intense physical and emotional impacts which can challenge identity, necessitating a dynamic recovery process*	*Burnout causes changes in appearance, behaviour, and mood*	-	*Felt components of burnout included cognitive, affective, behavioural, physiological, and a blend of these*	-	*Burnout experience includes a variety of physical and emotional impacts*	*Burnout impacts included physical and emotional components and self-doubt about career choices*	*Burnout experience encompasses physical and mental impacts of varying intensity and duration*

(d) Quality of workplace relationships and support can influence burnout experience	-	*Professional, managerial, and peer support and personal relationships with colleagues are protective against burnout*	*Interpersonal support and quality of professional relationships influences burnout*	*Supervision and co-worker support are important in reducing burnout*	*Social and emotional support from colleagues and supervision can positively influence burnout*	*Trusting and long term relationships protect against burnout*	-	*Interpersonal support including quality supervision are important in protecting against burnout*
(e) Workplace priorities and climate can influence burnout	*Organisational orientation can influence coping and recovery*	*Organisational climate and priorities influence vulnerability and support*	*Workload and workplace climate influence burnout*	*Organisations that support individual self-care and workplace protective practices may be most effective at reducing burnout*	*Work environment and practices can undermining social capital, contributing to burnout*	*Excessive workload and work schedule contribute to burnout*	*Mental health field and organisation as systemic contributors to burnout*	*Workplace culture contributed to perceived need to meet high expectations*

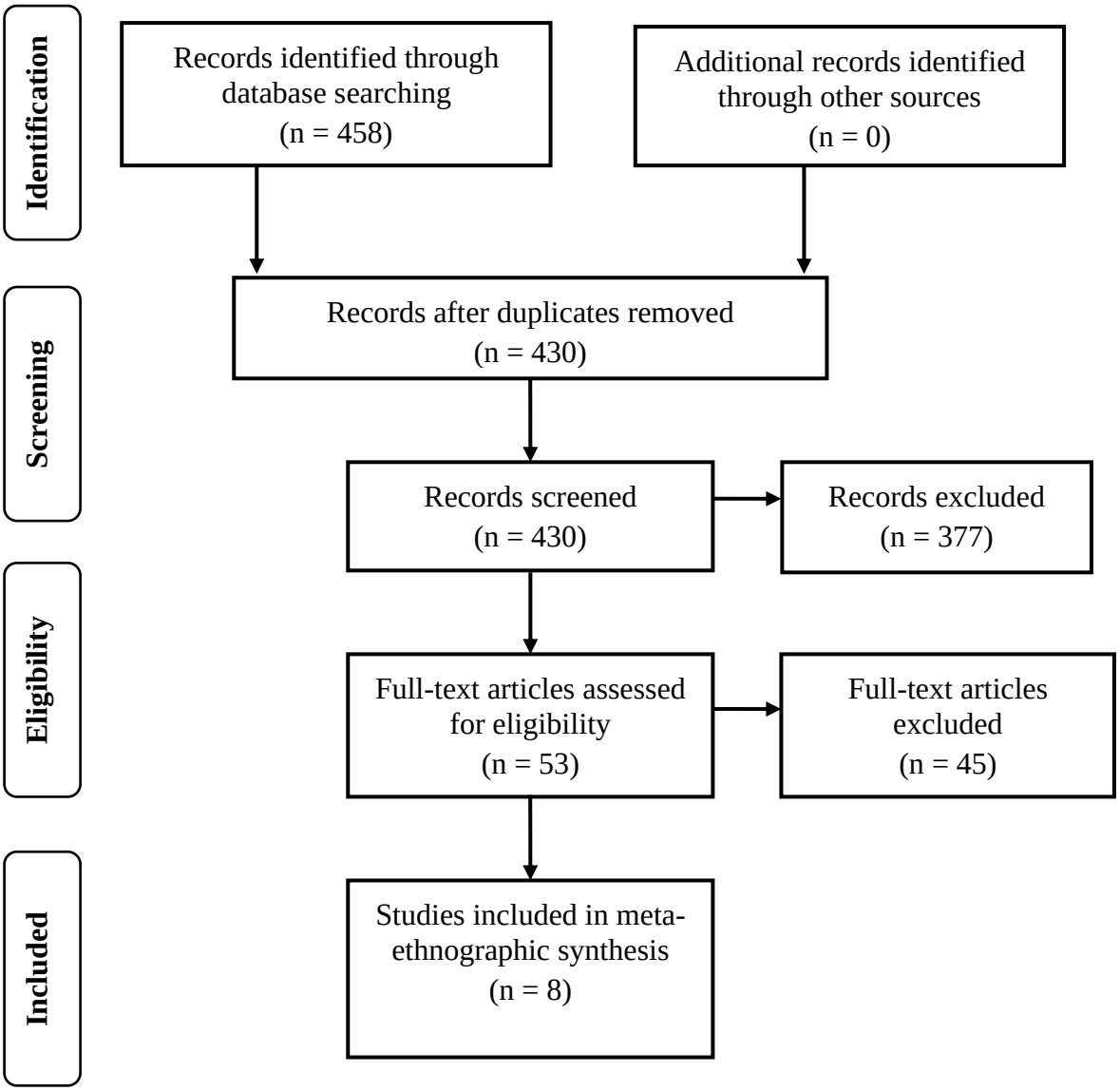
Table 5

Synthesis, encompassing first order constructs, second order constructs and third-order interpretations

First-order constructs	**Second-order constructs**	**Third-order interpretations**
Idealised carer expectations of self Burnout awareness / difficulty acknowledging vulnerability	(a) Extent of individual awareness of burnout and ability to seek support influences burnout experience	(f) Self-knowledge and boundaries can contribute to or protect against burnout
Boundaries and personal balance Self-knowledge and awareness	(b) Personal development and boundaries can protect against burnout and lead to growth	
Impact on self and perceived quality of care Physical impact of burnout Emotional impact of burnout	(c) Individuals experience intense emotional pressure, physical symptoms, and self-doubt	(g) Burnout can compromise carer's sense of self-efficacy and mental and physical wellbeing
Supported or unsupported carer Team spirit Value of supervision	(d) Quality of workplace relationships and support can influence burnout experience	(h) Workplace culture and values create an environment that contributes to or protects against burnout
Workload Workplace culture	(e) Workplace priorities and climate can influence burnout	

Figure 1

PRISMA Flow Diagram



Moher et al. (2009)

Appendix 1-A

CASP scores

	1. Clear statement of research aims?	2. Qualitative meth. Appropriate ?	3. Design appropriate to research aims?	4. Recruitment strategy appropriate to aims?	5. Data collection addressing research issues?	6. Relationship between researchers & participants considered?	7. Ethical issues considered?	8. Data analysis sufficiently rigorous?	9. Clear statement of findings?	10 How valuable is the research?
Bernier (1998)	3	3	2	3	3	2	2	3	2	3
Fischer, Kumar, & Hatcher (2007)	3	3	2	2	3	2	2	2	3	3
Sim, Zanardelli, Loughran, Mannarino & Hill (2016)	3	3	2	2	3	3	2	2	3	2
Beitel, Oberleitner, Muthuligam, Oberleitner, Madden, Marcus, Eller, Bono, & Barry (2018)	2	3	3	2	3	2	3	2	3	3
Eliacin, Flanagan, Monroe-DeVita, Wasmuth, Salyers, & Rollins (2018)	3	3	3	3	3	2	2	3	3	3
Hammond, Crowther, & Drummond (2018)	3	3	3	3	3	2	3	3	2	3
Viehl, Dispenza, Smith, Varney, Guvensel, Suttles, McCullough, Chang, Brack, & Kaufmann (2018)	3	3	3	3	3	3	2	3	3	3
Turnbull & Rhodes (2019)	3	3	3	2	2	3	3	3	3	3

Appendix 1-B

Author Guidelines

The Journal of Mental Health Training, Education and Practice (JMHTEP) highlights critical issues in educating and developing a skilled, healthy and committed mental health workforce. *JMHTEP* draws upon international experiences, reflecting common global challenges as well as the scope for international learning and development.

The journal takes a broad interdisciplinary approach and acknowledges that all mental health disciplines have an important role in workforce development. Integral to this approach is the meaningful involvement of service users and their families.
JMHTEP includes:

- Research papers which contribute to the evidence base
- Case studies and narrative accounts of innovative programmes or evidence in practice of new methods of working
- Viewpoint, expert opinion or conceptual papers
- Literature reviews
- Review papers

JMHTEP is a high quality source of information and evidence for managers, practitioners, researchers, students and trainers.

Manuscript requirements

Before you submit your manuscript, it's important you read and follow the guidelines below. You will also find some useful tips in our **structure your journal submission** how-to guide.

Format	Article files should be provided in Microsoft Word format While you are welcome to submit a PDF of the document alongside the Word file, PDFs alone are not acceptable. LaTeX files can also be used but only if an accompanying PDF document is provided. Acceptable figure file types are listed further below.
Article length / word count	Articles should be between 3500 and 6500 words in length. This includes all text, for example, the structured abstract, references, all text in tables, and figures and appendices. Please allow 350 words for each figure or table.
Article title	A concisely worded title should be provided.

Author details	The names of all contributing authors should be added to the ScholarOne submission; please list them in the order in which you'd like them to be published. Each contributing author will need their own ScholarOne author account, from which we will extract the following details: • Author email address (institutional preferred). • Author name. We will reproduce it exactly, so any middle names and/or initials they want featured must be included. • Author affiliation. This should be where they were based when the research for the paper was conducted. In multi-authored papers, it's important that ALL authors that have made a significant contribution to the paper are listed. Those who have provided support but have not contributed to the research should be featured in an acknowledgements section. You should never include people who have not contributed to the paper or who don't want to be associated with the research. Read about **our research ethics** for authorship.
Biographies and acknowledgements	If you want to include these items, save them in a separate Microsoft Word document and upload the file with your submission. Where they are included, a brief professional biography of not more than 100 words should be supplied for each named author.
Research funding	Your article must reference all sources of external research funding in the acknowledgements section. You should describe the role of the funder or financial sponsor in the entire research process, from study design to submission.
Structured abstract	All submissions must include a structured abstract, following the format outlined below. These four sub-headings and their accompanying explanations must always be included: • Purpose • Design/methodology/approach • Findings • Originality The following three sub-headings are optional and can be included, if applicable: • Research limitations/implications • Practical implications • Social implications You can find some useful tips in **our write an article abstract** how-to guide.

	The maximum length of your abstract should be 250 words in total, including keywords and article classification (see the sections below).
Keywords	Your submission should include up to 12 appropriate and short keywords that capture the principal topics of the paper. Our Creating an SEO-friendly manuscript how to guide contains some practical guidance on choosing search-engine friendly keywords. Please note, while we will always try to use the keywords you've suggested, the in-house editorial team may replace some of them with matching terms to ensure consistency across publications and improve your article's visibility.
Article classification	During the submission process, you will be asked to select a type for your paper; the options are listed below. If you don't see an exact match, please choose the best fit: • Expert opinion paper/ viewpoint • Research Paper • Literature Review • Impact case study • Conceptual paper • Service user perspective • Case Study • Book Review You will also be asked to select a category for your paper. The options for this are listed below. If you don't see an exact match, please choose the best fit: Research paper. Reports on any type of research undertaken by the author(s), including: • The construction or testing of a model or framework • Action research • Testing of data, market research or surveys • Empirical, scientific or clinical research • Papers with a practical focus Viewpoint. Covers any paper where content is dependent on the author's opinion and interpretation. This includes journalistic and magazine-style pieces. Technical paper. Describes and evaluates technical products, processes or services. Conceptual paper. Focuses on developing hypotheses and is usually discursive. Covers philosophical discussions and comparative studies of other authors' work and thinking. Case study. Describes actual interventions or experiences within organizations. It can be subjective and doesn't generally report on research. Also covers a description of a legal case or a hypothetical case study used as a teaching exercise. Literature review. This category should only be used if the main purpose of the paper is to annotate and/or critique the literature in a particular field. It could be a selective bibliography providing advice on information sources, or the paper may

	aim to cover the main contributors to the development of a topic and explore their different views. General review. Provides an overview or historical examination of some concept, technique or phenomenon. Papers are likely to be more descriptive or instructional ('how to' papers) than discursive.
Headings	Headings must be concise, with a clear indication of the required hierarchy. The preferred format is for first level headings to be in bold, and subsequent sub-headings to be in medium italics.
Notes/endnotes	Notes or endnotes should only be used if absolutely necessary. They should be identified in the text by consecutive numbers enclosed in square brackets. These numbers should then be listed, and explained, at the end of the article.
Figures	All figures (charts, diagrams, line drawings, webpages/screenshots, and photographic images) should be submitted electronically. Both colour and black and white files are accepted. There are a few other important points to note: • All figures should be supplied at the highest resolution/quality possible with numbers and text clearly legible. • Acceptable formats are .ai, .eps, .jpeg, .bmp, and .tif. • Electronic figures created in other applications should be supplied in their original formats and should also be either copied and pasted into a blank MS Word document, or submitted as a PDF file. • All figures should be numbered consecutively with Arabic numerals and have clear captions. • All photographs should be numbered as Plate 1, 2, 3, etc. and have clear captions.
Tables	Tables should be typed and submitted in a separate file to the main body of the article. The position of each table should be clearly labelled in the main body of the article with corresponding labels clearly shown in the table file. Tables should be numbered consecutively in Roman numerals (e.g. I, II, etc.). Give each table a brief title. Ensure that any superscripts or asterisks are shown next to the relevant items and have explanations displayed as footnotes to the table, figure or plate.
References	All references in your manuscript must be formatted using one of the recognised Harvard styles. You are welcome to use the Harvard style Emerald has adopted – we've provided a detailed guide below. Want to use a different Harvard style? That's fine, our typesetters will make any necessary changes to your manuscript if it is accepted. Please ensure you check all your citations for completeness, accuracy and consistency. Emerald's Harvard referencing style

	References to other publications in your text should be written as follows: • Single author: (Adams, 2006) • Two authors: (Adams and Brown, 2006) • Three or more authors: (Adams *et al.*, 2006) Please note, '*et al*' should always be written in italics. A few other style points. These apply to both the main body of text and your final list of references. • When referring to pages in a publication, use 'p.(page number)' for a single page or 'pp.(page numbers)' to indicate a page range. • Page numbers should always be written out in full, e.g. 175-179, not 175-9. • Where a colon or dash appears in the title of an article or book chapter, the letter that follows that colon or dash should always be lower case. • When citing a work with multiple editors, use the abbreviation 'Ed.s'. At the end of your paper, please supply a reference list in alphabetical order using the style guidelines below. Where a DOI is available, this should be included at the end of the reference.
For books	Surname, initials (year), *title of book*, publisher, place of publication. e.g. Harrow, R. (2005), *No Place to Hide*, Simon & Schuster, New York, NY.
For book chapters	Surname, initials (year), "chapter title", editor's surname, initials (Ed.), *title of book*, publisher, place of publication, page numbers. e.g. Calabrese, F.A. (2005), "The early pathways: theory to practice – a continuum", Stankosky, M. (Ed.), *Creating the Discipline of Knowledge Management*, Elsevier, New York, NY, pp.15-20.
For journals	Surname, initials (year), "title of article", *journal name*, volume issue, page numbers. e.g. Capizzi, M.T. and Ferguson, R. (2005), "Loyalty trends for the twenty-first century", *Journal of Consumer Marketing*, Vol. 22 No. 2, pp.72-80.
For published conference proceedings	Surname, initials (year of publication), "title of paper", in editor's surname, initials (Ed.), *title of published proceeding which may include place and date(s) held*, publisher, place of publication, page numbers. e.g. Wilde, S. and Cox, C. (2008), "Principal factors contributing to the competitiveness of tourism destinations at varying stages of development", in Richardson, S., Fredline, L., Patiar A., & Ternel, M. (Ed.s), *CAUTHE 2008: Where the 'bloody hell' are we?*, Griffith University, Gold Coast, Qld, pp.115-118.
For unpublished conference proceedings	Surname, initials (year), "title of paper", paper presented at [name of conference], [date of conference], [place of conference], available at: URL if freely available on the internet (accessed date). e.g. Aumueller, D. (2005), "Semantic authoring and retrieval within a wiki", paper presented at the European Semantic Web Conference (ESWC), 29 May-1 June,

	Heraklion, Crete, available at: http://dbs.uni-leipzig.de/file/aumueller05wiksar.pdf (accessed 20 February 2007).
For working papers	Surname, initials (year), "title of article", working paper [number if available], institution or organization, place of organization, date. e.g. Moizer, P. (2003), "How published academic research can inform policy decisions: the case of mandatory rotation of audit appointments", working paper, Leeds University Business School, University of Leeds, Leeds, 28 March.
For encyclopaedia entries (with no author or editor)	*Title of encyclopaedia* (year), "title of entry", volume, edition, title of encyclopaedia, publisher, place of publication, page numbers. e.g. *Encyclopaedia Britannica* (1926), "Psychology of culture contact", Vol. 1, 13th ed., Encyclopaedia Britannica, London and New York, NY, pp.765-771. (for authored entries, please refer to book chapter guidelines above)
For newspaper articles (authored)	Surname, initials (year), "article title", *newspaper*, date, page numbers. e.g. Smith, A. (2008), "Money for old rope", *Daily News*, 21 January, pp.1, 3-4.
For newspaper articles (non-authored)	*Newspaper* (year), "article title", date, page numbers. e.g. *Daily News* (2008), "Small change", 2 February, p.7.
For archival or other unpublished sources	Surname, initials (year), "title of document", unpublished manuscript, collection name, inventory record, name of archive, location of archive. e.g. Litman, S. (1902), "Mechanism & Technique of Commerce", unpublished manuscript, Simon Litman Papers, Record series 9/5/29 Box 3, University of Illinois Archives, Urbana-Champaign, IL.
For electronic sources	If available online, the full URL should be supplied at the end of the reference, as well as the date that the resource was accessed. Surname, initials (year), “title of electronic source”, available at: persistent URL (accessed date month year). e.g. Weida, S. and Stolley, K. (2013), “Developing strong thesis statements”, available at: https://owl.english.purdue.edu/owl/resource/588/1/ (accessed 20 June 2018) Standalone URLs, i.e. those without an author or date, should be included either inside parentheses within the main text, or preferably set as a note (Roman numeral within square brackets within text followed by the full URL address at the end of the paper).

For data	Surname, initials (year), *title of dataset*, name of data repository, available at: persistent URL, (accessed date month year). e.g. Campbell, A. and Kahn, R.L. (2015), *American National Election Study, 1948*, ICPSR07218-v4, Inter-university Consortium for Political and Social Research (distributor), Ann Arbor, MI, available at: https://doi.org/10.3886/ICPSR07218.v4 (accessed 20 June 2018)

Section Two: Research Paper

How organisational factors influence clinical psychologists' decisions to leave the NHS

Word count: 7,998

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Abstract

Background: The wellbeing of the mental health workforce is an area of concern, with problems of burnout and retention of particular interest. Research has highlighted the role of organisational issues in burnout and turnover, yet limited research has explored how organisational factors may influence decisions to leave the NHS. *Aims*: The aims of the study were to explore how organisational factors may influence clinical psychologists' decisions to leave the NHS. *Method*: Seven participants were interviewed and grounded theory methodology was used. *Results*: Organisational processes perceived to influence decisions to leave the NHS consisted of: trying to achieve the impossible, cycle of imposed change, and shifting organisational valuing. Psychologist categories describing participant experience and coping in relation to organisational processes, with impacts contributing to decisions to leave consisted of: striving for autonomy and integrity, valuing people, trying to make things better, seeking sustainability and growth, and a push to leave / pull to return. A tentative conceptual model was presented. *Conclusions*: Organisational factors played a role in participant decisions to leave the NHS. *Declarations of interest*: None

Key Practitioner Message

- Organisational factors can play a role in clinical psychologists' wellbeing and retention

Keywords: Clinical psychology; retention; organisational issues; NHS

The mental wellbeing of health professionals has become a growing area of concern in recent years, and poor wellbeing is considered a threat to care quality (Søvold et al., 2021). As links between staff mental wellbeing, retention, sickness absence, and burnout, as well as patient outcomes and satisfaction, have become better understood, more focus and importance has been attached to improving staff wellbeing (Boorman, 2009; National Institute for Health and Clinical Excellence, 2009; Stevens, 2014). The World Health Organisation (WHO) projects an estimated global shortfall of 18 million health workers by 2030 (World Health Organization, 2016). Staff wellbeing is considered an essential factor in both attracting and retaining skilled staff, and delivering safe effective services on a sustainable basis (Hall et al., 2016; Health Education England, 2019; Stevens, 2014).

Wellbeing is defined in terms of a spectrum with happiness and flourishing at one end and anxiety and depression at the other (Johnson & Wood, 2017). In the healthcare and mental healthcare workforce much research has focused on burnout, which has often been treated as a proxy measure of wellbeing (Hall et al., 2016; Lizano, 2015). Classified by the International Classification of Diseases as a 'state of vital exhaustion' (World Health Organisation, 2019), burnout consists of three dimensions of emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach et al., 1981). Staff burnout is associated with sickness absence and turnover (Rollins et al., 2010; Schaufeli et al., 2009), and is of particular concern within the mental health workforce where rates are among the highest of any health speciality (Paris & Hoge, 2010). High levels of burnout have been found in between 21 percent to 67 percent of mental health practitioners across a variety of US and UK studies (G. Morse et al., 2012), and rates up to 68.6 percent within UK Improving Access to Psychological Therapies (IAPT) practitioners (Westwood et al., 2017).

The focus on burnout makes sense given psychotherapeutic work is considered particularly challenging; practitioners are exposed to high emotional demands, may manage

significant risks, often have little autonomy over their workload and excessive demands on their time, and may be exposed to secondary distress and trauma (D'Souza et al., 2011; Rupert & Morgan, 2005; Westwood et al., 2017). However, the burnout research base leans heavily on correlational studies, which makes determining causal relationships difficult (Yang & Hayes, 2020). The relationship between wellbeing and burnout has also been contested in the literature, and a systematic review by Lizano (2015) considered burnout and wellbeing separate but related constructs, concluding that the relationship between them remained unclear.

A qualitative study by McLellan (2018) explored the domains perceived as impacting the wellbeing of psychological practitioners working in the UK National Health Service (NHS). The study identified five key themes. Personal Support consisted of friends and family, colleagues, and supervision. 'Traumatised Systems' (the NHS context), consisted of demands and pressure, and hopelessness. Positive and Negative job aspects, consisted of control and autonomy, feeling valued, opportunities to learn, a 'safe space', balance, and synergy of job with personal life. Inter-professional Agents consisted of management, and understanding. Drive to Improve Staff Wellbeing, consisted of hope, and support for staff. McLellan (2018) noted that participants focused more on frustrations related to organisational issues rather than client work. This mirrors findings by Sciberras and Pilkington (2018) where psychologists perceived their negative emotions arising from their organisational context (the Maltese public health system) were more distressing than those from client work.

Drawing on McLellan's (2018) study, Summers et al. (2020) developed a psychological practitioner workplace wellbeing measure (PPWWM) incorporating features considered relevant to psychological practitioner wellbeing. These included clinical supervision, organisational factors (culture and climate), physical environment, and support from outside work. The first PPWWM study investigated UK psychological practitioner

wellbeing, found wellbeing below the general population, and lower in NHS-employed versus private/independent and third/charitable sector groups. It also found small but significant negative wellbeing correlations with age, post-qualification years, and pay scale, meaning higher pay was not associated with higher wellbeing (Summers, Morris, Bhutani, et al., 2020). While wellbeing and burnout are not synonymous as previously noted, the finding contrasts with international research where younger, less experienced psychologists typically score much higher on measures of burnout (Di Benedetto & Swadling, 2014; Dorociak et al., 2017; Rupert et al., 2009) and become more satisfied as they progress in their careers. Given 88 percent of study respondents were NHS-employed, this suggests NHS-specific organisational factors impacting wellbeing may warrant investigation.

Workforce wellbeing surveys of UK psychological professions have highlighted consistently high rates of practitioners wanting to leave the NHS, with up to 74.7 percent reporting wanting to leave ‘at least once or twice a year’ in the most recent survey (Summers, Morris, Bhutani, et al., 2020); clinical psychologists constituted 49 percent of respondents. The Clinical Psychology Workforce Report (Longwill, 2015) found that the ‘overwhelming majority’ of UK clinical psychologists work in the NHS and have high historic retention levels, but noted a possible growing trend of working outside the NHS (including self-employment). Lavender and Chatfield (2016) also noted the proportion of graduates of a clinical psychology training programme working in private practice increased from 8.2 percent to 13.8 percent between 2012 and 2016. A recent survey by the British Psychological Society highlighted widespread role vacancies and difficulty recruiting to posts, influencing additional workload for other staff, reduced service quality, and longer waiting lists (Rhodes, 2020). However, there is a lack of research into clinical psychologist retention and reasons they may be leaving the NHS, in contrast to other health professionals such as GPs (Doran et

al., 2016), Allied Health Professionals (Loan-Clarke et al., 2010), and Speech and Language Therapists (Loan-Clarke et al., 2009).

Studies into the impact of NHS organisational change have highlighted how changes are often perceived as conflicting with professional values and integrity, undermining the focus on clinical work, and negatively impacting morale (Colley et al., 2015; Hanley et al., 2017; Kingswood, 2014; Nutt & Keville, 2016). The NHS trains and employs the vast majority of UK clinical psychologists; it has undergone regular and frequent organisational change since its foundation, and clinical psychology has changed alongside it (Turpin & Llewelyn, 2009). However, from the 1980s onwards, the drivers of change in the NHS have increasingly focussed on 'efficiency' and 'value for money' (Gordon, 2008). The role and focus of clinical psychology within the NHS has shifted and narrowed (Hassall & Clements, 2011), and the 'industrialisation' of services (Ballatt & Campling, 2011) has increased pressure to perform a more psychotherapy-focussed role defined by service managers and commissioners, accompanied by 'the requirement to achieve stringent performance targets set by commissioners, the progressive dismantling of professional line management, the micro-management of professionals' work, and [a] reduction in security and professional identity' (Hassall & Clements, 2011, p.8). Since 2010 the austerity agenda added pressures as cuts were made to mental health services tasked with managing both more complex cases and more referrals, leading to increased stress, exhaustion, and burnout (Wilkinson, 2015). A review by Durdy and Bradshaw (2014) highlighted how recent NHS organisational change was perceived to have had a predominantly negative impact on mental health professionals. In a qualitative study with Child and Adolescent Mental Health Services (CAMHS) staff Kingswood (2014, p.45) suggested 'the greater impact appeared to concern changes encroaching on deep-seated values and priorities, clinical preserves, territory, implicating clinical role and identity'. Together with Summers et al.'s (2020) findings, these

developments may have implications for the role of clinical psychology and long-term viability of the NHS clinical psychology workforce. As yet, no studies have explored the reasons clinical psychologists may be leaving the NHS. Thus, the aims of this study were to understand how organisational factors may influence clinical psychologists' decisions to leave the NHS.

Method

Design

Qualitative methods can be useful for early explorations into poorly understood areas (Sullivan & Forrester, 2019). My research question and position informed the choice of constructivist grounded theory (GT) methodology (Charmaz, 2014) as well fitting the area of study, and aligning with my own position and values with its emphasis on mutuality and reciprocity between researcher and participant in the construction of meaning (Mills et al., 2006). Constructivist GT provides a systematic inductive method for qualitative research which enables meaning to develop as theoretical sampling and constant comparative analysis are conducted, which can be put to work pragmatically (Timonen et al., 2018). Rather than beginning with a theoretical framework, constructivist GT aims to develop one inductively from the data. The methodology seeks to generate a description which makes sense of participant perspectives via inductive organisation of the data they provide (Charmaz, 2014; Charmaz & Bryant, 2011; Timmermans & Tavory, 2012). Thus constructivist GT represents both a practical methodology, and a product of the inquiry that is conducted (Bryant & Charmaz, 2007). The conceptual model which is developed should enable others to understand participants' experiences, and provide a framework to inform future research in this area (Mills et al., 2006).

Procedure

Recruitment and sampling.

Following ethical approval from the Lancaster University Faculty of Health and Medicine Research Ethics Committee (see Ethics section), recruitment took place via an advert placed within the 'UK based Clinical Psychology Facebook Group', a private members group of qualified clinical psychologists. Inclusion criteria were having worked for the NHS as a clinical psychologist for at least a year post-qualification, left the NHS within the previous 3 years, and left for reasons other than retirement. Exclusion criteria were still being employed by the NHS part time or still under contract with the NHS even if in the process of leaving. Potential participants meeting the criteria could opt in by reviewing a Participant Information Sheet and completing the eligibility screening questions on a Qualtrics website created for the study. Individuals could contact the researcher with any further questions before deciding to opt into the study. Sandelowski (1995, p,183) suggests choosing a sample big enough to enable new and rich understanding, while small enough to allow 'deep case-orientated analysis', therefore a sample size of 10-15 was sought, utilising a snowball/total population sampling approach.

Participants.

Fourteen individuals opted into the study. The researcher contacted these individuals to schedule the interview and answer any further questions. Three participants did not to meet the eligibility criteria (still employed in the NHS part time or still in the process of leaving), and four participants did not respond when contacted. Further attempts to contact them were unsuccessful so this was taken to mean they no longer wished to take part. The recruitment period coincided with the beginning of Covid-19 lockdown and it was assumed this may have played a role in some participants not responding. Thus, seven UK-qualified clinical

psychologists who left the NHS between 2018 and 2020 for reasons relating to organisational issues and values participated. Given the number of participants and snowball/total population approach adopted, this meant purposive sampling was not possible. Tables 1 and 2 contain an overview of participant characteristics and demographics.

---Table 1 here---

---Table 2 here---

Data Collection.

Data were collected through semi-structured interviews conducted remotely via online video calls. At the beginning of each interview, participants were asked to confirm they had read the Participant Information Sheet and invited to ask any further questions. The consent form was read out and verbal consent recorded before the interview took place. Interviews lasted between 55 and 75 minutes and were digitally audio recorded. After each interview, recordings were transferred to secure storage before being transcribed. The data were anonymised, and each participant was allocated a pseudonym to ensure anonymity.

Analysis.

Data collection and analysis were carried out simultaneously per grounded theory methodology (Charmaz, 2014). Line by line coding was applied to the first three interview transcripts using gerunds where appropriate to identify processes. Focussed coding were then generated to identify larger chunks of data (see Appendix 2-A). Focussed codes and relevant quotes from the initial three interviews were captured on post-it notes and compared and contrasted applying a method of constant comparison to determine similarities, differences, and relationships (Charmaz, 2014). Through this process, the data were grouped into provisional conceptual themes, informing areas for additional exploration in the subsequent interviews. The remaining interviews were conducted, transcribed, and coded in a similar

manner and the new focussed codes were compared with the provisional conceptual themes, leading to adapting themes, generating new ones as needed, and combining themes to form conceptual categories. Table 3 illustrates how focused codes contributed to conceptual themes, and Table 4 illustrates how themes contribute to categories. Throughout this process memo-writing, free writing, and early conceptual model drafting supported thinking, analysis, and reflection, and helped to conceptualise categories and links between them in a tentative conceptual model (Charmaz, 2014) (Appendix 2-B & 2-C). Throughout this process regular research supervisor discussions were conducted as a further means of checking the rigour of the process and analysis.

Results

After analysis of the data three categories relating to organisational processes, and five categories relating to psychologist experience and coping with organisational processes were constructed. The organisational categories described salient organisational processes perceived to influence decisions to leave the NHS. These consisted of: trying to achieve the impossible, with a contributing theme of unrealistic expectations from the top; cycle of imposed change, with contributing themes of disempowered staff, and repeated top-down change; and shifting organisational valuing, with contributing themes of target culture, increasing power of operational management, and declining power of psychology.

Psychologist categories described participant experience and coping in relation to organisational processes, with impacts contributing to decisions to leave. One theme, upholding values and professional identity, contributed to all psychologist categories and constitutes an existential theme concerned with the psychologists' own values and sense of their role. Psychologist categories consisted of: striving for autonomy and integrity, with a contributing theme of trying to get on with the job; valuing people, with contributing themes of maintaining commitment to clients, and struggling with unvalued self and staff; trying to

make things better, with a contributing theme of struggling to innovate and improve; seeking sustainability and growth, with contributing themes of recognising and prioritising own needs, and seeking opportunities to develop. The final psychologist category was push to leave / pull to return, with contributing themes of pushed to leave, and pulled to return. Table 4 details each category and contributing themes. The categories are presented narratively after which a tentative conceptual model is presented.

Organisational concepts

Trying to achieve the impossible

This concept is contributed to by a single conceptual theme, trying to achieve the impossible, and describes pressure perceived to derive from the competitive commissioning environment leading senior management to over-promise to win or retain contracts, leading to unrealistic expectations of services and clinicians, and pressure on staff to deliver to targets perceived as impossible.

Participants perceived unrealistic expectations about what services could deliver came from the top of the organisation down and saw this as related to the competitive commissioning environment coupled with a constrained funding environment: "[Senior management] are always trying to achieve the impossible rather than saying, actually what you're commissioning is just not achievable. I think that's the whole dodgy foundation that all of this is sat on" (Diane). Participants perceived that pressure to win and retain service contracts led senior NHS management to over-commit, leading to services being tied to contracts that were impossible to deliver. Senior management were seen as unwilling to assert to commissioners what was achievable. Cuts were seen as having escalated these competitive pressures: "…I think the model now is much, much harsher in that respect. Much more about bottom lines and promising things you can't deliver." (Fran). There was recognition that senior management were responding to pressures of the competitive commissioning system

which shaped their behaviour: "…everyone was just tired and broken by the system, you know the senior management were tired and broken by the system and they needed to do what it took to win the bid." (Barbara).

A dynamic was described where clinicians' perception of what was achievable and the indicators services were held accountable against diverged: "I feel like when the CQC comes along… it's a bit of a joke. Because they're looking at assessing us on standards that are not really very realistic in the first place. Things like waiting lists and things like that." (Charlie). Participants perceived that rather than acknowledge expectations were unrealistic, senior management saw clinicians as 'inefficient' and therefore blamed them for failure to deliver: "…they [managers] were just stuck in this myth that eventually they could probably get there if only they could get the clinicians, the naughty clinicians, to work a bit harder" (Diane).

Cycle of imposed change

This concept is contributed to by two conceptual themes, repeated top-down change, and disempowered staff. It describes an ongoing cycle of organisational change perceived as imposed from above and largely impervious to staff opinion and expertise. It describes staff who are distanced from decision making and perceive lack of transparency or collaboration in the change process.

Ongoing organisational change had come to be expected: "…the NHS changes every five years regardless of where you are or what you're doing" (Grace). Organisational changes were often perceived as driven by the need to make services fit top-down plans and financial considerations. Attitudes towards change were not predominantly negative; participants often supporting the rationale for changes: "I am a lover of change so each time new change was introduced I was like, ok what are the angles of how this could be cool…" (Alex). However,

the way change was implemented was typically experienced very negatively: “There’s no change management. None. None.” (Diane). Participants felt increasingly disempowered and shut-out of collaboration: “What I want is collaboration and that’s what I felt really disappeared. So it became this very top-down hierarchical model…” (Barbara). Organisational changes were typically perceived as developed with negligible input from clinical staff and then imposed on services after a “box-ticky” consultation:

> It tended to be that [senior managers] would come up with… some kind of big proposal and then say… what do you like and not like about this proposal, and people would be like, well I don’t like the fact that it’s completely unworkable, and they’d be like, well we’ll give it a try. (Alex)

Participants had experienced a wide variety of organisational changes but the common theme was organisational change typically felt ‘done to’ them. The negative impact of imposed change was magnified by lack of collaboration:

> [My team] was disbanded… It would have been bad enough… but it was the fact that people had come in and talked about listening and talked about how they really wanted to hear what was important to us. And we believed them, foolishly. And then within 6 months they'd decided that our team was no longer important and valuable. (Fran)

Shifting organisational valuing

This concept was contributed to by three conceptual themes, target culture, increasing power of operational management, and declining power of psychology. It describes perceived shifting organisational valuing over time towards a productivity culture focussed on numerical performance metrics, targets and decreasing space for nuance and complexity. Operational management power was perceived to have increased as clinical leadership, and especially the relative power of psychology, declined, making resisting unhelpful change more difficult.

This shift towards a productivity culture was perceived to have increased operational management power to direct clinical activity, and shape service priorities. This led to increasing time diverted towards target-related activity, and the de-valuing of other clinical activity:

> There was a lot more admin. And a lot more paperwork… it began to seem less clinically relevant than it had done previously, so there's lots of needs for key performance indicators to be completed for Commissioners. Expectations of masses and masses of forms to be filled in regardless of whether or not they were relevant to the clinical work you were doing. And a lot less time spent with patients or consultations with staff. (Grace).

As the power of operational management grew, valuing of clinical expertise and leadership declined: "…it felt like clinical skills, clinical leadership was being ignored and they thought clinical leadership, so having services led by clinicians that are jobbing clinicians that work, that understand the needs of the client group… is just not important" (Diane). Financial considerations played an increasingly important role in clinical decision-making: "…you could spend a lot of time sitting in meetings with potentially someone from… a finance background, telling you they didn't think an admission was appropriate and a group of health professionals… explaining why it [was]…" (Grace).

While clinical skills and leadership as a whole were perceived to have become less valued, the psychology profession in particular was perceived as having gone along with changes and lost power. Understanding and valuing of psychology within the wider NHS was perceived as varying significantly, in some areas "forgotten about, not valued, not consulted, not included…" (Alex), and in others more valued at both the team level and senior management level, but misunderstood by middle management "...[they] just think we're quite expensive and, can't we just get a CBT therapist in to do the same job?" (Grace).

Psychology's role promoting 'badged' therapies was also perceived to have contributed to reduced organisational valuing of psychology:

> I think psychology has done a job of selling itself and selling CBT in particular. … we've sold this idea that all you have to do is kind of challenge some thoughts and feelings and everything will be fine. And so it completely undoes our role and the complexity of our role. (Fran)

Psychologist concepts

Striving for autonomy and integrity

This concept is contributed to by two conceptual themes: trying to get on with the job, and upholding values and professional identity. It describes participant attempts to perform their role in accordance with their concept of their professional identity as a psychologist and related sense of what is important, in relation to the organisational processes outlined above.

Professional autonomy was highly valued by participants, but experienced as having declined within the NHS, with targets and tightly defined role plans perceived as impinging on participants' ability to perform the role of psychologist in the way they wanted to: "…job roles have become very specific… you need to have a target for specific things, but that leaves people feeling very disempowered I think in terms of being able to do what they really think is important." (Fran). Challenges to professional autonomy were perceived to have increased over time and particularly challenged by management pressure to focus clinical activity towards targets.

Targets themselves also created professional concerns when they were perceived as arbitrary or inappropriate to the service, as did management decision-making considered to lack clinical credibility. Variable quality of operational decision-making and leadership was consistently highlighted: "Leadership is just so important and I [didn't] like how I [was]

being led…" (Alex), and was considered particularly impactful when in direct conflict with professional judgement: "…the last straw really was being subject to an operational manager who just didn't understand the client group at all and made decisions that had no clinical validity whatsoever" (Barbara).

Feeling professionally 'misused' was identified as a common concern, including being required to perform tasks considered irrelevant to client needs or of low value, being unable to make use of specialist skills, and being required by managers to work in ways they disagreed with. Participants also identified expectations of 'the system' requiring them to operate in ways conflicting with professional integrity:

> …you can't acknowledge what you can't do. You have to talk about how great we are and what we are doing all the time. …you can't engage with people at a real level, you have to constantly be selling what you're trying to achieve. …It makes everybody feel like they have to pretend a lot of the time I think. Honesty is no longer helpful. (Fran)

Squaring the demands of 'the system' with professional integrity could become irreconcilable: "…in the end I just couldn't stomach it. I felt like I was colluding with a system that was just fundamentally wrong." (Barbara).

Valuing people

> "That willingness to fight for the client. I just saw it disappear… there was no advocacy for the client anymore. And that's the thing that felt desperately wrong" (Barbara).

This concept is contributed to by three themes, maintaining commitment to clients, struggling with unvalued self and staff, and upholding values and professional identity. It describes participant valuing of and attempts to maintain focus on clients, and the sense of being unvalued alongside other NHS staff in relation to the organisational concepts outlined above.

Participants perceived the NHS's orientation towards service users had shifted over time as performance metrics became more valued: "…[historically] we never ever regarded the clients' demands as demands. We regarded them as needs, and something changed in the interim… it was like every referral was like some kind of affront to the service." (Barbara). Participants perceived that services had shifted to valuing throughput and speeding clients through the system, and that managing performance metrics and 'how things looked' had become most important, so participants perceived clients became more superficially engaged with. Financial considerations were also perceived as increasingly valued over clients' needs: "… having to go through 10 layers of management to get an OK to run a group that had an evidence base because you might need to hire a room to run it in. The price of the room was more of an issue…" (Grace). As focus increasingly shifted towards numbers, valuing clients was perceived to have become lost leading to an uncomfortable disconnect between participants' sense of their own roles and values, and the systems within which they worked.

Organisational undervaluing of staff was also consistently highlighted and considered "really demotivating" (Alex), particularly lack of acknowledgement for good work: "…the thing that really seems like it's entrenched is the not rewarding and noticing good performance, grafting, you know, those sorts of things." (Alex). Participants held a positive orientation towards other NHS staff but perceived "…staff members are not held in mind by the people above them, and they're not looked after…" (Diane).

Participants highlighted a perceived organisational shift away from trusting staff and the growth of management myths about staff:

> …there's [management belief about] all these kind of rotten staff who are not doing their jobs properly. And this idea that everyone's off sick… and they're fiddling their time sheets and they're fiddling their travel expenses. … There was this idea of threats

> coming through the whole time. And that to me was just wrong. Not understanding why we were there! (Barbara)

Perceived lack of management valuing of staff wellbeing conflicted with participants' concept of their role and identity, which included staff wellbeing. The perceived organisational shifts away from valuing people were experienced as a betrayal, and source of disillusionment.

Trying to make things better

This concept was contributed to by the themes of struggling to innovate and improve, and upholding values and professional identity. It encompasses participants' efforts to innovate and improve services as part of the way they understood their roles and professional identities, and struggles and frustrations in relation to bureaucratic and hierarchical barriers restricting their ability to innovate and improve.

Participants consistently articulated a strong orientation towards innovating and improving services and saw creative thinking and service development as integral to their roles and professional identities. A proactive 'can do' orientation was consistently demonstrated by participants, who shared a perception that increased organisational hierarchy and bureaucracy limiting their ability to innovate and make positive change:

> You couldn't go, here's a load of people with these issues. This is probably the method and the approach we need to take. Let's crack on and do it. It would be... we've got to go to 8 different meetings and submit 10 different bits of paperwork to hopefully have someone agree that we can do the clinical work we could have just started last week. ... It drags you down after a while. (Grace)

The difficulty of innovating within the NHS was negatively contrasted with experiences in other organisations and post-NHS experience of feeling 'liberated' to

innovate. Barriers to innovating within the NHS led to frustration and the perception that extreme energy and efforts were needed to effect change.

Participants also perceived that resource constraints had further narrowed scope for positive change. The cumulative effect of declining ability to make positive change was experienced as counter to participants' sense of their role and professional identity, leading to frustration, loss of motivation, and loss of hope: "…it's very difficult when you go to work and you feel like, …what am I doing here? What am I offering? What powers do I have now to effect change?" (Diane).

Seeking sustainability and growth

Themes of recognising and prioritising own needs, seeking opportunities to develop, and upholding values and professional identity contributed to this concept. Participants came to recognise the unsustainability of their roles in relation to personal priorities and need to maintain boundaries, particularly regarding work life balance, family life, and own mental health. It also encompasses frustrations where job opportunities within the NHS were perceived as limited or unattractive, leading to exploration of alternative options for some participants. Participants described difficulties maintaining a sense of role sustainability in congruence with their professional identity and values, in relation to organisational concepts described above, influencing decisions to leave: "It literally did feel like I have to choose. I have to choose myself over this really destructive system." (Barbara).

Sustainable work-life boundaries and professional and career development were highly valued by all participants, and seen as integral to professional identity, but impacts related to organisational concepts specifically relating to the non-clinical parts of the role reduced motivation and attractiveness for some. Recognition of the high emotional and mental cost and the onset of burnout was also highlighted by a number of participants:

> …my job was making me miserable. …I was going to work and closing the door and wanting to basically, sit at my desk and cry all day. [I felt] I don't want to be cross. I don't want to be angry at work. This is affecting me. I can't cope with this anymore" (Diane).

The demands and stress of maintaining the role were often felt to be incompatible with family life, which was perceived to suffer due to job demands: "I needed home to be as important as work." (Grace). Several participants perceived professional and career development opportunities within the NHS to be limited, unattractive, or both: "…as people get more experienced and senior they're just like, whoa, those 8b and 8c roles are just, they seem like they're grim." (Alex).

Push to leave / pull to return

> "In the end I actually left with no plan whatsoever. I just got to the point where, that was it, I couldn't do it anymore. I handed in my notice and I didn't think about what I was going to do next." (Barbara)

This concept is contributed to by three themes, pushed to leave, pulled to return, and upholding values and professional identity. Participants felt 'pushed' to leave the NHS, yet retained a powerful emotional 'pull' back towards the NHS. Participants had typically seen themselves working in the NHS long-term, yet the majority of participants cited 'push' factors relating to organisational and psychologist concepts described above, that ranged from the practical: "[Working in the NHS] just didn't make sense anymore." (Ellie), to the existential: "…for my own mental health. I needed to go..." (Diane). Many found leaving the NHS extremely hard and felt deeply conflicted: "I felt very guilty about leaving the team and leaving the [clients]…. And that guilt didn't go away for quite a long time. (Barbara). Several participants expressed moral distress arising from the decision, questioning whether it was possible to be a 'proper' psychologist outside the NHS.

Participants articulated a complicated ongoing relationship with the NHS involving attraction and repulsion, which one participant likened to: “a dysfunctional marriage… you sort of love it but you kind of get the sense that you and it need to have a bit of time away from each other.” (Grace). All participants expressed strong positive feelings about the NHS founding values, and several anticipated returning for a clinical role that felt boundaried and professionally sustainable. The need for boundaries from the “organisational dysfunction of the NHS” (Grace) was shared by participants open to returning. For all participants, the pull to return was tempered by acknowledgement of current reality:

> As much as I love it and I do believe in it desperately… it's hard to work in the NHS at the moment. I think morale is low. Everyone is very tired. People are very burnt out. There's a lot of stress. There's a limit to how long you can ask people to provide more with less without it just starting to buckle. (Grace)

Tentative Conceptual Model

A tentative conceptual model was developed as part of the analysis process (Figure 1). The illustrates pressures from the competitive commissioning environment flowing downward within the organisation, feeding into a cycle of imposed change and shifting organisational valuing away from people and towards ‘certainty’, greater management control, and performance metrics. Friction from these organisational processes impact on the psychologist domains, which together constitute the valued identity of the NHS psychologist, generating a push to leave the NHS, while continuing commitment to the NHS’s founding values maintain a pull to return.

---Figure 1 here---

Discussion

The aim of the study was to understand how organisational factors in the NHS can influence clinical psychologists' decision to leave the NHS. The findings suggest that organisational factors characterised as: trying to achieve the impossible, cycle of imposed change, and shifting organisational valuing, influence a 'push' towards a decision to leave by impacting psychologist categories described as: striving for autonomy and integrity, valuing people, trying to make things better, and seeking sustainability and growth.

The finding that exercising autonomy and integrity is important to participants' values and professional identities aligns with self-determination theory, which holds that psychological wellbeing and optimal functioning are promoted by interpersonal contexts supporting autonomy (Deci & Ryan, 2000). This highlights the importance of clinicians' feeling trusted and empowered by managers and systems to exercise clinical skills and judgement. Perceived erosion of role autonomy increasing over time related to both perceived divergence between management and clinician priorities, and resource pressures exacerbating organisational dynamics that participants perceived were influenced by the competitive commissioning environment. The influence of perceived reduced professional autonomy on decisions to leave the NHS is supported by research with GPs where organisational changes reduced autonomy by elevating performance targets, leading many to feel the doctor-patient relationship was undermined and their roles professionally compromised; this has become an important driver of GP decisions to quit the NHS (Doran et al., 2016).

The finding of the importance of autonomy and integrity may have implications for how clinical psychologist roles are designed, specified, and managed. Promoting and empowering autonomy and exercising clinical judgement within roles may be important for satisfaction and retention. However, the finding about mixed understanding of psychology within sections of NHS management, where clinical psychologists may be seen as analogous

to CBT therapists, and just ‘do therapy’ may narrow the scope and complexity of clinical psychology’s potential contributions. This finding mirrors research by Patel et al. (2018) who found clinical psychologist roles were often misunderstood by the public, and perceived to only work with ‘minor’ difficulties. This may present a barrier to improving scope and autonomy within job roles, and may imply a need for greater education and advocacy from psychology professionals and representative bodies (Patel et al., 2018). Study participants negatively contrasted British Psychological Society advocacy for clinical psychology with the Royal College of Psychiatrists’ advocacy for psychiatry, feeling this had played a role in psychology’s relative decline. At the system level, awareness about clinical psychology has ramifications for broader understanding of the psychology role, relative power of the profession, and therefore ability to advocate for psychologically-informed understandings of clients’ interests within NHS systems (Association of Clinical Psychologists, n.d.).

Participants did not cite burnout as the reason they left the NHS, and while three participants highlighted awareness of burnout risk in relation to their decision, this was attributed to organisational frustrations rather than clinical work. This is consistent with Maslach and Leiter (1997), who propose burnout should be thought of primarily as a symptom of organisational dysfunction. Yang and Hayes (2020) suggest characteristics of mental health settings, rather than service setting per se, likely contribute to burnout. The absence of burnout as a reason for leaving within the findings however, may reflect limitations of the sample size.

Given participants came from a diverse range of mental health services and represented decades of professional experience within the NHS, the findings may support the suggestion of NHS-specific factors potentially impacting wellbeing and therefore highlight a need for further investigation. If so, the findings may help illuminate Summers et al.’s (2020) anomalous results for UK psychological professionals’ workplace wellbeing versus

international comparisons, as most study participants were NHS-employed, and the age group recording low wellbeing scores were the same 35-44 age group represented in the present study. The demographics of the present study participants, with a median age of 40, and 86 percent female balance broadly align with the UK clinical psychology profession with median age approximately 42 and 80 percent female (Longwill, 2015). However, given the size of the sample, and limitations in recruitment and sampling, the sample could not be said to be representative of the profession, therefore broader implications arising from the findings should be treated tentatively.

Participants felt strongly committed to the NHS yet unable to continue working within it, even while remaining committed to its founding values. While perceived organisational impacts on participants were multi-faceted, participants voiced distress from 'colluding' with a system perceived as 'broken', 'inhumane', and 'destructive', and perceptions the NHS was betraying its values. NHS staff 'moral distress' from inability to psychologically, emotionally, or physically engage with patients due to system pressures has been highlighted (The Point of Care Foundation, 2017). Participant perceptions of shifting organisational valuing towards metrics, and increasing power of operational management over clinicians echo longstanding concerns about the trend of NHS reforms and the 'industrialisation' and 'marketisation' of services potentially conflicting with practitioner values (Ballatt & Campling, 2011). Participant distress and difficulties coming to terms with leaving the NHS speaks to the importance of values in professionals' work and decision-making, and the need to consider alignment of values between clinicians and broader NHS systems.

The NHS Long Term Plan (NHS England, 2019, p.86) aspires to an NHS where "the values we seek to achieve for our patients - kindness, compassion, professionalism - are the same values we demonstrate towards one another". It recognises the negative impact of an 'overly rigid' competitive commissioning regime on providing integrated healthcare. The

Staff and Learners' Mental Wellbeing Commission report (Health Education England, 2019) recognises the crucial role of values in staff motivation and role sustainability and makes proposals to improve wellbeing. However, research indicates the way services are specified, monitored, and evaluated influences clinical practice (Goddard et al., 2000; Ham, 1999; Seddon, 2008), but this is not acknowledged or considered; the report (Health Education England, 2019) does not reference 'competition'.

Participants perceived the competitive commissioning system as an important driver of pressures that impacted them and influenced their decision to leave the NHS. At the system level, this finding may highlight a potential disconnect between an organisational context defined by intense competitive pressure, that is likely to influence management priorities and behaviour, and the aspiration for an NHS organisational culture based on 'kindness, compassion, professionalism'. This suggests a need to examine the values implicit in how services are specified, monitored, and evaluated, and those within NHS managerial culture, with the aim of aligning structural and clinician values and incentives, to support positive change desired by NHS England (NHS England, 2019).

Reflexivity

The researcher is a trainee clinical psychologist working within NHS services and holds views in favour of a public health service and sceptical about the role of competition and marketisation within the NHS on services and staff. The researcher also has prior career experience with organisational change and the impact this can have on staff, therefore the researcher's position may have influenced the process of theoretical sampling and interpretation of the data. Reflexivity is considered further in the Critical Appraisal section.

Limitations

The interviews were in depth and utilised open questions which tend to produce richer data (Ogden & Cornwell, 2010), and the more usable data collected from each participant the smaller the sample needed (J. M. Morse, 2000). However, the sample was small, and a process of self-selection may have occurred with participants who externalised the causes of their negative experiences, locating them within NHS systems, potentially being more likely to opt into the study than participants who internalised the causes of their reasons to leave. The decision to use broad inclusion and exclusion criteria was taken to maximise potential participants and reflect a range of geographic areas and types of service; uncertainty about size of the potential population given lack of previous research in this area informed this decision. The exclusion criteria were chosen to limit participation to psychologists who had actually left the NHS, given this step represents crossing a boundary, as the overwhelming majority of UK psychologists work in NHS services (Longwill, 2015). A larger initial group could have been recruited, from which purposive or criterion sampling of initial participants for interview could have enabled recruitment of a more representative group. Adopting total population sampling meant that while the demographics of study participants did broadly align with those of the UK clinical psychology workforce, for example in terms of median age and gender balance (Longwill, 2015), this was incidental rather than planned. The sample cannot be considered to be representative of the workforce as a whole, or of psychologists that permanently left the NHS.

Similarly, theoretical sampling was used during the process of data collection and analysis to direct data collection by determining both additional questions beyond the initial interview protocol and widening the scope of initial interview questions after constant comparison after each interview, in accordance with constructivist grounded theory methodology (Charmaz, 2014). However, while theoretical sampling guided data collection

within the sample of seven participants, it was not used to recruit further participants nor to identify new groups of participants which may for example have included those who left the NHS but later returned. Timonen et al. (2018) note theoretical sampling can be extremely challenging to implement in practice given constraints on additional data collection. They suggest theoretical sampling should be directed towards expanding on and delineating categories, and ideally integrating theory that explains relationships between concepts, rather than simply expanding the data set. Nonetheless, all study data did originate within the sample of seven participants originally recruited, and while data saturation is always a subjective judgement (Pergert, 2009), the limiting of theoretical sampling to this group raises doubts about whether data saturation for the research question could have been reached. Recruitment and sampling represent limitations in the research which limit the generalisability of the findings. The tentative conceptual model was developed from the individual experiences and the common themes and processes they described, and given the limitations in recruitment and sampling may represent a model of this specific sample; other clinical psychologists may experience NHS organisational issues in different ways.

Clinical Implications & future research

The findings suggest a number of potential implications for the NHS and clinical psychologists. The recent emphasis on workforce wellbeing (Health Education England, 2019), contains proposals including training in self-awareness, self-care, mental health support and signposting, greater organisational emphasis on mental health and wellbeing, and increased emphasis on supervision and reflective practice, among other measures. However, these measures appear to focus on improving symptoms rather than underlying drivers. This research highlights the perception of participants that the competitive commissioning environment may be influencing management behaviour and valuing, in turn influencing organisational priorities and the pressures that impact clinicians. The planned workforce

wellbeing approach appears to be aimed at helping staff cope within the present system, rather than considering systemic impacts on wellbeing. It does not seem likely that participant distress relating to feeling professionally disempowered by 'unrealistic' management priorities and targets would have been ameliorated by greater access to mental health support. The findings therefore raise questions as to how successful the wellbeing approach on its own would be for at least some of the workforce. If so, this may imply problems with wellbeing and retention would be likely to continue, with likely implications for sustainability and patient safety.

In the findings, senior clinical psychologists found their roles unsustainable due to organisational issues, and early career psychologists viewed progression within the NHS hierarchy as unattractive for similar reasons. This raises the question as to whether, or to what extent, these perceptions are held within the broader psychology workforce, as this may then have implications for workforce sustainability and potentially, psychological advocacy and leadership at higher levels of the NHS, and the ability of the psychology profession to positively influence further NHS change and decision-making. Exploring this question further may therefore be of interest to the professional representative bodies.

The current study highlights a number of areas for further research. The potential link between psychologists' workplace satisfaction and autonomy could be explored empirically, administering a combination of the Psychological Practitioner Workplace Well-being Measure (Summers, Morris, & Bhutani, 2020) and a measure of workplace autonomy support such as the Perceived Autonomy Support Scale for employees (PASS-E) (Moreau & Mageau, 2012). Research could also focus on the experience of psychologists who have considered leaving the NHS but chosen to remain, exploring factors that enabled them to continue working within the system.

Conclusion

The influence of organisational factors on the decision to leave the NHS was explored with seven clinical psychologists. The organisational categories described salient organisational processes perceived to influence decisions to leave the NHS and consisted of trying to achieve the impossible, cycle of imposed change, and shifting organisational valuing. Psychologist categories described participant experience and coping in relation to organisational processes, with impacts contributing to decisions to leave. Psychologist categories consisted of striving for autonomy and integrity, valuing people, trying to make things better, seeking sustainability and growth, and push to leave / pull to return.

A tentative conceptual model described pressures generated by the competitive commissioning environment and resource constraints flowing down within the organisation, feeding into a cycle of imposed change, and shifting organisational valuing away from people and towards greater management control, and performance metrics. Participants' efforts to maintain their values and professional identities were impacted by these processes, generating a push to leave, while continuing commitment to the NHS's founding values maintained a pull to return one day.

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Table 1

Participant Characteristics

Post-qualified NHS experience [median]	**Age on leaving NHS [median]**	**Region worked in on leaving**	**Clinical speciality worked in on leaving (some participants in split posts)**	**Other clinical specialities worked in during NHS career**
3 to 17 years [12]	34 to 44 [40]	London, North Wales, Midlands, North West, South East	CAMHS; Community LD; Looked-after children; Neuro; Occupational health; Pain management; Perinatal; Sexual health	CAMHS including specialist CAMHS services; adult CMHT; DClinPsy clinical tutor; IAPT; LD including children, adult, and inpatient

Table 2

Participant Demographics

Participant pseudonym	**Agenda for Change banding on leaving**	**Gender**
Alex	8a	Female
Barbara	8d	Female
Charlie	8b	Male
Diane	8b	Female
Ellie	7	Female
Fran	8c	Female
Grace	8c	Female

Table 3

Conceptual Theme Construction

Focused codes	Conceptual theme
	Organisational themes
Feeling accountable for unrealistic targets, Feeling senior managers don't challenge, Needing to do what was necessary to survive, Perceiving competitive pressure to win bids, Perceiving senior management in impossible position, Perceiving senior managers overreach to win bids, Senior management overpromising and lacking resources to deliver, Senior management trying to impose unrealistic change, Subjected to unrealistic promises and targets, Tired and broken by the system, Undeliverable bids and promises, Unrealistic exhortations to work harder in the face of cuts	Trying to achieve the impossible
Distanced from decision-making, Feeling threatened, Lack of transparency, Locked out of collaboration, Making plans without staff involvement, Managers telling not listening, Perceiving decisions made elsewhere, Shift from collaboration to hierarchy, Threat of cuts, Unheard by managers	Disempowered staff
Comparisons with better past, Constant change, Cuts imposed, Relentless reorganisation, Targets imposed from above, Top-down reorganisation imposed, Unresponsiveness to staff feedback, Unwillingness to adjust plans, Values imposed from above	Repeated top-down change
Clients seen as demanding, Clients seen as problem to be managed, Defaulting to safety, Emerging perverse incentives and gaming targets, Focus on time and costs, Focus shifting towards admin away from patients, Loss of focus on clients, Perceiving disconnect between targets and resources, Pressure to hit targets, Resources focused on targets not what matters, Shifting focus towards targets and measured activity, Shifting management structure driving shifting priorities, Shifting towards a 'business' model, Staff blamed for waiting lists, Staff motives not trusted	Target culture
Clinical judgement overridden, Clinical leadership devalued, Disconnect between judgement and management priorities, Feeling unsupported by managers, High influence of immediate leadership,	Increasing power of operational management

Importance of local management attitude & perspective, Mismanaging clinical skills and resources, Perceiving poor quality management, Protecting team from managers, Pushed around and disrespected by managers, Seeing management as lacking compassion	
Declining power and control, Discomfort with asserting and negotiating, Feeling let down by psychologists, Feeling psychology forgotten and unvalued, Going along with changes, Losing operational management responsibilities, Losing power over clinical decision-making, Losing senior psychology roles & expertise, Misunderstood by middle management, Psychology analogous to CBT, Psychology role and skills not understood, Responsibility without power	Declining power of psychology
	Psychologist themes
Acting up and filling gaps, Declining autonomy over time, Desire to be left to get on with the job, Fighting and advocating, Flying under the radar, Making a contribution, Making the best of things, Stepping up to fill gaps, Trying to avoid dramas, Trying to make things work, Trying to uphold values, Unseen and getting on with the job, Weighing up pros and cons, Working to improve things	Trying to get on with the job
Commitment to clients, Fighting managers to meet client needs, Focused on what clients needs, Motivated toward clinical work, Prioritising clients over numbers, Retaining care for clients despite pressures, Trying to do the best for clients	Maintaining commitment to clients
Coping with team and organisational politics, Efforts unseen and unacknowledged, Feeling unappreciated and let down, Feeling unvalued, Forced to compete with colleagues, Low morale, Perceiving staff not cared for, Perceiving staff wellbeing not considered, Relying on staff goodwill, Staff expertise misused, Undervaluing staff knowledge and experience, Unsupported and unheld, Valuing team and colleagues' wellbeing	Struggling with unvalued self and others
Blocked from making improvements, Bureaucratic and hierarchical barriers to change, Creativity stifled, Frustrated and fed up, Frustrated by barriers to change, Huge efforts and energy to try new ideas, Political barriers to change, Struggling to make change	Struggling to innovate and improve

Clarifying personal priorities, Feeling angry and betrayed, Feeling depleted and demotivated, Feeling isolated, Needing to be there for children, Prioritising own needs, Recognising costs to family, Recognising personal costs of struggling, Recognition of burn out beginnings, Struggling to balance family and work needs	Recognising and prioritising own needs
Discovering demand for skillset, Feeling misused / deskilled, Feeling restricted within NHS, Lacking investment / CPD, Losing hope the system can change, Perceiving lack of attractive jobs, Put off by NHS career progression, Seeking career progression, Seeking opportunities to develop, Seeking opportunities to network, Surprised by opportunities outside NHS	Seeking opportunity to develop
Accepting own values in conflict with service, Fantasising about leaving, Feeling forced to choose, Feeling guilty about leaving, Feeling morally compromised by leaving, Having to assert boundaries, Leaving with no plans, Needing a break, Needing to go, Needing to quit, Protecting own mental health, Reaching breaking point, Running out of energy, Struggling to feel ok leaving	Pushed to leave
Aspiration to return, Emotional attachment to NHS, Feeling drawn to NHS, Feeling passionately about NHS, Loyalty to NHS values, Missing the NHS	Pulled to return
Clarifying what really matters, Clinging to psychologist identity, Defending own sense of role, Discovering identity through threats, Feeling personally conflicted and compromised, Hiding real feelings, Needing to be open and honest, Perceiving values not shared by organisation, Questioning / clarifying own values, Questioning own values, Sense of betrayal, Valuing professional identity	Upholding own values/professional identity

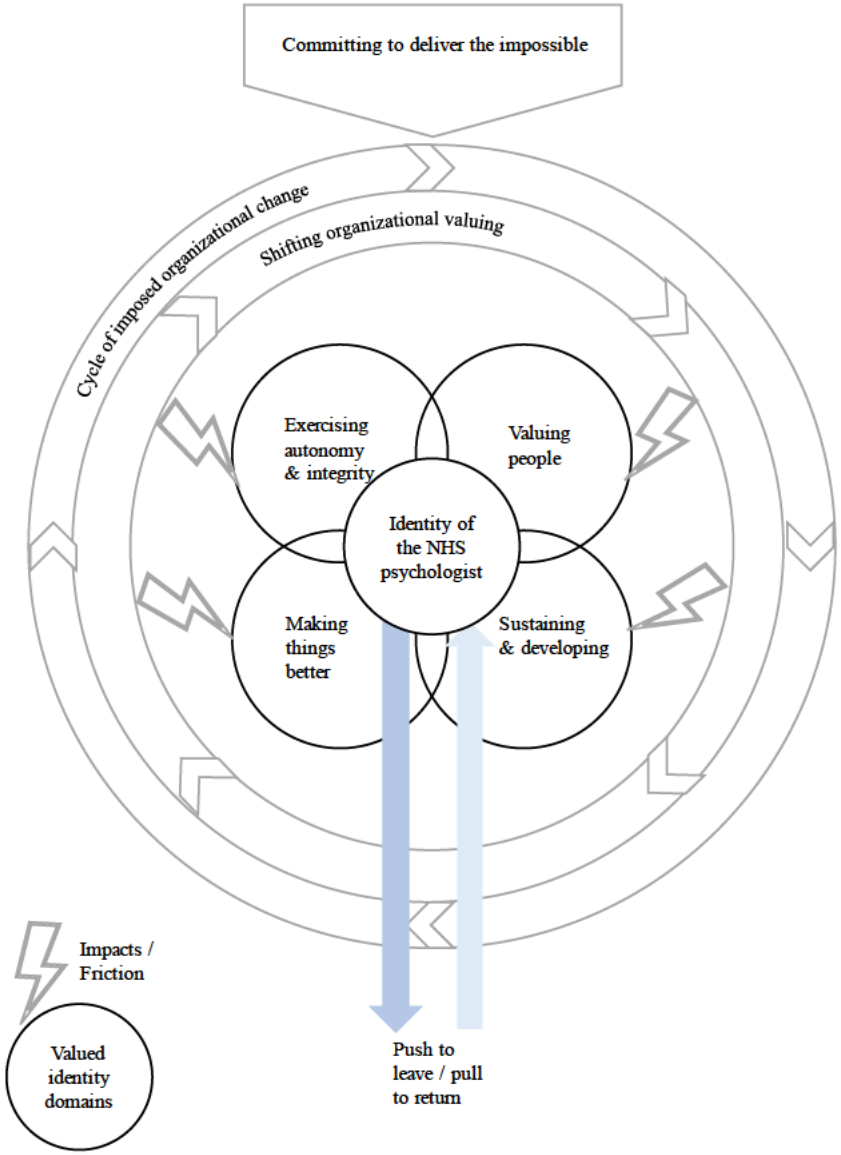
Table 4

Category Construction

Conceptual Theme		**Categories**
Organisational Themes		
Trying to achieve the impossible		Trying to achieve the impossible
Disempowered staff Repeated top-down change		Cycle of imposed change
Target culture Increasing power of operational management Declining power of psychology		Shifting organisational valuing
Psychologist themes		
Trying to get on with the job	Upholding values and professional identity	Striving for autonomy & integrity
Maintaining commitment to clients Unvalued self and staff		Valuing people
Struggling to innovate and improve		Trying to make things better
Recognising and prioritising own needs Seeking opportunities to develop		Seeking sustainability and growth
Pushed to leave Pulled to return		Push to leave / pull to return

Figure 1

Tentative conceptual model of NHS organisational issues impacting Clinical Psychologists' professional identities generating a push to leave the NHS



Appendix 2-A

Excerpt from Transcript: 'Diane'

Text	Initial Coding	Focussed Coding
I: Just how it came about… What was the driver for it basically?		
P: So there was some sense and some logic in this. In that, we had the County that I work in, it's a funny County and partly because it's got lots of [removed] authorities, so there's lots of different local authorities within [the County], and there was five or six CAMHS teams that each interacted with a different local authority, and partly because of that, and partly because of the geographical nature, you've got [city] at one end and [town] at the other. Lots of uhm, uhm, ethnic diversity, and it's an inner city and lots of people that traditionally don't engage in services and then right at the other end of the County you've got [county town] and masses of rural land. Also full of pockets of real social deprivation and then [town] and [town], you know that they're quite kind of different, so services developed differently. So there was no equity of service so you could get play therapy in one team, but not at all in another, and you might wait two years for an autism assessment in one team and four months in another. And there was psychotherapists in some teams but not in another, so they wanted a service where wherever you lived you could have, you'd be able to access the same kind of resources and they also wanted rather than us having small community teams where we were kind of trying to do everything and we were a bit, they were a bit chaotic. You kind of picked up clients and depending on who they saw depended on what intervention they got. They wanted us to kind of develop specialist interventions and be able to offer the right thing to the right person to drive up standards. So they set up these virtual teams across the County that specialized in certain things. So there was some logic to it, some sense. There was lots of stuff that I kind of agreed with, but other bits that I kind of didn't. And of course, it's all these things that, you know, our input was sought, but the decision-making was done	Seeing some sense and logic in change Acknowledging fragmented provision Identifying diversity of needs in community Recognising reasons for different services Recognising currently no equity of service in provision Acknowledging problems with old way of working Identifying aims of the change plans Recognising logic in change plans Agreeing with parts, disagreeing with others Being consulted	Agreeing with change rationale Accepting need for change Weighing up pros and cons Perceiving decisions

elsewhere. And there was a kind of, you know lots of kind of myths and rumours about who was kind of driving the changes that were being made and whether they were sensible or not. I: OK. So when that was implemented, it sounds like the implementation was very difficult. I'm wondering how much involvement did staff have in that, or did psychology have in that? P: So then focus groups were set up to develop certain pathways, and I think I sat on one of them because I, yeah, I know this is a thing. So in my team I was… they'd spent quite a lot of money training me to do ASD assessments and I was, the clinician that was involved in all of the ASD assessments. And we'd done very well. We had a short waiting list and it has been very long. So I was involved in the planning around what that was going to kind of look like. But in terms of how they were going to move personnel around, and how it was going to be managed and how people's feelings and welfare was going to be looked after that, you know, nothing like that ever happens… Nothing at all. And, you know… We all had to do a skills audit on ourselves and then apply for jobs, and be interviewed. Pitted colleague against colleague and… There was no attention to us as a team working in a difficult environment. What does this do to our relationships and how do we manage it? None of that. None of that talk went on. I: OK. So what impact did it have on morale? P: Terrible. Terrible impact on morale. Yeah, and actually I think, work literally grounds to a halt for quite a few months. People just couldn't work because they hadn't been cared for or looked after. I think this is the kind of mistake that we make in the in NHS, in mental health services, is that we don't attend to our own needs and you know, we do a really difficult job. And how can you expect teams to function and carry on if you're not thinking about, you know, what do they need to sustain themselves in this role? And when things get difficult and tricky for whatever reason, whether that's the pressure of you know how much demand there is on the service or the needs of a kind of a service change, you have to, almost, you know, slow down and	Decisions being made elsewhere Speculation about decision makers and sense of plans Getting involved in pathway development Specialising in ASD assessments Getting waiting lists down Involved in service change plans Perceiving no attention to people's feelings and welfare Having to apply for jobs Competing colleague against colleague Perceiving no focus on team and relationships Impacting morale Impacting work Uncared for and not looked after Perceiving common error in MH services Not attending to staff needs Feeling angry on behalf of colleagues Perceiving unreasonable expectations	made elsewhere Distanced from decision-making Actively engaging in change process Working to improve things Perceiving staff wellbeing not considered Competing for roles Perceiving disconnect between mgt. priorities and hers Change negatively impacting staff Perceiving staff not cared for Valuing team and colleague's wellbeing

think about your team first. But of course, the opposite always happens that they think about, you know, the demand, the pull, and they go for that, rather than thinking about the people that are involved, they just push it, push it forward, and hope for the best. And yeah, people just stopped working. They really did.	Valuing teams needs Seeing mgt. thinking about demand not their teams needs Seeing mgt. pushing for output	Experiencing disconnect between judgement and management priorities

Appendix 2-B

Series of memos about the 'getting on with the job' focused code (part of the 'exercising autonomy and integrity' category)

Memo (after P3)

All three participant are articulating a wish to be able to do their jobs the way they think they need to be done, but feel they are being restricted, blocked, or otherwise frustrated. That orientation and drive, the way they talk about their work, seems to permeate the way they think about their roles and see themselves as clinicians. There's a disconnect between how they want to work and how the system is seeing them/allowing them to work.

There seem to be different ideas being expressed here, one relating to psychology not being 'seen' be the organisation the same way they see it - so something fundamental about what clinical psychology is and does meaning something different between how they, and how the organisation views it (is it the whole organisational or just parts of it? If so which parts? Why different?). Its constrained and limited, like psychology's been put in a neat box (relating to badged therapies? relating to perceived relative decline?) that they don't agree with and struggle against.

The other idea seems to be related to practical limitations from structures, management priorities etc. tied into the dashboards coming down the hierarchy – so being directed as to how they should be spending their time. There's a conflict between what they think is important and what they think they should be doing according to their understanding of their role and profession, and their assessment of the needs of the client group, and what they're being told to do by their managers. There's a strong link to the theme around how the culture has been changing and valuing different things – where its ok for managers to intervene and override clinicians, to decide they need to stop doing activity the clinicians

think is important, and start doing activity clinicians don't think is important because it will count towards a target.

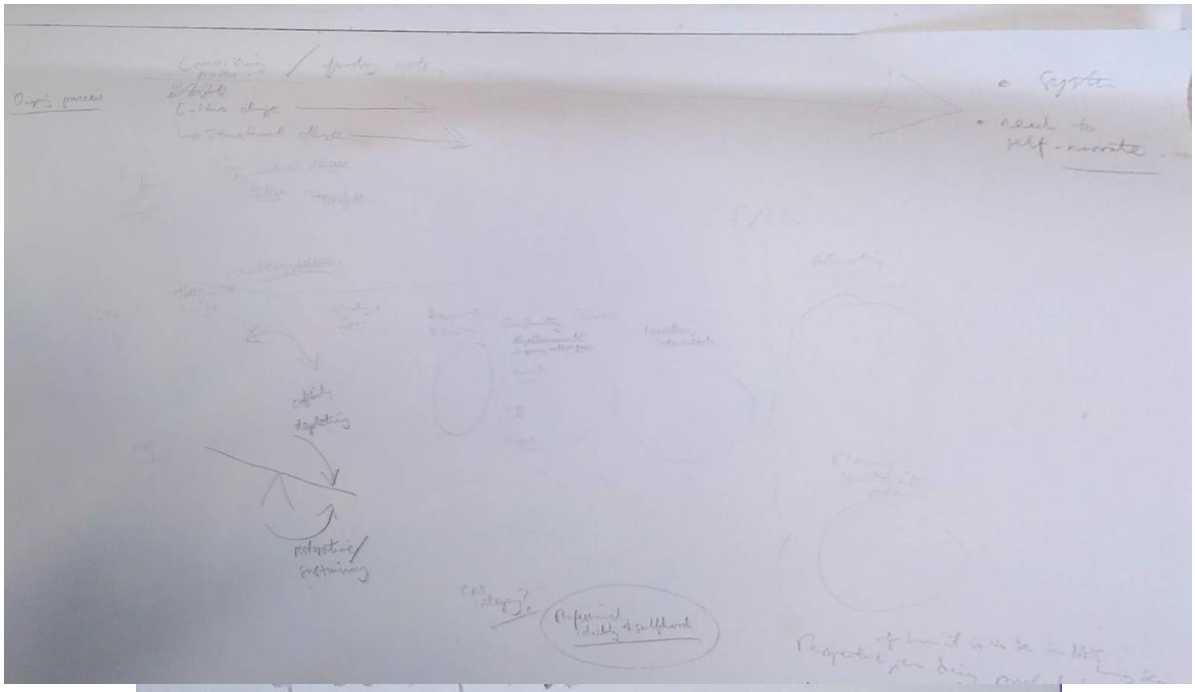
The sense of frustration with psychologists for not standing up for themselves more and pushing back against the system also aligns with P2. The views around psychology power declining and psychologists 'fitting in' or trying to 'fly under the radar' seems to support the need to explore how psychology is seen and how powerful it is – how able is the profession to advocate and stand up for its view of what clinical psychology is? How have these views diverged?

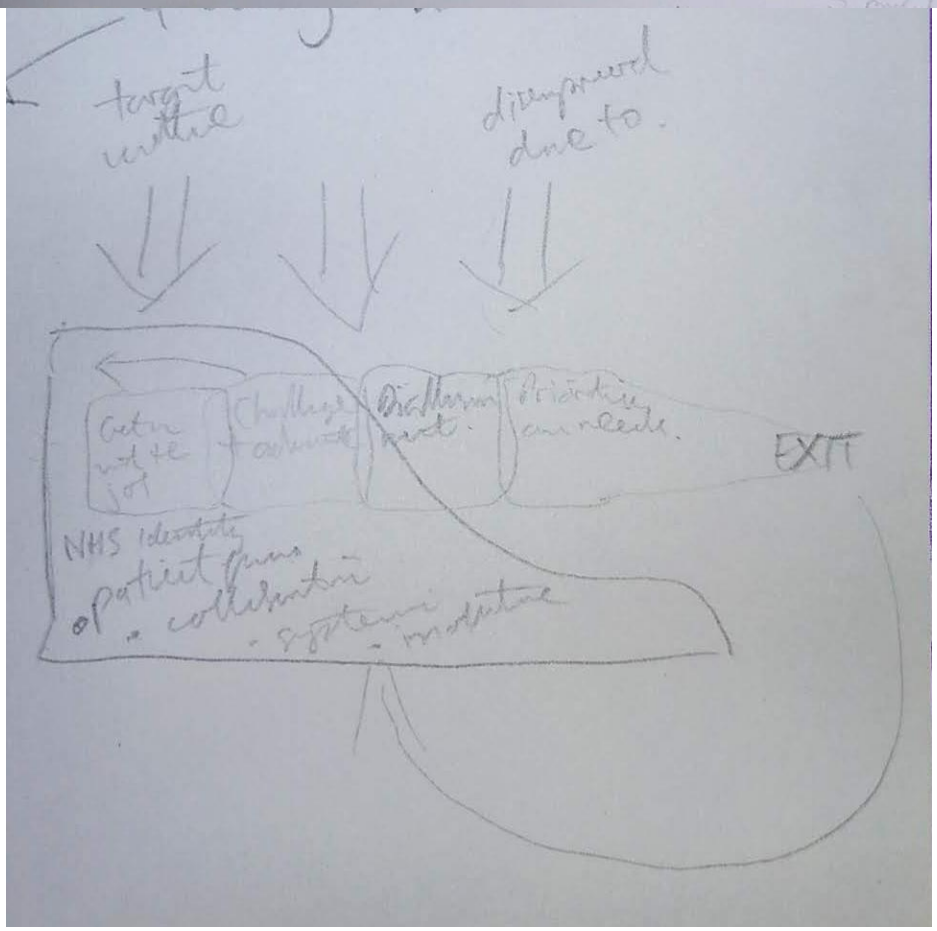
Memo (after P6)

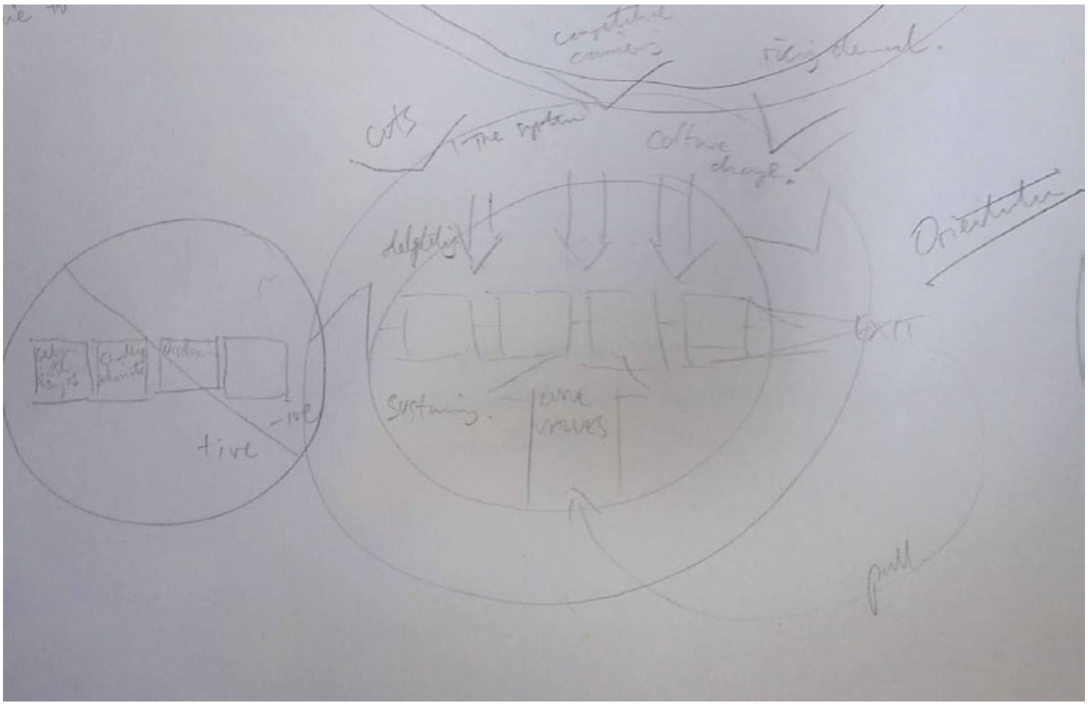
Ways of trying to get on with the job are becoming clearer with more focused questioning. Some participants are trying to stay out of the way of the political/organisational 'stuff' and do their job as they think they need to do, so not actively fighting the system but trying to mitigate its impact on their teams and service users as best they can – is 'flying under the radar' one way they cope within this system? Others are trying to fight it more actively by 'advocating from within', being more assertive in saying no to things, and trying to advance change and different ways of doing things within the system. Its striking though how both ways of trying to get on with the job are ways of coping with a system that's fundamentally in conflict with the way they want to work and see their role and profession. Also striking how their ideas and awareness of the sense of professional identity seems to have been emerging because of this conflict – this awareness that the system is operating in a way that they're struggling to reconcile with their own professional identity and values.

Appendix 2-C

Visual memos with early model development exploring interrelationships between emerging focussed codes/categories






Orientation
culture change
sustaining
pull

Appendix 2-D

Notes for Authors

Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

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7. Data Availability Statement
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10. References;
11. Tables (each table complete with title and footnotes);
12. Figure legends;

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Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from *http://www.youtube.com/watch?v=Vja83KLQXZs*

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Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should

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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.

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Section Three: Critical Appraisal

Critical appraisal focused on the grounded theory and extended discussion

Word count: 3,944

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This thesis focuses on burnout and retention among psychological practitioners. The literature review presents a systematic review and meta-ethnography of practitioners' experiences of burnout. It provides a line of argument that burnout can compromise practitioners' physical and mental wellbeing and sense of self-efficacy, that practitioner self-knowledge and boundaries can contribute to or protect against burnout, and that organisational culture and values can create a workplace that can be protective against burnout or contribute to it. In doing so it draws attention to the predominantly individually-oriented approaches and interventions aimed at reducing and preventing burnout, and systemic and cultural contributors to burnout which may be beyond the control of the individual.

The empirical paper explores how organisational factors may influence clinical psychologists' decisions to leave the NHS. The study provides three organisational categories: trying to achieve the impossible, cycle of imposed change, and shifting organisational valuing, which described salient organisational processes perceived to influence decisions to leave the NHS. It also provides five psychologist categories: striving for autonomy and integrity, valuing people, trying to make things better, seeking sustainability and growth, and push to leave / pull to return, which described participant experience and coping in relation to organisational processes, with impacts contributing to decisions to leave. A tentative conceptual model described pressures generated by the competitive commissioning environment and resource constraints flowing down within the organisation, feeding into a cycle of imposed change, and shifting organisational valuing away from people and towards greater management control, and performance metrics. Participants' efforts to maintain their values and professional identities were impacted by these processes, generating the push to leave, while continuing commitment to the NHS's founding values maintained a pull to return one day.

When planning the thesis I anticipated burnout would be a central contributor in decisions to leave in the empirical study, given the link between burnout and staff retention

found in the literature (Johnson et al., 2018). It was unanticipated that burnout did not feature more strongly as a theme in my research, and burnout was only peripheral in decisions to leave in a minority of participants. As such, the literature review and empirical paper may appear somewhat disjointed, and this may reflect limitations in both papers. While the literature review reflects mental health practitioner experiences of burnout from a range of countries and settings, no papers were from the UK or an NHS setting, and given the cultural differences between the study countries and different types of mental health settings including both public and private, this may limit the generalisability of findings, and applicability to an NHS context. With the empirical paper, the study focus on organisational issues may have been excessively narrow and reflected my assumption and expectation that burnout relating to organisational factors would have been an important driver of decisions. Had the study focus more broadly explored why psychologists left the NHS, rather than focusing on the influence of organisational factors, more participants that conceptualised their reasons for leaving more individualistically as burnout may have been recruited. The implication of the study's focus and limited sample size means it is unclear if the minimal role of burnout in the findings reflects burnout not being an important factor in decisions to leave, or reflects a limitation of the study. Given the study was limited to seven participants and that theoretical sampling explored new questions from participants' data within the participant group, but did not sample for new participants or groups including disconfirming participants, it seems likely the minimal role of burnout in the results represents a limitation of the study, which therefore may limit generalisability of the results.

Approaching the thesis and reflexivity

Through the process of conceptualising, planning, and conducting the thesis I sought to maintain a critical stance. In Constructivist Grounded Theory (CGT) Charmaz (2017) advocates for developing 'methodological self-consciousness' to turn a reflexive gaze onto

ourselves, the research process, and the empirical world. This requires scrutinising the researcher's position and considering how it can affect the way the research is conducted, and relationships with participants. The active researcher role and emphasis on mutuality and reciprocity between researcher and participant as meaning is constructed in CGT (Charmaz, 2014; Mills et al., 2006) was attractive to me and aligned with my own values, informing my choice of methodology, and Yardley (2007) highlights the importance of the researcher acknowledging their own position. Thus during the course of the research I used a reflective journal to consider feelings, assumptions, and reactions and their bearing on the research process.

Within the literature review, my position informed my choice of topic and expectation that organisational factors may be part of participant burnout experiences. This may have influenced my relationship with the data and therefore a reporting bias which could have contributed to the strength of the theme that organisational culture and values can create a workplace that can contribute to or protect against burnout. However, I feel that the strength of that organisational theme is counterbalanced with the finding that practitioner self-knowledge and boundaries can contribute to or protect against burnout and I do not feel that the results were unduly influenced by my position. That said, my reaction to the findings was to consider potential implications for NHS contexts and service models, thus minimising cultural differences between the UK and study countries, and study limitations. While these considerations were not included in the final version of the paper, I feel the pull to over-interpret the findings in this direction was influenced by my own feelings about productivity-oriented mental health service models, and awareness of high staff burnout rate in such models (e.g. Westwood et al., 2017).

With the empirical paper, past experience both delivering organisational change and experiencing it, informed my overall study topic and expectation that burnout would feature

prominently within psychologists' narratives about leaving the NHS. This assumption led to the mismatch between the literature review and empirical paper where burnout did not play a large role in the findings of the latter. My expectations led to a research question that may therefore have been too narrow, and a recruitment and sampling approach which compounded that issue, ultimately limiting the generalisability of results. During data collection, use of my reflective diary helped me consider my position; I empathised with participants and shared feelings of distress and injustice, leading me to reflected on how my position as a trainee clinical psychologist intending to work in the systems being discussed may influence participant responses. As a trainee interviewing experienced clinicians I was also mindful of my lower power position, despite being the researcher, and wondered if this could have allowed participant narratives to excessively influence my thinking and analysis. During data collection, I noticed a pull to identify with participants, which along with my prior experience could have influenced my interpretation and theoretical sampling of the data, in particular influencing a potential bias to 'blame' systems. As burnout may be implicitly construed as an individual 'failing', participants may have perceived their experiences in terms of organisational 'failings' rather than burnout, while different participants may have interpreted their experiences differently, and this may account for the smaller than anticipated role of burnout within the findings. The results of the study highlight how perceptions of organisational factors may influence decisions to leave, and these results may have been anticipated by the study design which focuses on the role of organisational factors. I feel the tentative conceptual model as co-constructed describes the experience of study participants. However, I also feel that my own position in relation to the participants may have influenced decisions that limited the data to within the sample, and therefore limited theoretical sampling of other participants and groups which may also have included disconfirming data.

Strengths and limitations

In evaluating grounded theory research Charmaz (2014) suggests the following criteria: credibility, originality, resonance, and usefulness, and these will be used to consider the strengths and limitations of the research.

Charmaz and Thornberg (2020) propose credibility begins with having enough data that is relevant to enable asking incisive questions of the data, make systematic comparisons through the process, and develop a thorough analysis. While the necessary extent of data collection in grounded theory study and relationship between sample size and credibility of findings is extensively debated (Francis et al., 2010), the study's small sample of seven participants bears examination. Many consider the concept of theoretical sufficiency an appropriate means to determine when sufficient data have been gathered (Dey, 1999), meaning the point at which further data do not add additional insights into core categories or extra properties of categories (Charmaz, 2014; Glaser & Strauss, 1971). In this study I recruited the seven participants at the beginning, then conducted and coded the initial three interviews on a line by line then focused basis and compared and contrasted applying a method of constant comparison (Charmaz, 2014) to develop provisional conceptual categories. I used theoretical sampling to direct data collection by refining questions for subsequent interviews based on emerging conceptual categories, but did not use theoretical sampling to sample for new participants or groups outside the original participants, based on concepts emerging from the data. While the seven participants worked in a diverse range of NHS service settings encompassing decades of NHS work experience, this sampling approach may have limited my ability to access sufficient relevant data, as available data were limited to original participants. Limiting the data in this way may have impacted my ability to make systematic comparisons between potential different groups that may have experienced organisational issues in different

ways through the research process and subsequently impacted the credibility of the resulting analysis.

These challenges to credibility emerged from limitations in my recruitment and sampling approach. The data and concepts generated from the analysis were confined to the original seven participants. Within that sample, after continuing with the remaining interviews and applying constant comparison, new incidents or properties of categories were no longer being discovered, indicating coding for categories could stop (Charmaz, 2014). The most widely used principle for determining data sufficiency is saturation (Vasileiou et al., 2018). Hennink et al. (2017) differentiate between 'code saturation' where the researcher has 'heard it all' which they suggest can be reached in nine interviews, and 'meaning saturation' where the researcher 'understand[s] it all (p.1)' which can be reached in 16-24 interviews, indicating seven interviews in the present study may be considered insufficient. Within constructivist grounded theory, new themes are developed and refined until saturation occurs, and this is considered to be the point when no new concepts are introduced, and the characteristics of the phenomena are the same (Morse, 2007). While I felt theme saturation had occurred after the seven interviews as no new concepts were being introduced, confidence in saturation in relation to the research question may be limited by restriction of the data to the same group, and lack of sampling for new participants or groups, particularly disconfirming ones. Credibility within the sample could have been improved through member checking and validation of the concepts with participants (Doyle, 2007). Overall, the sample size, sampling approach, and saturation are weaknesses of the study and restrict credibility. This is likely to limit generalisability of the results, and raises the question as to whether the tentative conceptual model proposed may be confined to this specific sample.

Credibility in constructivist grounded theory also requires strong reflexivity and the explication of taken for granted assumptions and awareness of how beliefs can come into the

research process (Charmaz, 2017). Through the process I sought to practice reflexivity, but as discussed earlier, I feel my own prior knowledge and assumptions did influence the way the research was carried out through different stages, perhaps influencing the results and outcome of the empirical paper to feel excessively 'blaming' of organisational processes and as such, to feel quite positioned. As such, researcher bias could be considered to challenge credibility of the findings.

Regarding the criteria of originality (Charmaz, 2014), it seems reasonable to claim this study may have generated original insights given minimal research had explored this area. The study provides potential illumination into UK psychological practitioner workplace wellbeing where those later in their careers were found to be less satisfied than international comparisons (Summers, Morris, Bhutani, et al., 2020), and provides a potential starting point for further study in this area.

The criterion of resonance (Charmaz, 2014) relates to how well the categories portray the fullness of the studied experience, and how links have been drawn between higher level activities or institutions and individual lives. The concepts and tentative conceptual model illuminate links between structural and environmental factors within which the organisational context is defined and operates, and how this may influence the experience of the individual practitioner. However, the use of single interviews can be considered a limitation, as participants did not have the opportunity to reflect further on their interview and provide reflections on resonance with their own experiences. Member checking and validation would have helped assess resonance of the findings with the participants (Doyle, 2007), thus resonance of concepts with the study participants is uncertain. Building in several interviews with the participants may have been a useful alternative study design that would have enabled this to be better assessed. Resonance must also demonstrate concepts have been constructed that provide insight to others (Charmaz & Thornberg, 2020), and given the limitations with the

recruitment and sampling approach outlined earlier, it is unclear to what extent the concepts provide insight into the experiences of other clinical psychologists.

Finally, the criterion of usefulness (Charmaz, 2014) relates to the extent to which the analysis provides interpretations of use to people in their everyday worlds, can form a foundation for policymaking and practice, can lead to further research in other areas, and reveal processes and practices (Charmaz & Thornberg, 2020). The findings from this research provide a tentative conceptual model about how organisational factors may influence decisions to leave the NHS and may provide a framework to help individuals to make sense of their own experiences. The study highlights the importance of practitioners' values, which may have some practical relevance for policymaking, particularly in relation to where practitioner values and those of the operation of systems may not be in alignment. The study may also be considered as a starting point for further research into how organisational factors may influence decisions to leave, and point to further research areas which are discussed further below. However, the methodological limitations discussed earlier limit usefulness, as the tentative conceptual model may only apply to the sample itself, while resonance with this group is unclear. The study as it stands cannot form a foundation for policymaking and practice and would require further development and supplemental research before this may be feasible. As such, usefulness of the research may be limited.

Further research

The findings about the importance of values in participants' roles within the NHS highlights the importance of meaning and perceptions of clinicians' psychological contracts with the NHS. The study conceptual category of the 'push' to leave the NHS suggests a rupture in this psychological contract as leaving can be a 'violation' response (Cortvriend, 2004). Management of the psychological contract has implications for levels of commitment and retention (Bartlett, 2007; Rousseau, 1995). Fielden and Whiting (2007) found that NHS-staff

psychological contracts were relational and based on perceived investment by both parties. Further investigation into the current state of the psychological contract for mental health professionals may be an area for future research arising from this study. This could be explored via a mixed method study utilising a method such as the Repertory Grid Technique (Kelly, 1955) to elicit clinicians' perceptions of their exchange relationship and identify categories perceived as most important in that relationship, and quantitative follow-up exploring clinician satisfaction with each category, in addition to a measure of wellbeing such as the psychological practitioner workplace wellbeing measure (Summers, Morris, & Bhutani, 2020). This would enable a clearer understanding of the current health of clinicians' current psychological contracts with the NHS, explore correlation with wellbeing, and further illuminate the impact of organisational factors, enabling improved decision making to address workforce wellbeing and retention.

Study participants perceived the competitive context within which health services are commissioned, and pressures generated by the target and management regime, shaped the culture of the NHS and impacted participants, influencing decisions to leave. This raises questions about the influence of the purchaser/provider split and competitive culture within which NHS services are commissioned and managed, highlighting an area of potential further study exploring how or to what extent different NHS structures and frameworks (e.g. competition vs collaboration) influence organisational issues and workforce wellbeing. In Scotland for example the NHS has evolved differently under devolved powers, so the purchaser/provider split does not exist and 14 geographically based NHS boards both plan and deliver services; cooperation and collaboration are promoted rather than competition (Timmins, 2013). An equivalent study therefore could explore what clinical psychologists perceive the main organisational issues in the Scottish NHS to be. This may allow comparison with the present study and enable further study into the impact of different competitive versus

collaborative structural and governance regimes on NHS workforce wellbeing and sustainability.

Further potential implications and discussion

Study participants perceived a constant cycle of imposed organisational change, with change implementation negatively impacting staff, causing distress, disempowerment, and disillusionment. This aligns with earlier research that identified a similar constant cycle of change, resulting in staff negativity, reduced motivation, perceptions the psychological contract had been damaged, and leading many to quit or want to leave (Cortvriend, 2004). The broader theme of NHS organisational change being predominantly negatively experienced by staff is also consistent with Durdy and Bradshaw's (2014) literature review on this topic. NHS organisational change has been characterised as typically 'top down', with minimal consideration or planning around its impact on staff (Ballatt & Campling, 2011), and studies in different mental health settings have supported this characterisation, variously experienced by staff as 'massively disempowering' (Nutt & Keville, 2016, p.229), 'aversive and imposed in the absence of any meaningful consultation' (Colley et al., 2015, p.4), and 'the pitting of a powerful and controlling force that impacted on [clinicians'] clinical autonomy and, in turn, sense of agency' (Kingswood, 2014, p.137). Participants' perceptions from the present study suggest problems with NHS organisational change implementation may be continuing to occur and negatively impact staff. However, organisational factors, and their potential impact on wellbeing, is not considered within the recent NHS Staff and Learners' Mental Wellbeing Commission report (Health Education England, 2019). The present study findings suggest organisational factors can influence wellbeing and decisions to leave, and the ongoing potential impact on staff wellbeing and sustainability may suggest the professional bodies may be well placed to advocate for exploring, and addressing such potential issues.

These apparent disconnections also point to a potential role for psychology within the wider NHS at policy level in the planning and implementation of NHS change, and within broader managerial decision making with the application of a systemic, formulation-led approach to organisational problems, staff wellbeing, and change processes. Given that further large-scale NHS change is on the horizon (Anderson et al., 2021), improving the way NHS change is implemented appears important, particularly given the NHS's aspiration to be an organisation where "the values we seek to achieve for our patients - kindness, compassion, professionalism - are the same values we demonstrate towards one another" (NHS England, 2019, p.86). This may therefore represent an opportunity for the psychology profession to advocate for and expand into strategically orientated roles that span a clinical and organisational focus. Participants within the study perceived clinical psychology's current potential contribution to the NHS is not being realised, and felt increasingly constrained to fulfil tightly defined roles, with barriers and bureaucracy frustrating attempts to making positive change. As the clinical psychology workforce is currently expanding, a broader scope of NHS psychology roles could also provide new potential career trajectories for new entrants, potentially increasing attractiveness of an NHS career and therefore improving future retention.

The findings of the empirical study and systematic literature review both highlight the role of organisational and systemic factors in mental health practitioner wellbeing. For burnout, the systematic review contributes a line of argument that practitioner self-knowledge and boundaries can contribute to or protect against burnout, and that organisational culture and values can create a workplace that can be protective against burnout or contribute to it. The influence of the latter, by defining the context within which the individual is able to assert boundaries and self-care practices, may be more influential in practitioner burnout than individual factors. In the empirical paper, a similar theme meant psychologists committed to NHS values could not continue working within it due to organisational factors and conflict

with professional identity. These reflections contrast with much burnout prevention and workforce wellbeing research and interventions, which often reflect assumptions of individual failure to cope. Current interventions tend to focus on helping the individual better cope within existing systems, such as improving practitioner awareness and coping skills for burnout (Salyers et al., 2011), and improving access to mental health support for NHS staff among measures (Health Education England, 2019). That the organisation may play an important role in staff wellbeing and workforce sustainability is not a new insight (Maslach & Leiter, 1997) but nonetheless appears to be downplayed in the current context. The contribution from both the empirical paper and literature review therefore is to re-centre the importance of organisational factors within efforts to improve the wellbeing and sustainability of the mental health workforce.

Final reflections

As a new meta-ethnographer and grounded theorist, exploring potential epistemological and methodological approaches aligning with the research and my own values proved challenging given the possibilities, and it felt necessary to approach learning grounded theory and conducting the research as a process of experiential learning which at times felt murky and frustrating. However, learning to trust the process, and utilising reflective journaling and memos during the research helped illuminate themes and prompt reflection on potential connections. Hearing participants' experiences was difficult at times as they spoke about problems with a system I hope to work within. It sometimes felt frustrating to have a single interview as several participants mentioned they hadn't spoken about their experiences before and I perceived they may have been processing their experiences through explaining them. Speaking over several sessions may have helped refine their reflections further, potentially deepening the richness of data.

Through conducting the research, I also developed a greater awareness of my emerging professional identity, strongly identifying with the psychologist conceptual categories. This led me to reflect on what I will look for in qualified roles, particularly potential for professional autonomy and opportunity to improve services and systems. Through the research, I've reflected on similarities between aspects of my previous career and clinical psychology, particularly applying systemic approaches and formulating difficulties in relation to context, and potential to apply these skills organisationally as well as clinically. Several participants expressed concerns their experiences might put me off the NHS, but I feel the opposite occurred, and conducting the research clarified my own values and reasons for wanting to work in the NHS. My position at the end of the research is encapsulated by one participant, to whom I give the last word:

> I'd really like to go and [work to improve the NHS] 'cause I feel passionately about it. Even more so now, because I've had my own experience. So yeah, I definitely will be back in the NHS. But it's a really hard environment to work in. And we need to do something about it for everybody, or we'll lose all of our clinicians. (Diane)

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Section Four: Ethics Documents

Evidence of ethical applications and approval

Word count: 3,715

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Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHMREC) Application

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover cursor over 'guidance'.

Guidance on completing this form is also available as a word document

Title of Project: Clinical Psychologists' reflections on leaving the NHS: impact of organisational issues and values on professional identity

Name of applicant/researcher: David Saddington

ACP ID number (if applicable)*: N/A **Funding source (if applicable)** N/A

Grant code (if applicable): N/A

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist

2. Contact information for applicant:
E-mail: d.saddington@lancaster.ac.uk **Telephone**: 07793222920 (please give a number on which you can be contacted at short notice)

Address: Clinical Psychology, Division of Health Research, Lancaster University, Lancaster, LA1 4YG

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr Pete Greasley Research Supervisor
Dr Petra Gwilliam Field Supervisor

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Dr Pete Greasley (Research Supervisor), Dr Petra Gwilliam (Field Supervisor)

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**: Teaching Fellow, Health Research Division, Lancaster University

SECTION TWO
Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk
3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' n o
4c. If yes, where relevant has permission / agreement been secured from the website moderator? n o
4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? n o

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? n o
6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder
7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE
Complete this section if your project includes *direct* involvement by human subjects

SECTION THREE
Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Studies have found organisational change in NHS mental health services are often perceived negatively, and conflict with staff professional values and integrity. The values dominant in the current NHS, particularly the focus on targets and 'output', may be undermining the integrity of independent clinical judgement and fuelling an exodus of mental health staff. These trends appear to have implications for the role and viability of the NHS clinical psychology workforce. This study will explore how organisational change and values relating to Clinical Psychologists' professional identity contributed to psychologists' decisions to leave NHS practice.

Semi-structured interviews will explore UK Clinical Psychologists that left the NHS within the past 3 years' experiences of organisational change and values, and impact on professional identity. Interviews will be analysed to identify common themes, which will then lead to the generation of theory for why psychologists leave the NHS.

2. **Anticipated project dates (month and year only)**

Start date: April 2020 End date: March 2021

Data Collection and Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The participants will be between a minimum of 10 and maximum of 15 UK-qualified Clinical Psychologists living in the UK, with a minimum age of 25 and maximum age of 65. Participants will have worked as a Clinical Psychologist within the NHS for at least 1 year, and left within the past 3 years. Participants that left the NHS due to retirement or early retirement will be excluded as they would be outside of the scope of the research.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (e.g. adverts, flyers, posters).

Participants will be invited to participate via an advert on the 'UK based Clinical Psychology' Facebook Group, potentially accessing up to 5,290 clinical psychologists (recruitment materials attached in Appendix). I will use a professional Facebook account not linked to my personal account, to publicise the study. Participants who are interested in participating in the study will click through the Facebook advert and be taken to a Qualtrics page containing the participant information sheet. They will then have the opportunity to read about the study, and decide whether they wish to participate. My university email address will be contained on the sheet if they have further questions before deciding to participate. If they decide to participate, they will click through a link on the participant information page to new Qualtrics page summarising the eligibility criteria where they will confirm eligibility and enter contact details to opt in. Qualtrics will allow a maximum of 15 participants to opt in before displaying a message apologising that the study has been fully recruited. I will

contact the participants by phone to confirm eligibility and arrange a date and time for a telephone/Skype interview. If any participants are found to be ineligible, they will be removed at this stage.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data collection will utilise semi-structured interviews with broad open-ended questions allowing for in-depth exploration of the issues, and the emergence of participant stories. Interviews will all take place via a university telephone/Skype and there will be no face to face contact, ensuring a safe working environment. Interviews provide a flexible, emergent data collection approach whereby ideas and issues that come up can be immediately followed up. Data analysis will utilise grounded theory; interview transcripts will be transcribed and analysed.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

The data collected for this study will be stored securely, and only the researchers conducting this study will have access to it.

Participant contact details and confirmation of eligibility will be completed online via the Qualtrics platform. Qualtrics uses Transport Layer Security (TLS) encryption (also known as HTTPS) for all data transmitted. Only myself and my supervisor will have access to the responses. These data will be stored on Qualtrics until the study has been fully recruited, at which point they will be exported securely to Excel for the allocation of study codes to each participant. This file will be password protected and stored on University approved cloud storage for 10 years.

Audio files will be stored on the University encrypted drive until the thesis has been examined, at which point they will be permanently deleted. The transcribed interview data will be stored in digital (MS Word) format on the University encrypted drive as the research is being carried out, and when complete these electronic data will be stored on University approved secure cloud storage for 10 years.

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video
a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Audio recordings of interviews will be made on a University recording device attached to a University phone, or Skype. If Skype is used then I will utilise a Skype account created specifically for this research (not my personal Skype address). It is important to note that Skype is a programme which facilitates communication over the internet and as such it cannot be guaranteed to be a completely secure means of communication. This is communicated to participants in the participant information sheet. The audio file for each interview will be moved to the University encrypted drive as soon as the interview ends, and the original file will be immediately deleted from the phone. If it is not possible to transfer the file immediately (e.g. internet connection failure) the device will be stored securely until such time that the file can be transferred.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Audio files will be stored on University approved cloud storage until the final thesis has been examined. At this point the audio files will be permanently deleted.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder
8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

All relevant files with documentation will be stored in Lancaster University's data repository (via Pure) where it will be preserved according to Lancaster University's Data Policy for a minimum of 10 years.

8b. Are there any restrictions on sharing your data ?

Anonymous data can be made available on request to bona fide researchers who provide information regarding proposed use. Access will be granted on a case by case basis by the Faculty of Health and Medicine.

9. Consent
a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

Consent will be obtained from each participant prior to the interview taking place. Consent will be discussed at the beginning of the phone call and I will inform the participant that I will audio record the consent process.

I will read the consent form to the participant and ask that they can give a verbal response to each item. Participants will again be given the opportunity to ask questions. The audio recording will be saved as a separate audio file to the main interview and the consent audio recording will be stored and transferred securely to the Research Coordinator/Administrator in the Division of Clinical Psychology at the end of the study for storage.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

It is unlikely that participation in the study could cause discomfort, inconvenience, or danger given the focus on experience working in the NHS, rather than specific focus on distressing or sensitive topics. However, to mitigate any risk if this was to occur, possible sources of support will be provided within the Participant Information Sheet that will be given to all participants. Participants are welcome to withdraw from the study at any time before or during the interview, and up to 2 weeks after the interview. After this point it would not be possible to withdraw as the interviews will have been transcribed, anonymised, and may already have been incorporated into themes.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

As interviews will be conducted by phone or Skype, there are no physical potential risks, and a University email address and phone will be used for correspondence and interviews. If Skype is used for interviews, an account will be created specifically for the research (not my personal account). It seems unlikely that the interviews will lead to sensitive or distressing material being disclosed. However if this were to be the case it would be possible to discuss these with the Field Supervisor.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There may be no direct benefit to participation in this study. However, people may find it a positive experience to participate because many people choose to become Clinical Psychologists out of a desire to make a positive difference, and to work in the NHS. Thus the opportunity to share their experiences that led to a decision to leave the NHS may prove positive and validating.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

No incentives or payments will be made to participants.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?
yes
b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Data will be collected through semi-structured interviews conducted over the phone or Skype. It is important to note that Skype is a programme which facilitates communication over the internet and as such it cannot be guaranteed to be a completely secure means of communication. This is communicated to participants in the participant information sheet. The audio recordings will be transcribed by myself, and anonymised with any identifying information (names, locations) removed. Interviews will not be confidential, but will be anonymous, and direct quotes will be used. Project participants will be anonymised after recruitment has taken place. Eligible participants will be allocated a participant ID which will be used instead of personal information to identify the participant in subsequent data collection and storage.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

My target participation group is indirectly involved in the design and conduct of my research via consultation and input with my field supervisor, who meets the participant eligibility criteria (though will not be a participant in the study). My field supervisor has provided consultation on recruitment procedures and drafts of semi-structured interview questions that will be used in the study.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

Data from the study will be seen by my research and field supervisors. My published thesis will be available for dissemination via the University, and results of the research will be submitted for publication in an academic journal.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

It is conceivable that given the study relates to former NHS employees' experiences, participants may feel inhibited from openly expressing their views due to concerns about impacting any potential future NHS employment. However, this seems unlikely given the anonymous nature of the interviews, and the fact that participants will be drawn from across the UK. Thus the likelihood of any participant being able to be identified from any published quotes from their interviews does not appear probable. This risk will be mitigated as far as possible by highlighting the steps taken to anonymise participants, and detailing how their accounts will be used in the Participant Information Sheet, enabling participants to weigh this for themselves and make a fully informed decision to take part.

SECTION FOUR: signature

Applicant electronic signature: DSaddington Date 4/2/20

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Dr. Pete Greasley Date application discussed 4/2/20

Submission Guidance

1. Submit your FHMREC application by email to Becky Case (fhmresearchsupport@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*

ii. **Supporting materials.**
Collate the following materials for your study, if relevant, into a single word document:

a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
b. Advertising materials (posters, e-mails)
c. Letters/emails of invitation to participate
d. Participant information sheets
e. Consent forms
f. Questionnaires, surveys, demographic sheets
g. Interview schedules, interview question guides, focus group scripts
h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:

i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

a. existing documents/data only;
b. the evaluation of an existing project with no direct contact with human participants;
c. service evaluations.

3. <u>You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application</u>

Lancaster University

This form should be completed by PGR students together with the supervisor in all cases, and by staff whose project has NOT been costed on ACP

Governance checklist

Introduction

Please complete all sections (1 to 4) below. If none of the self-assessment items apply to the project then you do not need to complete any additional LU ethics forms.

Further information is available from the FREC webpage

Note: The appropriate ethics forms must be submitted and authorised to ensure that the project is covered by the university insurance policy and complies with the terms of the funding bodies.

Name: David Saddington **Department**: Clinical Psychology, Health Research

Title of Project: Clinical Psychologists' reflections on leaving the NHS: impact of organisational issues and values on professional identity **Supervisor** (if applicable): Dr Pete Greasley

Section 1A: Self-assessment

1.1 Does your research project involve any of the following?

a. Human participants (including all types of interviews, questionnaires, focus groups, records relating to humans, use of internet or other secondary data, observation etc)

b. Animals - the term animals shall be taken to include any non-human vertebrates or cephalopods.

c. Risk to members of the research team e.g. lone working, travel to areas where researchers may be at risk, risk of emotional distress

d. Human cells or tissues other than those established in laboratory cultures

e. Risk to the environment

f. Conflict of interest

g. Research or a funding source that could be considered controversial

h. Any other ethical considerations

x Yes - complete Section 1B

☐ No - proceed to Section 2

Section 1B: Ethical review

If your research involves any of the items listed in section 1A further ethical review will be required. Please use this section to provide further information on the ethical considerations involved and the ethics committee that will review the research.

Please remember to allow sufficient time for the review process if it is awarded. The ethical review process can accommodate phased applications, multiple applications and generic applications (e.g. for a suite of projects), where appropriate; the Research Ethics Officer will advise on the most suitable method according to the specific circumstances.

1.2 Please indicate which item(s) listed in section 1A apply to this project (use the appropriate letter(s), eg a,c,f)

Items: a

1.3 Please indicate which committee you anticipate submitting the application to:

☐ NHS ethics committee

☐ Other external committee

☐ LU FASS/LUMS Research Ethics committee

☐ LU FST Research Ethics committee

x LU FHM Research Ethics committee

☐ LU AWERB (animals)

Section 2: Project Information

This information in this section is required by the Research Support Office (RSO) to expedite your proposal.

2.1 If the establishment of a research ethics committee is required as part of your collaboration, please indicate below. (This is a requirement for some large-scale European Commission funded projects, for example.)

☐ Establishment of a research ethics committee required

2.2 If the research involves either the nuclear industry or an aircraft or the aircraft industry (other than for transport), please provide details below. This information is required by the university insurers.

N/A

Section 3: Guidance

The following information is intended as a prompt and to provide guidance on where to find further information. Where appropriate consider addressing these points in the proposal.

- If relevant, guidance on data protection issues can be obtained from the Data Protection Officer - see Data Protection website
- If relevant, guidance on the Freedom of Information Act can be obtained from the FOI Officer - see FOI website
- The University's Research Data Policy can be downloaded here
- The health and safety requirements of each research project must be considered, further information is available from the Safety Office website
- If any of the research team will be working with an NHS Trust, consider who will be named as the Sponsor (if applicable) and seek agreement in principle. Contact the Research Ethics Officer for further information
- If you are involved in any other activities that may result in a conflict of interest with this research, please contact the Head of Research Services (ext. 94905)
- If any of the intellectual property to be used in the research belongs to a third party (e.g. the funder of previous work you have conducted in this field), please contact the Intellectual Property Development Manager (ext. 93298)
- If you intend to make a prototype or file a patent application on an invention that relates in some way to the area of research in this proposal, please contact the Intellectual Property Development Manager (ext. 93298)
- If your work involves animals you will need authorisation from the University Secretary and may need to submit an application to AWERB, please contact the University Secretary for further details
- Online Research Integrity training is available for staff and students here along with a Research Integrity self-assessment exercise.

3.1 I confirm that I have noted the information provided in section 3 above and will act on those items which are relevant to my project.

x Confirmed

Section 4: Statement

4.2 I understand that as researcher I have overall responsibility for the ethical management of the project and confirm the following:

- I have read the Code of Practice, Research Ethics at Lancaster: a code of practice and I am willing to abide by it in relation to the current proposal
- I have completed the ISS Information Security training and passed the assessment
- I will manage the project in an ethically appropriate manner according to: (a) the subject matter involved; (b) the code of practice of any relevant funding body; and (c) the Code of Practice and Procedures of the university.
- On behalf of the institution I accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- On behalf of the institution I accept responsibility for the project in relation to the observance of the rules for the exploitation of intellectual property.
- I will give all staff and students involved in the project guidance on the good practice and ethical standards expected in the project in accordance with the university Code of Practice. (Online Research Integrity training is available for staff and students here.)
- I will take steps to ensure that no students or staff involved in the project will be exposed to inappropriate situations.

x Confirmed

Please note: If you are not able to confirm the statement above please contact Faculty Research Ethics Officer and provide an explanation

Applicant
Name: David Saddington Date: 4/2/20 Signature: *DSaddington*

***Supervisor (if applicable):**
Name: Pete Greasley Date: 4/2/20 Signature: *PGreasley*

**I declare that I have reviewed this application, and discussed it with the applicant as appropriate. I am happy for this application to proceed to ethical review.*

Head of Department
(or delegated representative)

Name: Bill Sellwood Date: 25th March 2020 Signature: [redacted]

Please return this form to your Faculty Research Ethics Officer

Research Protocol

Clinical Psychologists' reflections on leaving the NHS: impact of organisational issues and values on professional identity

Version: 0.3 Created: 24/03/20

Applicants

Principal Investigator

- David Saddington

Trainee Clinical Psychologist, Lancaster University, Lancaster, LA1 4YT
Email: d.saddington@lancaster.ac.uk

Chief Investigator

- Dr Pete Greasley

Research Supervisor, Lancaster University, Lancaster, LA1 4YT
UK T: +44 (0)1254 593 535 Email: p.greasley@lancaster.ac.uk

Introduction

Studies focused on the impact of organisational change in mental health services on professionals, highlight how changes are often perceived as conflicting with professional values and integrity, undermining the focus on clinical work, and negatively impacting morale (Kingswood, 2014, Colley et al., 2015, Nutt & Keville, 2016, Hanley et al., 2017). Following publication of the results of their wellbeing survey of psychological therapy professionals, the BPS Division of Clinical Psychology / New Savoy Partnership (2017, p.1) suggested that 'the sustainability and transformation plans in mental health will be undeliverable unless psychological staff wellbeing, capacity and retention issues are urgently addressed'. Clinical psychologists made up 48% of respondents; less than a third of respondents considered their service had enough staff to deliver a safe and effective service, and almost a quarter were thinking of leaving the NHS.

Clinical psychologists constitute a highly trained and valuable part of the mental health workforce, however little research appears to exist on clinical psychology workforce retention and reasons they are leaving the NHS, as opposed to other professionals such as GPs (Doran et al., 2016), Allied Health Professionals (Loan-Clarke et al., 2010), and Speech and Language Therapists (Loan-Clarke et al., 2009). Tracking graduates of the Canterbury Christ Church clinical psychology training programme, Lavender and Chatfield (2016) found historic retention rates within the NHS compared favourably with doctors and nurses, however the proportion working in private practice had nearly doubled from 8.2% in 2012 to 13.8% in 2016.

The NHS has undergone frequent organisational change since its foundation, and clinical psychology has changed alongside it, partly from within the profession and partly by externally driven change (Turpin & Llewelyn, 2009). From the 1980s onwards, the NHS became increasingly centralised, focused on 'efficiency' and 'value for money', with clinical

judgement increasingly accountable to management oversight and targets (Gordon, 2008). The 2010 austerity agenda brought further changes; cuts were made to services tasked with managing both more complex cases and more referrals, leading to stress, exhaustion, and burnout (Wilkinson, 2015).

The role and focus of clinical psychology also changed and narrowed (Hassall & Clements, 2011). The 'industrialisation' of services (Ballatt & Campbell, 2011) has increased pressure to perform a more proscribed, psychotherapy-focussed role defined by service managers and commissioners, accompanied by ‘the requirement to achieve stringent performance targets set by commissioners, the progressive dismantling of professional line management, the micro-management of professionals’ work, and [a] reduction in security and professional identity’ (Hassall & Clements, 2011, p.8).

Durdy (2014) highlights the predominantly negative impact that organisational change in recent years has had on NHS mental health professionals, and Kingswood (2014, p.45) has suggested that 'the greater impact appeared to concern changes encroaching on deep-seated values and priorities, clinical preserves, territory, implicating clinical role and identity'. These trends appear to have significant implications for both the role of clinical psychology, and the long-term viability of the clinical psychology workforce within the NHS. This study will explore these themes by exploring how organisational change and values relating to the professional identity and role of Clinical Psychology contributed to psychologists’ decision to leave the NHS.

Qualitative interviews utilising grounded theory (Glaser & Strauss, 1967) will allow issues to be explored in depth. Given this area of research lacks existing theory, grounded theory represents an appropriately flexible inductively driven approach with which to explore and define fundamental processes occurring within the participant group, leading to the

generation of theory. Tweed and Charmaz (2012) also note grounded theory is particularly suitable for investigating how policies and services can impact upon behaviour.

Method

Design

The aim of this study is to collect data on the experiences of organisational change and values of Clinical Psychologists who have left the NHS. Semi-structured interviews will be used to explore their experiences.

Methodology for analysis will be grounded theory (Glaser & Strauss, 1967). This flexible and inductively driven methodology is appropriate for this study as there is currently little prior research into the impact of organisational change on Clinical Psychologists' values and professional identity, nor into why psychologists leave the NHS. Thus there is currently a lack of existing hypotheses to guide questioning.

Participants

To be included in this research participants will be aged between 25 and 65 (i.e. typical UK working, accounting for time to qualify as a clinical psychologist and practice in the NHS for at least 1 year). They will have worked as a qualified Clinical Psychologist in the NHS for at least 1 year, and left the NHS within the past 3 years for reasons relating to NHS organisational issues and values. Individuals who left the NHS due to scheduled retirement at the standard age (i.e. the year they would qualify for a full NHS pension, which may vary according to when they started working for the NHS) would be excluded. This decision was taken to focus on individuals that have made the active choice to leave NHS service before the end of their normal working lives.

The study will aim to have 10-15 participants, in line with Glaser & Strauss (1967) concept of ‘theoretical saturation’, when categories are well developed, the relationship

between categories are established and validated, and no new or relevant data seems to emerge. In grounded theory, the number of participants should be indicated by theoretical saturation, and can only be properly assessed during data collection. This range of participants was chosen to reflect this measure of imprecision, as well as the practical constraints inherent with professional doctoral thesis research.

Interview schedule

The interviews will be semi-structured and initial questions are based loosely on the research question. The schedule (Appendix 5) is designed to be used as a flexible guide with open high level questions, and topic area prompts to guide appropriate followup questions as required. The schedule will be reflected on after each interview and may evolve as data collection proceeds. This will enable me to investigate emerging themes from participant accounts and adapt and respond to aspects that are particularly salient.

Grounded theory practice suggests that existing knowledge of the area may give rise to existing ideas and experience leading the generation of theory rather than being wholly grounded in the data. Having existing knowledge of organisational change theory and practice, as well as lived experience, means I may bring some pre-conceptions to this area. However, being mindful of personal assumptions through the interview process, and using a reflexive journal and supervision to continually reflect on these issues should mitigate this risk as far as possible.

Procedure

Recruitment

Participants will be invited to participate via an advert on the UK based Clinical Psychology Facebook Group, potentially accessing up to 5,290 clinical psychologists. A professional Facebook account set up for this study will be used to post this advert. Of these

potential participants it is estimated that up to 300 may have left the NHS in last 3 years and of those up to 50 may respond. Given the likely emotive nature of a decision to leave an NHS career I anticipate that people are more likely to be motivated to respond to the study and want to talk about the issues.

Participants who wish to learn more about the study will click on a link from the advert that goes to the Participant Information Sheet displayed on a Lancaster University Qualtrics page. If they choose to take part, they will click the link on this page, which will then display a page displaying the eligibility criteria, where they will enter basic demographics and contact details. Qualtrics will be set up to allow 15 participants to opt-in, after which it will display a message with apologies that the study has been fully recruited. I will then contact each by phone to confirm eligibility and to arrange a date and time for the interview. Participants that are found not to have met the eligibility criteria will not move forward for interview.

Consent

Each participant will provide consent prior to taking part in an interview. Consent will be discussed at the beginning of the phone call and I will inform the participant that I will audio record the consent process.

I will read the consent form to the participant and ask that they can give a verbal response to each item. Participants will again be given the opportunity to ask questions. The audio recording will be saved as a separate audio file to the main interview and the consent audio recording will be stored and transferred securely to the Research Coordinator/Administrator in the Division of Clinical Psychology at the end of the study for storage.

Participants will be able to withdraw from the study at any point until the interview has taken place.

Analysis

Data collection

Basic demographics will be collected via a Qualtrics form as part of the recruitment process. All subsequent data will be collected via semi-structured interviews to allow questions to be framed in relation to participants' understanding of organisational issues and values, but also to ensure the interviews are guided by participants' responses. Semi-structured interviews are commonly used in grounded theory research (Glaser & Strauss, 1967). All interviews will take place by phone and will be audio recorded.

Analysis

Following each interview, I will transcribe verbatim and anonymise the data. Data analysis will be done in accordance with the principles of grounded theory (Glaser & Strauss, 1967). As soon as initial interviews have taken place and been transcribed, initial coding will be done alongside further interviews, leading to initial memos raising codes to initial categories. This will lead on to further interviews and more focussed coding, and advanced memos that further refine the categories, and adoption of some as theoretical concepts (Charmaz, 2014).

Themes that emerge will be categorised, and re-reading and the addition of further data will maximise the opportunity for individual accounts to be reflected within the themes. Direct quotes that are used will be anonymised, and bias will be reflected on and minimised throughout the study via the use of supervision.

Ethical Concerns

Risk to participants

It is not anticipated that participation in the study could cause discomfort, inconvenience, or danger given the focus on experience working in the NHS, rather than specific focus on distressing or sensitive topics. As the interviews will be conducted by phone, distress may be difficult to detect. However, if any distress is noticed the interview will be stopped immediately and the participant will be offered a break. Following a break, they will be asked if they wish to end the interview completely, or continue from a different question. Participants will also be given the option to reschedule the interview for a different data if preferred. Irrespective of if any discomfort is detected during the interview, the researcher will check in with the participant about their wellbeing at the end of the interview.

Risk to researchers

A professional Facebook account will be created to advertise the study which will not be linked to my personal account in any way. Interviews will take place via University telephone or a Skype account set up specifically for the study, and electronic communication will take place via University email address. No personal researcher contact details will be known to participants, and no face to face contact will take place. Thus risk to researchers is considered to be minimal.

Confidentiality and anonymity

Participants will be advised about issues of confidentiality, anonymity, and commitment involved in taking part in the research, and will be free to withdraw from participation at any point up until two weeks after an interview has been conducted. The reason for this limitation is that at this time point the interview will have been transcribed and anonymised, and data may have been incorporated into themes. Participants are not required to give any reason for withdrawing from the study, and all reasons given will be recorded.

All personal information provided by participants will be kept confidential. Participant basic demographics will be downloaded from Qualtrics into an Excel file, and participants will be allocated a code number which will be used to anonymously identify all subsequent data. This Excel file will be password protected and this along with all other study data will be securely stored on Lancaster University approved cloud storage and only the researchers will have access. Interview audio recordings will be transferred onto University approved cloud storage as soon as they are made, and will be stored until the completed thesis has been examined, at which point they will be permanently deleted. The data will be anonymised during transcription by the removal of any identifying information. Anonymised typed interview transcripts will be stored on University approved cloud storage while the research is being conducted. Anonymised direct quotations may be used in the published study. Anonymised interview transcripts and consent forms will be stored by Lancaster University in approved cloud storage for 10 years after the research has been completed or 10 years after publication (whichever is longer). The Lancaster University Division of Health and Medicine DClinPsy course Research Coordinator will be responsible for the data over this time period.

Timescale

- February 2020: Ethics application
- March 2020: Ethics approval
- March - August 2020: Recruitment and data collection
- August 2020 - March 2021: Data analysis and writing

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Loan-Clarke, John, Arnold, J., Coombs, C., Hartley, R., & Bosley, S. (2010). Retention, turnover and return—A longitudinal study of allied health professionals in Britain. *Human Resource Management Journal*, *20*(4), 391–406. https://doi.org/10.1111/j.1748-8583.2010.00140.x

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Appendix 4-A

Recruitment Advert

Advert to be placed in Facebook private group ‘UK Clinical Psychologists’

Doctorate in Clinical Psychology | Lancaster University

Clinical Psychologists' reflections on leaving the NHS: impact of organisational issues and values on professional identity

My name is David Saddington and I am interested in your experience of the impact of organisational change and values in the contemporary NHS on your professional identity as a Clinical Psychologist, and your decision to leave NHS practice.

We are recruiting UK Clinical Psychologists that have worked in the NHS for at least 1 year, and have chosen to leave NHS practice within the past 3 years for reasons relating to organisational change and values.

If you are interesting in taking part or have questions, please go to the link below for further information about the study, to contact me if you have questions, and to take part:

URL to Qualtrics participant information page

Appendix 4-B

Participant Information Sheet

Clinical Psychologists' reflections on leaving the NHS: impact of organisational issues and values on professional identity.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

My name is David Saddington and I am conducting this research as a trainee on the Doctorate in Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to explore how organisational change and values relating to Clinical Psychologists' professional identity contributed to psychologists' decisions to leave NHS practice

Why have I been approached?

You have been approached because the study requires information from people who are UK qualified Clinical Psychologists that worked in the NHS for at least 1 year, and left within the last 3 years for reasons relating to organisational change and values.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be asked to take part in a telephone or Skype interview with myself, which may last for 30 minutes to an hour. We will arrange a time to discuss your experiences and agree how best to enable you to participate via telephone or Skype depending on what is practically possible. Please note that Skype is a programme which facilitates communication over the internet and as such it cannot be guaranteed to be a completely secure means of communication.

Will my data be Identifiable?

The data collected for this study will be stored on University approved secure cloud storage and only the researchers conducting this study will have access to this data:

- Audio recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Principle Investigator

- David Saddington

Trainee Clinical Psychologist, Lancaster University, Lancaster, LA1 4YT
Email : d.saddington@lancaster.ac.uk

Chief Investigator

- Dr Pete Greasley

Research Supervisor, Lancaster University, Lancaster, LA1 4YT
UK T: +44 (0)1254 593 535 Email: p.greasley@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

- Dr Ian Smith

  Research Director, Health Research Division, Lancaster University, Lancaster, LA1 4YW

  UK T: +44 (0)1524 592 282 Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

Samaritans
Tel: 116 123 (freephone)
Email: jo@samaritans.org

SANE

Tel: 0300 304 7000

Mind

Tel: 0300 123 3393

Text: 86463

These resources will be repeated at the end of the study, but if any of the questions or themes discussed raise distress you are advised to contact your GP for support or discuss them with a person that you trust.

Appendix 4-C

Demographic Information Sheet (Qualtrics)

The following questions ask for some basic demographic information, inclusion criteria.

About you:

Name:	
Telephone:	
Email:	

Please choose from the following options:

	Question	Options
1)	I worked in the NHS as a Clinical Psychologist for at least 1 year.	Yes
		No
2)	I left the NHS within the past 3 years.	Yes
		No
3)	I left the NHS for reasons not relating to retirement.	Yes
		No

Appendix 4-D

Consent Form

Study Title: Clinical Psychologists' reflections on leaving the NHS: impact of organisational issues and values on professional identity

We are asking if you would like to take part in a research project that explores the experiences of organisational change and values of Clinical Psychologists who have left the NHS.

Before you consent to participating in the study we ask that you read the participant information sheet and answer "yes" to each question below if you agree. If you have any questions or queries before answering the consent questions, please ask me now.

	Please answer "yes" or "no" to each statement
1. I confirm that I have read the information sheet and fully understand what is expected of me within this study.	☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.	☐
4. I understand that audio recordings will be kept until the research project has been examined.	☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.	☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project.	☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events.	☐
9. I understand that the researcher will discuss data with their supervisor as needed.	☐
10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor.	☐
11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	☐
12. I consent to take part in the above study.	

Appendix 4-E

Interview schedule

Initial questions

- Tell me about when you started working in the NHS - what it was like at that time?
- Tell me about the main organisational changes your experienced over the years? How did they impact on you and your work?
- What made you decide to leave the NHS?

Topic area prompts for followup questions

- Values/Integrity
- Morale/Wellbeing
- Safety/Effectiveness
- Role change/Independence
- Targets/Dehumanisation
- Trauma/Burnout

Appendix 4-F

Debrief Sheet

Thank you for taking part in this study.

The recording of your interview will be transcribed and anonymised, and this transcript will then be analysed along with others and parts of it may be grouped into themes. Anonymous quotes from your interview may be used in the thesis, which may be published in academic or professional journals.

If you have any questions or concerns about the study, please contact the principle investigator. The contact details are as follows:

Principle Investigator
David Saddington

Trainee Clinical Psychologist, Lancaster University, Lancaster, LA1 4YT
Email : d.saddington@lancaster.ac.uk

Chief Investigator
Dr Pete Greasley

Research Supervisor, Lancaster University, Lancaster, LA1 4YT
UK T: +44 (0)1254 593 535 Email: p.greasley@lancaster.ac.uk

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

Samaritans
Tel: 116 123 (freephone)
Email: jo@samaritans.org

SANE
Tel: 0300 304 7000

Mind
Tel: 0300 123 3393
Text: 86463

Appendix 4-G

Letter of Approval from FHMREC

Lancaster University

Applicant: David Saddington
Supervisor: Pete Greasley
Department: Health Research
FHMREC Reference: FHMREC19053

02 April 2020

Dear David

Re: Clinical Psychologists' reflections on leaving the NHS: impact of organisational issues and values on professional identity

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

[redacted]

Becky Case
Research Ethics Officer, Secretary to FHMREC.