PROFESSIONAL DOCTORATES

Staff Perspectives on challenges of working within the contemporary NHS

Willoughby, Erica

Award date:
2024

Awarding institution:
Bangor University

PRIFYSGOL
BANGOR
UNIVERSITY

STAFF PERSPECTIVES ON CHALLENGES OF WORKING WITHIN THE CONTEMPORARY NHS.

Erica Bryony Fern Willoughby

North Wales Clinical Psychology Programme

Sept 2023

Submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology

Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

Erica Willoughby

14.09.2023

Acknowledgments

First and foremost, I would like to thank the participants of my empirical study. Without them this would not have been possible. I thank them not just for their time, but also their honesty and vulnerability. Thank you for trusting me.

I would also like to thank all of the staff within the NWCPP. The wonderful administrators who have cheer-leaded me on throughout my training journey. Debbie, Fiona and Mared you three have consistently been cheerful faces I could turn to when I needed some light relief. The course staff who have supported me through placements, coursework and much more over the past few years, in particular my wonderful and ever patient training co-ordinator Renee. And finally, to Donna and Michaela. You two have sat with me when I have been at my best and my worst. Thank you for everything you have done over the last few years, I can safely say I would not be in the position I am now, almost finishing the D-Clin Psy had it not been for your consistent patience and kindness. Additionally, I would like to thank my supervisors; Elizabeth, Mike and Chris. You guys all supported endlessly with reflective spaces and motivating me to 'just write it down'. I appreciate the time and knowledge you have brought to this, and I know it would have been a much poorer thesis had it not been for the reflective spaces you each provided in your own ways. It would feel remiss to not acknowledge the influence Dr David Oakley had upon this entire thesis, sadly he could not finish as part of the team. However, he was crucial in getting this thesis off the ground and supplying me with some motivation when things were challenging in the early stages. Additionally, I would like to thank Andrea Reynolds who supported me with managing my dyslexic brain and helped me feel this was 'possible'.

Outside of the course I have had many wonderful women cheering me on, both from within and outside of the psychology bubble. To name a few; Erin, Jess, Pam and Ellen and of course Lowri, Llinos, Louise, and Lisa (the ladies with babies). Each of you have supported me in so many ways, allowing me to complain, cry, laugh and at times listen. More recently, you have provided physical support as well as emotional, the endless car journeys, visits to see me, and lifts became highlights as I got to spend time with you all. I'm looking forward to being able to celebrate my graduation and roam the hills again with you on a slightly drizzly walk somewhere, babies, dogs, and partners in tow. To Erin, Jess, and Pam specifically – WE DID IT!!!!!

Then, to my immediate bubble. Stu and Minna. As Stu romantically summarised to me at the end of his doctorate; "I acknowledge your support in the writing of this thesis". In all honestly though, there is no way I could have completed this doctorate without either of you. I'm looking forward to a time where our evenings aren't structured around fitting in an extra bit of work, talking about our research, working out what forms need to be submitted when. Thank you for the consistent ad-hoc reflective opportunities, help with organising what I need to do, and being a fabulous father to Min throughout all the challenges we have faced recently. Minna, thank you for NOT providing a reflective space. Your lack of involvement or regard for anything 'doctorate' has provided me with much needed respite from the ongoing stress and strife of this training programme. Reading books, playing with blocks, and scribbling on paper with you has been a vital part of the thesis process.

Table of contents

Thesis summary

This thesis consists of three chapters, the first chapter is a systematic literature review investigating staff's experiences of burnout during the covid-19 pandemic. Thematic-meta-synthesis was used to analyse the available data, which was extracted from 11 selected papers during which seven themes were identified: 'our hands were tied', 'you put yourself last', 'hey we're all here, where are you?', 'we weren't prepared (for the unpreparable)', 'our voices were quashed'. Finally, the seventh theme 'I found that really hard' described how the challenges of working through the pandemic impacted staff, overarching all the prior 6 themes. The findings highlighted several cultural aspects of working in the NHS which negatively impacted on staff's wellbeing during the covid-19 pandemic.

Chapter two investigates staff's perspectives on their ability to speak up during multidisciplinary team (MDT) meetings. Semi-structured interviews were conducted with 11 team members of a Child and Adolescent Mental Health Service, analysed using thematic analysis. Four themes were identified: 'Control Vs Collaboration', 'Expectation Vs Reality', 'Conflicting Vs Motivational responsibilities' and 'Connection'. The findings highlighted how staff's experience of being in positions of threat and working under hierarchical structures impacted their ability to speak up within MDT meetings. The findings also suggest that a change in culture from a hierarchically based team culture to a leadership-based team culture may enable staff feeling able to speak more freely in MDT meetings. The third chapter explores the implications of findings from the previous two chapters and their contributions to existing theory and or clinical practice. It also includes a reflective section providing personal reflections on the process of completing the research.

Chapter one – Literature review

This chapter has been prepared for the submission to the journal of Social Science and Medicine.

https://www.elsevier.com/journals/social-science-and-medicine/0277-9536/guide-for-authors

"Systematic/scoping reviews and literature reviews of up to **15000** words including abstract, tables, figures, references and (printed) appendices as well as the main text. Systematic/scoping reviews must be reported according to PRISMA guidelines"

AN EXPLORATION OF STAFF BURNOUT WITHIN THE NHS: STAFF PERSPECTIVES ON EXPERIENCES FROM COVID-19

Erica Willoughby[1], Dr Elizabeth Burnside[2], Dr Mike Jackson[2], Dr Christopher Saville[2]

[1] – North Wales Clinical Psychology Programme, Bangor University

[2] – School of Psychology, Bangor University

Abstract

The National Health Service (NHS) is facing a crisis in terms of staff retention and wellbeing, with increasing numbers of staff leaving posts to move elsewhere or taking early retirement. The current meta-synthesis investigated clinical staff's experiences of burnout during the covid-19 pandemic within the NHS. A systematic search of the literature was conducted, and 11 papers were included in the final synthesis. First order data (extracts of participants words from interviews), and second order data (researchers' interpretations of the data) from each paper was extracted and analysed using thematic-meta-synthesis. In total seven themes were identified: 'our hands were tied', 'you put yourself last', 'hey we're all here, where are you?', 'we weren't prepared (for the unpreparable)', 'our voices were quashed', and 'I found that really hard'. Each theme describes difficult experiences which staff encountered over the course of the covid-19 pandemic, which added to their experience of job dissatisfaction, burnout, and alienation. The current review adds to the growing literature and understanding of the wellbeing of healthcare workers, but more specifically the experience of working within the contemporary NHS.

Registration

This meta-synthesis was registered with PROSPERO in September 2022, with edits in May 2023.

CRD42022362928

Available from: crd.york.ac.uk/PROSPERO/display_record.php?RecordID=362928

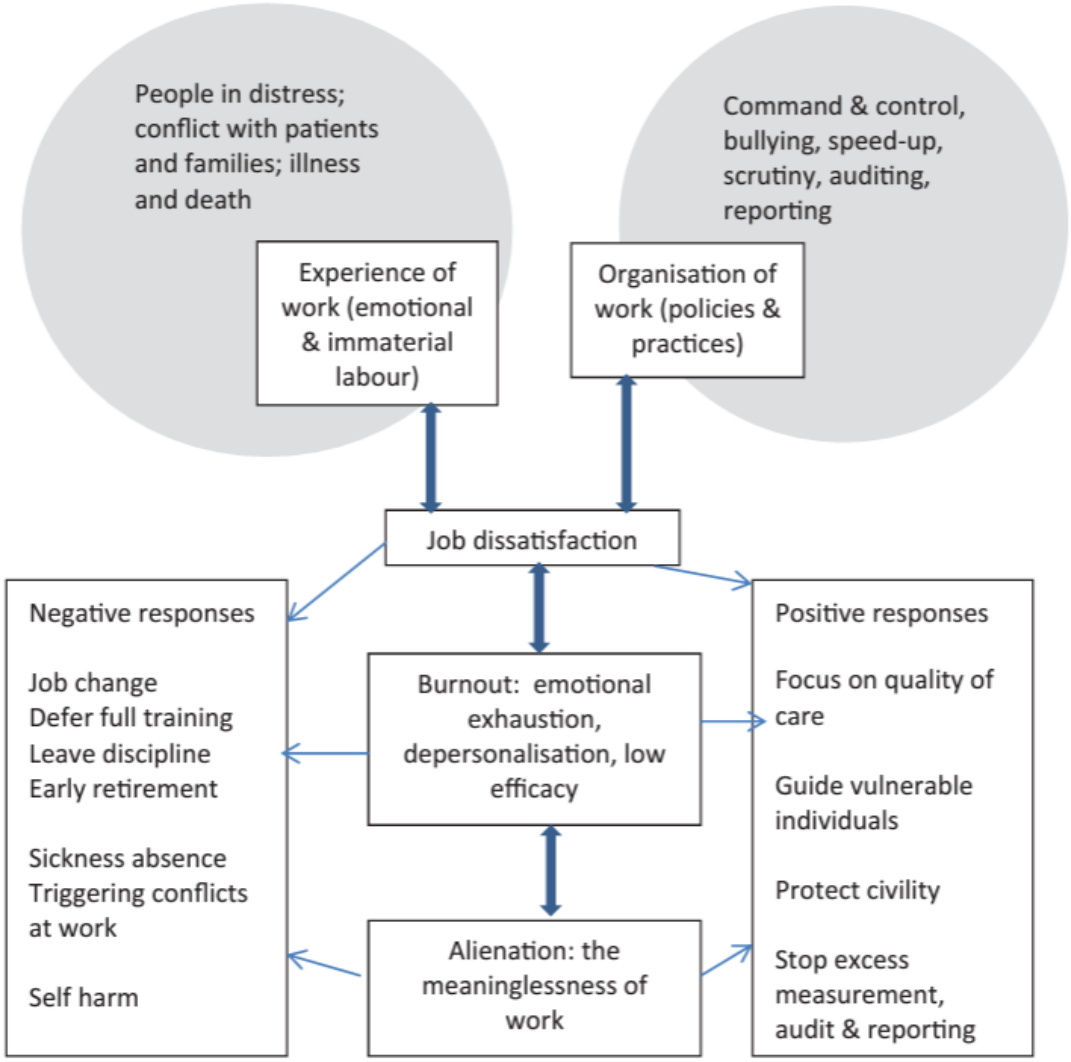
Introduction

Maslach and Jackson (1981) presented a commonly used definition of burnout with the experience of burnout being related to three factors:

1) Increased feelings of emotional exhaustion.
2) Increased display of cynicism or depersonalisation towards others.
3) Negative self-evaluation or reduced sense of personal accomplishment leading to reduced sense of self-efficacy.

More recently Iliffe and Manthorpe (2019) hypothesised that burnout does not simply occur when these factors are present, but that it is part of a cumulative process initially starting with job dissatisfaction, developing into burnout, and finally alienation where people see work as meaningless (see figure 1 for Iliffe and Manthorpe's (2019) model). All three states have shared negative or positive responses, which leads to negative or positive (respectively) impacts on healthcare workers and the systems they are a part of. Whether someone responds positively or negatively is suggested to be due to individual emotion management styles, named 'deep acting' or 'surface acting'. Surface actors are proposed to not modulate their emotional responses to things, resulting in them experiencing more cognitive dissonance. Deep actors on the other hand are able to modulate their emotional responses, resulting in reduced likelihood of cognitive dissonance. Deep actors are felt to respond to work-based stress with more 'positive' responses, and surface actors more 'negative' responses. This model also states that individual vulnerabilities come into play, acknowledging that job dissatisfaction alone does not automatically result in experiencing burnout. An important factor of this model is that the three of these factors can be reversed by looking at the reasons people are in any one of the three negative states and addressing these issues, where possible.

Figure 1: Iliffe and Manthorpe's model of job dissatisfaction, burnout, and alienation.



Historically the experience of burnout was viewed as something that only naive or unexperienced professionals experienced (Schaufeli, et al., 2009), although the term 'burnout' is felt to be a socially accepted label within Europe (Schaufeli, et al., 2009). More recently the concept of burnout has become one of the most studied aspects of distress within healthcare professionals in response to the prevalence and negative impact it has upon healthcare workers upon healthcare workers (Trockel, et al., 2020).

In a study looking into prevalence of dimensions of burnout in consultants' doctors within the NHS it was found that almost 40% reported emotional exhaustion and 20% reported depersonalisation. emotional exhaustion was found to be associated with an intention to retire early (Khan, et al., 2018), which is of particular concern with the current NHS model whereby the most experienced clinicians have a significant role in training more junior clinicians. Additionally, In a study conducted by the British Medical Association (BMA) 44%

of doctors reported that working through the covid-19 pandemic resulted in increased experiences of burnout and other mental health conditions such as depression and anxiety (BMA, 2020). However, burnout is not something that is limited to doctors. A Canadian study found that 66% of newly qualified nurses had very high levels of emotional exhaustion (Cho, et al., 2006). Staff working within mental-health settings have been found to be particularly vulnerable to experiencing burnout, with 21 – 67% of this group experiencing high levels of burnout (Morse, et al., 2012; Johnson, et al., 2018). Furthermore, 34% of psychologists have been found to be experiencing emotional exhaustion associated with burnout (McCormack, et al., 2018). A review of literature examining burnout and patient safety found that higher levels of burnout and poorer overall staff wellbeing were associated with higher levels of errors being made (Hall, et al., 2016) and reduced patient safety (Salyers, 2017). It has been acknowledged that more research looking at burnout in the UK healthcare workforce is needed (Hall, et al., 2016). Additionally, there is very little research which looks at the experience of burnout across multiple staff groups (Summers, et al., 2021).

The covid-19 pandemic brought unprecedented challenges and rapid across healthcare delivery in the UK (Hutchings, 2020; French, et al., 2021), and is expected to have a long-term impact on the NHS (Hutchings, 2020). Many services in the UK reported an initial drop off in patient attendance through the pandemic, resulting in an increased complexity and volume of patients re-entering services as restrictions lifted (Fersia, et al., 2020; Morris, et al., 2021). Additionally, health boards were grappling with developing new services to provide support for those experiencing covid-19 syndrome (Parkin, et al., 2021) at a time when the UK had a workforce shortage with over 100,000 vacant posts (Buchan, et al., 2019). The high rates of staff shortages pre-date covid-19 as the UK was recovering from the impact of reduced training rates following the period of austerity and increased challenges regarding international recruitment into healthcare following Brexit (Beech, et al., 2019).

In the last two years the staff leaving rates from the NHS has risen from 9.6% leaving in the year 2021 to 12.5% leaving in the year 2022. Although reasons for leaving are not always clear it appears that difficulties maintaining a work-life balance and incompatible working relationships are increasingly being cited as the reason for leaving, (NHS digital, 2023) which could be indicating an increase in the first factor of burnout, increased emotional exhaustion, although these categories are quite broad. It is also important to note that there are significant differences between different professions, Heath Trusts, and regions across the UK (Kelly, et al., 2022). High staff turnover is associated with increased costs to healthcare providers (Halter, et al., 2017), poorer patient experiences, and perceived reduction in quality of care (Sizmur & Raleigh, 2018). Additionally, it is reported that only

25% of doctors find their work fulfilling and rewarding, down from 40% two years ago, and only 14% report actually enjoying patient contact (General Medical Council, 2023). These findings, along with an increase in people leaving posts due to limited professional opportunities (NHS digital, 2023) seem to be connected to the third factor of burnout, specifically thinking about reduced sense of self-efficacy and sense of accomplishment in the workplace. It is therefore important that we begin to understand the experiences of staff working within the contemporary NHS, to better understand how to support staff retention and staff wellbeing. Existing reviews have largely had a focus on quantitative findings (Alanazi, et al., 2022; Wright, et al., 2022; Hannemann, et al., 2022; Lluch, et al., 2022; Chutiyami, et al., 2022) or have been conducted solely with international data (Al-Gobari, et al., 2022).

Research question

The current meta-synthesis seeks to understand staff's own perspectives on their experiences of burnout throughout the covid-19 pandemic in the UK by synthesising available qualitative empirical literature. It is hoped that the current meta-synthesis will add a rich insight into this subject and therefore support and guide future changes within the NHS as it navigates pre-existing and emerging challenges moving into the future.

Method

Rationale for meta-synthesis

Meta-synthesis as a methodology derives from Meta-ethnography (Noblitt & Hare, 1988). There is no specific gold standard approach for meta-synthesis, with a variety of methodologies falling under this umbrella term (Mohammed, et al., 2016). Meta-Synthesis can best be described a collection of methods which aim to review outcomes of qualitative research, which have some degree of shared methodological and epistemological approaches, not just by aggregating the data but applying additional interpretation (Fingfield-Connett, 2014; Fingfield-Connett, 2010; Leary and Walker, 2010; Thomas & Harden, 2008). It was hoped that this process would produce a rich new set of findings (Leary and Walker, 2018) which has increased generalisability and transferability (Fingfield-Connett, 2010).

For the current literature review thematic synthesis was selected (Thomas & Harden, 2008). This methodology is recommended when there is a shared methodological and epistemological approach between studies selected for synthesis (Thomas & Harden, 2008; Sibeoni, et al., 2022, see Table 2 for summary of study characteristics), whilst also producing clear results in the form of identified themes. Best practice guides (Siddaway, et

al., 2019; Mohammed, et al., 2008; Sandelowski, et al., 1997; Korhonen, et al., 2013) were consulted throughout the meta synthesis to ensure the current meta synthesis was high quality.

Search strategy

A systematic search of available literature was completed in October 2022. The relevant parts of the Preferred Reporting Items for Systematic Reviews and Meta Analysis (PRISMA) guidelines (Page, et al., 2021) were followed to support completion of the current thematic-meta-synthesis.

Five electronic databases (Medline, CINAHL, Psych Info, Psych Articles, and PubMed) were searched to identify relevant studies. An additional manual search of the reference lists and citations for any selected papers was then completed. Three sets of keywords were used to search each database;

("burnout, professional" OR "burnout" Or "fatigue" OR "exhaustion" OR "carer burnout") AND ("NHS" OR "National Health System" OR "healthcare" OR "health care" OR "healthcare services" OR "health care services" OR "health services") AND ("covid-19" OR "covid-19" OR "coronavirus" OR "2019-ncov" OR "Sars-cov" OR Cov-19").

Additional filters or limits were then applied for 'English language', 'peer reviewed', published after 2020, and where the option was available to be from the United Kingdom (Medline and CINAHL only).

Inclusion and exclusion criteria

All titles and abstracts were screened by the first author using the inclusion and exclusion criteria summarised in table 1. The fourth author conducted a reliability check of this screening process on a random selection of 50 articles that were accepted and rejected for full review with 94% agreement (Cohen's K 0.85) between the first and fourth authors. Papers where there was disagreement were subsequently discussed. It is worth noting that none of the papers where there was disagreement were ultimately included in the final synthesis. Papers on the theme of fatigue, burnout, and exhaustion were all included to reflect the discussion of burnout within the broader literature.

Table 1 – Inclusion and exclusion criteria

	Include	Exclude
Phenomenon of interest	Staff experiences of burnout (including fatigue, burnout, exhaustion as search terms to capture burnout in it's entirety) during the covid-19 pandemic	No focus on staff experiences of burnout Not experiences of covid-19 pandemic.
Publication date	2020 – search date (Oct 2022)	Publications outside of these dates
Publication type	Primary research	Commentaries, grey literature, reviews, editorials
Participant info	NHS employees in the UK	International participants where UK data cannot be separated. Non-UK participants only Non-staff group
Design and method	Qualitative or mixed methods	No qualitative element
Data	Must contain first order data from participants regarding their experiences of burnout during the covid-19 pandemic in the UK	no

Quality Appraisal

The Critical Appraisal Skills Programme (CASP) checklist for qualitative research (CASP, 2018) was used to appraise the quality of papers selected for the final synthesis (See table 3 for CASP ratings). The CASP checklist covers ten areas (aims of the study, methodology, design, recruitment, data collection, consideration of bias, ethical considerations, data analysis, clarity of findings, and overall value of the study) to rate research on its overall quality. The rating of each paper was guided by the CASP, 2018, document as well as the work by Butler, et al., (2016) who provide explicit guidance on quality ratings and what this suggests regarding the quality of the paper.

Data extraction

Study characteristics were extracted from each paper alongside the quality assessment process. First order data, the participants own words reported in each study, and second order data, the authors analyses of the first order data, regarding participants experiences of burnout through the covid-19 pandemic were extracted. The second order data was used to give important context to the first order data alongside the authors descriptions of the

themes they identified. For studies which had a mixed methods design only the qualitative data was extracted for analysis with no analysis of quantitative data taking place in accordance with the protocol for thematic-meta-synthesis as presented by Thomas and Harden (2008). Analysis of quantitative data was beyond the scope of this review.

Analysis

Analysis was conducted following the methodology of Thomas and Harden (2008), guided further by other researchers who had utilised this methodology (Sibeoni, et al., 2022). Thomas and Harden (2008) propose a three-step process for analyses, with acknowledgment that step one and two often occur co-currently (please see appendix a-d for examples of the analytic process):

1) Step one coding the data:
    a. Familiarisation with the data.
    b. Line by line coding of all available data.
2) Development of descriptive themes:
    a. Translating themes across all papers.
    b. Developing theme titles, creating new codes to summarise clusters of initial codes from step one.
3) Step three: generating analytical themes:
    a. Revisiting all available data and themes to create overarching descriptive themes.
    b. Reflecting with the wider research team to ensure themes are doing justice to the data, integrating appropriate interpretations of the data at this stage.

Researcher reflexivity

Due to the researcher interpretation element of meta-synthesis, it was crucial that the first author dedicated time during the analysis stage to consider their position and how this could influence their interpretations of the data. This first author, as a trainee clinical psychologist, was actively working in a variety of NHS services throughout the covid-19 pandemic. The second and third authors were actively working in the NHS as clinical psychologists through the pandemic. The fourth author did not work clinically, working as a university based academic throughout the pandemic, and was particularly involved during the analysis phase of the current review. At times the themes identified resonated with both the first and fourth authors, despite their different experiences of working through the pandemic. It was important that the research team were able to reflect upon their own positions and

experiences to consider what they were bringing to the research and reflect upon how this may be similar or different to the data at hand. The first author kept detailed notes of the progression of codes and themes throughout the analytic process and returned to the data to cross check developing codes and themes. Additionally, the first author kept an informal reflective log of their experience of analysing the data and used safe reflective spaces to explore this. Whilst the authors experiences and insights into working through the covid-19 pandemic may have influenced their interpretations of the data, it is hoped that the steps made increase the validity and generalisability of the findings.

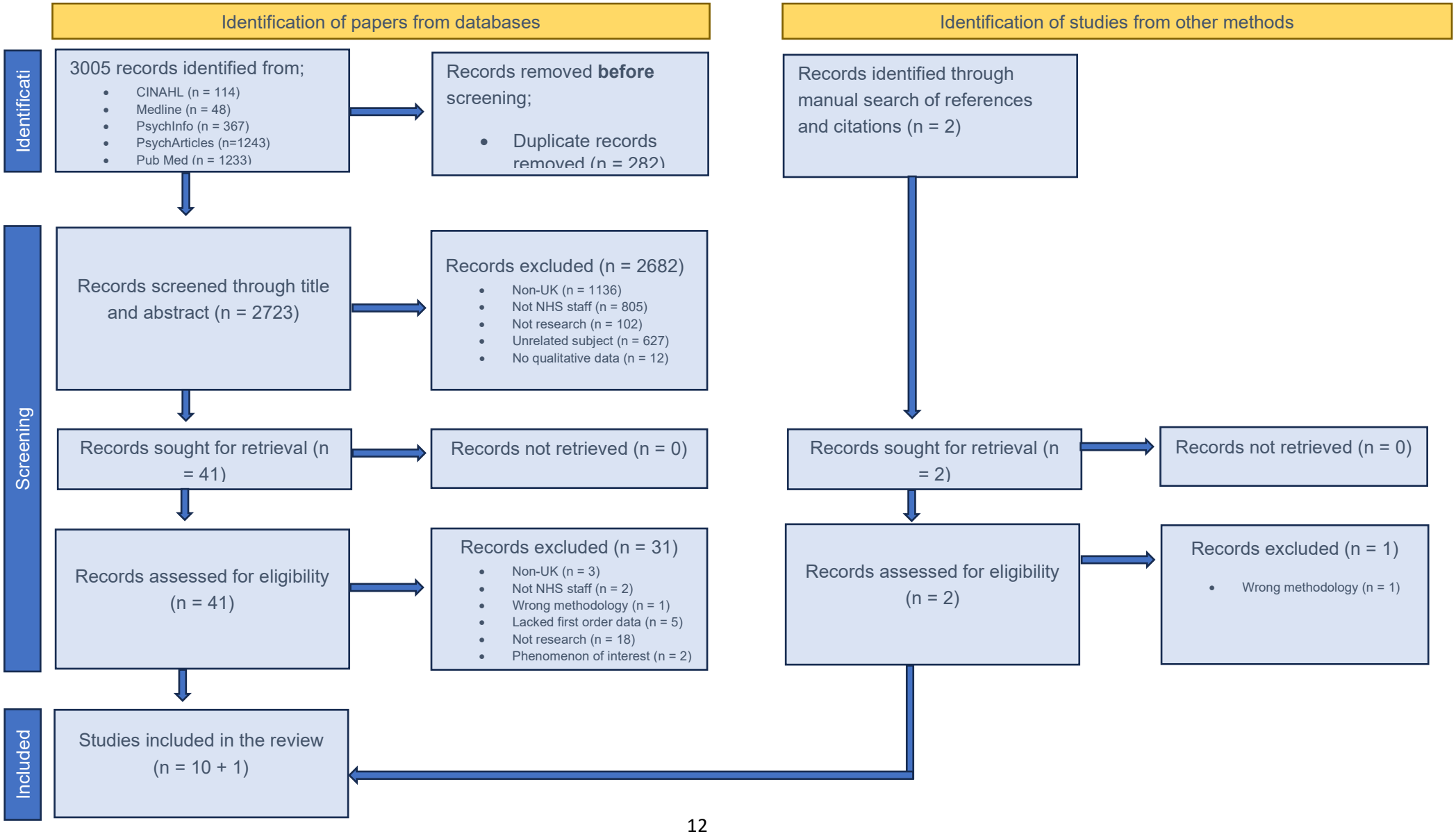
Results

Study selection

The study selection process is summarised in the following PRISMA diagram (Figure 2). The initial search resulted in 3005 studies, after removing 282 duplicates this left 2723 papers. The first author proceeded to screen the titles and abstracts of the remaining papers, excluding a further 2689 papers using the pre-defined exclusion criteria. This left 41 papers remaining for full review. Many excluded studies breached more than one of the exclusion criteria, however only one reason was recorded.

The 41 remaining papers were then reviewed by reading the full text. Again, papers were screened according to the predefined inclusion/exclusion criteria with a further 31 papers being excluded at this stage. This left 10 papers for the final thematic meta-synthesis. Two additional papers were identified through a manual search of the references and citations of the 10 identified papers. One of these papers was excluded resulting in 11 papers for the final thematic meta-synthesis.

Figure 2 - PRISMA 2020 flow diagram of study selection



Summary of study characteristics

Each paper has been assigned a number, 1-11, which will be used for the remainder of the current paper. Key aspects of each paper are summarised in table 2.

All 11 selected papers were published between January 2020 and October 2022, at which point the literature search took place. Paper 11 was identified through the manual search of references and citations of the 10 identified through database searching. This final paper was published on October 16th 2022, which is likely why it was missed in the initial search.

Of the 11 papers selected 10 exclusively recruited from clinical staff within the NHS across the UK. One paper (9) had a mixed recruitment across health and social care. This paper was selected for inclusion as the first order data was presented in such a way that NHS workers were easily identifiable. Additionally, all themes identified had quotations from NHS staff, with no theme being solely represented by social care employees.

There was significant variety when it came to the number of participants recruited with the minimum number recruited being n=14 (6) and the largest being n=257 (1). It is noteworthy that the paper with the largest participant group was a mixed methods analysis paper where the emphasis of the work appeared to be on the quantitative analysis, although the qualitative analysis still had value.

In terms of the analysis methodology all 11 papers used thematic analysis to support coding and identification of themes across the data. Four of the papers (1, 2, 8, 10) had data in the form of free text responses to online surveys. Six of the papers (3, 4, 6, 7, 9, 11) had audio recoded data from one-on-one interviews with participants. One paper (5) had audio recorded data from focus groups.

Table 2: summary of study characteristics

Paper	Authors, publication date	Publication title	participant information	Aims	Study design and methodology	Identified themes and subthemes
1	Gemine, et al., 2021.	Factors associated with work-related burnout in NHS staff during COVID-19: a cross-sectional mixed methods study	257 NHS staff members from across Hywel Dda University Health board	To measure work-related burnout in all groups of health service staff during the COVID-19 pandemic and to identify factors associated with work-related burnout.	Mixed methods analysis of responses to online questionnaire. **Thematic analysis** of free text responses	- Workload and changes to role - Concerns over redeployment - Issues with IT, lack of equipment and training - Not taking adequate breaks - Changes to working relationships. - Fatigue and exhaustion - Impact of covid-19 on wider healthcare systems
2	Bennett, et al., 2020.	COVID-19 confessions: a qualitative exploration of healthcare workers experiences of working with COVID-19	54 healthcare workers from the NHS	To gain insight into the experiences and concerns of front-line National Health Service (NHS) workers while caring for patients with COVID-19.	**Inductive Thematic Analysis** of stories submitted to an anonymous online platform regarding staff experiences of working during covid-19	- The shock of the virus - Self-sacrifice and dedication - Collateral damage ranging from personal health concerns to the long-term impact on, and care of, discharged patients. - A hierarchy of power and inequality within the healthcare system
3	Grailey, et al., 2021.	Lived experiences of healthcare workers on the front line during the COVID-19 pandemic: a qualitative interview study	49 members of the team working within the emergency and critical care departments of one National Health Service Trust in London	To investigate the presence of perceived stressors, psychological safety, and teamwork in healthcare professionals with data collected through the covid-19 pandemic.	**Thematic Analysis** of semi-structured interviews conducted over Microsoft Teams	- Psychological effects (of the pandemic) - Changes in team dynamics - Changes in psychological safety - Impact of personal protective equipment - Changes in workplace stressors
4	French, et al., 2022	"If I Die, They Do Not Care": U.K. National Health Service Staff Experiences of Betrayal-Based Moral Injury During COVID-19	16 NHS staff members recruited through social media	To investigate NHS staff experiences of burnout and betrayal-based moral injury, in which a trusted authority betrays "what is right."	**Thematic Analysis** of semi-structured interviews	- Abandonment and betrayal - Dishonesty and lack of accountability - Fractured relationships to management or the NHS
5	Davey, et al., 2022	It's What We Do: Experiences of UK Nurses Working during the COVID-19 Pandemic: Impact on Practice, Identity	Five focus groups with 22 nurses recruited from NHS trust	To explore the experiences of nurses working during the COVID-19 pandemic and the impact of this on their	**Thematic analysis using the framework method** of focus group discussions	- Rapid changes and contexts in flux - Loss and disruption - Findings opportunities for positive transformation

		and Resilience	communications, posters, and social media	psychological health, wellbeing and resilience.		- Reinforcing and strengthening identity
6	Borek, et al., 2022.	Experiences and concerns of health workers throughout the first year of the COVID-19 pandemic in the UK: A longitudinal qualitative interview study	14 NHS workers recruited using a snowballing approach through authors professional contacts within the NHS	To identify the experiences and concerns of health workers (HWs), and how they changed, throughout the first year of the COVID-19 pandemic in the UK.	**Thematic analysis using the framework method** of 105 interviews conducted throughout the covid-19 pandemic	(Narrative themes presenting staff experiences over the course of the pandemic) Emergency and mobilisation - Shifting responsibilities and redeployment - New skills and training required. - Challenges in patient care - Perceived risk of COVID-19 and impact on others - Tiredness and emotional weariness - Experiencing patient and public attitudes Consolidation and preparation - Gradual return to usual care and responsibilities - Sense of professional development and improvement in services and care - Learning and preparing for the future - Frustration with working conditions - Patial recouperation - Concerns about risk of complacency and the future Exhaustion and survival - Shifting responsibilities and redeployment - Balancing covid-19 and non-covid care - Concerns about long term impact of unceasing pressure - Changed perceptions of risk of covid-19 - Exhaustion and resignation - Experiencing changes public and patient attitudes and behaviour
7	San Juan, et al., 2021	Mental health and well-being of healthcare workers during the COVID-19 pandemic in the UK: contrasting guidelines with experiences in practice	33 front line NHS healthcare workers in the UK	to assess the applicability of well-being guidelines in practice, identify unaddressed healthcare workers' needs and provide recommendations for supporting front-line staff during the current and future pandemics.	**Thematic analysis using the framework method** of semi-structured interviews	- well-being support and 'pulling together' - Concerns, unsettling experiences and key difficult moments - Experiences around PPE - Morale and barriers to performing confidently. - Life outside the clinical role
8	Al-Ghunaim, et al., 2020	Psychological and occupational impact of the COVID-19 pandemic on UK surgeons: a qualitative investigation	141 surgeons working within the NHS from across the UK	to understand the professional and personal effects of COVID-19 pandemic on surgeons working in the UK NHS.	**Thematic Analysis** of free text responses to two questions: 'What challenges are the COVID-19 crisis currently presenting to you in your work and home life?'	- Changing and challenging work environment - Challenges to professional life and development - Management of change and loss in the respondents' personal lives - Emotional and psychological impacts

					and 'How is this stress affecting you personally?'	
9	Augheterson, et al., 2021	Psychosocial impact on frontline health and social care professionals in the UK during the COVID-19 pandemic: a qualitative interview study	25 professionals across health and social care (not just NHS participants but not NHS data was easily extracted)	To explore the psychosocial well-being Of health and social care professionals working during the COVID-19 pandemic.	**Thematic Analysis** of semi-structured interviews	- Communication challenges - Work related stressors - Support structures - Resilience - Personal growth
10	Kanavaki, et al., 2021	Kidney Care during COVID-19 in the UK: Perspectives of Healthcare Professionals on Impacts on Care Quality and Staff Well-Being	59 healthcare professionals from 8 NHS trusts across England (UK)	To explore the impact of changes to healthcare delivery in the UK as a result of the covid-19 pandemic on healthcare professionals working in Kidney care in the UK.	**Inductive Thematic Analysis** of free text survey responses and interviews	Rapid changes and adaptation in care delivery - Reduced patient contact and services - Remote team communication - Infection control and prevention Impacts on care quality - Drawbacks and concerns for care quality - Efficiencies and benefits of implemented changes Impacts on staff wellbeing. - Increased stress and anxiety - Mental exhaustion, negative affect and fatigue Team and organizational support - Team support and teamwork - Difficulties in communication from remote working and low team morale - Need and availability of organisational support
11	Hegarty, et al., 2022	'It hurts your heart': frontline healthcare worker experiences of moral injury during the COVID-19 pandemic	30 frontline NHS staff from 14 NHS trusts from across England		**Reflexive Thematic Analysis** was used to analyse data from one on one semi-structured interviews	Ill-equipped and under supported to respond to crisis - Feeling betrayed by the government - Systemic issues within the NHS - Strained working relationships with management Feeling unable to fulfil ones duty of care towards patients Avoiding moral dissonance Psychological toll of potentially morally injurious events - Anger and guilt - Disillusionment with the NHS - Deterioration of mental health Adaptively managing moral distress - Resolution of moral distress

Quality appraisal

10 of the 11 papers were identified as being adequate quality. With nine papers being rated as high in quality (2, 3, 4, 5, 6, 7, 9, 10, 11) and one paper being rated moderate quality (8). Only one paper was rated as being low in quality (1). In the case of this paper, it is worth noting that this was based mainly on the presentation of the qualitative findings and the emphasis of this study was on the quantitative results of their mixed method analysis.

The authors of four of the papers did not explicitly state their reflexive position or process in terms of the research. This was the most common critique of the 11 identified papers. This being said, all of the 11 papers were felt to be positively contributing to the understanding of staff experiences of burnout through the covid-19 pandemic.

Each rating was discussed with the fourth author with 100% agreement on the final ratings. Inclusion was not reliant upon the overall rating, in line with the ethos that literature reviews "are simply a means of synthesizing whatever evidence is available" (Siaddaway, et al., 2019, p.749), irrespective of the quality of that data. The quality of each paper should, however, be commented on.

Table 3: CASP ratings for final papers selected for synthesis.

Paper number	Aims	Method	Design	Recruitment	Data collection	Bias	Ethics	Analyses	Clear findings	Value	rating
1	Y	Y	S	Y	Y	Can't tell	Can't tell	S	N	Y	**Low**
2	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**high**
3	Y	Y	Y	Y	Y	Y	Y	Y	S	Y	**high**
4	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**high**
5	Y	Y	Y	Y	Y	Can't tell	Y	Y	Y	Y	**high**
6	Y	Y	Y	Y	Y	S	Y	S	Y	Y	**high**
7	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**high**
8	Y	Y	Y	Y	Y	Can't tell	S	Y	S	Y	**moderate**
9	Y	Y	Y	Y	Y	Can't tell	Y	Y	Y	Y	**high**
10	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**high**
11	y	Y	Y	y	y	Y	Y	Y	Y	Y	**high**

Note.

1 - CASP (2018) questions in full: (1) Aims: Was there a clear statement of the aims of the research? (2) Method: Was a qualitative methodology appropriate? (3) Design: Was the research design appropriate to address the aims of the research? (4) Recruitment: Was the recruitment strategy appropriate to the aims of the research? (5) Data collection: Was the data collected in a way that addressed the research question? (6) Bias considered: Has the relationship between researcher and participants been adequately considered? (7) Ethics considered: Have ethical issues been taken into consideration? (8) Data analysis: Was the data analysis sufficiently rigorous? (9) Findings: Is there a clear statement of findings? (10) Value: How valuable is the research?

2 – Quality rating procedure/scoring (in accordance with Butler, et al., 2016): "Yes" = 1 point; "somewhat"; "can't Tell" = 0.5 points; "no' = 0 points. Total score indication: 9–10 = high quality paper; 7.5–8.5 = moderate quality paper; 7 and under = low quality paper (in accordance with Butler, et al., 2016).

Thematic synthesis findings

Six independent themes were identified, with a seventh theme that spans across all the identified themes. The relative endorsements of all seven themes are summarised in Table 4. The identified themes are described below.

Table 4:

Theme	1	2	3	4	5	6	7	8	9	10	11
1. Our hands were tied	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. You put yourself last	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
3. Hey we're all here, where are you?	✓	✓	✓	✓	-	✓	-	-	✓	✓	✓
4. We weren't prepared (for the unpreparable)	✓	✓	✓	-	-	✓	-	✓	✓	✓	✓
5. You need to have somebody to offload to	✓	-	✓	-	✓	✓	✓	✓	✓	-	-
6. Our voices were quashed	✓	✓	✓	✓	-	✓	-	-	✓	-	✓
7. I found that really hard	**✓**	**✓**	**✓**	**✓**	**✓**	**✓**	**✓**	**✓**	**✓**	**✓**	**✓**

Our hands were tied.

This theme encapsulates the experience of working under immense limitations, and the subsequent moral injury and emotional distress experienced when staff were unable to deliver high quality or satisfactory care to patients and service users.

> ***"I had families crying down the phone to me saying I need some help…our hands were tied"*** **(11)**
>
> *"we're essentially trying to almost work in war-like conditions where you're trying to save lives, but it is quite hard when you're used to giving really good care to a very high standard with all that holistic care" (6)*

The limitations staff reported included physical resources such as staffing and equipment as well as limitations in the form of frequently changing policies and guidance.

> *"we did absolutely the best that we could possibly do, but it just in no way shape or form was good enough. But we did what we could in the confines of the environment" (3)*

There were several references to personal pain staff experienced knowing that the care they were delivering was sub-par compared to the standards of care they previously delivered. This delivery of substandard care appeared to infringe on staff's values, resulting in moral injury and emotional distress.

> *"When you are unable to do that because of the just general resources so human resources and capacity then that's really, really hurtful so it really hits you, it hurts your heart." (11)*

The experience of moral injury connects with the theme of 'loss and disruption as described within paper five. The sub-theme of resilience and wellbeing within loss and disruption in part describes how the changes to clinical practice because of covid-19 restrictions was difficult for staff.

> 'Participants also expressed loss of self-efficacy, certainty, confidence, and control in their ability to adapt to changing circumstances, deliver the best quality patient care…' (5)

This theme connects to the theme of 'Psychological toll of PMIEs' (Potentially Morally Injurious Events) described in paper 11. This describes how moral injuries negatively impacted healthcare workers throughout the pandemic.

> 'Guilt was experienced when HCWs felt personally responsible for letting others down. HCWs mainly felt this related to not being able to provide person-centred care during the pandemic, but interestingly HCWs voiced a degree of guilt by association, feeling complicit in a system they viewed as increasingly less equipped to service public need and provide high quality care.' (11)

There were some examples where staff appeared to avoid moral injury by accepting things that were beyond their control, working to their values despite environmental limitations. These examples appear to highlight that moral injury is not an inevitable outcome of working with limitations.

> *"A significant element of growth has happened from the experience I would say. And a feeling that actually yeah, I do have some power in these situations [. . .] there are situations that I can have some influence over, you know in line with my values." (4)*

> *"Because of my job, I think I'm aware that we're not really in control of lots of things in our life…I see that all the time with patients and people I care for… we don't have control over everything, and we have to have a level of acceptance for that." (9)*

These experiences of people being able to navigate moral injury crosses over with the theme of 'resilience' identified in paper 9, specifically the subtheme of 'accepting uncertainty', and the theme of 'Avoiding moral dissonance' identified in paper 11. Both themes describe a sense of freedom some participants had by accepting the uncertainties

around them and how this enabled them to avoid moral injury as a result of limitations to their clinical practice.

> ‘Participants had a degree of personal, psychological resilience linked to an acceptance, or ‘letting go’, of what they had no control over’ (9)

> ‘They [staff] sometimes prevented moral dissonance by rationalising their actions in the context of the systemic constraints. This was only effective at preventing moral dissonance where no harm was caused to the patient.’ (11)

You put yourself last.

This theme highlights the prevalence of self-sacrifice by NHS workers, with patient care taking priority over their own wellbeing, and the negative impact it had upon them over time.

> ***“…Every shift was busy. Every shift was stressful. Everyone said from the beginning, you are last. You put yourself last…”*** **(5)**

A common experience of staff was that there seemed to be an unspoken rule about putting their own needs to one side, focusing solely on their clinical work and patient care. Observing other staff modelling this behaviour reinforced individual’s own sense that they should be doing this too.

> *“Just feel I need to keep going as everyone else is.” (1)*

Self-sacrifice appeared to come in many forms such as working longer hours, knowingly putting themselves at increased risk to support patients, and not taking adequate breaks, either because of time pressures or due to the perception that no one else was.

> *“…If somebody is dying, I'm going to go in without anything on and I just accept the risk...” (4)*

> *“(I) Feel guilty that I am not doing enough to help with the crisis so don’t feel taking a break is a priority” (1)*

> *“I feel exhausted after shifts and have worked late on regular basis to try and keep up” (10)*

Additionally, staff reported feeling guilty for not being able to fulfil all aspects of their role due to covid-19 restrictions. They reported feeling as if they were not doing their part, contributing to them feeling unable to access support that was available.

"[I felt] worthless and guilty about not doing my bit for the NHS" (2)

"I'm waking up in the middle of the night thinking of my patients. . . There is emotional support but I'm not sure why I'm not accessing it. I think I need to do it now. . . I need to start off-loading all of this because I'm feeling quite burnt out. I just need to find the time and the space to do it." (6)

Self-sacrifice was also represented within the identified themes of many papers. For example, the theme of 'increased pressure to work' from paper one which described staff's perception that there was an increased pressure to work and the impact this had on them.

> 'Being too busy, increased workload and reduced staffing meant people did not take good quality breaks, allowing for adequate rest and recovery. This was accompanied by feelings of pressure and guilt to continue working. In addition, the culture of working through has an impact. People stated that they worked through their break or took shorter breaks because others did so, and their managers did not actively encourage their staff to take restorative breaks and there were expectations placed on staff, in some cases, to continue to work.' (1)

Additionally, self-sacrifice is represented within paper two's theme of 'Staff sacrifice and dedication' which describes the efforts staff made, often sacrificing their own wellbeing, to help manage and navigate the increases in workload and complexity that were present throughout the pandemic.

> 'The dedication of staff and their commitment to fulfil their duty of care was described as 'Herculean…the extra work and hours that have been put in to support the NHS.' (Nurse, 930–931). This is in spite of the practical and emotional challenges…' (2)

Hey we're all here, where are you?

This theme describes the experience of staff feeling abandoned or let down by the lack of presence from management or more senior colleagues. There were many reports of staff on the ground being placed in risky positions, whilst those in senior positions were supported to work from home or work elsewhere within the hospital.

> ***"In terms of, you know, these clinical well, nonclinical managers, all very substantial bandings, no-one was really on the shop floor face-to-face… there was a real general . . . just a feeling of [being] pissed off. That it was like hey we're all here where are you"*** **(4)**

> *"The medical team they weren't really inside. there was the inside and the outside, it was like through the glass. You're in the PPE and there's everyone outside. So, you're a bit more on your own" (3)*

The experience of abandonment and power imbalances is present in many of the themes identified by authors in the selected papers. For example, it is represented within paper two's theme of 'Hierarchy of power and inequality' which describes the disconnection between those with 'power' and those on the wards.

> 'Participants felt that risk was disproportionately assigned to the front line and that those who were most vulnerable were not adequately protected…the majority described a sense of abandonment by management' (2)

Additionally, the theme of 'Abandonment as Betrayal' described in paper four describes the experience of being abandoned by those with more power than them leaving them with a reduced sense of value.

> 'Participants discussed perceptions of a lack of care from leadership, in which they were deemed to be disposable or replaceable … one participant voiced feelings that their death would be meaningless to the leadership … they see their personal worth as employees devalued or dehumanized.' (4)

We weren't prepared (for the unpreparable).

This theme describes the sense of not being prepared for the pandemic.

> ***"We weren't prepared. We were not ready."* (2)**

Additionally, it covers the sense of the pandemic being an unbelievable or shocking event with some recognition that there was no ability to prepare for it.

> *"I certainly wasn't prepared for the horror that is covid-19, anyone that says they were is a liar. Before the government announced anything, we pulled together a team as we realised we could quickly be getting cases but were not prepared for it." (2)*

Several people acknowledged that the sense of uncertainty added to their experience of pressure when providing care to covid-19 patients, with this being a new presentation that lacked clarity both in terms of clinical care and infection transmission.

> *"I think it was, most of all, not knowing what was happening, not knowing how to make a patient better" (3)*

> *"Just having to deal with the stress and pressure of essentially keeping someone alive when you don't really. . . it's sort of like flying a plane and not knowing what to do." (6)*

None the less, staff were left working in the unprepared environments and there was a sense of uncertainty, with staff struggling to keep up with policy changes, best practice guides, and this ultimately having a negative impact on their wellbeing and sense of self-efficacy.

> *"Have*(ing) *to adapt to ever changing advice and situation related to covid-19 can be stressful and constant worry if* (we are) *doing all we can to stop spread."* *(1)*

> *"What was good management this week would probably have been seen as not very good management in two weeks' time. Thats what I think was very stressful and difficult." (4)*

Several themes identified within the 11 papers reference the 'unknown' nature of the virus and how this impacted staff.

> 'The 'unknown' nature of the pandemic and COVID-19 was a substantial cause of distress for participants…' (3)

Additionally, many themes described how being unprepared led to difficulties accessing equipment, personal protective equipment, and effective delivery of guidance. This prevented staff from being able to effectively provide care and often put staff in increased positions of physical and psychological risk.

> '[There were] pre-existing systemic issues, felt to contribute to staff feeling ill equipped and under-supported by the NHS during the pandemic. A perceived lack of funding to the NHS was felt by participants to increase their exposure to situations of moral conflict. HCWs on wards routinely found themselves understaffed on shifts, with inadequate medical equipment to serve the volume of patients. Additionally, several HCWs struggled with organisational regulation of scarce PPE, including inequitable distribution and delays mandating PPE use; both situations were viewed to put staff and non-COVID patients at risk.' (11)

You need to have somebody to offload to.

This theme describes the loss of connections people experienced either due to redeployment and being placed in a new team, changes to scheduling, or because of barriers such as how break spaces were being used.

“it was more difficult when I was just surrounded by people whose names I didn’t know, whose backgrounds I didn’t know, I didn’t even know who was more competent than me doing what. If you are with people you don't know much about then it gets difficult” (3)

Interestingly even in teams that seemed to remain stable these losses of connections and a breakdown in teamwork were still reported due to changes in how the team was functioning and the burden people were feeling leading to a breakdown in collaborative working.

“To be a nurse, you need to have somebody to offload to, to support you, no matter what job you do in health care, whether it’s your team that support you or at home. And if you haven’t got that that’s quite hard, and I think we didn’t all have that for a little while” **(5)**

“Nobody really had a chance to support each other actually it’s been off the back of the peak what we've seen the teamwork slightly breaking down just because I think people are mentally and physically exhausted and so they don’t have the time and the energy to be able to put in to do those extra things." (3)

There was also sadness over not being able to connect with colleagues in the way they used to, with recognition being given to how rapidly that changed, increasing their sense of isolation.

““I was just suddenly very conscious of being on my own and just having to get on with it . . . And that all those the corridor chats there, you lost all that support didn’t you, that talking with colleagues and saying, I’m not coping with this or I am . . . That, just overnight disappeared” (5)

Additionally, several staff who were working from home either due to policy changes or because of their own individual needs, reported feeling isolated and being separate from their team as there were no corridor conversations or other opportunities to connect with their colleagues.

“I was doing purely telephone consultations from home and I felt very isolated there, and I didn’t feel like I was part of the team at all.” (9)

Emotional distress as a result of lost professional connections could be seen in many of the themes identified by authors of the 11 papers.

‘There was evidence of psychological distress from participants feeling isolated either as an individual (often due to short staffing and high workload) or as a department struggling to get support from other clinical divisions.’ (3)

‘The pandemic also disrupted many of the various support structures and coping mechanisms traditionally used by participants to manage work-related stress. Most significantly, this included the dislocation of team working, leading to less frequent handovers, debriefs and incidental conversations, fewer opportunities to share experiences, and increased isolation.’ (5)

Our voices were quashed.

***“…our voices were quashed in a sea of management meetings, who frankly were rearranging deckchairs rather than encouraging us to make the changes we needed to make…”* (2)**

This theme covers the anger and frustration many staff experienced when trying to initiate open communication with people higher up in the traditional NHS hierarchy. Many people speaking on this theme discussed how it felt like a one directional passage of communication, with staff not being listened to. This included issues around scheduling as well as wanting to make changes to clinical practice.

> *“My rota and role has been completely changed without taking into account my thoughts or preferences, not even asked if I was okay with this.” (1)*

> *“We wanted to make changes but were not heard.” (2)*

This loss of faith in the organisations they worked with appeared to be contributing to several people considering their position within the organisation.

> *“I’ve never felt more detached from senior management. After this is over, I’m going to seriously reflect on whether I feel this is an organisation I want to work for and with. I’m seeing it in a different light. I no longer think this is for me” (2)*

> *“I feel extremely frustrated, I feel powerless, I do not feel listened to, I feel like I have nowhere to go with anything. That’s why I feel like I’ve reached the end of the road. I do feel like that. It feels like a sad decision to come to, but I cannot feel like this anymore and I do not want to just go to a different hospital because I’d just be walking into something the same. So I need to try something else.” (4)*

This sense of being silenced was not always as a result of other people’s actions, at times being a result of the increased pressures staff were under leading to a less psychologically safe environment within which they could speak up.

> ‘It seemed impossible for these concerns to be raised without it being regarded as critical and unhelpful for morale’ (2)

‘Some new barriers to a psychologically safe environment were described as arising due to the pandemic. These included changes in the team and a hectic working environment, with ‘no time’ to speak up or propose new ideas. In this context, having ‘no time’ was a feeling experienced by all those within the working environment...’ (3)

There were however a small number of examples where staff reported a flattening of the NHS hierarchy. In these examples individuals at the ‘top’ seemed to acknowledge that they didn’t have answers and this creating space and opportunity for people lower down in the hierarchy to speak up and feel heard.

“no one knew what they were doing. And I was like the research so I would be reading journals and I could ask the consultants… So you just ask which was nice to be able to have a more level field on that kind of thing. But there might not be as much experience with just the whole situation in general. Even if it was things about staff management or I don’t know ppr or positioning or something like that. I do think that it was easier to vocalise if there was anything” (3)

“I think most trainees feel that it is very easy to make suggestions on how things can be improved, and I think the more senior clinicians and management team have been quite receptive, have taken many of these on board” (7)

I found that really hard.

This theme straddles across all the previous themes. It describes how the nature of the work during the pandemic was hard, alongside the societal changes that meant that typical coping strategies were no longer available for many people and there were challenges outside of work as well as inside.

“…I couldn’t just go and check-in with multiple people in multiple areas like I normally would do, and I really found that very hard…” **(3)**

There was widespread agreement that the work during this period of time was more challenging physically and emotionally than typical NHS work and this naturally had a negative impact on staff wellbeing.

“A lot of us have very bad memories of that time and don’t really want to go back to that period of time, and I think that’s the big worry. I feel emotionally and physically exhausted. My patient died on Monday, he was only 44 and then it’s just very tough.” (6)

"If I'm not crying because I'm scared of getting ill or infecting my loved ones, then I'm awake at 3am after hearing families sob their hearts out because they cannot hold their loved ones in their last moments" (2)

Several people reflected on how the pandemic was unlike anything they had experienced.

"It's been, by far, the hardest 20 months of my nursing career. And I've been a nurse for a long time" (5)

"I couldn't even speak to someone without bursting into tears or just the despair of the situation, thinking this is like nothing I've ever–I mean I've been nursing for 30 years, I'm not new to this business. But it was pretty horrific." (6)

"They were the most sick people I've ever seen and there are so many people dying" (2)

The experience of trauma through the pandemic was represented within several of the themes identified by authors of the 11 papers.

'Participant accounts clearly identified a paradox for many working on the front line during COVID-19. Their work was both immensely rewarding and profoundly traumatic. However, the costs frequently outweighed the emotional benefits. Many talked about feeling 'broken'…'(2)

'Participants' mental health was also impacted by the traumatic experience of phase 1, worry about being redeployed again, and seeing many patients die.' (6)

People also recognised that they were experiencing fatigue from the amount of information they were having to take in, with cognitive fatigue playing a role in reducing their wellbeing.

"I felt mental exhaustion. That was the difference." (3)

"It is intellectually tiring to make decisions" (8)

Many themes described the exhaustion staff experienced as a result of the changes in their work over the course of the pandemic.

'Feelings of exhaustion and burnout were freely reported in relation to changes placed on them.' (1)

'The exact manner in which responsibilities changed was dependent on a participant's original job role, but the impact was similar—increased feelings of stress and a sense of being out of control.' (3)

Discussion

The current meta-synthesis provides evidence for different types of difficult experiences staff have come across over the course of the covid-19 pandemic, which seem to contribute to their experience of burnout in accordance with the definitions presented by Maslach and Jackson (1981) and Iliffe and Manthorpe (2019). Interestingly staff appeared to experience cynicism and depersonalisation towards management as opposed to patients. This review is particularly of interest given Iliffe and Manthorpe's (2019) finding that the progression of burnout can be reversed. Thus, this review provides some insights into the areas that would benefit from additional attention to facilitate the reversal of this process.

"Our hands were tied" speaks to the experience of moral injury as a direct result of not being able to deliver healthcare in accordance with the values healthcare professionals identified with. This was not just about ensuring patients' needs were met, but about delivering holistic, person centred, and personable care. This risk of moral injury seems to be something that healthcare providers are likely going to be at vulnerable to during any time of excessive burden or challenge given how universally it was reported on in some way or another within the 11 selected papers for the current review. Participants spoke about the emotional impact this had upon them, seeming to provide evidence of factor one of burnout as presented by Maslach and Jackson (1981). This is of particular concern given the pre-existing issues with recruitment (Buchan, et al., 2019) and the post-covid issues of staff retention (NHS Digital, 2023).

Importantly in the small selection of individuals who avoided moral injury there was a focus on taking a broader view of what they were doing and why. This seems to support Iliffe and Manthorpe's (2019) suggestion that individual vulnerabilities impact whether staff will experience burnout. This ability to cognitively frame restrictions differently supported them in being able to connect to their values and feel pride over the care they were providing, as opposed to focusing on the things they no longer could do, indicating support for the presence of the third factor of burnout. This finding that moral injury was not universal suggests that psychological support during times of difficulty could have a powerful role in supporting, or guiding, vulnerable individuals through their emotional distress, thus avoiding the progression to them experiencing burnout.

"You put yourself last" again was a widely reported phenomenon within the 11 selected papers. There appears to be evidence that in some cases staff were motivated to do more as they evaluated their contributions as low quality. This may provide evidence for factor 3 of burnout (Maslach & Jackson1981). This concept of putting yourself last appeared to be

something that pre-dated covid, becoming more problematic during covid. One explanation for this being so widely reported is that the pandemic resulted in an unusually long stretch of time during which self-sacrifice was required or expected, preventing staff from being able to put themselves first. As a research team we reflected upon the principles that guide the NHS and the NHS values (NHS Health Education England, N.D) which focus on providing care to patients, with no mention of supporting staff to provide the best care possible. It seems that at the very core there is a culture of not valuing people providing care within the NHS. The findings of this review highlight how this is not sustainable long term. Additionally, the current review provides some support to suggest that self-sacrifice can be a function of alienation (Iliffe & Manthorpe, 2019), with participants describing feelings of worthlessness as motivating their self-sacrifice, although this was limited.

Moving into the future it feels that the NHS has a responsibility to consider how they can navigate this engrained cultural norm to ensure that staff wellbeing is always supported. Of particular concern is how to support staff feeling that attending activities or opportunities to support their wellbeing is not a burden or an additional task.

'Hey we're all here, where are you' seemed to describe not just the feeling of being abandoned by management but also the subsequent damage that has occurred to relationships between staff and management. This theme seems to provide evidence for the presence of the 2nd factor burnout as defined by Maslach and Jackson (1981). On reflection the research team felt that in some ways this was an inevitable tension due to need to strictly manage infection control throughout the pandemic. However, it seems that the experiences associated with this added to staff feeling that they were no longer able to work within their organisation or in some cases their profession altogether. This is a particularly poignant finding given the difficulties with staff retention (NHS digital, 2023). Careful consideration needs to be given by those with positions of power within the NHS as to how to repair and support positive working relationships between working groups in a meaningful way and support staff feeling that management are accessible.

"We weren't prepared (for the unpreparable)" seems to highlight that the experience of not knowing the answer for what best practice should be negatively impacted people's emotional wellbeing and their confidence in they were providing good care. Alongside this however, this theme also appeared to acknowledge that there was no way to predict what working though a pandemic would be like seemed like an honest, and non-judgemental sentiment that was shared by many staff. This non-judgemental view of working through covid felt like an honest reflection that everyone was shocked, regardless of their experience

or level of responsibility. It seems to indicate that staff can hold a compassionate stance towards each other during times of difficulty, something that could be important to hold in mind when attempting to repair the afore mentioned damaged relationships and reverse the progression of cynicism that seems to be present within the workforce (Iliffe and Manthorpe, 2019).

"You need to have somebody to offload to" focuses on the value of the professional and personal connections between staff. It highlights the value of facilitating and supporting relationships within teams and wider healthcare networks in terms of supporting staff wellbeing. When this was discussed, lost connections seemed occur within all settings. The inability to form or maintain connections seemed to have a negative impact on their ability to work together. It seemed that connections were about more than just spending time together, it is about gathering information about the network around people and identifying who to go to for different problems or solutions. Furthermore, when considering Iliffe and Manthorpe's (2019) this could be an organisational issue adding to workplace stress. This finding would be useful to consider moving into the future as well as for any service that regularly requires PPE. It appears that teams would benefit from additional support to connect both within the team and the wider network of staff within a given health board or specialism.

"Our voices were quashed" described the experience of not being heard, and the impact it had not only on staff but on their feelings towards management. This theme of not being heard appeared to contribute to staff feeling unable to continue working within their organisation, a finding which appears to be in line with the recent increases in rates of staff leaving their chosen profession or organisation (NHS Digital, 2023). In terms of the long-term sustainability of the NHS this finding indicates that particular effort is required to support staff being able to share ideas and opinions and feel heard when doing so. When considering Iliffe and Manthorpe's (2019) model, the experience of not being heard could be considered as an organisational factor that adds to stress and difficulty within the workplace. However, there is some evidence to suggest that flattening hierarchies increases psychological safety, and supports staff being able to speak up and feel heard. This theme also provides limited insight evidence to suggest that more senior staff in the traditional NHS hierarchy have an important role to play in supporting colleagues with speaking up and feeling heard. It appears that when senior clinicians acknowledge their gaps in knowledge or skills set this increased the perceived psychological safety for more junior clinicians which added to their ability to speak up.

"I found that really hard" was the final theme the research team agreed. There was much discussion over this theme as it connects with each previous theme. However, on reflection the research team felt that if all other themes were addressed the nature of the work and the increased workload and complexity it brought would still exist; the work was still harder. This connects with the burden of healthcare work contributing to the experience of job dissatisfaction, burnout, and alienation as described by Iliffe and Manthorpe (2019). For many years the NHS has been chronically understaffed (Beech, et al., 2019). This inevitably increases the burden upon clinicians who are in post. As healthcare opens post covid the workforce is faced with more complex presentations as many health conditions were unable to be adequately addressed throughout the pandemic, either due to resources or non-attendance by the service users (Fersia, et al., 2020; Morris, et al., 2021). It is likely that the issue of work being more challenging is going to be present for many years. All the 11 papers selected for the current review commented on the work being harder, which suggests it is a relatively universal experience. People spoke of the increased mental fatigue and emotional responses they were having as a result of the work being undertaken, highlighting the impact that increased workloads and pressures has on wellbeing. As with other themes, it will be important to consider how staff can be supported to find ways of maintaining wellbeing during working hours.

Limitations

When reviewing the 11 selected papers it is noteworthy that non-clinical staff were missing as a result of the search terms. When discussing the themes, the team reflected that clinical staff are part of a system which involves a great number of non-clinical roles in order to deliver clinical interventions. Moving into the future the research team felt it would be important to include non-clinical staff to ensure that the NHS workforce as a whole can be supported, with recognition that different staff groups may require different forms of support. Similarly, it was noteworthy that there did not appear to be a significant number (or any) representatives from clinical management teams within the 11 papers included in the current review. Although this cannot be confirmed given the available participant information it was still a point of reflection for the research team. In particular, the research team felt that the spectrum of hierarchy within the NHS was not captured, with the 11 selected papers focusing heavily on clinical staff with the voices non-clinical roles and the most senior roles being missing. The research team were left feeling curious about the theme of 'hey we're all

here, where are you?' and how this was experienced by staff involved in clinical and operational management.

Finally, the research team acknowledged that in terms of the NHS workforce as a whole the 11 selected studies interviewed a small number of people. Alongside the afore mentioned missing groups it is likely that there will be staff experiences from throughout the pandemic that are not represented within the current review.

Conclusion

The focus of the current review is on the experiences of burnout throughout the covid 19 pandemic in the UK. It also provides important insights into the experiences of working in the contemporary NHS and how to navigate some of the experiences which may be adding to the experience of burnout. Moving into the future it appears there needs to be a significant cultural shift within the NHS to support staff feeling valued and heard, with staff at the top of the traditional NHS hierarchy having a potentially powerful role in modelling this shift.

Declaration of interest

There are no conflicts of interest to report from the authors.

Funding

None. This review was undertaken as part of a research project for the doctorate in Clinical Psychology award.

Acknowledgements

The authors would like to thank **Yasmin Noorani**, Bangor University, for her support in the initial stages of developing search strategies and providing some much-needed confidence to the first author.

References

Studies included in the meta-synthesis are marked with an asterisk (*)

Alanazi, T. N. M., McKenna, L., Buck, M., & Alharbi, R. J. (2022). Reported effects of the COVID-19 pandemic on the psychological status of emergency healthcare workers: A scoping review. *Australasian emergency care*, *25*(3), 197-212.

*Al-Ghunaim, T. A., Johnson, J., Biyani, C. S., & O'Connor, D. (2021). Psychological and occupational impact of the COVID-19 pandemic on UK surgeons: a qualitative investigation. *BMJ open*, *11*(4), e045699.

Al-Gobari, M., Shoman, Y., Blanc, S., & Canu, I. G. (2022). Point prevalence of burnout in Switzerland: a systematic review and meta-analysis. *Swiss Medical Weekly*, *152*(3738), w30229-w30229.

*Aughterson, H., McKinlay, A. R., Fancourt, D., & Burton, A. (2021). Psychosocial impact on frontline health and social care professionals in the UK during the COVID-19 pandemic: a qualitative interview study. *BMJ open*, *11*(2), e047353.

Beech, J., Bottery, S., Charlesworth, A., Evans, H., Gershlick, B., Hemmings, N., ... & Palmer, B. (2019). Closing the gap. *Key Areas for Action on the Health and Care Workforce*.

*Bennett, P., Noble, S., Johnston, S., Jones, D., & Hunter, R. (2021). COVID-19 confessions: a qualitative exploration of healthcare workers experiences of working with COVID-19. BMJ Open. 2020; 10 (12): e043949.

*Borek, A. J., Pilbeam, C., Mableson, H., Wanat, M., Atkinson, P., Sheard, S., ... & Tonkin-Crine, S. (2022). Experiences and concerns of health workers throughout the first year of the COVID-19 pandemic in the UK: a longitudinal qualitative interview study. *PLoS One*, *17*(3), e0264906.

British Medical Association. (2020). Almost half of UK doctors suffering from burnout, depression or anxiety, BMA survey reveals. https://www.bma.org.uk/news-and-opinion/stress-and-burnout-warning-over-covid-19#:~:text=A%20BMA%20survey%20finds%20that,continuing%20shortage%20of%20protective%20supplies.&text=The%20mental%20health%20of%20doctors,survey%20from%20the%20BMA%20finds.

Buchan, J., Charlesworth, A., Gershlick, B., & Seccombe, I. (2019). A critical moment: NHS staffing trends, retention and attrition. *London: Health Foundation*.

Butler, A., Hall, H., & Copnell, B. (2016). A guide to writing a qualitative systematic review protocol to enhance evidence-based practice in nursing and health care. Worldviews on Evidence-Based Nursing, 13(3), 241–249.

Cho, J., Laschinger, H. S., & Wong, C. (2006). Workplace empowerment, work engagement and organizational commitment of new graduate nurses. *Nursing Leadership-Academy of Canadian Executive Nurses-*, *19*(3), 43.

Chutiyami, M., Cheong, A. M., Salihu, D., Bello, U. M., Ndwiga, D., Maharaj, R., ... & Kannan, P. (2022). COVID-19 pandemic and overall mental health of healthcare professionals globally: a meta-review of systematic reviews. *Frontiers in psychiatry*, *12*, 2600.

Critical Appraisal Skills Programme. (2018). CASP qualitative checklist. https://casp-uk.net/images/checklist/documents/CASP-Qualitative-Studies-Checklist/CASP-Qualitative-Checklist-2018.pdf

*Davey, Z., Srikesavan, C., Cipriani, A., & Henshall, C. (2022, September). It's What We Do: Experiences of UK Nurses Working during the COVID-19 Pandemic: Impact on Practice, Identity and Resilience. In *Healthcare* (Vol. 10, No. 9, p. 1674). MDPI.

Finfgeld-Connett, D. (2010). Generalizability and transferability of meta-synthesis research findings. *Journal of advanced nursing*, *66*(2), 246-254.

Finfgeld-Connett, D. (2014). Metasynthesis findings: potential versus reality. *Qualitative Health Research*, *24*(11), 1581-1591.

*French, L., Hanna, P., & Huckle, C. (2022). "If I die, they do not care": UK National Health Service staff experiences of betrayal-based moral injury during COVID-19. *Psychological Trauma: Theory, Research, Practice, and Policy*, *14*(3), 516.

*Gemine, R., Davies, G. R., Tarrant, S., Davies, R. M., James, M., & Lewis, K. (2021). Factors associated with work-related burnout in NHS staff during COVID-19: a cross-sectional mixed methods study. *BMJ open*, *11*(1), e042591.

General Medical Council, 2023. The state of medical education and practice in the UK Workplace experiences 2023. Available at https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

*Grailey, K., Lound, A., & Brett, S. (2021). Lived experiences of healthcare workers on the front line during the COVID-19 pandemic: a qualitative interview study. *BMJ open*, *11*(12), e053680.

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: a systematic review. *PloS one*, *11*(7), e0159015.

Halter, M., Boiko, O., Pelone, F., Beighton, C., Harris, R., Gale, J., ... & Drennan, V. (2017). The determinants and consequences of adult nursing staff turnover: a systematic review of systematic reviews. *BMC health services research*, *17*(1), 1-20.

Hannemann, J., Abdalrahman, A., Erim, Y., Morawa, E., Jerg-Bretzke, L., Beschoner, P., ... & Albus, C. (2022). The impact of the COVID-19 pandemic on the mental health of medical staff considering the interplay of pandemic burden and psychosocial resources—A rapid systematic review. *PLoS One*, *17*(2), e0264290.

*Hegarty, S., Lamb, D., Stevelink, S. A., Bhundia, R., Raine, R., Doherty, M. J., ... & Wessely, S. (2022). 'It hurts your heart': frontline healthcare worker experiences of moral injury during the COVID-19 pandemic. *European journal of psychotraumatology*, *13*(2), 2128028.

Hutchings, R. (2020). The impact of Covid-19 on the use of digital technology in the NHS. *Nuffield Trust*, *27*, 2002-2008.

Iliffe, S., & Manthorpe, J. (2019). Job dissatisfaction,'burnout'and alienation of labour: undercurrents in England's NHS. *Journal of the Royal Society of Medicine*, *112*(9), 370-377.

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International journal of mental health nursing*, *27*(1), 20-32.

*Kanavaki, A. M., Lightfoot, C. J., Palmer, J., Wilkinson, T. J., Smith, A. C., & Jones, C. R. (2021). Kidney Care during COVID-19 in the UK: perspectives of healthcare professionals on impacts on care quality and staff well-being. *International Journal of Environmental Research and Public Health*, *19*(1), 188.

Kelly, E., Stoye, G., & Warner, M. (2022). *Factors associated with staff retention in the NHS acute sector*. Institute for Fiscal Studies.

Khan, A., Teoh, K. R., Islam, S., & Hassard, J. (2018). Psychosocial work characteristics, burnout, psychological morbidity symptoms and early retirement intentions: a cross-sectional study of NHS consultants in the UK. *BMJ open*, *8*(7), e018720.

Korhonen, A., Hakulinen-Viitanen, T., Jylhä, V., & Holopainen, A. (2013). Meta-synthesis and evidence-based health care–a method for systematic review. *Scandinavian journal of caring sciences*, *27*(4), 1027-1034.

Leary, H., & Walker, A. (2018). Meta-analysis and meta-synthesis methodologies: Rigorously piecing together research. *TechTrends*, *62*(5), 525-534.

Lluch, C., Galiana, L., Doménech, P., & Sansó, N. (2022, February). The impact of the COVID-19 pandemic on burnout, compassion fatigue, and compassion satisfaction in healthcare personnel: a systematic review of the literature published during the first year of the pandemic. In *Healthcare* (Vol. 10, No. 2, p. 364). MDPI.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of organizational behavior*, *2*(2), 99-113.

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause (s) of burnout among applied psychologists: A systematic review. *Frontiers in psychology*, *9*, 1897.

Mohammed, M. A., Moles, R. J., & Chen, T. F. (2016). Meta-synthesis of qualitative research: the challenges and opportunities. *International journal of clinical pharmacy*, *38*, 695-704.

Morse, Gary, Michelle P. Salyers, Angela L. Rollins, Maria Monroe-DeVita, and Corey Pfahler. "Burnout in mental health services: A review of the problem and its remediation." *Administration and Policy in Mental Health and Mental Health Services Research* 39 (2012): 341-352.

NHS digital, 2023. NHS Workforce Statistics - September 2022 (Including selected provisional statistics for October 2022) available at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2022#.

NHS Health Education England, N.D. Retrieved from https://www.hee.nhs.uk/about/our-values/nhs-constitutional-values-hub-0

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies* (Vol. 11). sage.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., ... & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International journal of surgery*, *88*, 105906.

Parkin, A., Davison, J., Tarrant, R., Ross, D., Halpin, S., Simms, A., ... & Sivan, M. (2021). A multidisciplinary NHS COVID-19 service to manage post-COVID-19 syndrome in the community. *Journal of primary care & community health*, *12*, 21501327211010994.

Salyers, M. P., Bonfils, K. A., Luther, L., Firmin, R. L., White, D. A., Adams, E. L., & Rollins, A. L. (2017). The relationship between professional burnout and quality and safety in healthcare: a meta-analysis. *Journal of general internal medicine*, *32*, 475-482.

*San Juan, N. V., Aceituno, D., Djellouli, N., Sumray, K., Regenold, N., Syversen, A., ... & Vindrola-Padros, C. (2021). Mental health and well-being of healthcare workers during the COVID-19 pandemic in the UK: contrasting guidelines with experiences in practice. *BJPsych Open*, *7*(1), e15.

Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career development international*, *14*(3), 204-220.

Sibeoni, J., Massoutier, L., Valette, M., Manolios, E., Verneuil, L., Speranza, M., & Revah-Levy, A. (2022). The sensory experiences of autistic people: A metasynthesis. *Autism*, *26*(5), 1032-1045.

Siddaway, A. P., Wood, A. M., & Hedges, L. V. (2019). How to do a systematic review: a best practice guide for conducting and reporting narrative reviews, meta-analyses, and meta-syntheses. *Annual review of psychology*, *70*, 747-770.

Sizmur, S, & Raleigh, V. "The risks to care quality and staff wellbeing of an NHS system under pressure." *The King's Fund: Oxford* 24 (2018).

Summers, E. M., Morris, R. C., Bhutani, G. E., Rao, A. S., & Clarke, J. C. (2021). A survey of psychological practitioner workplace well-being. *Clinical Psychology & Psychotherapy*, *28*(2), 438-451.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, *8*(1), 1-10.

Trockel, M., Corcoran, D., Minor, L. B., & Shanafelt, T. D. (2020, November). Advancing physician well-being: a population health framework. In *Mayo Clinic Proceedings* (Vol. 95, No. 11, pp. 2350-2355). Elsevier.

Wright, T., Mughal, F., Babatunde, O. O., Dikomitis, L., Mallen, C. D., & Helliwell, T. (2022). Burnout among primary health-care professionals in low-and middle-income countries: systematic review and meta-analysis. *Bulletin of the World Health Organization*, *100*(6), 385.

Appendix

a. Example of data extraction

following i) a betrayal of what's right, ii) in a high-stakes situation, iii) by someone who holds legitimate authority. This transfers the initial responsibility, placing emphasis on the trusted authority as the perpetrator rather than the individual, and exploring the impact of leadership and institutional culture on incidence of moral injury (Wiinikka-Lydon, 2017).

Shay's original term considered moral injury to be an issue of hierarchical power and betrayal of trust (Shay, 2002, 2012, 2014). Moving to the newer definition (Litz et al., 2009) hinders the ability to look at moral injury through an institutional lens, and to consider the influences of social and political context that may change the focus for intervention (Wiinikka-Lydon, 2017). This individualistic approach overlooks the systemic factors that could be interacting with burnout and moral injury. Rather than exploring moral injury solely from the perspective of perpetration, a focus on betrayal-based moral injury allows an analysis of the influence of management and leadership, both within the institution and beyond. In order to develop a more detailed understanding of staff experiences through the COVID-19 pandemic, it is important to explore experiences of burnout in health care and consider whether the catchall term "burnout" may be obscuring incidences of betrayal-based moral injury. This article aims to explore NHS staff experience of burnout, incidences of potentially morally injurious events and associated emotion, and thoughts around responses and impact of leadership.

Methods

Participants and Procedure

Sixteen working-age participants from a wide range of clinical roles in the NHS formed the sample for this analysis, including nurses (staff, practice development and community), doctors (ST3, specialty and surgical), occupational therapists, trainee clinical psychologists, a paramedic, an employment specialist, and a member of senior management (head of nursing). Twelve of the 16 participants identified as female, mirroring the gender breakdown of the NHS workforce where 77% percent of staff identify as female (NHS Digital, 2018). Fifteen of the participants identified as White, and one identified as Asian Indian. To ensure their anonymity, participants have been identified by their gender and professional background, and given a numerical identifier to distinguish between them.

This project received a favorable opinion from the University of Surrey Ethics Committee. Participants were recruited via social media advertising and word of mouth, allowing participants to discuss their leadership and organization without concern of their NHS trust being identified. Recruitment materials invited participation from NHS clinical staff who had worked during the COVID-19 pandemic and self-identified as having experienced work-related stress or "burnout." Data were collected by the first author using a semistructured interview technique. This method allowed open exploration of topics of burnout, moral injury, and experiences of leadership, while giving participants freedom and flexibility to discuss experiences and emotions that were most significant for them (DeJonckheere & Vaughn, 2019). Online video interviews were conducted due to restrictions related to the pandemic, and to remove geographical limitations on a participant sample. Interviews lasted between 30 and 75 minutes and were digitally recorded and transcribed.

Data Analysis

This research was conducted from a critical realist approach, in which "knowledge and experience [are] mediated and constructed through language, while acknowledging material and social structures that generate phenomena" (Hayfield et al., 2019, p. 530). Data analysis was undertaken using reflexive thematic analysis (Braun & Clarke, 2019), in which literature enhanced the analysis by sensitizing the researcher to more subtle features of the data (Tuckett, 2005), and followed the six stages suggested by Braun and Clarke (2006).

Results

Throughout the corpus of data three themes were identified: abandonment as betrayal; dishonesty and lack of accountability; and fractured relationship to management or the NHS.

second order data

Abandonment as Betrayal

Betrayals were identified as situations in which trust had been violated, by either an individual, the organization, or "those in charge." The most prevalent types of betrayal, identified by 13 of 16 participants, were related to the theme of "abandonment." Participants discussed perceptions of a lack of care from leadership, in which they were deemed to be disposable or replaceable. In discussing the response of the current government, one participant voiced feelings that their death would be meaningless to the leadership:

first order data

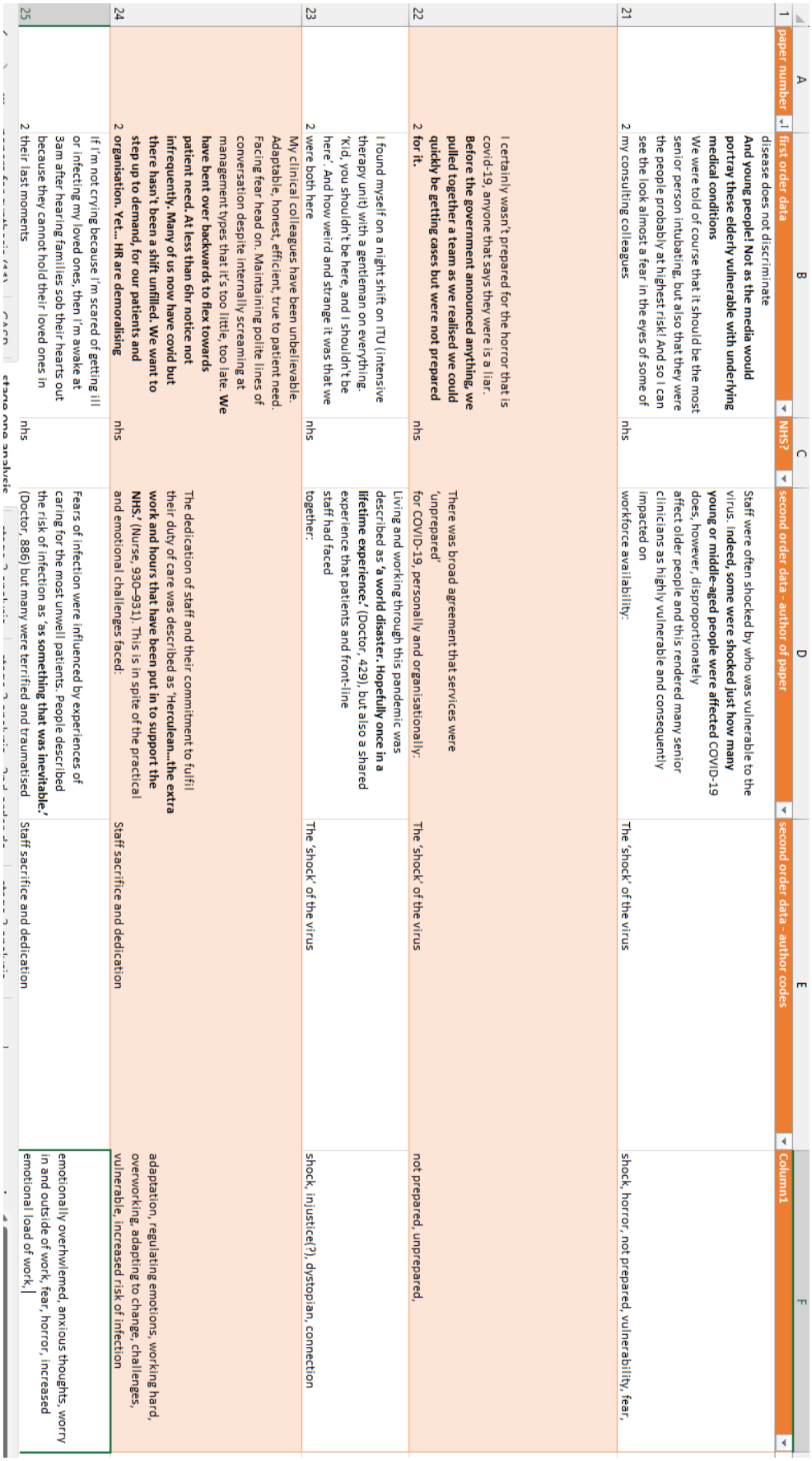
> "If I die, they don't care. It doesn't matter if [they] get like, you know, 600 nurses have died from COVID-19, and you know, with higher exposure being linked to severity and things like that. And it just felt like [they] don't care, they'll just get somebody else in my shoes tomorrow." — participant 1: Female, Nursing

In the extract above, the participant draws on notions of a lack of "care" to present an account in which they see their personal worth as employees devalued or dehumanized. Through reference to "they'll just get someone else in my shoes," the participant brings to the foreground their dispensability. Such an understanding appears to mirror that of the "betrayal by institution" in which soldiers were seen as tools rather than individuals (Farmer & Bessa, 2011). While media coverage depicted health care staff as "wartime heroes" (Benziman, 2020), participants described themselves as "cannon fodder," feeding into the narrative of "not mattering" and being replaceable. As the following participant comments,

> "It felt like we were just the cannon fodder because at the beginning no one knew you know what what's happening. What is COVID? How's it spread? Are we gonna get it? And we weren't wearing masks. [. . .] And then as research has gone on and they said now you need all this PPE, well we didn't have that and it feels like they knew that we should have had it, but they just weren't gonna say it 'cause they didn't have the equipment and it didn't matter 'cause it was only us going in there." — participant 2: Female, Nursing

Highlighted here is a perception of devaluation and being considered a throwaway resource: not only feeling disposable, but feeling disposable in relation to others who are seen to have greater value. There is also an element of intention in these

b. Example of part of stage one analysis



	A	B	C	D	E	F
1	paper number	first order data	NHS?	second order data - author of paper	second order data - author codes	Column1
21	2	disease does not discriminate **And young people! Not as the media would portray these elderly vulnerable with underlying medical conditions** We were told of course that it should be the most senior person intubating, but also that they were the people probably at highest risk! And so I can see the look almost a fear in the eyes of some of my consulting colleagues	nhs	Staff were often shocked by who was vulnerable to the virus. **Indeed, some were shocked just how many young or middle-aged people were affected** COVID-19 does, however, disproportionately affect older people and this rendered many senior clinicians as highly vulnerable and consequently impacted on workforce availability:	The 'shock' of the virus	shock, horror, not prepared, vulnerability, fear,
22	2	I certainly wasn't prepared for the horror that is covid-19, anyone that says they were is a liar. **Before the government announced anything, we pulled together a team as we realised we could quickly be getting cases but were not prepared for it.**	nhs	There was broad agreement that services were 'unprepared' for COVID-19, personally and organisationally:	The 'shock' of the virus	not prepared, unprepared,
23	2	I found myself on a night shift on ITU (intensive therapy unit) with a gentleman on everything. 'Kid, you shouldn't be here, and I shouldn't be here'. And how weird and strange it was that we were both here	nhs	Living and working through this pandemic was described as '**a world disaster. Hopefully once in a lifetime experience.**' (Doctor, 429), but also a shared experience that patients and front-line staff had faced together:	The 'shock' of the virus	shock, injustice(?), dystopian, connection
24	2	My clinical colleagues have been unbelievable. Adaptable, honest, efficient, true to patient need. Facing fear head on. Maintaining polite lines of conversation despite internally screaming at management types that it's too little, too late. **We have bent over backwards to flex towards patient need. At less than 6hr notice not infrequently. Many of us now have covid but there hasn't been a shift unfilled. We want to step up to demand, for our patients and organisation. Yet... HR are demoralising**	nhs	The dedication of staff and their commitment to fulfil their duty of care was described as '**herculean...the extra work and hours that have been put in to support the NHS.**' (Nurse, 930–931). This is in spite of the practical and emotional challenges faced:	Staff sacrifice and dedication	adaptation, regulating emotions, working hard, overworking, adapting to change, challenges, vulnerable, increased risk of infection
25	2	If I'm not crying because I'm scared of getting ill or infecting my loved ones, then I'm awake at 3am after hearing families sob their hearts out because they cannot hold their loved ones in their last moments	nhs	Fears of infection were influenced by experiences of caring for the most unwell patients. People described the risk of infection as '**as something that was inevitable.**' (Doctor, 886) but many were terrified and traumatised	Staff sacrifice and dedication	emotionally overhwlemed, anxious thoughts, worry in and outside of work, fear, horror, increased emotional load of work,]

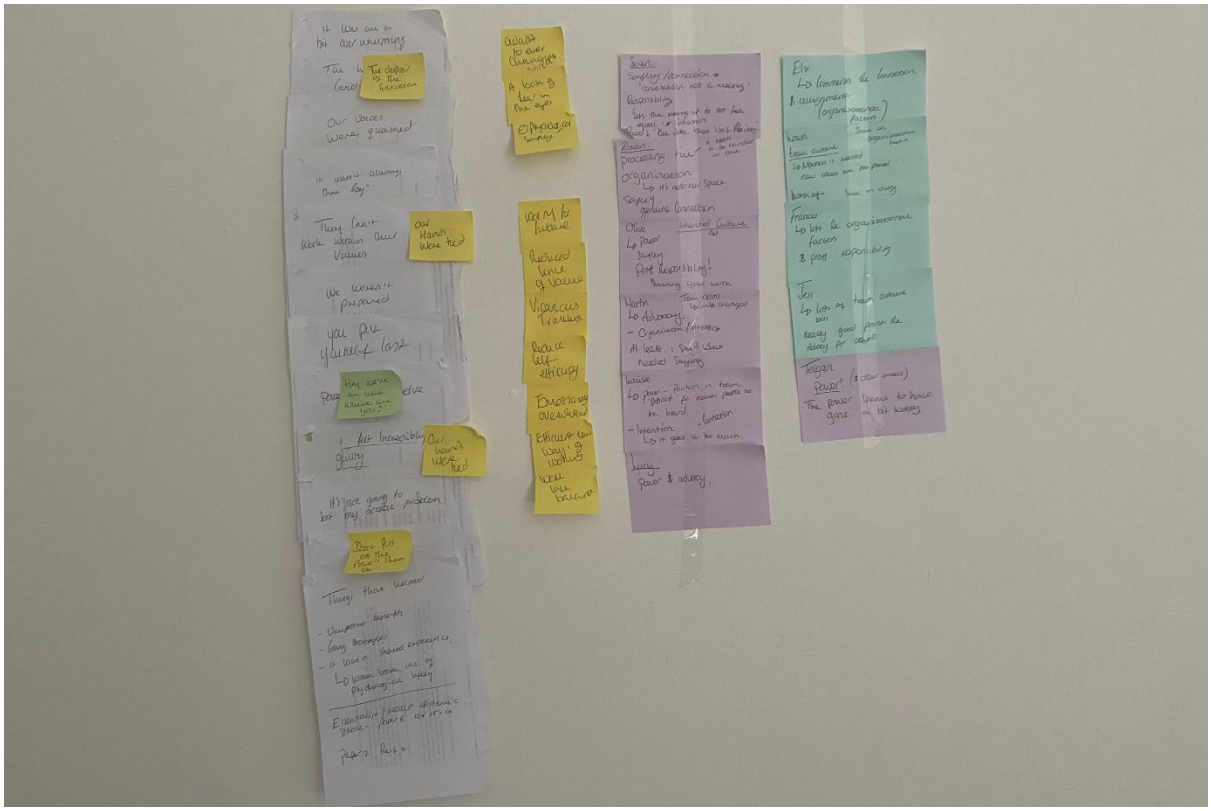
c. Example of part of stage two analysis

	A	B	C	D	E	F
1	paper	first order data	initial theme idea (stage 3ish)	thoughts and comments	extra themes (?)	extra themes 2
184		after school care'				
185	8		I found that really hard	personal lives also burdensome	personal lives	
186	8	'Loss of communication with wife'	I found that really hard	personal lives also burdensome	personal lives	
		'Wedding, honeymoon and annual				
187	8	leave cancelled'	you put yourself last	personal lives also burdensome		
188	8	'Travel. The pub is shut and I can't go on holiday'	I found that really hard	personal lives also burdensome	personal lives	
189	8	'Some sleeplessness'	I found that really hard	personal lives also burdensome		
		'Fear of bringing virus home and infect(ing) my family and my mother in law with lung cancer' 'Increased anxiety about the				
190	8	future'	I found that really hard	personal lives also burdensome. People were fearing for the future		
191	8	'Often struggle to find motivation'	I found that really hard	emotional impact due to challenging work lives		
192	8	'Very much, started having irritability' 'Feeling hopeless'	I found that really hard	emotional impact due to challenging work lives		
219	8	'Very stressful both at home and work'	I found that really hard	personal lives also burdensome	personal lives	
220	8	'Burnout'	our hands were tied	unable to have one on one time with patients		
	10	During inpatient ward rounds less likely to sit at the bedside and talk Less physical patient				
	10	contact unless absolutely necessary less face-to-face appointments in clinic. Face-to-face meeting with members of study team has beenstopped. We communicate using zoom, emails and phone, etc. We are still able to have proper communication with	surprise benefit	remote meetings worked surprisingly well in some instances		
221	10	the help of different technology And even now, we have a thermometer and a sats machine, a portable one, so every time we go inside, we need to make sure that everything is safe. So yeah, that changed.	I found that really hard	constant reminders of the risks around them		
		However, for some patients, telephone clinics mean problems are not being sorted,				

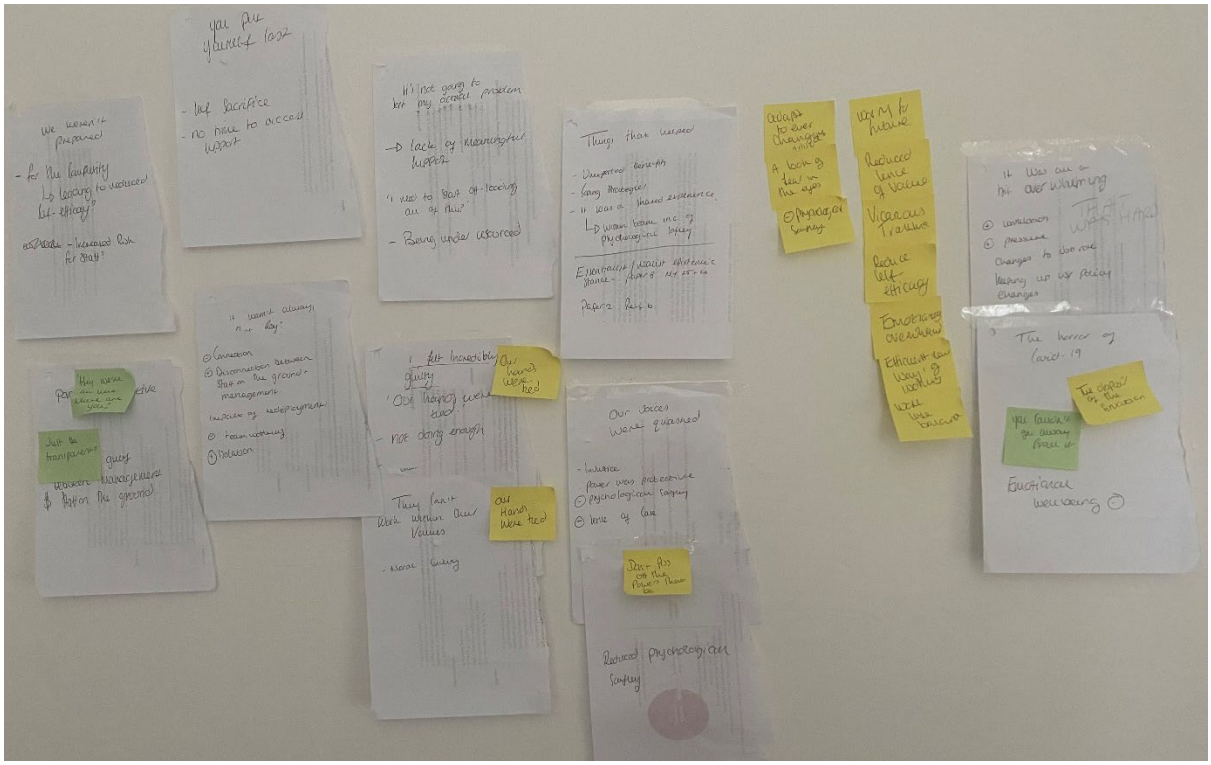
papers for synthesis (11) | CASP | stage one analysis | stage 2 analysis | stage 2 analysis - 2nd order da | stage 3 analysis

d. Example of part of stage three analysis

i. Example of theme development process



ii. Part of theme development process



iii. Final table of themes

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	theme and subtheme name	1	2	3	4	5	6	7	8	9	10	11	total	theme description
2	Our hands were tied	1	1	1	1	1	1	1	1	1	1	1	11	moral injury, not able to do the job they trained for, have to provide substandard care
3	you put yourself last	1	1	1	1	1	1 x		1	1	1	1	10	self-sacrifice from staff and the impact this had on them
4	hey we're all here, where are you?	1	1	1	1 x	x	1 x	x	x	1	1	1	8	sense of being abandoned with mangement and senior staff not being present
5	we were unprepared (for the unpreparedable)	1	1	1 x	x		1 x		1	1	1	1	8	acknowledgment that they were unprepared for what they were facing resulting in staff needs not being met
6	you need to have somebody to offload to	1 x		1 x		1	1		1	1 x	x		7	loss of connections led to increased isolation and difficulties as staff had to process their difficulties alone
7	Our voices were quashed	1	1	1	1 x	x	1 x	x	x		1 x		7	staff felt unable to speak up or were not listened to when they did
8	it was really hard	1	1	1	1	1	1	1	1	1	1	1	11	sits over all the previous themes, the nature of the work was challenging emotionally, cognitively, and physically.

Chapter two – Empirical paper

This journal has been prepared for submission to the journal of sociology and illness

https://onlinelibrary.wiley.com/page/journal/14679566/homepage/forauthors.html

"'Original article' refers to article presenting results from original research - usually, but not necessarily, empirical – and conceptual/theoretical development (maximum word length= **9000** including notes and bibliography"

FINDING A VOICE IN THE MULTI-DISCIPLINARY TEAM. THE EXPERIENCE OF CAMHS STAFF.

Erica Willoughby[1], Dr Elizabeth Burnside[2], Dr Mike Jackson[2]

[1] – North Wales Clinical Psychology Programme, Bangor University

[2] – School of Psychology, Bangor University

Abstract

Multidisciplinary teams (MDTs) are common throughout different sectors within the NHS, including Child and Adolescent Mental Health Services (CAMHS) . A core principle of MDTs is that all team members have valuable insights and opinions which should be shared. The NHS has a hierarchical structure, issues related to which correlate with poorer clinical outcomes. More recently in efforts to overcome hierarchical cultures there has been an interest in psychological safety and the concept of leadership. To achieve effective MDT working it is important that we investigate staff's experiences of sharing their thoughts, or speaking, within MDT settings. This study investigated what staff felt supported or hindered their ability to speak up in MDT settings, with the aim of revealing areas for development in terms of team functioning. Overall, 11 members of a CAMHS MDT participated in semi-structured interviews. Thematic analysis of the interview data identified four themes: Control Vs Collaboration, Expectation Vs Reality, Conflicting Vs Motivational responsibilities, and Connection. The findings indicated that connection to the team and collaborative team working supported speaking up whilst hierarchical working and a lack of intentional organisation of meetings did not.

Introduction

The National Health Service (NHS) in the United Kingdom (UK) is funded by general taxation in order to provide equitable healthcare to all residents within the UK, in what is now called the Beveridge model (Kulesher and Forrestal, 2014). Whilst this model is not unique, it is not the most common healthcare system internationally, with many countries using a social insurance or private insurance model (Kulesher and Forrestal, 2014). The NHS has changed drastically from its inception in 1948, although it was not until 1987 that a unified service to support children's mental health needs was established, with guidance for how these teams should be functioning not being offered until 1995 (Barrett, 2019). This resulted in what we now call Child and Adolescent Mental Health Services (CAMHS). CAMHS has tier 1-4 services, with tier 1 and 2 typically being delivered within GP or school settings and tier 4 typically involving inpatient or crisis care. Tier 3 CAMHS is for people whose mental health needs require more specialist support but can be met within the community. These teams ideally are made up of multiple professions working together to collaboratively meet the needs of people accessing the service typically as part of a multidisciplinary team (MDT). Professions represented within CAMHS teams often include psychotherapists, psychologists, psychiatrists, mental health nurses, occupational therapists, family therapists, and social workers, although other roles may also be found (Barrett, 2019).

MDTs are defined by the National Health Service (NHS) as being

'a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients' (NHS Data Model and Dictionary, 2023).

This definition appears to acknowledge that all clinicians hold valuable and worthy information and opinions that are important for patient care. Over the years MDT working has become standard practice across many healthcare settings in the UK, such as cancer care (United Kingdom NHS, 2017) and heart failure management (Morton, et al., 2018) and CAMHS (Bhardwaj, et al., 2021; Rauf, et al., 2021; Papadopoullos, etal., 2021).

Working as an MDT has been shown to lead to improved innovation and increased safety for patient and hospital care (Ancarani, et al., 2016). However, there is recognition that simply coming together as a team is not enough to be an effective MDT (Atwal & Caldwell, 2005; Caldwell and Atwal, 2003; Cronin and Weingart, 2007; Forsyth and Mason, 2017) with teams experiencing difficulties with power struggles (Papadopoullos, et al., 2021) which can lead to within team conflict (Smart et al., 2018). Additionally, it has been found that not all colleagues are able to contribute equally within MDT settings, with those at the top of the traditional hierarchical ladder within the NHS often contributing more than those at the

bottom (Atwal and Caldwell, 2005; Reitz and Higgins, 2020). Interestingly, there appears to be a difference in how the frequency of speaking up, or feeling able to volunteer information or opinions, within a team meeting is perceived, with team members who are higher up the hierarchical ladder viewing it as something that is happening more frequently than those who are lower down (Reitz and Higgins, 2020). This highlights the need to actively seek opinions from all members of a team in terms of how to best support speaking up within MDT setting. It appears that hierarchy is still a key factor of working within the contemporary NHS, but having an overly hierarchical culture has been associated with environments which are driven by fear or threat and worse clinical outcomes (Meterko, et al., 2004; Davies, et al., 2007).

Within discussions and literature about MDTs there is a growing focus on the concept of psychological safety and the impact that this has on team functioning. Psychological safety in a team, as described by Edmonson (1999), is *'a shared belief held by members of a team that the team is safe for interpersonal risk taking'.* This sits comfortably aside Kleine et al's., (2019) findings that a key factor in staff thriving in the workplace is the concept of trust, with 'trust' being defined as *the willingness of a party to be vulnerable to the actions of another party, based in the expectation that the other will perform a particular action important to the truster, irrespective of the ability to control the other party'* (Mayer et al., 1995, p 172, as referenced in Klein et al., 2019). These definitions highlight that trust and psychological safety both revolve around working with colleagues, being able to hear critique and offer critique to ideas or concepts presented by colleagues free of fear of negative consequences, with the knowledge that all views presented by colleagues, including one's own, will be respected and considered in the decision-making process. An environment fuelled by fear and threat would therefore be unlikely to be trusting or psychologically safe. According to Kleine et al (2019) the concept of 'trust' includes trust directed towards management, colleagues, and supervisors, which sits alongside psychological safety to create a trusting workplace. For trust as they define it to be genuinely felt throughout a team it must be felt towards all levels of the traditional hierarchical ladder, however it has been found that nursing and other healthcare staff are often working in an environment underpinned by the feeling of threat and potential for punishment (George, 2017).

In addition to conversations about psychological safety there have been discussions about leadership as a philosophical concept that can help navigate the challenges of hierarchy within teams. Lateral leadership has been described as a leadership method which focuses on insight, collaboration, coordination, and creativity throughout teams, aiming for all members to feel able to contribute. In a move away from the traditional hierarchically related view of power within teams, lateral leadership seeks to create an environment of trust within

teams through ensuring there is shared understanding within a team (Koçak, 2019). Similarly, compassionate leadership seeks to create psychologically safe environments through a focus on compassionate support to colleagues and modelling positive non-shaming, as opposed to punitive or punishing, responses to challenges or difficulties (de Zulueta, 2015). Both of these models value the role of leaders, acknowledging that some members of a team will have different responsibilities. However, the ethos that these models present suggests that reaching goals and upholding responsibilities can be achieved through the development of a trusting and psychologically safe environment. This results in a team where colleagues are supported to contribute to decision making processes, underpinned by curiosity and development, as opposed to the commonly reported environment of threat seen in the NHS (Koçak, 2019; de Zulueta, 2015).

Aim

With these considerations in mind there is a need to continue to develop the understanding of the challenges staff face within the contemporary NHS to best guide team practice. It is important that we seek to understand the factors that influence whether staff feel able to speak up or not if we wish to understand, and possibly alter, the current engrained hierarchical culture of the NHS. The current study seeks to further understand the experiences of staff within tier 3 CAMHS settings in the UK, specifically in relation to their ability to speak up, or not, within team meetings.

Method

Design

Individual semi-structured interviews were held with members of a CAMHS team in North Wales. CAMHS was selected as a team of interest due to the wide variety of professions likely to be members of the team, resulting in a variety of professional experiences, training, and stances. Additionally, the first and second researcher had professional connections within the wider CAMHS network and were aware that all CAMHS teams within the locality were working as MDTs with regular MDT meetings being held. Prior to each interview some time was devoted to answer questions and settle into some natural conversation. After this each interview began with the same core question (see appendix a), from there participants were invited to share as much or as little detail as they wanted to about their own experiences of speaking up within an MDT setting. The interviewer gave prompts throughout the interview using open questions and checking understanding where needed. Near the end of the interview the interviewer asked each participant to summarise their main points to support a natural ending of each interview.

Participants

Inclusion criteria:

- To be a substantive member of the local CAMHS team
- To have held that post for more than 3 months at the time of interview

Participants were recruited through a team wide invitation to take part in the research which was made by the principal investigator during a face-to-face team meeting. During this meeting the principal investigator presented the research proposal and provided contact details should any members of the team choose to take part.

In total 12 members of the team consented to participate in the research, with 11 completing interviews. All levels of the traditional hierarchical team were represented within this sample, however no further participant details were reported to protect the anonymity of participants.

Procedure

Prior to each interview participants were sent information about the study (see appendix b) and a consent form. Participants were invited to consider any questions they had regarding the study which they could ask either by email or at the start of the scheduled session for the interview. Each participant submitted a consent form (see appendix c) confirming that they were happy to take part. Participants were interviewed between Dec 2022 and Feb 2023. Each interview lasted between 41-59 minutes, with some time devoted prior to the interview for answering questions and checking consent.

Participants were then invited to share their experiences of speaking up and not speaking up within different MDT settings. They were asked to reflect on different experiences they had and to share only what they were comfortable sharing. Each interview was audio recorded and was fully transcribed and anonymised within 72 hours of the interview having taken place by the principal investigator to maintain the anonymity of participants.

At the end of the interview each participant was provided with a debrief form (see appendix d) which reiterated researcher information and provided them with information regarding support available to them.

Ethical considerations

A major issue underpinning this study is the sensitivity of the material being discussed. Ethical approval was granted by the University of Bangor and supported by the local NHS research and development team. Within each interview it was possible that highly sensitive information was discussed. Because of this the researchers ensured that within 72 hours of the recording having been made any identifiable information had been anonymised and the interview itself had been fully transcribed. This included removing locations, names of team

members and service users, and details relating to provision of care or support if it was deemed possible to trace back to an individual. Furthermore, the extracts in the write up were selected to be as minimally identifiable as possible, whilst still displaying each theme clearly. Within the consent form participants were informed that they had the right to withdraw their data with no negative consequences for doing so. Additionally, prior to recording participants were invited to ask any questions they had remaining about the study and interview process and were again asked whether they were happy to proceed. No deception took place with the current research and participants freely took part. Participants were aware of the aims and procedures in full.

Analysis

The data was analysed using Thematic Analysis as guided by Clarke and Braun (2013), following the seven steps of coding and analysis (see Table 1)

Table one: steps for thematic analysis as defined by Braun and Clarke (2013). (please see appendix E-H for examples of the analytic process)

Stage	**task**
1	Transcription
2	Reading through and familiarising with the data; taking note of items of potential interest
3	Coding across the whole data set
4	Identifying themes
5	Reviewing themes and creating a thematic map
6	Defining and naming themes
7	Finalising the analysis and formally writing results

This seven-step process was not a linear process, but rather an iterative process of going back to the data to ensure the accuracy or appropriateness of the themes as they developed, with coding in particular being ‘an ongoing organic process’ (Braun and Clarke, 2006). The majority of this process was done using paper notes and hard copies of the transcriptions. This supported the process of spotting themes as similar themes were grouped together, creating visual maps of themes and codes as the process developed. The first author used visual mapping of codes and themes, then presenting these in written and verbal from to the second and third author, which resulted in all authors carefully considering the language used to describe the emerging themes.

Validity

When reviewing the themes each theme was considered in terms of how accurately they represented the meaning and intention of each individual participant or individual extracts of interest as well as how they represented the dataset as a whole (Braun and Clarke, 2006). To support the interpretation of the data the principal researcher was supported to take a reflexive stance on their own position as well as the data set itself. Additionally, shared analysis took place between the research team for a sample of the data set, with codes and themes being discussed throughout the analysis phase.

Reflexive statement

All members of the research team have worked within a variety of teams within the NHS. The first and second author have spent many years working within CAMHS teams, and adjacent children's services. The first author has an interest in MDT functioning generally, having previously researched how power presents within MDT meetings. Throughout the analysis phase researchers were careful to consider the question 'is this coming from the data or is this my experience?' in recognition of the fluctuating contexts of the researchers and their previous research interests. Throughout the analysis a decision was made to consider and step outside of pre-held positions, with researchers prompting each other to discuss their own position and experiences. This enabled the researchers as a team to disentangle themes that were coming through from the data and themes that were being shaped by researchers own experiences. At times knowledge of how CAMHS teams functioned proved helpful when understanding the structure of where participants sat within their team or different processes participants were discussing. Researchers were however careful to consider the evidence that was being presented by the research participants, naming points where this was congruent/incongruent with their own experiences of working within these services. Additionally, as a team researchers tried to go beyond the words that were being said, truly trying to understand the underlying sentiment of the accounts that were being presented by each participant.

Findings

After analysis four themes were identified (see table 2). Three themes focused on different experiences and reflections on how different spaces felt, the final theme focused on one phenomenon. Over half of the participants spoke on all the themes (See appendix i).

Table 2 - *Summary of themes*

Theme	Description
Control Vs Collaboration	*Control:* The internal experience of a meeting being controlled by others with a strong tendency towards power being held within the traditional hierarchical structures in the NHS made speaking up aversive. *Collaboration:* when colleagues were working together on an equal footing it was easier to be a part of conversations.
Expectation Vs reality	*Expectations:* what people wanted and expected to see in different meetings. *Reality:* how the meeting actually was.
Conflicting Vs Motivational Responsibilities	*Conflicting responsibilities*: when team members felt they had more than one role or responsibility within a meeting which weren't both acting as motivators to speak up this created an internal tension which negatively impacted them. *Motivational responsibilities:* the experience of being motivated to speak up.
Connection	A sense of connection to others within the meeting supported their ability to speak up and increased their sense of safety.

Transcript notations are as follows:

'Italics' - participant quotation

… - data omitted for confidentiality or clarity

[text] - notation added by researcher to aid understanding.

Control Vs Collaboration

This theme describes the experiences staff had in different settings, with some spaces feeling collaborative and safe to speak up in. In the spaces that felt like there was more control these were often more challenging for staff to speak up in. This is discussed in more detail below;

Controlled spaces

These were meetings during which people felt it was challenging to speak up as the space felt controlled by the more senior clinicians.

> *'There is almost a sense that there's power that's being held by one profession in that meeting. It's not a meeting of equals… it feels like that mismatch, the power bit seems to have gone a bit wobbly. I thought we were colleagues, but actually ohh I've read it wrong that I forgot power has to come into play'*
>
> (Teigan)

The subsequent power differential resulted in other clinicians not feeling heard, or able to take part in decisions:

> *'I just felt that they have totally overruled me on cases… I feel that they discount the fact that I work on a weekly basis … and they sit in that position of being a senior clinician. So they say "no, I don't think it's there. I think it's that" and I find it very hard to stand up for my thoughts and feelings in that situation, and I feel I don't really get heard by them and their way is the way that we have to go.'*
>
> (Lucy)

At times people controlled the space through their conduct, silencing others as a result:

> *'it was people not behaving, cutting across each other and body language when an opinion was shared that somebody else might disagree with…real, what I would class as, quite aggressive behaviour ... that in turn sort of left us not able to have productive conversations really because there were people, like myself, who felt they couldn't share anything at all due to fear of that reaction'*
>
> (Elsi)

Additionally, there was a sense of threat around speaking up in these settings, and throughout the team as a whole, resulting in silence or even absence altogether:

> *'It was deathly silent … they felt like they were bringing their homework to be marked [and] didn't feel able to ask questions or be curious I think both because they didn't want to come across as judging or criticising [and] they didn't want that in return … It*

was feeling really unsafe emotionally for people to so a lot of people were avoiding the meeting altogether because it felt so difficult'

(Seren)

Achieving collaboration

In contrast the collaborative meetings were reported a much more open and shared feeling where it felt safe to speak up.

'It feels very inclusive, very much about working together and that everybody's voice and thoughts are valuable'.

(Teigan)

These meetings were often described as having lots of different professions within them which facilitated creative thinking within the clinical discussions.

'It's loads of people coming at things from different directions and I find it really helpful … thinking about things more broadly, sort of pulling the lens out and being a bit more systemic about stuff'

(Lucy)

There was acknowledgment from several participants that these safe, collaborative spaces took effort to achieve, with meaningful consideration being given to the needs of all attendees. Here, Martin shares their perspective on how the team were able to step away from the challenging power dynamics that had been noticed to create a safer space together.

'from their position of not being management they were able to call a meeting … and that was just people being honest about how they were finding the meeting and what changes it was felt needed to be made … it was agreed that we could [contribute] through choice'

(Martin)

However, it seemed that to change the culture of a meeting active effort needed to be made for any change to happen. When attempts to change the culture of a meeting were attempted without consultation or collaboration with others they were felt to be unsuccessful.

'the MDT [meeting] *is really top-down-driven and i have tried to hell and back to make it not like that…I work my socks off to try and could open up space and soften it and make it more reflective and make it more exploratory with limited success, there's something about it that keeps on returning to the mould… inherited through the passage of time where different people have been facilitating or leading...somehow something's been kind of passed down'*

(Olive)

Overall, there seemed to be more experiences of 'control' stemming from engrained professional hierarchies, and inherited culture which prevented all staff from being able to speak up. Experiences of 'collaboration' however seemed to stem from open discussion and interprofessional equality which left staff feeling safe and supported and therefore able to speak up.

Expectation Vs reality

This theme describes the experience of having a sense of clarity or transparency regarding the intention or organisation of a given meeting. A common reflection from participants was that when their expectation or desire for a meeting and the reality of attending a meeting were congruent then the meeting was felt to have more equal participation from all people in attendance.

'We all knew why we were there, and we were only talking about that one person and unlike many other meetings we left with some really positive outcomes that were realistic. I guess the expectation for the meeting was realistic, not just this but the intention for the meeting was clear, we knew why we were there… we all knew what we wanted to talk about and we were able to do it'

(Lowri)

However, the majority of people experienced occasions where the intention for the meeting was ambiguous and therefore unrealistic to achieve, which seemed to contribute to creating an unsafe environment. Additionally, how meetings came together seemed to be a mystifying or 'magical' process at times.

'I think I notice the times where I don't speak, even now I feel sometimes like I'm in a meeting and everyone knows what the meeting was for and how it is supposed to go. Sometimes it feels like there is an unwritten or an unspoken thing about how this magical meeting is supposed to go …I find personally that that can really prevent me [from speaking up]'

(Seren)

Many participants spoke about taking part in a meeting because they wanted or needed support from the with the wider team, but the reality of that meeting was that it was a punitive or punishing space where they felt judged, or scrutinised.

'It feels like a space to defend my practice. Whereas actually I'm going for help.'

(Teigan)

Overall, when the meeting and people's expectation of a given meeting are congruent people feel able to speak up. When this is not the case it acts as an additional barrier to people speaking up.

Conflicting Vs Motivational Responsibilities

This theme describes the different types of responsibilities participants reported and how they impact them in terms of speaking up in a meeting or not.

Motivational responsibilities

Advocating for service users was hugely motivational, facilitating speaking up to ensure that service users views were represented well.

'I have to be the voice for the patient I have to step up…I am the one holding that relationship with the young person…so even if the ultimate decision isn't what I asked for or what I thought it could be I need to discuss that in the room and I think as well it comes with the relationship'.

(Jess)

Additionally there was reflection on clinical responsibility as a motivator to speak up. These reflections seemed to relate to a position of 'threat' of getting things wrong as opposed to advocating for service users:

> *'sometimes all you can do is to voice concerns or share the issue or to speak up and sometimes that makes the difference, and sometimes that doesn't…I suppose there is something about just that determination to not be the one who didn't say anything. It's like if I don't say anything then if nothing changes I'm then responsible, whereas if I say something and nothing changes then at least I did what I could and said what needed saying'*
>
> (Martin)

Conflicting responsibilities

There was acknowledgement from several participants that having multiple responsibilities had a negative impact on their ability to speak freely.

> *'I've got my own ideas as well sometimes … but being chair and presenting ideas I'm wary, I don't want to speak too much so I spend quite a lot of time like biting my tongue to try and give space you know to try and let people talk'*
>
> (Frances)

Additionally, there was a significant amount of reflection about showing the team their value, proving their own worth both as a clinician and a source of support to others within the team.

> *'it's about wanting to be of value to the team and feeling I can and I should add value by contributing but you also then get the no one else is speaking …it feels like you don't want to take up too much time or too much space because that then feels unequal again in a different way'*
>
> (Seren)

Several participants also reported feeling responsible for other people's wellbeing within the team which at times became a barrier to speaking up freely.

'this tension again part of this responsibility as well as having a responsibility to 'do' stuff we also have a responsibility to look after our team and not make stressed people feel worse'

(Frances)

This responsibility to look after colleagues' wellbeing also impacted on people's ability to ask for help from each other.

'I think everybody's trying really hard to do a really good job…but it just feels like there's this tremendous amount of overwhelm on all levels and so that stops you talking as well, doesn't it. That stops you wanting to put more pressure onto the people that you're supposed to go to with difficulties because you already know that they are quite overwhelmed'

(Lucy)

Overall advocating for service users was experienced as increasing people's ability to speak up during a team meeting, although this often seemed to be underpinned by a feeling of threat. In contrast, additional responsibilities, be that organisational or interpersonal, seemed to prevent people from feeling able to speak up freely.

Connection

This theme encapsulates how a sense of connection to others facilitates people's ability to speak up, both when it is present and when it is missing. This is discussed in more detail below;

When connection is present

Almost all clinicians commented on how having a sense of connection with other people within a given meeting was an important factor of them being able to speak up. Many clinicians discussed how connection with other people in the meeting supported their ability to understand the different perspectives within a meeting which helped create a safe environment to speak up in:

'I think things are changing though as we start to understand each other's challenges and difficulties and certainly holding that understanding is really helpful' (Lowri)

This sense of connection and shared understanding helped meetings feel safe, seeming to reduce their sense of threat.

> *'If someone else is in that meeting who works in a similar way … it feels a lot safer, and it feels a lot more held in … it feels like they're supporting my perspective and my clients perspective rather than 'ohh no … you're not doing one of our accepted approaches'* (Teigan)

This connection did not always need to be within the team as a whole, many participants reflected that this connection could come through supervision.

> *'I really struggle to voice my opinion in the meeting, so I decided to take it supervision and express my concerns and obviously that's a lot easier because you've got a good relationship with your supervisor usually, which I do. I took it there and I explored it and we practiced ways having that conversation'* (Elsi)

But having strong connections within the meeting helped them feel more conversational and relaxed which helped people feel able to speak up:

> *'I definitely notice I speak a lot more in meetings where I the meeting is full of people that I feel I have a really good connection with, that I feel I know really well and that I'm comfortable in the setting with. I notice there's less of even a decision of 'am I going to speak' and more of a it happens, it flows, its free-er. It is a conversation not a meeting'* (Seren)

When connection is missing

When connection was missing their seemed to be agreement that this had a negative impact on people's wellbeing reducing their ability to speak up in meetings, or even attend meetings.

> *'I still wasn't feeling connected to other colleagues and still left [meetings] feeling really alone... so many things are asked of you and it becomes really difficult to decide what to go to and what not to go to. I noticed myself that I was paring back what I went to just so I felt like my head was above water'*
>
> (Lowri)

It seemed also that when a sense of connection was missing the overall goal of any meeting was unclear, which led people to question why they were there and what they could meaningfully contribute:

> *'I'm noticing it's this mishmash ... it feels disjointed, that cohesion of what we're trying to achieve as a team is as a little bit splintered and I struggle a little bit and then I struggle to know what my role is'*
>
> (Rowan)

Overall, a sense of connection between colleagues seems to add to peoples sense of being able to speak up during team meetings. When connection is missing this seems to be associated with a negative impact on individuals wellbeing and sense of self-esteem which reduces their ability to speak up within team meetings.

Discussion

Each of the themes provide a valuable insight into the experience of speaking up within team meetings, or not, with four themes being identified. Each participant was able to reflect on times that they felt more able to speak up which also provides evidence for how best to support speaking up within team settings.

Control and Collaboration: This theme provided insight into how collaborative spaces could be achieved, and the contrast between the experience of being part of a collaborative or controlled meeting. The long-standing culture of hierarchy holding power within the NHS appears to be challenging for people to navigate. It seems that when the hierarchy is too engrained in the organisation of a meeting then it is no longer felt by all clinicians to be an open and collaborative space, instead feeling psychologically unsafe and threatening. There is some cross over between this theme and that of 'expectation and reality' with there being a sense of people wanting an open and equal space, but the experience being that only people with power can speak in these spaces. As Lucy said 'the power has gone a bit wobbly' within these meetings. The experience of controlled meetings had a negative impact on people's wellbeing, with a sense of hopelessness over how to be heard coming through. Additionally, many participants reported these spaces as threatening and shaming, further leading them to a position of silence, or absence.

Collaborative meeting, in contrast, were reported as meetings where everyone felt able to share with no reports of threat or shame. However, it seems that achieving collaboration is complex and power needs to be sensitively handled. Staff who were involved in the redesign of one meeting spoke about the importance of stepping away from power dynamics during the consultation and information gathering phase of the process. The success of this process in part was related to stepping away from people in positions of power being the decision makers, providing a trusting platform within which discussions can take place, therefore empowering colleagues to take part in sharing their views and what is needed. This appears to be in line with recommendations by both Koçak (2019) and de Zulueta (2015) who state that creating trusting environments through leadership, as opposed to hierarchy, is an important step to supporting staff involvement in discussions. Importantly, both collaborative and controlled meetings occur within the same team, highlighting the importance of how the spaces come together as opposed to the individuals within them.

Expectation and reality: This theme highlights the importance of clarity over the intention of the meeting. A common experience was that meetings were organised with no explicit framework being offered for the intention of the meeting, despite people wanting and expecting that to happen. This left people with uncertainty about why they were there, and as a result confused about how they were meant to take part. When people were in this position of 'not knowing' it left them feeling less able to participate in the meeting. Interestingly this also applied to situations where people were wanting help from their colleagues, where in the controlled spaces there was an additional layer of threat or judgement, adding to an overall experience of shame when they did not know answers or needed support.

Clearly defined meetings, on the other hand, were experienced as helpful and useful meetings, where people felt able to take part. These were reported as meetings that were free of threat or tension. Overall, the value of these clearly defined meetings appears to have been greater with recognition being given that there were good outcomes at the end, adding to participants sense of achievement and success at work. This finding is in line with Koçak's (2019) recommendation that the creation of a shared understanding, or common conceptual framework, helps the formation of shared goals, and is an important factor in sustaining lateral leadership within teams.

Conflicting vs motivational responsibilities: Participants shared the things which motivate them to speak up in team meetings. Service user advocacy was widely reported as being a positive motivator, seeming to connect to the values of participants as healthcare

providers. However, motivating factors were not always related to service users. Several participants spoke about their concerns about getting things right, or clinical implications of not sharing information. This seemed to speak to participants being in a position of threat, as seen throughout the NHS (George, 2017).

Additionally, several participants spoke about having multiple responsibilities and the internal conflict they experienced regarding speaking up or not. Responsibilities seemed to derive from organisational aspects of holding a meeting, such as being a chair, team orientated responsibilities such as caring for other people's needs, and clinically based responsibilities around sharing clinical information. Navigating the needs of others within a meeting, seemed to prevent people from speaking up or asking for support or help due to fear of adding to the burden others may be experiencing. This did not appear to be something that was ever explicitly discussed, with participants making their own judgements about the needs of other people within the meeting. This connects to 'expectation Vs reality' in terms of there not being explicit conversation about people's responsibilities. However, there appears to be something particularly challenging about responsibility within MDT meetings. It seemed that some participants struggled to let go of some responsibilities, although the reasons for this were not clear from the data. One hypothesis is that this indicates a lack of psychological safety (Edmonson, 1999), and therefore a lack of 'trust' as described by Kleine et al (2019). Without psychological safety there cannot be a trusting environment, according to Klein et al (2019), which would make sharing responsibilities very difficult, creating a cycle of upholding responsibilities, increased stress, and decreased safety.

Interestingly, when considering responsibilities towards colleagues within a meeting, this was not something that seemed to be spoken about when participants were discussing the types of meetings that were viewed as collaborative. This indicates a relationship between collaboration and connection, and people's perceived responsibility to others. This adds weight to the hypothesis that having a trusting and psychologically safe environment results in people feeling that they are not solely responsible for all aspects of the meeting.

Connection: connection was described in many ways, connection to people in the meeting in terms of knowing who is there, knowing their role, feeling supported by people of a similar therapeutic stance, as well as having connection to the wider team or a supportive supervisor. In all examples connection to others was something that supported people's ability to speak up. It is interesting that connection within supervision and feeling safe in supervision was reported as this seems to be an indirect connection that still benefitted

speaking up within team meetings. Additionally, it seemed that having a sense of connection to others within a meeting was helpful in terms of reducing the feelings of threat, particularly when there were colleagues who had similar training or therapeutic backgrounds. This knowledge about colleagues' stances only comes through having opportunities to connect, and it may not be possible to have this in all settings. It may be that connecting through discussion around team values, specifically attempting to foster an environment of innovation and learning as part of a 'team vision' as opposed to focusing on training or experience, would be a useful way forward, in line with work by Edmonson's work on psychological safety (Edmonson 1999 & 2014) and West's work around compassionate teams (West, 2012; West and Chowla, 2017; West, et al., 2011).

When connection was missing however it seemed to not only negatively impact participants ability to speak up within a meeting, but also their wellbeing and sense of purpose within the team or the meeting itself. This later point was surprising, but it seems that connection to others within a meeting supports the understanding of the intention of a meeting and therefore each individual's role within that meeting. Both Koçak (2019) and de Zulueta (2015) reference how supporting connections between colleagues, and other professionals, are important in terms of having positive and responsive relationships within teams.

Throughout the themes there seems to be an undercurrent of threat. Whilst there has been research that has found that working environments within the NHS are often underpinned by the feeling of threat and potential for punishment (George, 2017), it was nonetheless surprising to the researchers that this sense of threat came through in such a small example of the NHS workforce. However, the feeling of being in threat did not always prevent people from being able to speak up, sometimes being a motivating force. However, this fear and threat-based motivation is surely not the optimal position for healthcare workers to be coming from. When considering how to support staff feeling able to speak up this perceived threat seems to be important and should be taken into account as it may prevent team members from risking being seen to be fallible. To have compassionate leadership leaders must be vulnerable, it is not enough to say 'it is safe to make mistakes'; leaders also have to be seen to be making the mistakes, they must also take risks. This crosses over with the work of Amy Edmonson (Edmonson, 1999 & 2014) and Michael West (West, 2012; West and Chowla, 2017; West, et al., 2011), however a full exploration of this is beyond the scope of this paper.

It would feel remiss to present any research or discussion about working in the contemporary NHS without acknowledging the dramatic impact that the covid-19 pandemic

has had upon healthcare workers throughout the UK, with the participants of this paper having meetings both online and in person. Meeting virtually has been found to be qualitatively different to face to face meetings, which healthcare workers describe as being an important factor in them building stronger relationships with their colleagues, supportive and encouraging of more robust conversations than their online counterparts, and richer in terms of spotting non-verbal cues from colleagues within the meeting (Sidpra, et al., 2020). There is a consensus that that virtual MDT meetings work well and have good outcomes even if nuance within conversations can sometimes be lacking. It is therefore likely that virtual meetings will remain a part of MDT working for the foreseeable future, far beyond Covid-19 (Curie, et al., 2021). It is important that moving into the future teams consider the impact of virtual meetings on the experience of being in an MDT meeting.

Limitations and future research

This study aimed to increase understanding of factors that supported or prevented staff from being able to speak up during team meetings. This study was conducted in one team, within one health board in the UK with self-volunteered participants. This was a choice was made by the research team to focus on one setting, aiming to get a rich understanding across the hierarchy of the experiences of one homogenous team as opposed to snapshots from multiple teams. As a result, the findings of this study may not apply to all settings. This being said, it is felt that the current findings add to the growing body of work looking at MDT functioning.

An interesting element of the findings was the variation in how threat was experienced by participants. The experience of threat itself was not specifically explored in this study, however it seems to be having a significant impact on staff's ability to speak up as well as their wellbeing. It seems that this is a gap in the current study that could be explored more explicitly in future research. Additionally, the personal sense of responsibility many participants reported, which feels like it is linked to the feeling of threat, would be an interesting avenue to explore more robustly in the future.

The data collection for the current study occurred between December 2021 and the end of February 2022, as healthcare systems were still in a state of recovery from the covid-19 pandemic. It is likely that the pandemic and subsequent restrictions and changes to how people were working impacted the findings of the current study, although it is impossible to

untangle any influence with the current methodology. This would be an interesting consideration for future research.

Implications

These findings provide an insight into what may support staff in feeling able to speak up within this CAMHS setting, and by implication possibly other MDT settings. Specifically, the above findings suggest that it could be helpful to step away from hierarchical power being central to MDT meetings, moving towards positions of leadership instead.

This could include, but is not limited to the following, in line with Koçak (2019) and de Zulueta (2015):

- Training regarding leadership, and the ethos behind it to those in positions of power.
    - One example of training which highlights the philosophically different stance of 'leadership' vs power-based management is the Affina team journey, which was reviewed positively by Kilgannon (2019).
- Creating meaningful opportunities for connection between colleagues to develop a shared understanding between professionals.
    - This could be achieved through team away days and peer discussions as advocated by the Choice and Partnership Approach (York & Kingsbury, 2013).
- consultation with staff when designing or reviewing the function of a meeting.
    - The goal and the ultimate outcome may be the same in some instances, but this process will likely result in a safer environment. The emphasis is not on changing what happens, but changing how it is done.
- being mindful of the state of threat that may be underpinning people's difficulties and the impact language can have on this.
    - This is in acknowledgement that leaders have a role to play in terms of creating and supporting a safe environment through, for example, their language and modelling of fallibility.

Conclusion

The current paper focuses on the experiences of team members. However, it provides important insights for team leads and senior members of staff in terms of supporting the creation of psychologically safe spaces, embodying the concept of leadership as opposed to the traditional hierarchical way of working within the NHS. Of note is the finding that the creation of safe spaces is an effortful process that involves consultation, ongoing discussion and exploration, and active maintenance. It is not enough to model safety this must be created. Clinical Psychologists, with their core training in reflexive practice, systemic thinking, and formulation, and holding difficult or challenging conversations are well placed to take a role in this process. It would be important however that staff who are involved in the process are mindful of existing power structures, with effort being made to support psychological safety to circumnavigate the risk of the process itself being threatening. It is important to note that other members of a team can also take part in these processes. Specifically, team leads, senior members of staff, and other people in positions of power can be supported to be open to feedback and altering ways of working to support the team as a whole feeling empowered, heard, valued, and most importantly safe. Where Clinical Psychologists are not available within the team consultation or external supervision would likely be a worthwhile addition to supporting the process of change within a team, given their training in reflexive practice and systemic thinking.

References

Ancarani, A., Ayach, A., Di Mauro, C., Gitto, S., & Mancuso, P. (2016). Does religious diversity in health team composition affect efficiency? Evidence from Dubai. *British Journal of Management*, *27*(4), 740-759.

Atwal, A., & Caldwell, K. (2005). Do all health and social care professionals interact equally: a study of interactions in multidisciplinary teams in the United Kingdom. *Scandinavian Journal of Caring Sciences*, *19*(3), 268-273.

Barrett, S. (2019). From adult lunatic asylums to CAMHS community care: the evolution of specialist mental health care for children and adolescents 1948-2018. *Revue Française de Civilisation Britannique. French Journal of British Studies*, *24*(XXIV-3).

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Caldwell, K., & Atwal, A. (2003). The problems of interprofessional healthcare practice in hospitals. *British Journal of Nursing*, *12*(20), 1212-1218.

Clarke, V., & Braun, V. (2013). Successful qualitative research. SAGE Publications.

Cronin, M. A., & Weingart, L. R. (2007). Representational gaps, information processing, and conflict in functionally diverse teams. *Academy of management review*, *32*(3), 761-773.

Currie, G. P., Kennedy, A. M., & Chetty, M. (2021). Covid-19 and the Multidisciplinary Team Meeting:'Should Old Acquaintance be Forgot?'. *Journal of the Royal College of Physicians of Edinburgh*, *51*(4), 327-329.

Davies, H. T. O., Mannion, R., Jacobs, R., Powell, A. E., & Marshall, M. N. (2007). Exploring the relationship between senior management team culture and hospital performance. *Medical care research and review*, *64*(1), 46-65.

de Zulueta, P. C. (2015). Developing compassionate leadership in health care: an integrative review. *Journal of healthcare leadership*, 1-10.

Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative science quarterly*, *44*(2), 350-383.

Edmondson, A. (2014, May 5). Building a Psychologically Safe Workplace. *TEDx Harvard Graduate School of Education*.

Forsyth, C., & Mason, B. (2017). Shared leadership and group identification in healthcare: The leadership beliefs of clinicians working in interprofessional teams. *Journal of Interprofessional Care*, *31*(3), 291-299.

Fournier, P. L., Bahl, L., van Dun, D. H., Johnson, K. J., & Cadieux, J. (2023). Let's talk about it: the impact of nurses' implicit voice theories on individual agility and quality of care. *International Journal of Operations & Production Management*.

George, M. (2017). How traditional management approaches damage staff wellbeing. *Nursing Times*, *113*, 35-38.

Kilgannon, H. (2019). Supporting the leadership development of Integrated Team Leaders; applying the essential building blocks to support and improve team performance.

Kleine, A. K., Rudolph, C. W., & Zacher, H. (2019). Thriving at work: A meta-analysis. *Journal of Organizational Behavior*, *40*(9-10), 973-999.

Koçak, R. D. (2019). Leadership without hierarchy and authority: Lateral leadership. *International Journal of Social Inquiry*, *12*(2), 657-680.

Kulesher, R., & Forrestal, E. (2014). International models of health systems financing. *Journal of Hospital Administration*, *3*(4), 127-139.

Meterko, M., Mohr, D. C., & Young, G. J. (2004). Teamwork culture and patient satisfaction in hospitals. *Medical care*, 492-498.

Morton, G., Masters, J., & Cowburn, P. J. (2018). Multidisciplinary team approach to heart failure management. *Heart*, *104*(16), 1376-1382.

NHS Data Model and Dictionary. Multidisciplinary Team. NHS Business definitions, 2023. Available online: https://www.datadictionary.nhs.uk/nhs_business_definitions/multidisciplinary_team.html

O'donovan, R., & Mcauliffe, E. (2020). A systematic review of factors that enable psychological safety in healthcare teams. *International journal for quality in health care*, *32*(4), 240-250.

Papadopoullos, R., Fisher, P., Leddy, A., Maxwell, S., & Hodgekins, J. (2022). Diagnosis and dilemma: Clinician experiences of the use of 'borderline personality

disorder'diagnosis in children and adolescents. *Personality and Mental Health*, *16*(4), 300-308.

Rauf, B., Sheikh, H., Majid, H., Roy, A., & Pathania, R. (2021). COVID-19-related prescribing challenge in intellectual disability. *BJPsych Open*, *7*(2), e66.

Reitz, M., & Higgins, J. (2020). Speaking truth to power: why leaders cannot hear what they need to hear. *BMJ Leader*, leader-2020.

Sidpra, J., Chhabda, S., Gaier, C., Alwis, A., Kumar, N., & Mankad, K. (2020). Virtual multidisciplinary team meetings in the age of COVID-19: an effective and pragmatic alternative. *Quantitative imaging in medicine and surgery*, *10*(6), 1204.

Smart, C., Pollock, C., Aikman, L., & Willoughby, E. (2018). Power struggles in MDT meetings: Using different orders of interaction to understand the interplay of hierarchy, knowledge and accountability. In *Interprofessional Care and Mental Health: A Discursive Exploration of Team Meeting Practices* (pp. 97-121). Springer International Publishing.

United Kingdom National Health Service. Achieving world-class cancer outcomes: a strategy for England 2015– 2020. 2017. Available online: https://www.england.nhs.uk/publication/achieving-world-class-cancer-outcomes-a-strategy-for-england-2015-2020/

West, M. (2012). *Effective Teamwork: Practical lessons from organisational research* (3rd ed.). Blackwell.

West, M., & Chowla, R. (2017). Compassionate leadership for compassionate health care. In P. Gilbert (Ed.), *Compassion: Concepts, Research and Applications* (pp. 237–257). Routledge. https://doi.org/10.4324/9781315564296-14

West, M., Dawson, J., Admasachew, L., & Topakas, A. (2011). *NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215455/dh_129656.pdf

York, A., & Kingsbury, S. (2013). CAPA: The choice and partnership approach: A service transformation model. CAPA Systems Limited.

Appendices

a) Interview procedure

I. Email correspondence with each participant to answer questions, provide documentation and information sheet and organise when the interview could take place.
II. Up to 15 minutes of the initial meeting dedicated to having 'natural' conversation and rapport building between researcher and participant.
    a. Opportunity to answer remaining/outstanding questions, check consent, and settle nerves/apprehension
III. Commence recording of interview (letting participants know that they would now be recorded, double check consent to proceed). Continue with the following statement, read verbatim at the start of the formal interview.

Initial question

"I'd like to talk to you today about times you have or have not felt able to talk in an MDT setting, this includes meetings or training or any situation where the MDT is working together. At times you may think about and discuss previous roles or previous experiences but I'll always trying to draw it back to our current role within the present team. I wonder if you have got any examples that you feel able to talk about or to share that have come to mind?

Prompts

Are there any factors that you think contributed to you speaking/not speaking?

How did it feel speaking/not speaking?

Do you think this is a typical example of your time within your current team? (If not was there anything that resulted in this anomaly?)

Do you have an example where you felt able/not able (depending on first example discussed) to speak up?

'Can you tell me more about that?' As a general open follow up, and clarification from the interviewer to check understanding where needed.

b) Information sheet

Project Title: Speaking up or not speaking up within an MDT setting: An exploration of voice in CAMHS"

Invitation and brief summary

We are conducting a research study to explore how we communicate within multidisciplinary teams. The importance of multidisciplinary working is well established, but currently there is limited research exploring what supports effective communication by all team members. The evidence that is available is mostly based on how people talk about team working. We would like to explore staff's perspectives on what helps or prevents them from speaking up within an MDT setting.

We are hoping that this is an opportunity to develop more understanding and to support the development of safe, inclusive and effective teams. We are hoping to explore different aspects of MDT functioning and are therefore inviting anyone within the team to take part.

What's involved?

Where logistically possible, a researcher will interview you face to face. Where this is not logistically feasible the interviews will be held over the online platform 'Microsoft Teams'. Each interview will be recorded on a Dictaphone. This data will then be transferred to an encrypted USB device.

Protecting your confidentiality so that you can speak openly is very important. We will transfer data securely using encrypted USB devices and within 72 hours of receipt we will have anonymised any identifiable information including the identity and location of you and your team. You may request for any part the transcript to be removed from the data set at any time

This research is focused upon your own experiences. The interviewer will invite you to answer questions about your experiences of working within an MDT setting and what might affect whether you decide to speak up, or not, within this setting.

The findings of the research will be fed back to you, both in written form, and should you wish, through aural presentation. As the data will be anonymised to protect your confidentiality, feedback will include the emerging themes and concepts rather than identifiable individual data.

What are the possible benefits of taking part?

Participation within the research will give you the opportunity to reflect on how your team works, and any barriers to communication you have experienced. It would also enable you to contribute to a project that is likely to have positive benefits for the development of staff teams across healthcare settings. As a participant you will also have the opportunity to ask any questions that you might have about this research, and we can provide background information to support any elements you wish to explore further in your service.

What are the possible disadvantages and risks of taking part?

It is possible when discussing relationships and events in the workplace that something may be raised that suggests a possible risk to yourself or others, or a significant and immediate risk to the public. If a serious risk was identified then this would be escalated, following standard organisational procedures. It is important to note that researchers would only break confidentiality and escalate matters if the risk identified was very serious, such as malpractice which poses an immediate risk to the public.

It is possible that people who participate in this research may become upset or distressed when discussing difficult or challenging aspects of team working. If this is the case information regarding supportive services will be provided. This will include internal services provided by Betsi Cadwalader University Health board, as well as external sources of support.

How will we use information about you?

We will need to use information from you for this research project.
This information will include your name and where you work. People will use this information to do the research or to check your records to make sure that the research is being done properly.
People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.
We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from Erica Willoughby
- by asking one of the research team
- by sending an email to Erica Willoughby on rcw19lbf@bangor.ac.uk, Elizbeth Burnside on e.burnside@bangor.ac.uk, or
- by ringing us on 01248 382204. Erica Or Elizabeth will be able to direct you directly to the University's Data Protection Officer, Gwenan Hine, Head of Governance and Compliance.

Further questions

- *Do I have to take part?*

You do not have to take part if you do not want to. Furthermore, if you do chose to take part but change your mind at a later date decide that you would prefer for you data to be withdrawn from the study you can contact the research team and any relevant data will be withdrawn. All participants who take part in will receive a £20 amazon gift card.

- *What will happen if I don't want to carry on with the study?*

Participation in the study is entirely voluntary, and you are free to withdraw participation at any time. If your data has already been collected, then you are free to withdraw consent up until June 2023, as after this date it will have been published. After publication participants can request that researchers destroy any data that remains in storage, as per university guidelines.

- *What if I am unhappy with something?*

If you have any questions or concerns about the research, then please do not hesitate to email any one of the researchers.

Additionally, should you be struggling with anything that the research has raised for you we have supplied contact details for services which may be helpful below.

Supportive services

BCUHB Occupational Health and wellbeing service: 03000 853853 (8:30 – 17:00)

Staff Wellbeing Support Service (SWSS): 03000 855924

Samaritans: tel – 116123, email – jo@samaritans.org

- *How will my information be kept confidential?*

Interview data will be given numerical names for storage purposes. Any references or use of names will be anonymised within the recording, by recording over each bit of identifiable information, so that this cannot be heard, before being transcribed. Careful selection will be made of quotations used within the write up of findings that do not refer to recognisable information.

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

A written summary of the study will be shared with participants once the project is completed. Colleagues within the health board might also have an interest in the findings and an appropriate opportunity and forum will be identified at that time, such as a power point presentation or research discussion. Additionally, the results of this study will hopefully

be published within a relevant journal. It is important to note that confidentially will be strictly adhered to throughout all stages of the research, including dissemination of findings.

- *Who is organising and funding this study?*

The study is being sponsored by Bangor University. One of the researchers is a Clinical Psychology Doctoral student and will use the research as part of their doctoral thesis. Another researcher, Dr Elizabeth Burnside is the academic director for the clinical psychology programme at Bangor University. Dr David Oakley is a local clinician who has an interest in team working, team dynamics, and creating psychologically safer working environments within the NHS.

- *Who has reviewed this study?*

The study has been reviewed by the ethics committee for the school of psychology within Bangor University.

For further information, and to take part, please contact:

Erica Willoughby at rcw19lbf@bangor.ac.uk

c) Consent form

Site file copy

Participant Consent Form

Participant number:

Consent Form

Title of Project: Speaking up or not speaking up within an MDT setting: An exploration of voice in CAMHS"

Name of Researchers: Dr Elizabeth Burnside, Erica Willoughby, and Dr David Oakley

Please initial each box and sign at the bottom.

1. I confirm that I have read and understand the information sheet **(v3 28/11/2022)** for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is entirely voluntary and that I am free to withhold my consent without giving any reason. ☐
3. I agree to being audio-recorded. ☐
4. I understand that I can review what I have said within the transcript and can request to withdraw my input in part or in its entirety until April 2023. ☐
5. I agree to take part in the above study. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Participant copy

Participant Consent Form

Participant number:

Consent Form

Title of Project: Speaking up or not speaking up within an MDT setting: An exploration of voice in CAMHS"

Name of Researchers: Dr Elizabeth Burnside, Erica Willoughby, and Dr David Oakley

Please initial each box and sign at the bottom.

6. I confirm that I have read and understand the information sheet **(v3 28/11/2022)** for the above study and have had the opportunity to ask questions. ☐
7. I understand that my participation is entirely voluntary and that I am free to withhold my consent without giving any reason. ☐
8. I agree to being audio-recorded. ☐
9. I understand that I can review what I have said within the transcript and can request to withdraw my input in part or in its entirety until April 2023. ☐
10. I agree to take part in the above study. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

d) Debrief form

Debrief Form

Title of Project: Speaking up or not speaking up within an MDT setting: An exploration of voice in CAMHS"

Name of Researchers: Dr Elizabeth Burnside, Erica Willoughby, and Dr David Oakley

Thank you for taking part in our research. The data we have collected will now be analysed carefully for areas of interest.

If you have any questions about the research, then please do not hesitate to email any one of the researchers. We have attached information about the study below and will be in touch with any relevant findings once the data has been processed and the research has been written up.

Additionally, should you be struggling with anything that the research has raised for you we have supplied contact details for services which may be helpful below.

Please be reminded that you are free to withdraw your data from the study if you wish to do so. If you would like any data to be excluded from the study, please request this before June 2023 as after this date the research will be published.

Once again, thank you for allowing us to collect data from you and the team you are a part of.

Sincerely,

Dr Elizabeth Burnside, Erica Willoughby, and Dr David Oakley

For further information, please contact:

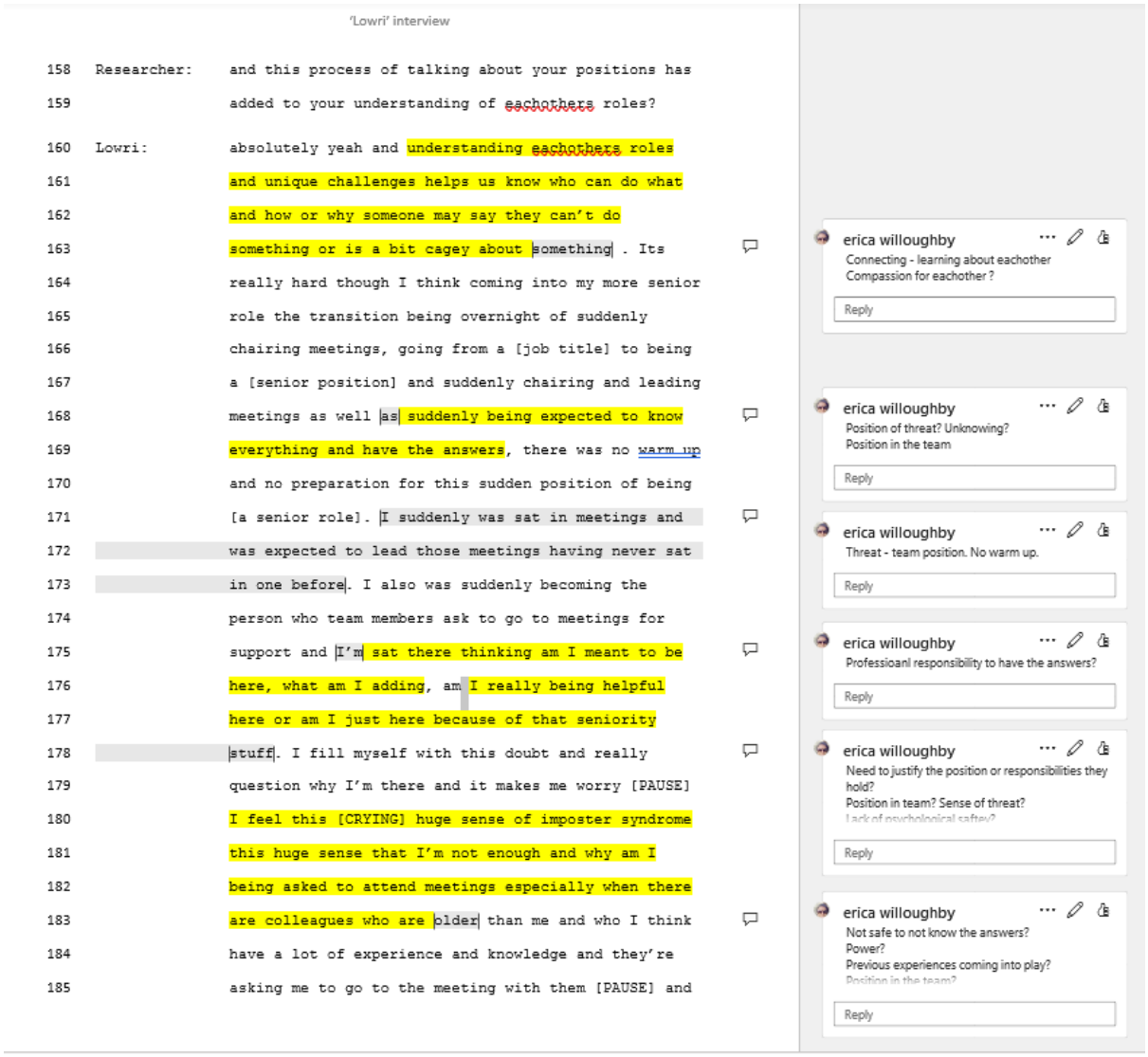
If you would like further information, please contact:

Erica Willoughby at rcw19lbf@bangor.ac.uk

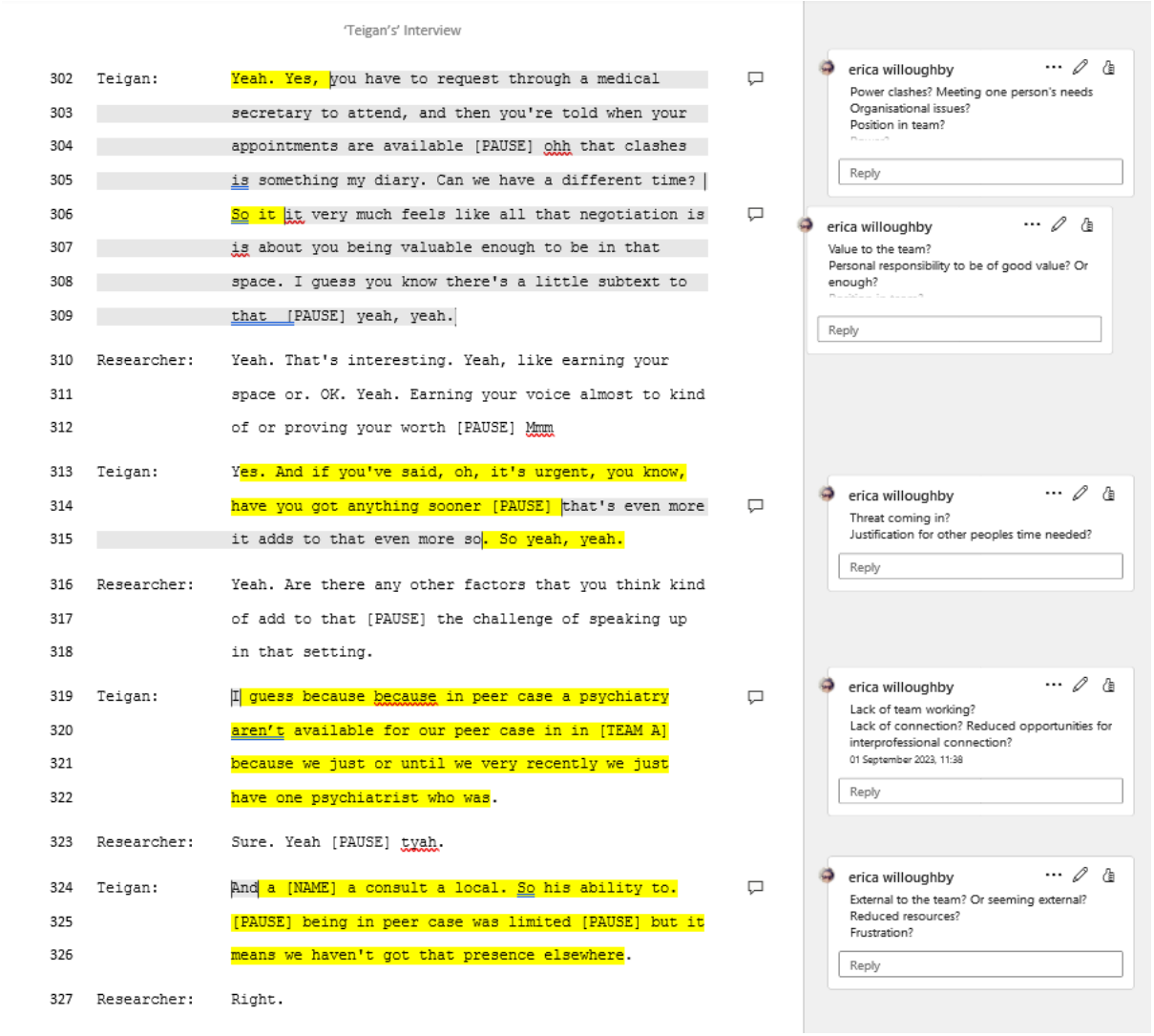
Supportive services
BCUHB Occupational Health and wellbeing service: 03000 853853 (8:30 – 17:00)
Staff Wellbeing Support Service (SWSS): 03000 855924
Samaritans: tel – 116123, email – jo@samaritans.org

e) Excerpt of coded transcripts

i. Extract from interview with ‘Lowri’



ii. Extract from interview with ‘Teigan’



‘Teigan’s’ Interview

302 Teigan: Yeah. Yes, you have to request through a medical
303 secretary to attend, and then you're told when your
304 appointments are available [PAUSE] ohh that clashes
305 is something my diary. Can we have a different time?
306 So it it very much feels like all that negotiation is
307 is about you being valuable enough to be in that
308 space. I guess you know there's a little subtext to
309 that [PAUSE] yeah, yeah.

310 Researcher: Yeah. That's interesting. Yeah, like earning your
311 space or. OK. Yeah. Earning your voice almost to kind
312 of or proving your worth [PAUSE] Mmm

313 Teigan: Yes. And if you've said, oh, it's urgent, you know,
314 have you got anything sooner [PAUSE] that's even more
315 it adds to that even more so. So yeah, yeah.

316 Researcher: Yeah. Are there any other factors that you think kind
317 of add to that [PAUSE] the challenge of speaking up
318 in that setting.

319 Teigan: I guess because because in peer case a psychiatry
320 aren't available for our peer case in in [TEAM A]
321 because we just or until we very recently we just
322 have one psychiatrist who was.

323 Researcher: Sure. Yeah [PAUSE] tyah.

324 Teigan: And a [NAME] a consult a local. So his ability to.
325 [PAUSE] being in peer case was limited [PAUSE] but it
326 means we haven't got that presence elsewhere.

327 Researcher: Right.

erica willoughby
Power clashes? Meeting one person's needs
Organisational issues?
Position in team?
Reply

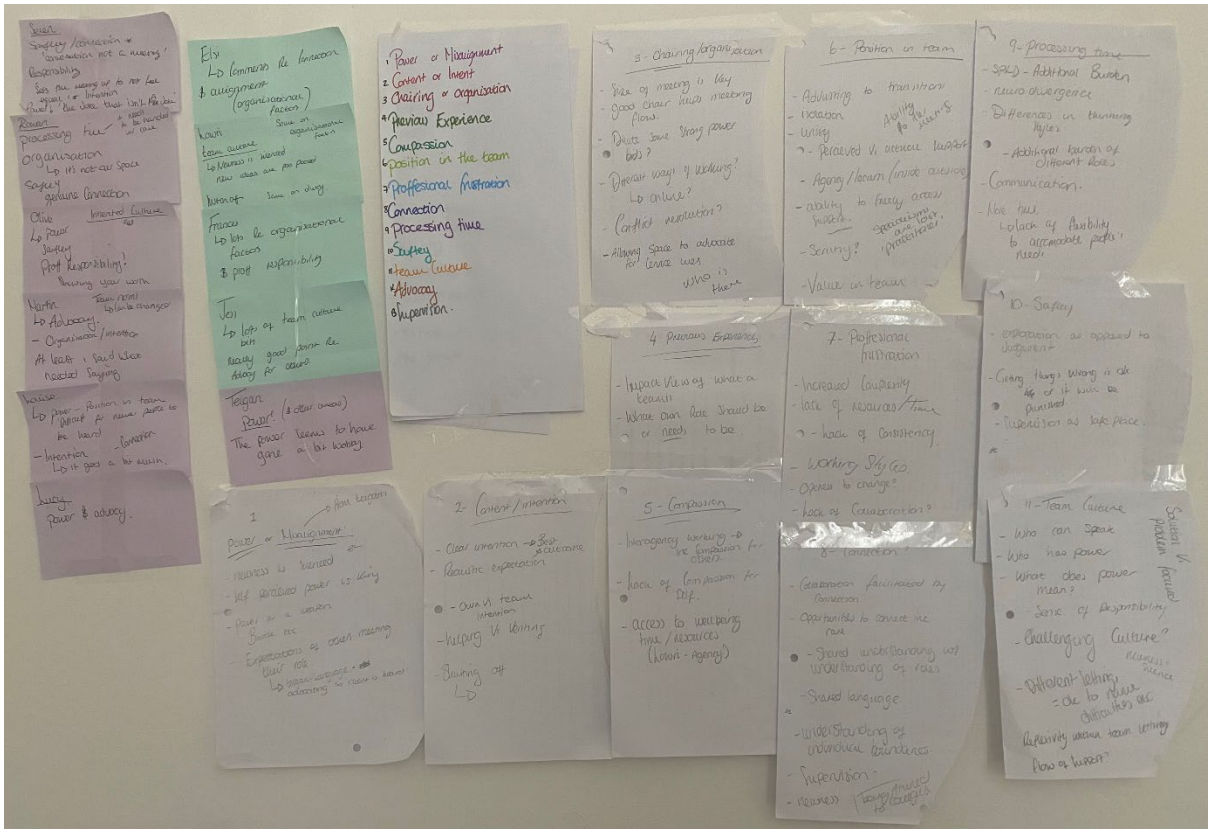
erica willoughby
Value to the team?
Personal responsibility to be of good value? Or enough?
Reply

erica willoughby
Threat coming in?
Justification for other peoples time needed?
Reply

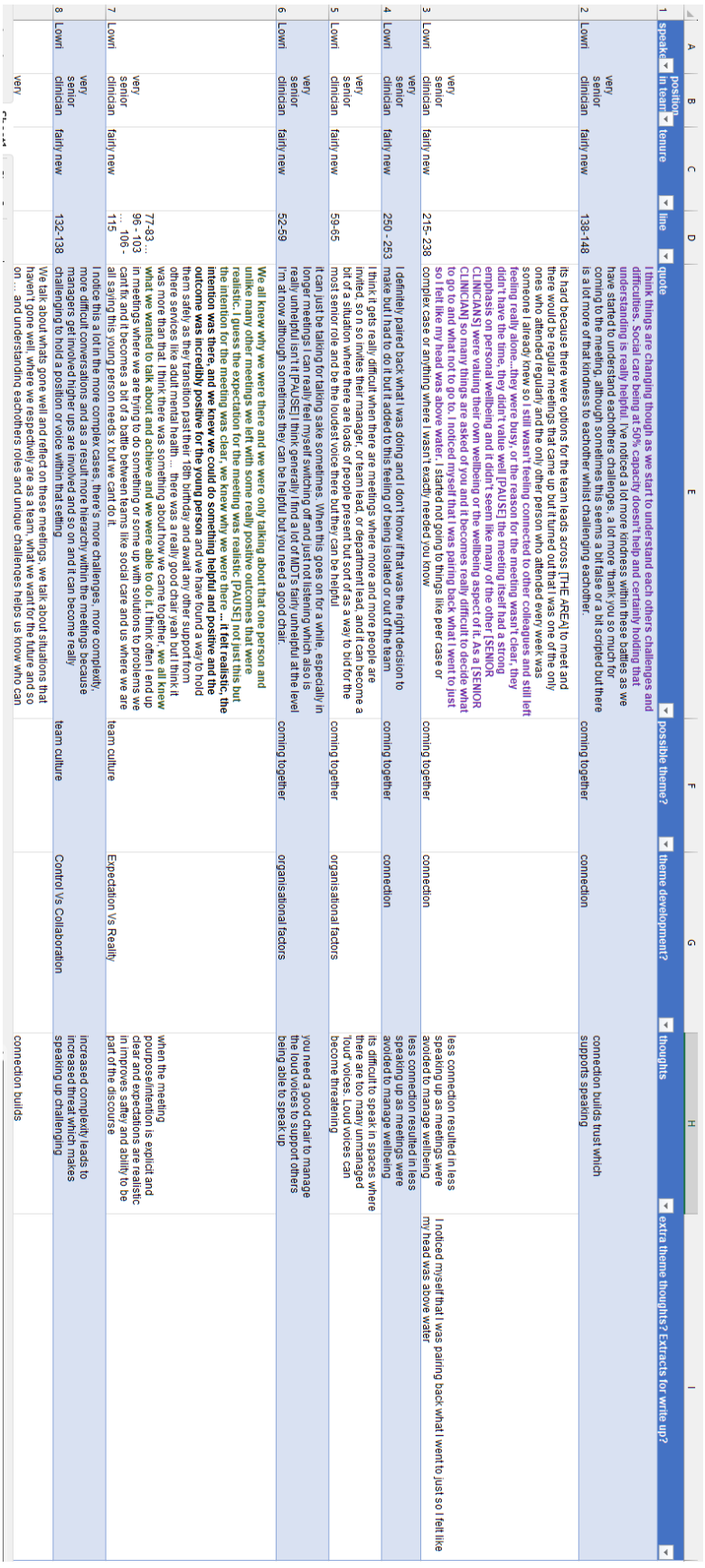
erica willoughby
Lack of team working?
Lack of connection? Reduced opportunities for interprofessional connection?
01 September 2023, 11:38
Reply

erica willoughby
External to the team? Or seeming external?
Reduced resources?
Frustration?
Reply

f) Example of part of the process of coding across the data set



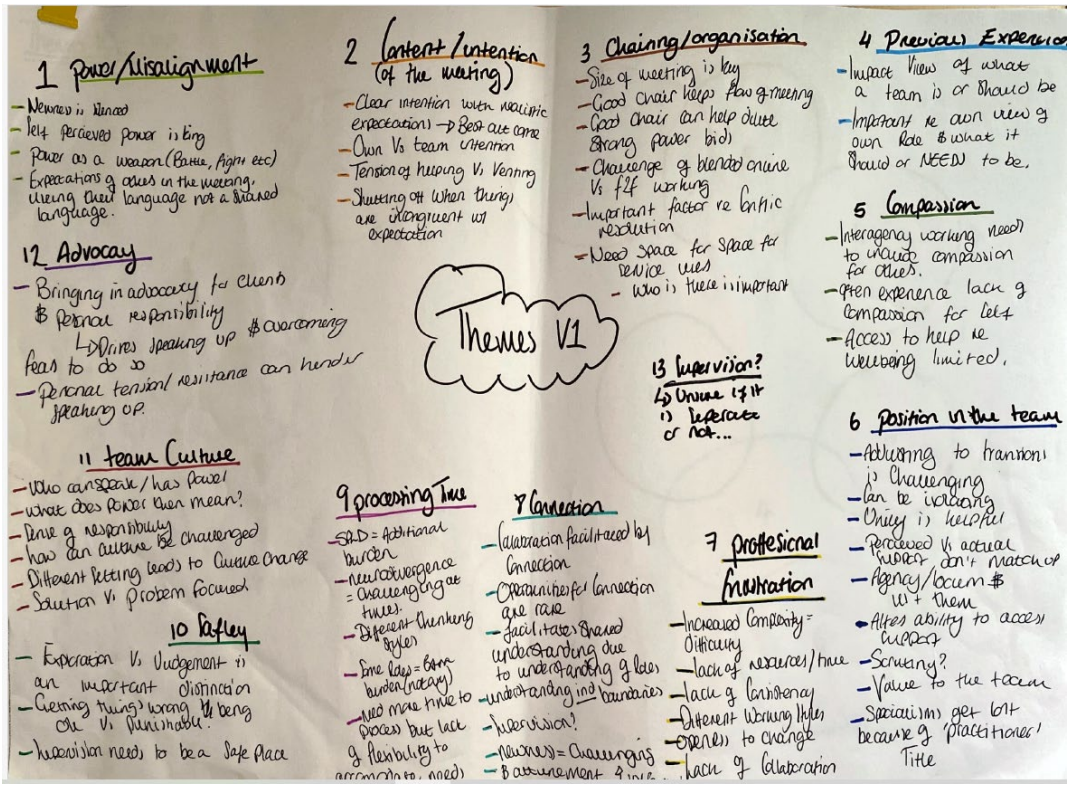
g) Example of part of the theme identification process



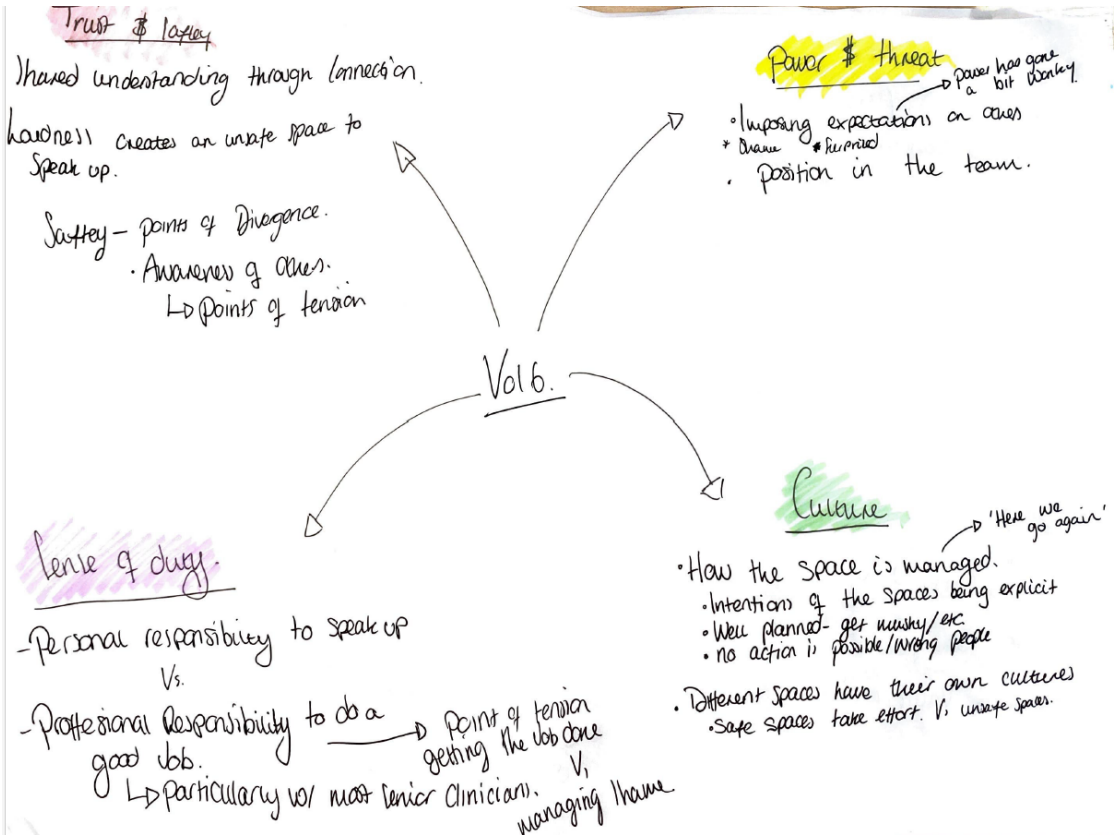
	A	B	C	D	E	F	G	H	I
1	speaker	position in team	tenure	line	quote	possible theme?	theme development?	thoughts	extra theme thoughts? Extracts for write up?
2	Lowri	very senior clinician	fairly new	138-148	its hard because there were options for the team leads across [THE AREA] to meet and there would be regular meetings that came up but it turned out that i was one of the only ones who attended regularly and the only other person who attended every week was someone I already knew so I still wasn't feeling connected to other colleagues and still left feeling really alone...they were busy, or the reason for the meeting wasn't clear, they didn't have the time, they didn't value well [PAUSE] the meeting itself had a strong emphasis on personal wellbeing and it didn't seem like many of the other [SENIOR CLINICIAN] were valuing their own wellbeing or the wellbeing aspect of it. As a [SENIOR CLINICIAN] so many things are asked of you and it becomes really difficult to decide what to go to and what not to go to. I noticed myself that I was pairing back what I went to just so I felt like my head was above water. I started not going to things like peer case or	coming together	connection	connection builds trust which supports speaking	
3	Lowri	very senior clinician	fairly new	215- 238	complex case or anything where I wasn't exactly needed you know	coming together	connection	less connection resulted in less speaking up as meetings were avoided to manage wellbeing	I noticed myself that I was pairing back what I went to just so I felt like my head was above water
4	Lowri	very senior clinician	fairly new	250 - 253	I definitely paired back what I was doing and I don't know if that was the right decision to make but I had to do it but it added to this feeling of being isolated or out of the team	coming together	connection	less connection resulted in less speaking up as meetings were avoided to manage wellbeing	
5	Lowri	very senior clinician	fairly new	59-65	I think it gets really difficult when there are meetings where more and more people are invited, so n so invites their manager, or team lead, or department lead, and it can become a bit of a situation where there are loads of people present but sort of as a way to bid for the most senior role and be the loudest voice there but they can be helpful	coming together	organisational factors	its difficult to speak in spaces where there are too many unmanaged 'loud' voices. Loud voices can become threatening	
6	Lowri	very senior clinician	fairly new	52-59	it can just be talking for talking sake sometimes. When this goes on for a while, especially in longer meetings I can really feel myself switching off and just not listening which also is really unhelpful isn't it [PAUSE] I think generally I find a lot of MDTs fairly unhelpful at the level I'm at now although sometimes they can be helpful but you need a good chair.	coming together	organisational factors	you need a good chair to manage the loud voices to support others being able to speak up	
7	Lowri	very senior clinician	fairly new	77-83... 96 - 103 ... 106 - 115	**We all knew why we were there and we were only talking about that one person and unlike many other meetings we left with some really positive outcomes that were realistic. I guess the expectation for the meeting was realistic [PAUSE] not just this but the intention for the meeting was clear, we knew why we were there... it felt realistic, the intention was there, and we knew we could do something helpful and positive and the outcome was incredibly positive for the young person** and we have found a way to hold them safely as they transition past their 18th birthday and await any other support from where services like adult mental health ... there was a really good chair yeah but I think it was more than that. I think there was something about how we came together, we all knew what we wanted to talk about and achieve and we were able to do it. I think often I end up in meetings where we are trying to do something or some up with solutions to problems we cant fix and it becomes a bit of a battle between teams like social care and us where we are all saying this young person needs x but we cant do it	team culture	Expectation Vs Reality	when the meeting pourpose/intention is explicit and clear and expectations are realistic in improves saftey and ability to be part of the discourse	
8	Lowri	very senior clinician	fairly new	132-138	I notice this a lot in the more complex cases, there's more challenges, more complexity, more difficult conversations and as a result more hierarchy within the meetings because managers get involved higher ups are involved and so on and it can become really challenging to hold a position or voice within that setting	team culture	Control Vs Collaboration	increased complexity leads to increased threat which makes speaking up challenging	
		very			We talk about whats gone well and reflect on these meetings, we talk about situations that haven't gone well, where we respectively are as a team, what we want for the future and so on... and understanding eachothers roles and unique challenges helps us know who can			connection builds	

h) Example of the development of thematic maps

i. Volume one of theme development



ii. Volume 6 of theme development



i) Summary of theme contributions

Theme	Lowri	Teigan	Elsi	Frances	Jess	Lucy	Louise	Martin	Rowan	Olive	Seren
Control Vs Collaboration	I	I	I	I	I	I	I	I		I	I
Expectation Vs reality	I	I	I	I	I	I	I	I	I	I	I
Conflicting Vs aligned responsibilities	I	I	I	I	I			I		I	I
Connection	I	I	I	I	I	I	I		I	I	I

Chapter three – Contributions to theory and clinical practice

CONTRIBUTIONS TO THEORY AND CLINICAL PRACTICE AND REFLECTIVE COMMENTARY

This chapter will attempt to summarise the contributions to theory and clinical practice which the first two papers offer. This will be followed by a reflective commentary about the research process and considerations for the future.

Contributions to theory and clinical practice

Chapter one

The literature review investigated how clinical staff within the NHS experienced burnout through the covid-19 pandemic. Thematic-meta-synthesis was used to analyse data from 11 papers that were selected for inclusion in this review, as summarised in chapter one.

The themes that were identified through this thematic-meta-synthesis were as follows: ‘Our hands were tied’, ‘you put yourself last’, ‘hey we’re all here, where are you?’, ‘you need to have somebody to offload to’, ‘our voices were quashed’, and ‘I found that really hard’. The findings of this chapter however seem to go beyond just the covid-19 pandemic, unveiling areas within the NHS where imbedded culture may be problematic.

Chapter one provides support for the model of job dissatisfactions, burnout, and alienation as described by Iliffe and Manthorpe (2019), a development from Maslach and Jackson’s (1981) definition of burnout. It is particularly interesting to consider the nuanced Iliffe and Manthorpe (2019) model as it gives a significant amount of value to individual factors that influence the development of burnout and alienation, summarised in Figure 1 in Chapter one. Something of interest is the lack of clarity around what the negative consequence of

workplace difficulty of ‘self-harm’ is referring to. Within the current review staff not prioritising their wellbeing could be interpreted as ‘self-harm’ due to their actions causing them harm in the long-term, however there was no evidence of staff reporting self-injurious behaviours that are more typically associated with the phrase ‘self-harm’. It is not clear whether the authors of this model intended self-harm to refer to the broader ‘wellbeing’ orientated interpretation of or the more typical definition of self-harm as self-injurious behaviours. Moving into the future it would be interesting to look at this aspect of the model.

Similar to Iliffe and Manthorpe (2019) the findings of the literature review provide insight into how best to repair issues relating to workplace challenges. This includes looking at improving relationships between clinical staff and clinical and non-clinical management, supporting staff to meaningfully access support, and supporting staff to navigate moral injury and connect with their values. At a team level change can be made to improve staff’s experience of working within the NHS, such as by creating meaningful opportunities for team members to connect to other team members as well as with other individuals and teams within the wider health system. Additionally, flattening hierarchies within teams, prioritising self-care, and improving access to psychological support may all help staff better navigate challenges of working within the NHS. However, some recommendations would require a commitment from management and executives within health boards. Additionally, the findings of the first chapter highlight the need for meaningful connection between management and clinical staff.

When considering the factors that contribute to burnout, and possible development of alienation, it is likely that it is more than just ‘being at work’ that adds to the experience of feeling overwhelmed. The cumulative impact of multiple negative or challenging experiences adds to job dissatisfaction, burnout, and alienation. This is also influenced by individual factors and personal characteristics such as coping styles and resilience as well as personal circumstances or life events outside of work. It is not a simple equation, and as a result there is no ‘one size fits all’ answer to supporting staff. There are numerous ways to support staff in mitigating the negative aspects of working within the NHS. Ultimately it is up to teams and health boards to be flexible to support changing needs of staff. Whilst clinical work can be challenging, having appropriate support systems around staff can help staff navigate these challenges successfully and protect them from feeling overwhelmed and burnt out.

Jordache, as part of Morbley (2017, pg 1) stated: ‘If burnout is not tackled, the NHS will fail’, this highlights the importance of tackling burnout. The findings of the current literature review suggest that tackling the issue of burnout within the NHS can be achieved by tackling ingrained cultural aspects of working within the NHS, and normalisation of self-sacrifice

within NHS staff groups, highlighting the importance of this literature review being specifically on NHS staff groups.

Chapter two

The second chapter aimed to investigate staff's experiences of speaking up within multi-disciplinary team meetings, looking at factors which supported or hindered their ability to speak up. Staff were recruited from a Child and Adolescent Mental Health Team, with 11 members of the clinical team sharing their reflections. After analysis four themes were identified, control Vs collaboration, expectation Vs reality, conflicting Vs aligned responsibilities, and connection. Control, Vs collaboration described different meetings that participants experienced. Some meetings were collaborative where everyone felt able to speak up free of judgement. Within these collaborative meetings Seren described that there wasn't a question about whether she should speak up, she just did, a sentiment shared by other participants. These collaborative meetings seemed to be free from the experience of threat and were often described as 'safe' but there was acknowledgement that these meetings required effort to create and maintain. The controlled meetings on the other hand were described as more hierarchically and were experienced a punitive and threatening. The theme 'expectation Vs reality' described the different ways in which participants expectations for a meeting did not match up with the reality of being within that meeting. A common thread within this theme was participants wanting some sort of explicit statement re the function or organisation of the meeting, but that this was often missing. This created an additional barrier to participants being able to speak up as they were uncertain of their role, the intention of the meeting, or did not know how the meeting was going to go. This uncertainty added to staff's experience of threat, as they seemed concerned about getting it wrong, or being seen to be getting it wrong. The theme of conflicting Vs motivational responsibilities described the experience of having different responsibilities within a meeting, and the impact this had in terms of their ability to speak up. Following on from 'expectation Vs reality' these responsibilities were rarely explicitly discussed, typically being responsibilities participants believed were theirs to uphold. Motivational responsibilities largely focused on advocacy for service users, although this was not always free of threat. Conflicting responsibilities occurred when people reported holding multiple roles in a meeting. These related to staff wellbeing, organisation of a meeting, and sharing of clinical information. In these instances, participants described feeling unsure of when to speak or not speak, describing feeling like they were silencing themselves at times. The final theme of connection described how a sense of connection was helpful in terms of speaking up. This

connection could come in the form of knowing who was attending a meeting, knowing what their roles were, feeling aligned to someone in terms of therapeutic stance or training, or having a good supervisor. However, the connection arose, it was consistently a helpful thing that supported feeling safe to speak up. When connection was missing it not only hindered participants ability to speak up within a meeting, it also resulted in loneliness and doubt over their clinical role or purpose.

Overall, this chapter highlights how psychological safety is a crucial part of positive in team functioning, but also gives some indication about how to achieve cultural change in order to support all team members feeling able to speak up. As I was writing the discussion for this chapter I kept coming back to a team I was in many years ago which underwent a 'team journey' which focused heavily on connecting as a team and developing a team identity. I latterly realised that this 'team journey' was heavily influenced by the work of Michael West (West, 2012). Within this text West (2012) described three possible ways of working. In order to decide there is an initial question which must be asked; 'do you work as part of a team?'. The vast majority of people will answer yes to this, but those who do not will not be working as a team. Out of those who responded 'yes' the following three questions can be asked to delineate between a 'real' or 'pseudo' team;

- Does your team have clear objectives?
- Do you work closely together to achieve those objectives?
- Do you meet regularly to review your performance and how it can be improved?

People working as part of a 'real' team will answer 'yes' to all three of these questions. If there is a 'no' to one or more of these questions this would indicate that someone is working within a 'pseudo team. These teams outwardly may appear to be a real team but there is a lack of safety within these teams which facilitates the necessary modelling of vulnerability and fallibility to openly discuss and explore objectives and performance.

When considering the findings of the empirical paper I was struck by how these could be indicating that the participants team was potentially a 'pseudo' team. When considering the theme of control Vs collaboration this provided a point of optimism as psychological safety was clearly evidenced in some meetings, although the lack of consistent safety could indicate a pseudo team. Similarly, within the theme of expectation vs reality it seemed that teams did not have aligned views, or objectives, of how the meeting should be organised or what to expect in different settings indicating a possible pseudo team. The theme of Conflicting Vs motivational responsibilities seemed to indicate that there was a lack of agreement regarding how to achieve outcomes of a meeting or who was responsible for these outcomes, again indicating a possible pseudo team. Finally, the theme of Connection

highlighted a focus on professional identity and training as a point of connection as opposed to values (for the most part). Again, this is indicative of a pseudo team as opposed to a real team. Within a real team you would expect there to be an awareness of everyone's values, and therefore cross profession/specialism connection naturally follows. When considering future research, it would be interesting to explore the concept of real vs pseudo teams and speaking up, with additional exploration to leadership and how the experience of 'leadership' as opposed to 'hierarchy' may be correlated with real/pseudo teams and speaking up.

Throughout the analysis there was a lot of back-and-forth conversation about power, where it was positive and negative, with all three researchers exploring all positions. We reflected as a team a lot on the different positions we each held professionally, and how the findings of this paper impacted our view of MDT work and our role within it. At times, I was required to consider my assumptions about and stance on power, explore how to communicate this compassionately, and ensure that the findings were representative of the data as opposed to my personal stance. I also was required to similarly challenge senior clinicians on their positions. At times this was challenging to navigate. Ultimately my stance about power within MDTs has not changed, however exploring this robustly was an important part of the research process that would not have been as effective without having two senior clinicians as part of the research team. Additionally, it raised my awareness for the difficulties of altering culture and how threatening this move away from power can be experienced. This is something I will hold on to as I progress in my career both academically and clinically and I'm extremely grateful to have had the chance to explore these issues in such detail in a safe and curious environment alongside my supervisors.

Reflective commentary

As a member of the d-clin psych 2019 cohort this thesis was designed and planned during the midst of the covid-19 pandemic. As a result, I have often thought about what I would differently now, given the differences in what is possible or realistic now we are on the other side of the worst of the pandemic. One point I have considered is that the current thesis lacks any involvement from service users, or the people panel. At the time of designing the study accessing the people panel was not possible as they were not meeting. Additionally, I felt extreme overwhelm, or burnout, myself as I was facing a number of personal challenges alongside navigating training during the pandemic. Accessing the people panel once they

were meeting again and making amendments to the project did not feel possible as a result. I often think about what they may have suggested, what questions they would have wanted me to ask staff, and how this could have impacted the project. I feel a bit sad that my cognitive space to take on more thoughts and opinions has only opened up as the project is coming to an end but as I progress into my hopefully qualified life it is something I will make sure to encourage strongly in any projects I come across.

I had delays to training initially due to maternity leave, and latterly following a serious accident which required an extended period of sick leave in the middle of completing the current thesis. Interestingly prior to my accident I felt really disconnected from the literature review, chapter one. I had never completed a systematic review before and the amount of reading and numbers felt overwhelming for me, in part I think because of my specific learning difference. As I started my phased return from my accident, whilst my arm was still restricted and healing, the only chapter I could work on was the literature review. At the start it involved a lot of 'clicking' and minimal typing. It also was less 'emotional' as I had a separation from the first order data, having not completed the interviews myself. At this time, I was learning to manage and navigate not only the impact of the physical injury but also my ongoing experience of PTSD. It was important that I was able to 'step away' from work as needed, and that the work itself was gentle enough for me to be able to focus on it and feel a sense of success. Despite my initial reservations, I soon found myself enjoying (!) the process and the literature review which left me with a personal sense of confidence in my abilities to return work and I will always have a gratitude towards this literature review as a result.

Unfortunately, the timing of my accident could not have been worse professionally. In total I had about 5 months off and upon my return had an extended phased return to duties. Whilst the project was registered with Prospero in good time for my original training schedule, due to time limitations following my accident I was unable to extend the literature review search time frames. This frustrates me as I know it is such a dynamic and fast paced area of research at the moment and this is a weakness for the current review. It is hoped however that despite this limitation the current review is still recognised as a valuable insight into the experiences of NHS staff working through the covid-19 pandemic which can add to the growing body of work on this topic.

In terms of the analysis process, as I immersed myself in the first and second order data, I found myself at times, disagreeing with the interpretations of the researchers. I am aware that the first order data is always only a snapshot of the possible data that could display a particular theme and concluded that at times the quotations selected were not the most

suitable or had some wider context that the researchers connected with. This was an important reflection for me when it came to selecting extracts for my empirical paper. I wanted to include context, and as a result have relatively long extracts. My hope is that this allows readers to have a sense of connection to the participants words, and therefore why each theme was defined as it was.

For the empirical paper, I completed the process of undertaking and transcribing all 11 interviews just days prior to my accident. I can without a shadow of a doubt say I am extremely grateful for my slightly overzealous ethically based rule (to preserve and respect anonymity of all participants) that all interviews had to be transcribed within 72 hours of the recording having been made. Whilst I was on sickness leave, I was comforted by the fact that 'at least my data is collected'. During the transcription process I had begun analysing the data, taking note of emerging codes and casting an eye to what themes may be emerging. I think had I completed my analysis according to a more typical timeframe, without a 5 month break my findings could be vastly different. The forced time and space I had resulted in a reduced personal connection to the data. When I came to the subsequent stages of the data analysis and was re-acquainting myself with the data, I was surprised by some of the initial themes I had felt were really strong. Although the initial coding didn't change much, the process of refining the codes led me to realise that a number of the codes had resulted in a particularly emotional moment or a strong connection I had felt with the participants during the interview process. Often the topic of the code had only appeared once, sometimes being just a comment made during the interview that had piqued my interest but was not elaborated on. Coming back to the analysis in this way taught me about separating my emotional responses to data, and what the data was 'actually' saying. This proved to be something that I utilised during the data synthesis and analysis process for my literature review also, and as a result I feel that both chapters are honest reflections of the available data and richer in some ways for this forced time away.

An interesting thing I noticed during the analysis phase of the second chapter was how my skills as an interviewer changed rapidly as I progressed through the interviews. I remember feeling nervous throughout the first interview, which was also highly emotional with some personal reflections from the participant which could not be included in the final write up due to potential breeches in confidentiality. I remember this preparing me for subsequent interviews, some of which were equally as emotional, but as a researcher and budding psychologist, I found myself able to manage these spaces more adeptly. Each interview felt more relaxed, with a significant increase in the amount of free speech from participants. At the end of my third interview the participant reflected that they had enjoyed the process and thanked me for how I managed the interview and supported their reflections, which gave me

a necessary confidence boost in my abilities as a researcher. It also left me feeling that I was getting the best out of the participants, supporting them to reflect honestly about the variety of experiences they experienced. I think this also contributed to the findings often having this dual nature, as participants fully explored their experiences of speaking up.

A seemingly unrelated thing is that this reflective chapter is being written around the time of the Lucy Letby trial, during which failings by NHS management and surrounding systems have been reported. The interesting aspect of this trial is how several members of clinical staff who are seen as having a lot of power were ultimately powerless to prevent further harm, their voices were quashed by management within their hospital and health board. This case will likely reverberate throughout the NHS for many years to come, for a variety of reasons, undoubtedly the most significant being the scale of the tragedy itself. I became aware of this case in the media around the time I was pregnant with my daughter and as a result it is hugely emotive for me, which is perhaps why I cannot help but consider the outcome of the trial in terms of this thesis. Increasingly I have reflected on it professionally, given the stories of doctors not being heard, and management not having been held accountable for judgements they made at the time of writing this chapter. As I completed the current thesis, I have continued to return to the model of work dissatisfaction, burnout, and alienation presented by Iliffe and Manthorpe (2019) within which one of the positive responses to experiencing work dissatisfaction, burnout, and alienation is listed as 'Stop excess measurement, audit & reporting'. My interpretation of this is mixed, whilst I think excess audit is not the correct way forward, I do feel that underlying this is a message that audit and measurement of competencies/outcomes is viewed as threatening and punitive which can make timely audit and attention to failings and successes in patient care difficult to do. I feel that both my first and my second chapter speak to how working within the NHS can be punitive, unpleasant, and unsupportive at times. The question I am left with is not how we reduce audit, but how to we change the culture of audit? How do we create an environment throughout the NHS that is safe enough for our work to be scrutinised so we can all learn and develop our practice without fear and where whistleblowing does not result in punishment. This is not something that can be answered within the scope of the current thesis, however as I move forward in my career is something I will personally be taking an interest in and attempting to model in each setting I find myself in. I hold a personal fear for the future of the NHS, I feel like it is at a knife edge, and is becoming an unsuitable environment for many clinicians to work within for any length of time. Whilst this is concerning, it also fills me with motivation to contribute to changing the current culture within the contemporary NHS. As I think about the change I would like to see and the possible

role(s) I could have within this as a scientific practitioner I am reminded of the following quote:

> *"You can't cross the sea merely by standing and staring at the water".*
>
> *Rabindranath Tagore*

References

Iliffe, S., & Manthorpe, J. (2019). Job dissatisfaction, 'burnout' and alienation of labour: undercurrents in England's NHS. *Journal of the Royal Society of Medicine*, *112*(9), 370-377.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of organizational behavior*, *2*(2), 99-113.

Moberly, T. (2017). Five minutes with... Suzy Jordache. *The BMJ* Available at https://www.bmj.com/content/357/bmj.j2371

West, M. (2012). *Effective Teamwork: Practical lessons from organisational research* (3rd ed.). Blackwell.

Word count

Thesis section	Excluding references, tables, appendices, figures, etc	Inclusive
Thesis Summary	-	267
Literature review	9,023	12,501
Empirical paper	7,565	10,879
Third chapter	3,753	3,824
Title pages, declaration, acknowledgments, contents, word count	n/a	1,008
Total	**20,341**	**28,479**