Intensive Care Society

Guidance and Service Specification:

Integrated Practitioner Psychologists in Intensive Care Units

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PINC-UK
PSYCHOLOGISTS IN INTENSIVE CARE UK

Contents

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Summary

Practitioner psychologists are an integral part of the modern intensive care unit. If sufficiently funded, they can provide input to the patient and their loved ones during the intensive care stay and following discharge home. They are also well placed to support the staff and system to manage the psychological work of intensive care. This guidance indicates a minimum service provision of 1.0WTE per 20 level 3 equivalent beds and outlines the detail of what can be provided, as well as cost-benefit analysis for employing a practitioner psychologist.

Introduction

Approximately 200,000 people are admitted to critical care units in England and Wales each year. 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[1,2]. The psychological impact of critical care upon families[3] and staff[4] is also well documented.

The Guidelines of the Provision of Intensive Care, version 2.1[5] recommends embedding practitioner psychologists within critical care teams to address the psychological health needs of patients, families, and staff. The NICE clinical guideline[6] and quality standard[7] on rehabilitation after critical illness recommend patients receive psychological assessments and interventions throughout the critical illness rehabilitation pathway. The Five Year Forward View (5YFV) for the NHS[8] calls for greater integration of physical and psychological care and the 5YFV for mental health[9] develops this further by calling for increased access to psychological services for people with long-term physical health conditions, of which post intensive care syndrome is one.

This set of guidelines incorporates all of these, summarises the evidence and offers a service specification for practitioner psychology in intensive care.

What is a Practitioner Psychologist?

Professional practitioner psychologists are uniquely placed to provide several useful functions for a critical care team. Practitioner psychologists are usually clinical psychologists, health psychologists, or counselling psychologists and are uniquely placed to provide useful functions for a critical care team. They have a minimum of six years of training to post-graduate level, are trained in multiple models of therapeutic approach and understanding, are trained across the lifespan, including a baseline training in neuropsychology[10].

Model for Practitioner Psychologist Service into Intensive Care

Psychologists can provide input into four key areas of intensive care: working with patients, families, staff members and working at a team or system level (e.g., considering team processes).

Working with the ICU patient

Working alongside multi professional colleagues, practitioner psychologists enable psychological problem-solving about the patient in addition to direct psychological intervention[11]; this is important as the critical care experience often leads to psychological sequalae which hinder patients' connection to treatments in ICU. Where there are factors inhibiting the patient's ability to engage in physiotherapy, accept nursing care or wean from the ventilator, the practitioner psychologist can use their broad psychological knowledge base to provide a formulation for each person at an individual level to understand the various factors which may be inhibiting engagement. They provide not only psychological first aid to the patients, but also a framework of understanding for the staff to enable treatment to move forward, or (by adding to the assessment of the patient's reversible factors, rehabilitation potential and thus overall prognosis), inform discussion of best interests and limitation of invasive treatments where appropriate. They can train staff in best psychological care for patients, and skills of communication with delirious or distressed patients. If patients are highly distressed on leaving ICU, psychologists can provide follow-up sessions on step-down wards. Patients may also be able to review their experiences with psychologists at ICU follow-up clinics or receive evidence-based therapies for continuing psychological difficulties.

Working with friends and family members of the patient

Having a family member or friend in the ICU is a devastating experience[3], and practitioner 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. Psychologists can also provide psychoeducation to families to help them understand how their loved ones' emotions or behaviours have been affected by delirium or acute stress. Families may also be able to receive support from intensive care psychologists at peer support groups or intensive care follow-up clinics.

Working with ICU staff members

There is evidence from pre-pandemic to indicate that working in intensive care in the UK has an association with psychological harm including estimated 30% prevalence of burnout[4], 13% prevalence of post-traumatic stress disorder[12] and high exposure to moral distress[13]. Studies conducted during the pandemic indicated prevalence rates of psychological harm increased[14,15,16,17]. It is important to take a primary preventative approach to workplace wellbeing, as described in the next section, and psychologists work alongside their intensive care colleagues and can help them to process the emotional burden of their work, through individual or group psychological intervention, and allow storytelling in a way that processes their traumatic experiences at work. They also enable new skills and ways of working to promote self-care and enhanced 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; however, the boundaries need to be carefully managed between the role for the patients and the role for the staff (see section 7 for some considerations).

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[18,19].

Working with the team or at a system level

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. They take a primary preventative approach to staff wellbeing, as recommended by the Intensive Care Society's Workplace Wellbeing Best Practice Framework. They can also facilitate the group responses to traumatic or clinically challenging situations, facilitating group discussions such as Reflective Rounds.

Recommended Standards for Psychology Staffing in Intensive Care

The psychologists in Intensive Care UK group (PINC UK) have conducted benchmarking of UK intensive care psychology services over 2020-2022 (appendix 1). Utilising the data across a number of services the following minimum standards were calculated:

- The qualified practitioner psychology staffing should be minimum 0.05 WTE per level 3 equivalent bed, which is 1WTE for every 20 beds
- A grade 8b is a minimum standard service in a standalone small to medium sized tertiary unit (up to 20 beds) due to the complexity of working in critical care. Non-tertiary small sites may employ an 8a psychologist provided the psychologist is managed by a band 8c consultant clinical psychologist. In larger tertiary units, or for those trusts employing psychologists across multiple sites, it is recommended to have an 8c consultant psychologist as the lead, potentially with support from qualified psychologists at lower bands.
- Smaller sites may combine resources to create one post, but travel time across units should be factored in.
- The job plan should consider the balance of time between direct input to patients and families and input to support staff and the system and enough time should be allocated for all activities.
- The service should also consider the boundaries of a role offering both input to staff and patients and families. Staff should be offered a choice of access to evidence based psychological therapies and be informed of alternatives (such as employee wellbeing or occupational health, local primary care and third sector offers). This boundary may be managed through creating two separate roles for psychology.
- The service may be supported by non-qualified staff such as band 4/5 assistant psychologists or psychological wellbeing practitioners, but these should not be employed without an on-site qualified practitioner psychologist to supervise them.
- The practitioner psychologist should be Health Care Professions Council (HCPC) registered.
- The practitioner psychologist requires access to a bookable private room on the hospital site of the intensive care for conducting sessions with relatives, outpatients, and staff where possible.
- The practitioner psychologist should be based on the same site as the intensive care- ideally within the footprint of the unit if their work involves working with inpatients on the intensive care.

Psychological Service Specification

The following indicates the service specification for a practitioner psychologist working in intensive care if fully funded to the standards outlined above.

Service specification for ICU practitioner psychologists working with patients and families

- The practitioner psychologist can work with patients during their intensive care stay and follow them up on the stepdown wards if indicated
- Delivering psychological education, information and advice to patients and families.
- As stipulated in NICE CG83 and QS158, facilitating early screening of the patient. This includes CAM-ICU[20], Intensive Care Psychological Assessment Tool (IPAT)[21] and PICUPS tool[22]. The psychologist is not the only team member who will conduct the CAM ICU or PICUPS. The psychologist can also conduct a short clinical assessment of the patient's psychological needs.
- Working with the team to enable delirium assessment, monitoring, and management. Assessment is via a validated tool and can be conducted by any member of the intensive care team. When delirium is detected, risk factors are reviewed and corrected by the intensive care team, and psychologists can advise and support with the delivery of non-pharmacological strategies to prevent and reduce delirium at the environment level and the patient level (to facilitate orientation, engagement and reducing distress).
- In patients identified at risk of current or future psychological concerns, the psychologist can directly deliver, and support the team to deliver, Psychological First Aid to promote safety, calm, self-efficacy, connectedness, and hope. Where patients can engage in conversations, psychologists can offer space for information sharing and reassurance. This is of particular importance to longer-stay patients.
- Providing consultation to the wider team in management of the patient, and in particular working alongside other therapies to ensure psychological goals and the understanding of the patient's psychological needs are factored into rehabilitation. The psychologist can also advise on psychological factors that may inhibit engagement with treatment or rehabilitation.
- Facilitating the use of intensive care patient diaries.
- Involvement in family meetings, including best interest meetings, where there is significant family distress or conflict.
- Raise awareness of complex family experiences, e.g., bereavement within families from the same illness, survivor guilt. This may allow signposting to community services such as bereavement counselling, local mental health services, and ICU steps.
- Psychological support for families. Relatives may need support to cope with the shock of a family member becoming critically ill and being admitted to the critical care unit, as well as stress and exhaustion from caring for a patient during a long-term admission.
- Working in conjunction with Liaison Psychiatry teams and wider or related hospital psychology teams.
- Provide consultation and outreach to step down wards from intensive care, providing short-term early intervention where possible, and signposting to community services on discharge.
- Enabling a psychologically informed ICU/ ward environment. Teaching skills to support patient care to increase knowledge and understanding of psychological reactions, delirium, environmental stressors and psychological outcomes of critical illness, and enhanced communication skills.
- Consultation with the multidisciplinary team on communication, sleep, effects of sedation, anxiety, stress, mood, delirium, family issues and holistic care plans.
- Planned review at an MDT outpatient Critical Care follow-up clinic at approximately 2-3 months post discharge as per NICE guidance[6].
- Early screening for cognitive impairments at outpatient review, where indicated.
- Facilitating outpatient peer support groups such as the ICU Steps model, in outpatients.

- Consultation and training for connected community services such as GPs.
- Signposting and working in liaison with other services to enable rehabilitation and psychological recovery.
- Well-funded services will also provide psychological intervention in outpatient settings e.g., Trauma Focussed therapies for PTSD[23]. This input should focus on patient's whose psychological needs are a result of their stay on intensive care.

Service specification for ICU practitioner psychologists supporting ICU staff and the system

- Reflective group discussion (e.g., reflective rounds, case discussion, post incident, supervision).
- Teaching skills to support the wellbeing of staff.
- Overseeing any support programmes for staff.
- Supporting leaders in ICU.
- Management or systems consultation, including supporting the system to assess and monitor risks in relation to workplace stress, and supporting the management team in designing interventions to mitigate work-related stress. The UK Health and Safety Executive considers it an organisational responsibility to modify factors that impact on work-related stress.
- Working in liaison with the intensive care management team to encourage adherence to the GPICS standards on workplace wellbeing[5], and the Intensive Care Society Workforce wellbeing best practice framework[24].
- Individual staff consultation on staff wellbeing.
- Working in liaison with the local provision, such as hospital occupational health and wellbeing services, resilience hubs, and organisational development to ensure timely access to evidence based psychological therapy for staff.

Well-funded services may also provide:

- Ongoing individual psychological intervention to staff for work related wellbeing.
- Well-funded services will also provide psychological intervention in outpatient settings e.g., Eye Movement Desensitisation Reprocessing (EMDR) for PTSD[23]. This input should focus on patients whose psychological needs are a result of their stay on intensive care. The funds for the practitioner psychologists should not be used to intervene with conditions or mental health concerns that pre-date the ICU admission or are not directly related to ICU stay.

Measuring Impact, Outcomes, and Screening Tools

The following are ways of measuring the patient reported outcome measures (PROMS) and screening tools and should be used as appropriate to the clinical need. Further measures can be added as appropriate if screening indicates need.

Table one: Recommended patient reported outcome measures:

Construct	Timing	Measure
ICU related distress	Within ICU only	IPAT PICUPS
ICU related delirium		CAM-ICU
Post ICU anxiety	Ward/ Outpatient	GAD 7
Post ICU depression		PHQ 9
Post ICU psychological distress		CORE-10
Post ICU psychological trauma screen		TSQ
Post ICU cognitive concerns screen		ACE-III

It is also important to incorporate patient reported experience measures (PREMS) such as testimonials and quality of experience. Given that screening tools are designed to be over-inclusive they are likely to elicit false positives; of course, this risk increases with multiple screens. We therefore recommend that services coordinate so screening results can be shared within a collaborative pathway, to avoid unnecessary repetition, risk of error and sub-optimal use of resources. This will be more likely if services use the same screening tools in a unified way. We also recommend a cautious approach to completing screening tools over video or telephone calls, due to the possibility that doing so threatens the validity of the screen (particularly relevant to cognitive screens).

Table two: Recommended staff psychological measures:

	Construct	Measure
Individuals	Anxiety	GAD 7
	Depression	PHQ 9
	Psychological trauma	TSQ
	Professional quality of life	Pro QoL
	Burnout	Maslach Burnout Inventory
	Psychological distress	CORE 10
	General wellbeing	Warwick Edinburgh Mental Wellbeing Scale
Teams		Health and Safety Executive management standards questionnaire

Cost Benefit Analysis and Evidence Base for Employing a Practitioner Psychologist

For patients

A study of 209 poly-trauma patients found 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[25].

The cost of a one-night stay in an intensive care bed varies, but published figures for reference indicate an average of £1392 in NHS England[26] and approximately £1932 in NHS Wales[27]. A psychology intervention can be 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 cost 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. NICE guidelines recommend 8-12 sessions of trauma focused therapy to address PTSD[22]. The median 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.

Anecdotal patient reports include:

"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."

For staff and employers

Recent research from The International Public Policy Observatory suggests that for every £1 spent on supporting their people's mental health, the NHS gains £2 back on their investment in reduced presenteeism, absenteeism and staff turnover[28].

Estimating 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 four.

Table four: 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

Anecdotal staff reports include:

"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."

"It is so important that the psychologist is embedded- I feel they really understand the context of my work."

The Position of the Practitioner Psychologist and Alternative Models

Although there are similarities across critical care units, one size will not fit all local needs and service provision should be considered.

There are the following alternative models to consider:

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.

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.

Psychology funding to a department of psychologists offering services to the hospital or liaison services

In some hospitals, a team offers across hospital 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.

Regional psychologist

Smaller units may employ a psychologist in conjunction with neighbouring intensive care units. These smaller units may be able to support a more junior grade of psychologist, providing there will be support from a central senior psychologist.

Appendix 1: Results of the PINC UK Benchmarking Exercise 2022

Between September 2021 and January 2022, the UK Psychologists in Intensive Care group (PINC-UK) were surveyed to benchmark current services. The last benchmarking exercise was January 2020, and results are given for comparison given that the recent benchmarking exercise took place during the pandemic.

At January 2022 there were 65 of the 230 intensive care units in England and Wales with dedicated practitioner psychologist posts. (This compares to 44 units in January 2020). Three in Northern Ireland, four in Scotland (two in 2020), three in Ireland.

68% of posts are at Agenda for change grade 8b or above

The average whole time equivalent per level 3 ICU bed was 0.03 (range 0.004-0.09).

- 79% offered ICU inpatient services.
- 74% attend ICU follow up clinics.
- 53% offer further outpatient psychological intervention.
- 51% offer ongoing staff 1-1 psychological intervention.

The benchmarking indicated the following demands for psychological services:

- Approximately 4 patient and/ or family referrals per bed are received per annum (range 0.3-10.18). This number has not changed since 2020, indicating there has not been a pandemic affect.
- Approximately 3 follow up clinical referrals per bed are received per annum (range 0.1-5.29). This number has not changed since 2020, indicating there has not been a pandemic affect.
- On average 12% of staff will request 1-1 support (range 4-58). The January 2020 exercise indicated an average of 18% of staff accessed support. The range however was smaller (10-30). This indicates variation across units and across time and would require further research to breakdown the factors.

To illustrate this, a 20 bedded intensive care is likely to generate 80 inpatient referrals, 60 outpatient referrals, and 24 staff referrals each year. Therefore, a minimum WTE service needs to be 1 WTE for every 20 level 3 equivalent intensive care bed.

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Notes

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