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Practitioner Psychologist: Baseline Business Case

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# Executive summary

In the Intensive Care Society, we know the value of a multi professional staff team in critical care. Through our Wellbeing and Resilience through Education (WARE) project, we are developing support to improve the critical care working environment and support workforce wellbeing. One part of that project is to help the development of professional Practitioner Psychology posts.

We have developed this baseline business case for use in your critical care unit. In addition, we are supportive of applications to NHS Charities Together and have suggested how to complete the application form in the appendix of this document.

This document has been reviewed by our Executive Team and by our Patient and Relatives Professional Advisory Group.

The document is free to use according to your local needs but remains the intellectual property of the Intensive Care Society. Therefore, we kindly request that you do not forward the document on to other units, but direct colleagues to the Intensive Care Society so that we may monitor the impact and utility of this work.

We wish you the best with the development of your services.

**Dr Julie Highfield**

**National Wellbeing Project Director**

**Dr Stephen Webb**

**ICS President**

**Dr Sandy Mather**

**Chief Executive Officer**

# Summary

* National guidance and evidence point to the prevalence of psychological and cognitive comorbidities post-discharge from critical care and advocate the inclusion of practitioner psychology services within critical care teams
* We advocate a model of directly employed practitioner psychologists, fully embedded within critical care teams
* Inpatient psychology services can seek to primarily target established risk factors for psychological and cognitive comorbidities post-discharge from critical care
* Outpatient psychology services can apply evidence-based psychological models to psychological and cognitive comorbidities post-discharge from critical care. Practitioner psychologists can also contribute to multi-professional ICU follow-up services
* The rates of secondary trauma and burnout found in critical care workforce suggest this is an important area for embedded psychological intervention.

# Introduction

Approximately 110,000 people are admitted to critical care units in England and Wales each year, of which 75% survive and are discharged. The prevalence of a range of psychological, cognitive and functional difficulties following ICU admission is well documented and the psychological impact of an intensive care admission may be severe, with up to 50% of patients suffering acute stress and long-term psychological morbidity (Wade, 2012) (Parker, 2015). The psychological impact of critical care upon families (Davidson, 2012) and staff (Vincent, 2019) is well documented.

The Guidelines of the Provision of Intensive Care, version 2 (ICS, 2019) therefore recommend embedding practitioner psychologists within critical care teams to address the psychological health needs of patients, families and staff.  For details please see:

<https://www.ics.ac.uk/ICS/ICS/GuidelinesAndStandards/GPICS_2nd_Edition.aspx>

The NICE clinical guideline (CG83) and quality standard (QS158) on rehabilitation after critical illness recommend patients receive psychological assessments and interventions throughout the critical illness rehabilitation pathway. The Five Year Forward View for the NHS (2014) calls for greater integration of physical and psychological care and the 5YFV for mental health (2016) further develops this by calling for increased access to psychological services for people with long term physical health conditions, of which post-ICU syndrome is one.

COVID-19 has significantly impacted upon our intensive care unit. These admissions have been difficult for patients, families and staff due to the current circumstances, where families have been unable to visit except in the circumstances of end of life care. While existing literature suggests that up to 50% discharged ICU patients experience psychological morbidity, additional stressors associated with the ICU context during the COVID-19 pandemic suggest prevalence rates may be higher. The psychological stressors during COVID-19 include unusually severe delirium, isolation from families, the experience of receiving care from staff in PPE and perhaps witnessing distressing medical procedures occurring to other patients in unusually crowded bays (intubation, CPR, etc). The work for staff has been incredibly stressful; the need for PPE, staff being redeployed to unfamiliar environments away from their usual colleagues, in some cases being unable to live at home with their families, coping with distressed families via video-link and the high mortality rates associated with COVID-19.

Please complete

Our admissions during the pandemic were………………………

Our patient mortality rate was: ………………………………………

Our staff sickness currently is…………………………………

# What is a Practitioner Psychologist?

Professional Practitioner Psychologists are uniquely placed to provide several useful functions to a critical care team.  Types of practitioner psychologist are usually clinical psychologists, health psychologists, or counselling psychologists.  They typically have about 6 years of training to post graduate level and so have a full grounding in what makes us human and what drives us psychologically. They are fully research trained.

# The role of a Practitioner Psychologist in intensive care

Psychologists can provide input into four key areas of intensive care:

## The patient

Working alongside multi professional colleagues, they allow for the psychological problem solving of the patient; this is important as the critical care experience often leads to psychological sequalae which hinder the patients’ connection to treatments in ICU. Psychologists have such a broad psychological knowledge base, they are able to formulate each person at an individual level to understand:- is this delirium, cognition, low mood, anxiety or psychological trauma which is inhibiting the patient’s ability to engage in physiotherapy, accept nursing care, wean from the ventilator etc. They provide psychological first aid to the patients and a framework of understanding for the staff to enable treatment to move forward, or the doctors to set limitations of treatment in best interests.

## The family

Having a family member or friend in the ICU is a devastating experience, and Psychologists provide a psychological safe space for loved ones to explore the impact of this and stay psychologically well themselves during this process. The provision of principles of psychological first aid helps families feel as safe as possible, thus reducing the likelihood of psychological trauma and reducing the demands families place upon medical teams. During the pandemic, the access to psychologists via the phone has helped families through their anxieties of not being able to be there with their loved ones.

## The staff member

Psychologists work alongside their ICU colleagues and can help them to process the emotional burden of their work, through individual or group psychological intervention, and allow story telling in a way that processes their traumatic experiences at work. They also enable new skills

and ways of working for self-care and for the care of the patients. Having a psychologist integrated into the ICU breaks down barriers to accessing support among staff who may struggle to access the help they need. Substantial evidence shows that staff wellbeing is essential for optimal patient-care, that workplace stress and burnout is associated with poorer clinical outcomes, including higher error, infection and mortality rates. Wellbeing also has a significant impact on staff levels of absenteeism, presenteeism and staff retention (e.g. Boorman, 2009; The Kings Fund, 2012; NHS Employers; Maben, 2016).

## The system

Psychologists are systemic thinkers and are well placed to help with system design and the humanisation of the ICU for staff, visitors, and patients alike.  They support managers in making sense of when teams are struggling and provide a way of facilitating and supporting team cohesion.

# Standards of Psychology staffing

The Guidelines for the Provision of Intensive Care (GPICS), version 2 (ICS, 2019) recommend employing a practitioner psychologist for patients, families and staff wellbeing.  For details please see

<https://www.ics.ac.uk/ICS/ICS/GuidelinesAndStandards/GPICS_2nd_Edition.aspx>

The [NICE clinical guideline (CG83) and quality standard (QS158) on rehabilitation after critical illness](https://www.nice.org.uk/guidance/qs158/resources/rehabilitation-after-critical-illness-in-adults-pdf-75545546693317) recommend patients receive psychological assessments and interventions throughout the critical illness pathway.

The 2020 benchmarking of UK Psychologists in critical care run by The Intensive Care Society and PINC-UK led to a service estimation algorithm, and a service specification by bed numbers was developed as per table one below.

We recommend appointing an 8b Practitioner Psychologist as the standard lead grade for providing services, especially if working in isolation. We recommend an 8a staff grade psychologist if in a fully supported hospital based clinical health psychology service with a band 8c, 8d or 9 lead.

Additional costs to consider:

* Budget for supervision costs. The cost of clinical supervision needs to be considered within a direct employment model. The British Psychological Society (DCP, 2012) recommends a minimum of 60-90 minutes of supervision for every 20 sessions worked (1 session is 0.1wte). Therefore, a full-time clinical psychologist requires 60-90 minutes supervision fortnightly, pro-rata according to hours worked. Clinical supervision must be accessed from a trained psychologist.
* Budget for non-pay costs (travel, CPD, computer equipment)
* The post holder needs access to a private/ bookable office, lockable storage or electronic records, and admin support

*Table one: Suggested job plan according to bed numbers and service specifications*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Job plan 10 beds | Job Plan 20 beds | Job Plan 30 beds | Job plan 40 beds | Job plan 50 beds |
| Inpatient work | 0.1 | 0.2 | 0.3 | 0.4 | 0.5 |
| Staff wellbeing | 0.1 | 0.2 | 0.3 | 0.5 | 0.5 |
| Follow up clinic  And supporting follow up groups (e.g. ICU Steps) | 0.05 | 0.1 | 0.1 | 0.2 | 0.2 |
| Outpatient ongoing input | 0.05 | 0.2 | 0.3 | 0.4 | 0.5 |
| Supporting professional activity | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| TOTAL WTE | **0.4** | **0.8** | **1.1** | **1.6** | **1.8** |

# Cost benefit analysis of employing a practitioner psychologist

## For staff and employers

Research from Deloitte suggests that on average, for every £1 spent on supporting their people’s mental health, employers get £5 back on their investment in reduced presenteeism, absenteeism and staff turnover (Deloitte, 2017).

Estimating that with all pay and non-pay costs, a Band 8(a-c) Practitioner Psychologist costs approximately £60-90 per every hour of work. An average psychology intervention is between 6-12 sessions- up to £1080. If a Psychologist were to enable a staff member back to work this cost is offset by the monthly costs of being off sick as illustrated in table two.

*Table two: approximate monthly sickness costs of various grades of ICU staff*

|  |  |  |
| --- | --- | --- |
| Pay Costs | Pay Scale | Approx. 1 months off sick- basic pay, top of scale |
| Consultant | ZM81 | £10,363.67 |
| Junior Doctor - StR | ST8 | £5,115.33 |
| Nursing (Reg) | Band 7 | £4,428.92 |
| Nursing (Reg) | Band 6 | £3,756.42 |
| Nursing (Reg) | Band 5 | £3,016.67 |
| Nursing (Unreg) | Band 2 | £1,847.67 |

Staff have reported:

*“Having an ICU Psychologist is so much more accessible than waiting to see my GP and being referred into mental health services. It means I can be seen quickly, without problems getting worse.”*

*“Its so important that the Psychologist is embedded- I feel they really understand the context of my work”*

## For patients

A study of 209 poly trauma patientsfound that offering an average of 6 sessions of clinical psychology service to critical care patients significantly reduced the incidence of PTSD and use of psychiatric medication at six months post critical care (Peris, 2011).

The cost of one-night stay in an intensive care bed varies, but published figures for reference indicate an average of £1392 in NHS England (NHS, 2016) and approximately £1932 in NHS Wales (Welsh Assembly Government, 2013). A psychology intervention is typically up to 6 sessions within the intensive care, depending on the circumstances (£540). If a Psychologist were able to improve engagement with care and reduce length of stay by just one day, then this would offset the costs of the intervention.

Furthermore, PTSD is usually treated in adult primary care psychology services (IAPT) at a cost of approximately £186 per session, or £2000 in total (references available on request). NICE guidelines recommend 8-12 sessions of trauma focused CBT to address PTSD. The median average of 10 sessions would therefore cost £1860. If a Psychologist working in critical care can help only a small percentage of those expected to benefit, the cost effectiveness is clear.

Patients have reported: *“It was so important for me to see that same face, offering care and support through the fog of delirium. They helped me to see the way through this”*

*“I remember the psychologist working with the physios when I was too scared to get up and get moving- I could not have done it without them”*

*“Seeing a psychologist as part of the follow up clinic helped me to understand what had happened, and make sense of my ICU stay. They also helped me think about how to manage my anxiety and confidence now I am at home”*

# Measuring impact and outcomes

The following are ways of measuring the patient reported outcome measures (PROMS) of the Psychology service.

*Recommended patient reported outcome measures:*

|  |  |
| --- | --- |
| Construct | Measure |
| ICU related distress | IPAT |
| ICU related delirium | CAM ICU |
| Post ICU anxiety | GAD 7 |
| Post ICU depression | PHQ 9 |
| Post ICU psychological trauma | TSQ |

It is also important to incorporate patient reported experience measures (PREMS) such as testimonials and quality of experience.

*Recommended staff outcome measures:*

|  |  |  |
| --- | --- | --- |
|  | **Construct** | **Measure** |
| Individuals | anxiety | GAD 7 |
| depression | PHQ 9 |
| psychological trauma | TSQ |
| Professional quality of life | Pro QoL |
| Burnout | Maslach Burnout Inventory |
| Teams | | Health and Safety Executive management standards questionnaire |

It is also important to incorporate patient reported experience measures (PREMS) such as testimonials and quality of experience.

# Expectations from the Intensive Care Society

1. The ICS expect all posts generated from this business case to be in contact with Dr Julie Highfield, the National Wellbeing Lead and to engage with the ICS Wellbeing and Resilience through Education (WARE) project as invited.
2. The ICS will only support posts where Practitioner Psychologists are registered with the HCPC and fully abide by the governance framework and the British Psychological Society code of conduct.
3. We expect all posts to work towards GPICS compliance.
4. We encourage all post holders to join the Psychologists in Intensive Care UK (PINC UK) network

Considering the Practitioner Psychology Model

Although there are similarities across critical care units, we do not advocate that one size fits all and you should take this business case and adapt to your local needs. One important point of consideration is whether to embed your Psychologist into your psychology team.

There are the following alternative models to consider:

1. **Psychologist as integrated part of multi professional team**

One benefit of an integrated Psychologist for staff is that they can fully understand the working environment of critical care staff, and develop relationships with the team over time, building trust. The Psychologist can benefit from taking both an “inside” and an “outside” perspective. However, the boundaries need to be carefully managed between the role for the patients and the role for the staff.

1. **Separating the role of patient and family Psychologist and staff Psychologist**

The boundary concerns raised in model one may be managed through creating two separate roles for psychology. This may be combined with model four for smaller critical care units.

1. **Psychology funding to a department of psychologists offering services to the hospital**

In some hospitals a team offers services to patients or to staff. Funding some specific sessions into these services can be of benefit in covering annual leave, having access to a broader range of experiences, and managing boundaries around direct staff wellbeing input.

1. **Regional Psychologist across a Network or part of a Network**

If your critical care unit is small, you may find it helpful to employ your Psychologist in conjunction with neighbouring critical care units.

# NHS Charities Together Questions

Applications to NHS Charities together are submitted via an online portal via member charities. The following are the questions they ask. We have a baseline suggestion for answering these questions to pump prime a Clinical/Practitioner Psychologist post into your Intensive Care Unit. Please edit according to your local needs. Areas highlighted in yellow require your specific attention.

|  |
| --- |
| **Please list the ways in which you have used the NHS Charities Together grant funds you have received to date under Stage 1 of distribution 1 & 2?** |
| *This answer would be specific to your organisation*[please complete] |
| **Within 300 words, please tell us how you have measured success and what have been the outcomes of distribution 1 & 2 covid-19 grant funding?** |
| *This answer would be specific to your organisation*[please complete] |
| **What amount of grant funds received under Stage 1 (distribution 1 & 2) remain unspent or unallocated?** |
| *This answer would be specific to your organisation*[please complete] |
| **If you have an amount of existing NHS CT grant funds unspent or unallocated, please explain** |
| *This answer would be specific to your organisation*[please complete] |

|  |
| --- |
| **What is the purpose of your application for further COVID-19 Stage 1 funding?** |
| We would like to apply for a Clinical Psychologist to provide input to our intensive care unit.  They will provide a clinical service to patients, families and staff. |
| **Summarise your application within 300 words** |
| The psychological impact of an intensive care admission may be severe, with up to 50% of patients suffering acute stress and long-term psychological morbidity (Wade, 2012) (Parker, 2015). It also impacts upon families (Davidson, 2012) and staff (Vincent, 2019), and often require psychological support. The Guidelines of the Provision of Intensive Care, version 2 (ICS, 2019) recommend employing a practitioner psychologist for patients, families and staff wellbeing.  For details please see:  <https://www.ics.ac.uk/ICS/ICS/GuidelinesAndStandards/GPICS_2nd_Edition.aspx>  The NICE clinical guideline (CG83) and quality standard (QS158) on rehabilitation after critical illness recommend patients receive psychological assessments and interventions throughout the critical illness pathway.    COVID-19 has significantly impacted upon our intensive care unit. These admissions have been difficult for patients, families and staff due to the current circumstances, where families have been unable to visit. With the evidence base suggesting 50% psychological morbidity in all ICU patients, it is likely to be higher with COVID-19. The work for staff has been incredibly stressful, with many changes, staff working under conditions of full PPE, and high mortality.    Our admission numbers during the pandemic were:[please complete]  Our patient mortality rate was :[please complete]  Our staff sickness currently is :[please complete]    A clinical psychologist would support patients in the “COVID blue/green” zone who are slow to wean from a ventilator, working with the multi professional team to enable rehabilitation from the unit onto the ward. S/he would also provide input to the families who needed additional support via telephone. S/he will work as part of a team following up patients at home to assess their ongoing needs and ensure they are linked into mental health pathways. S/he will provide in-house support and psychological intervention for the psychological wellbeing of staff. |

|  |
| --- |
| **How much are you asking for?** |
| [please edit as required]    Budget for an 8a staff grade psychologist if in a fully supported hospital based clinical health psychology service with an 8c lead.    Budget for an 8b psychologist if working independently of a hospital based clinical health psychology service    Suggested WTE based on job plan per beds as per table below    Additional costs:  Budget for supervision costs- two hours per month *£2500*  Budget for non pay costs  *Suggested additional non pay costs (Travel, CPD, computer equipment): £2500*    Needs access to a private/ bookable office, lockable storage or electronic records, and admin support  [Suggested job plan- please edit according to local needs]     |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | Job plan 10 beds | Job Plan 20 beds | Job Plan 30 beds | Job plan 40 beds | Job plan 50 beds | | Inpatient work | 0.1 | 0.2 | 0.3 | 0.4 | 0.5 | | Staff wellbeing | 0.1 | 0.2 | 0.3 | 0.5 | 0.5 | | Follow up clinic | 0.05 | 0.1 | 0.1 | 0.2 | 0.2 | | Outpatient ongoing input | 0.05 | 0.2 | 0.3 | 0.4 | 0.5 | | Supporting professional activity | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | | **TOTAL WTE** | **0.4** | **0.8** | **1.1** | **1.6** | **1.8** | |

|  |
| --- |
| **Within 300 words please define what problem your funding will address? \*** |
| 1. **Staff wellbeing**   Funding this post would provide accessible in-house support for staff  We would like our staff to access services from trained psychologists embedded in the unit with insight into the working conditions of staff  Our Psychologist will also be able to troubleshoot and advice and guide our management team  Our Psychologist will facilitate reflective practice sessions such as Reflective Rounds  Our Psychologist can provide the governance and supervision for staff wellbeing champions/ peer supporters.     1. **Patient psychological needs**   Our psychologist will work with those ICU patients who are de-sedated and remain on the ICU for an extended period. They will work to help the team manage and minimize delirium and work directly to reduce patient distress and increase engagement with rehabilitation.    The Psychologist will provide an outpatient follow up service to pick up on those patients post ICU who have ongoing needs. The service itself will provide a “sense making” of the ICU experience (many patients do not recall their stay and what they do recall is delirium related), screening and signposting.   1. **Family psychological needs**   Our psychologist will work with the families of ICU patients offering support during the inpatient stay and advice on supporting their family member of the return home. |
| **Does your project have an element supporting those disproportionately affected by COVID-19? E.g. Black, Asian and Minority Ethnic (BAME), disabled communities and/or other ‘hidden’ communities.** |
| *[depending on location and BAME admissions]* |
| **If ‘yes’, please explain within 300 words** |
| *[depending on location and BAME admissions]* |

|  |
| --- |
| **Describe in more detail the problem you want to tackle with this NHS CT COVID-19 grant and the impact it will have on this staff and/or patient cohort’s health and wellbeing.** |
| 1. **Staff wellbeing**   Pre-pandemic, 1 in 3 ICU staff members in the UK experience burnout (Vincent, 2019)  Intensive Care Units have a high sickness absence and a high staff turnover FIGURES  An embedded Psychologist would help the staff recover from work related stress and return to work.  They will also promote a healthier workplace, through wellbeing initiatives, potentially preventing sickness absence and longer term impacting on staff culture and staff retention  Research from Deloitte suggests that on average, for every £1 spent on supporting their people’s mental health, employers get £5 back on their investment in reduced presenteeism, absenteeism and staff turnover (Deloitte, 2017).    Estimating that with all pay and non-pay costs, a Band 8(a-c) Practitioner Psychologist costs approximately £60-90 per every hour of work. An average psychology intervention is between 6-12 sessions- up to £1080. If a Psychologist were to enable a staff member back to work these costs are offset by the monthly costs of being off sick as illustrated in the table below.     |  |  |  | | --- | --- | --- | | **Pay Costs** | **Pay Scale** | **Approx. 1 months off sick- basic pay, top of scale** | | Consultant | ZM81 | £10,363.67 | | Junior Doctor - StR | ST8 | £5,115.33 | | Nursing (Reg) | Band 7 | £4,428.92 | | Nursing (Reg) | Band 6 | £3,756.42 | | Nursing (Reg) | Band 5 | £3,016.67 | | Nursing (Unreg) | Band 2 | £1,847.67 |      1. **Patient psychological needs**   The psychological impact of an intensive care admission may be severe, with up to 50% of patients suffering acute stress and long-term psychological morbidity (Wade, 2012) (Parker, 2015).  The biggest predictor of post ICU psychological morbidity is distress experience within ICU. An ICU psychologist would help train staff and work directly and indirectly with patient distress reducing post ICU psychological morbidity (Birk, 2019).  The psychologist will also provide early intervention to psychological distress, and in particular post traumatic stress post ICU via the follow up clinic, reducing the need for onward referral to mental health services    The cost of one night stay in an intensive care bed is approximately £1932 (Welsh Assembly Government, 2013). A psychology intervention is typically up to 8 sessions within the intensive care, depending on the circumstances (£720). If a Psychologist were able to improve engagement with care and reduce length of stay by just one day, then this would offset the costs of the intervention.  Furthermore, PTSD is usually treated in adult primary care psychology services (IAPT) at a cost of approximately £186 per session, or £2000 in total (references available on request). NICE guidelines recommend 8-12 sessions of trauma focused CBT to address PTSD. The median average of 10 sessions would therefore cost £1860. If a critical care psychologist can help only a small percentage of those expected to benefit, the cost effectiveness is clear.     1. **Family psychological needs**   ICU stay also impacts upon the families of patients (Davidson, 2012) and this is worse due to the inability to visit during COVID-19.  Family miscommunication and dissatisfaction is often a source of ongoing complaints. The psychologist will provide support to the family during their loved one’s ICU stay. |
| **Within 200 words please describe how you have identified this need?** |
| We identified this need by benchmarking our critical care service provision against national guidance for the provision of intensive care services which require a Psychologist to work with ICU. |
| **In no more than 300 words please explain your mechanism for spending grant funds and how would you use your grant?** |
| The grant will fund the first year of a Clinical Psychologist post to establish a service and non pay costs to support the post.  After this time, the (local budget holder) will pick up the funding of the post with perpetuity. |

|  |
| --- |
| **In no more than 300 words, please explain how you will measure the difference your grant** |
| We will use PROMS and PREMS with patients (IPAT, GAD 7, PHQ 9, TSQ).  We will survey relatives of patients as a measure of quality impact of the service.  We will use PROMS and PREMS with staff (for example, GAD 7, PHQ 9, TSQ as appropriate).  We will use our staff retention and sickness absence figures as a measure of impact.  We will survey our staff for a measure of the quality impact of the service. |

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