National Critical Care Non-Medical Workforce Survey

Overview Report

March 2016

Foreword

This report is a high level overview of all of the data received from a National Critical Care Non-Medical Workforce Survey undertaken during the period of four months from September 2015 to December 2015.

It is the first time that a national survey has been undertaken to gather data from non- medical staff working within the speciality of critical care.

This report does not give detailed analysis of any of the surveys or makes recommendations but it provides feedback of the collated data from all of the submitting units. Further analysis will subsequently be required.

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Acknowledgements

We would like to take this opportunity to thank the Critical Care Network Lead Nurses for disseminating the information within their Networks. We would also like to say a huge thank you to the unit lead nurses for coordinating the data collection within their organisations and to all of the service leads who completed the surveys,

Ours thanks too to Craig Brown, Chair Intensive Care Society Nursing & Allied Health Professional Forum for providing an overview of the Allied Health Professionals (AHP) data and to Richard Bourne on behalf of the UKCPA Critical Care Group for his report on the pharmacist section.

We must also thank the Midlands Critical Care & Trauma Networks for allowing Steve Littleson (Network Data Analysist) to assist in the development of the survey and for the undertaking of the data analysis.

Without the support of all of these individuals, it wouldn't have been possible to undertake this survey and present the overall results within this report.

Executive Summary

This report provides a high level overview of the collated results from the Critical Care National Non-Medical Workforce Survey conducted in September 2015 as a snap shot survey on behalf of the Clinical Reference Group for Adult Critical Care & the Clinical Leadership Forum.

This is the first time that an attempt has been made to collect data on a national basis specifically on the various non-medical staffing groups that provide care and therapies to patients within critical services in England, Wales and Northern Ireland. Scotland was not included due to not having Operational Delivery Networks (ODN's) to assist with the dissemination and co-ordination of the data collection.

The survey was distributed through the Critical Care National Network Nurse Leads (CC3N) to disseminate to their critical care unit nurse leads for them to co-ordinate the data collection from within their organisations. The survey comprised of ten separate surveys to collect information on Demographics, Nursing, Outreach, Administration, Physiotherapy, Occupational Therapy (OT), Dieticians, Speech & Language (SALT), Pharmacists and Psychology which the leads for each service where asked to complete. All of the National professional groups / organisations assisted with the devising of the survey, and the data analysis was provided by the Midlands Critical Care & Trauma Network.

All of the data regarding staffing numbers was based on staff in post & budgeted establishments on the 1st September 2015 and information for the year was taken from the 1st September 2014 to 31st August 2015. Out of a total of 270 Units in England, Northern Ireland & Wales, there were 217 unique unit responses providing at least one survey.

The report provides a summary of the survey results for the data fields asked for in each of the surveys. Further analysis will subsequently be required.

Background

The Clinical Reference Group (CRG) for Adult Critical Care & the Clinical Leadership Forum made a request for assistance from the critical nurses to undertake a National Critical Care Non-Medical Workforce Survey.

Information regarding medical workforce has been readily available through workforce information that is collected and collated through the Faculty of Intensive Care Medicine (FICM) & The Intensive Care Society (ICS). However, no detail is available on a national level or has been collected specifically on nursing and the allied professionals who work in critical care and are associated with the delivery of critical care services. NHS Trusts submit workforce data on an annual basis to organisations like NHS England, Health Education England (HEE) but this is usually generic workforce information which does not relate specifically to the speciality or provide us with factual information or an overview that is require when planning and reviewing critical care services.

Much work has been conducted and continues to be undertaken around standards for Intensive Care, the planning of the services, reconfiguration & what the future might look like along with detailed standards for commissioning highlighted in the D16 Service Specification. All of this work requires a more in-depth knowledge of the non-medical workforce who work within the speciality, to compliment information already collected and collated on the medical workforce. The data collected from this survey will hopefully drive models of collaborative workforce planning in the future.

Development of the Survey

A lengthy lead in time of approximately 2 years was incurred from the original request being made to the survey being developed and circulated due to the lack of funding to support any data analysis and the identification of a data analyst to assist with the collation of survey results. Once they were in place, a data collection tool was created using Microsoft Excel 2003. This was chosen as there were no funds available to pay for a more appropriate platform, and the 'earlier' version of excel was selected to ensure compatibility within all Trusts. The tool was designed to look like a standard questionnaire form to ensure some degree of comfort for those with a dislike of spread sheets, and it had mostly drop-down lists for choices and only a few areas for free text. This not only helped speed up the completion process, but would ensure comparable data. The nursing survey was initially devised around the standards detailed within the Core Standards for Intensive Care (November 2013) and the draft D16 Service Framework for Adult Critical Care (February 2015). All of the allied professional surveys were devised by the professional organisations akin to the allied health profession e.g. AHP Board members of the ICS. A decision was made from the outset to omit Health Care Scientists from the survey as it was felt that there were so many connotations of the role that it would make data collection for this group very challenging and complicated. Prior to national roll out, the draft survey was discussed at CC3N and the nursing survey was piloted within 8 Trusts. The draft survey was also submitted to the FICM Workforce Group who provided feedback to content.

Dissemination of the Survey

Dissemination of the survey was conducted through the Network Lead Nurses (CC3N) who were requested to send all of the surveys to their unit lead nurses for distribution within their organisation. The survey was circulated at the end of August 2015 for the data collection to be undertaken during the month of September 2016. Two letters were circulated with the survey. One letter was addressed to the Critical Care Lead Nurse/Matron and copied to Trust Medical Directors, Directors of Nursing and Critical Care Medical Leads for information which was signed by Chair of the CRG for Adult Critical Care & Chair of the Clinical Leadership Forum. This letter gave the rationale and reasoning for the survey request. A second letter was sent from Chair of CC3N to the unit lead nurses who provided instructions about how the survey should be distributed and the results submitted.

Each survey consisted of 10 separate spreadsheets to collect information on Demographics, Nursing, Outreach, Administration, Physiotherapy, Occupational Therapy (OT), Dieticians, Speech & Language (SALT), pharmacists and Psychology. The surveys were deliberately sent as separate surveys to reduce the need of sending all of the surveys to each service lead for completion and avoid repetition and work load for the lead nurses to collate the results. The surveys were sent to 240 Trusts, the data analyst was expecting to receive back some 2400 spreadsheets of data. As they were undertaking this project in addition to their normal workload, almost all the processes in handling the returns and compiling the spreadsheets was automated to save time

Where data was requested retrospectively over a 12month period, the time frame identified was September 1st 2014 - 31st August 2015. Other information pertaining to staffing was based on those in post / funded from the 1st September 2015.

The survey was circulated to all the critical care units in England, Northern Ireland and Wales. Scotland was excluded as the Networks have no representation or contacts. The National Critical Care Directory maintained by the Network Directors / Managers was used as the baseline for identifying the information of the organisations for the survey to be distributed to. This in actual fact wasn't correct for all of the Networks so some amendments had to be made (Trusts that were now running under a different name, and networks that had merged). It was also noted there was a lack of information on the actual number of critical care units in each organisation.

Some issues arose mainly due to how files had been returned, and the automated process not picking them up (*newer file extensions, files sent in compressed folders, copying and pasting the 10 different worksheets into one workbook, completely creating a new spreadsheet based on the questions asked, etc)*. We had also asked units to send back all 10 spreadsheets, and if a unit didn't have access or input from a service such as SALT or psychology, there was an option to say that. In a number of instances, these surveys were not returned which has had an impact on the ultimate survey overall return rate, and more importantly the denominator.

Some units experienced delays in obtaining data back from their Human Resource Departments on workforce turnover. There was some clarification sought on the question about the amount of time a lead nurse spends in critical care.

Survey Results

There are thought to be 270 Critical Care units in England, Northern Ireland & Wales.

There was part of the survey received (at least 1 of the 10 spread sheets) from 217units. The actual number of returns (and therefore the denominator) for each of the 10 spread sheets is shown in table 1.

Table 1	
Speciality	**Number of returns**
Demographics	182
Nursing	188
Pharmacy	186
Administration & Clerical	171
Physiotherapy	161
Dietetics	160
Occupational Therapy	139
Speech & Language Therapy	139
Clinical Psychology	135

Demographics

The information requested relating to unit demographics included the type of unit are set out in table 2.

Additional demographic information included number of funded level 2/3 beds; total number of bed spaces; number of single rooms; designation of trauma status.

Not all units returning data completed the demographic survey.

Table 2	
Type of Unit	**No.**
Burns	1
Cardiac Surgery Level 3	1
Combined Cardiac Surgery Level 2/3	6
Combined General Level 2/3	130
Combined General/Cardiac Surgery	3
Combined General/Neurosurgery	6
Combined Neurosurgery Level 2/3	2
General	1
General Level 2	8
General Level 3	9
Neurosurgery Level 3	1
Neurosurgery Level 2	1
Other	11
Spinal	2
Grand Total	**182**

Nursing

Description (returns =188)

Total number of Band 5 - 8 wte registered nurse posts (table 3)

Table 3		
Band/Post	**Funded WTE**	**Head Count**
Band 5	9006.11	8893
Band 6	3134.54	3154
Band 7	970.64	955
Band 8	187.61	203
Educators	182.49	218
Researchers	45.31	60
Consultants	24.96	27
Totals	**13551.66**	**13510**

Chart 1

Nursing Bands %, by Funded WTE

Educators 1.3%
Researchers 0.3%
Band 8 1.4%
Consultants 0.2%
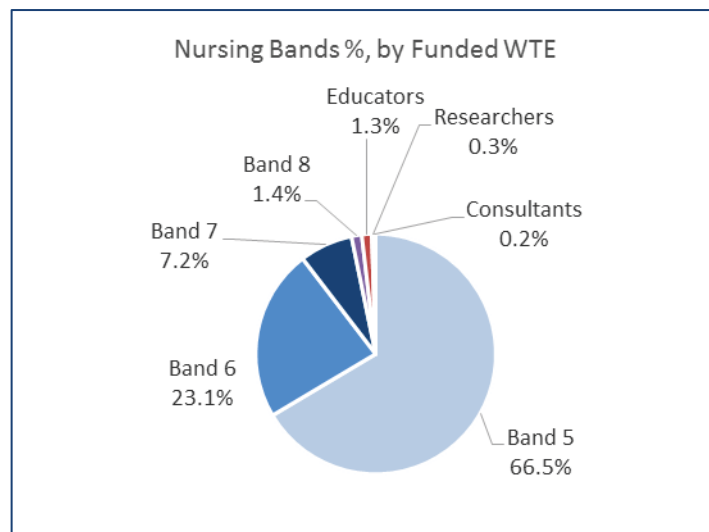Band 7 7.2%
Band 6 23.1%
Band 5 66.5%

Chart 1 provides an overview of how nursing establishments are divided by band.

At the current time there are 27 Nurse Consultants employed within critical care services; of those 27 only one nurse consultant indicated they spend > 50 % of their time working in clinical practice.

Number of Band 2 - 4 Support Staff

Of the nursing establishments 91% of critical care workforce are Bands 5 - 8; 9% are bands 2-4.

Within 70% of the units (132/188), bands 2 - 4 deliver direct patient care. Of these units, 1 include this staff group in the nurse: patient ratios

Table 4		
Band / Post	Staffed WTE	Head Count
2	849.57	840
3	368.54	339
4	59.2	66
Total	1277.31	1245

Nurse: Patient Ratio

The current nurse staffing ratios required according to both D16 and GPICS are:

*Level 3 patients (level guided by ICS levels of **care) require a registered nurse/patient ratio** of a minimum 1:1 to deliver direct care*

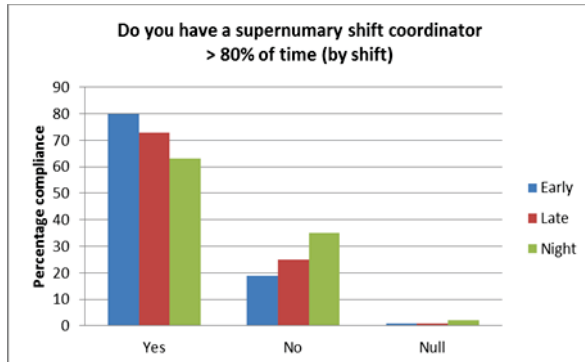Of the 188 responses **176 (93%)** were providing 1:1 care for level 3 patients

Level 2 patients (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum 1:2 to deliver direct care

Of the 188 responses **181 (96%)** were providing 1:2 care for level 2 patients

Provision of Supernumerary Clinical Coordinator Role

The GPICS standards state: *There will be a supernumerary clinical coordinator (sister/ charge nurse bands 6/7) on duty 24/7 in critical care units*

Graph 1

From the data submitted it would appear that there are differences in terms of compliance by shift. (Graph1). The early shift has the greatest compliance, the figure reducing slightly on the late shift and as few as 65% of units have a supernumerary co-ordinator during the night shift.

Of the 60 units who stated they didn't have a supernumerary shift coordinator at night; 80% had 12 beds or less (table 5).

Table 5		
No. of Beds	No. with no night coordinator	Percentage
<=6	17	28%
7-12	31	52%
13-20	9	15%
21-30	2	3%
31-40	1	2%
Total	60	

Registered Nurses over 50 years

It is acknowledged that a significant proportion of experienced critical care nurses are approaching retirement and the survey demonstrated that of the units participating on average 12.9% of registered nursing staff are over 50 years old. The networks with the highest percentage of registered nursing staff > 50 years in table 6.

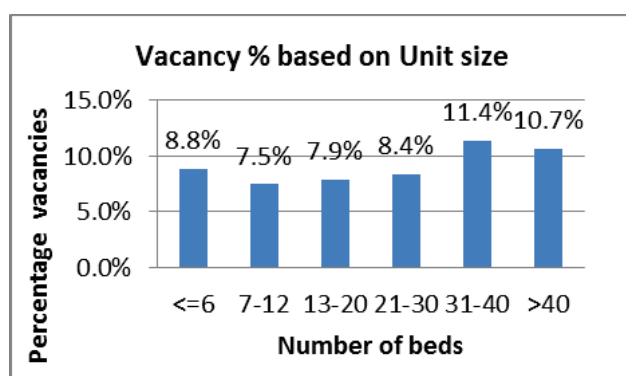| Table 6	
Top 5 networks with highest % over 50yrs	
North of England	25.1%
North Trent	21.7%
North Wales	21.1%
West Yorkshire	20.7%
Kent & Medway	20.5%

Registered Nurse Vacancies

The number of registered nurse vacancies for are set out below in table 7. The highest percentage of vacancies attributed to Band 6 nurses at 9.45%, followed closely by Band 5 nurses at 8.39%. Due to the difficulty in recruiting nurses in general, the Band 5 figure is not un-expected; the Band 6 percentage however raises questions.

Table 7	
Band	**Vacancy Percentage**
Band 5	8.39%
Band 6	9.45%
Band 7	6.32%
Band 8	4.00%

Graph 2

Graph 2 shows the relationship between the size of unit and the number of registered nurse vacancies.

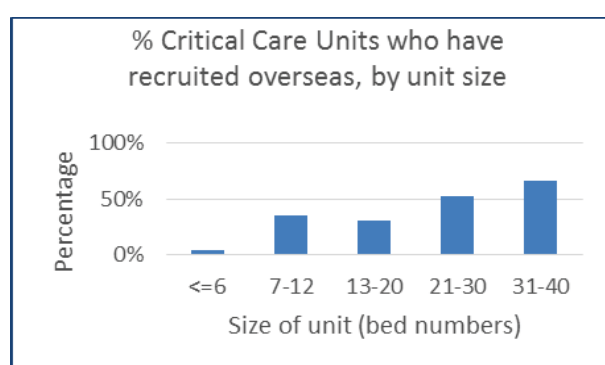The average percentage of vacancies is 9.1% for units surveyed.

Staff Turnover
The average turnover is 11% however 23 units reported ≥ 20% annual turnover shown (table 8).

Table 8			
Trust	Turnover	Trust	Turnover
The Princess Alexandra Hospital	35.0%	Cheltenham General	22.0%
Lincoln County Hospital	30.6%	Frimley Park Hospital	21.0%
Wycombe Hospital	28.0%	Dorchester Hospital	21.0%
Pinderfields General Hospital	27.2%	Barnet Hospital	20.0%
Chesterfield Royal Hospitals NHS Trust	25.0%	Whittington Hospital	20.0%
Belfast City Hospital	25.0%	Queen's Medical Centre	20.0%
Derriford Hospital, Plymouth	24.5%	The James Cook University Hospital	20.0%
St Peter's Hospital, Chertsey	24.3%	Doncaster Royal Infirmary	20.0%
Warrington Hospital	22.9%	RSUH	20.0%
Kings College Hospitals	22.9%	Weston General Hospital	20.0%
The Royal Surrey County Hospital, Guildford	22.9%	John Radcliffe Hospital	20.0%
Basildon Hospital	22.0%		

Overseas Recruitment
There has been an on-going requirement to recruit nurses from overseas to meet the demands placed on services. 108 units stated they had not actively recruited nurses from overseas; 57 units stated they had.

Graph 3

Of the 57 units recruiting overseas there would appear to be a correlation between recruitment activity and unit size (Graph 3).

Table 9	This table gives a breakdown by Networks of units recruiting overseas		
Network	No. of Trusts	Network	No. of Trusts
East of England	11	Cheshire & Mersey	2
South West	6	Sussex	2
Central England	5	Lancashire & South Cumbria	2
Thames Valley	4	London North Central & East	1
Wessex	4	North Trent	1
Kent & Midway	4	North West Midlands	1
Birmingham, Black Country	3	South Wales	1
Greater Manchester	3	West Yorkshire	1
Mid Trent	3	Total	57
North Yorkshire & Humberside	3		

Sickness Rates

The survey asked units to provide 12 months retrospective data in terms of sickness levels which has been linked to unit size. The level peaks just below 6% in units where there are > 20 beds; falling significantly in units with > 30 beds.
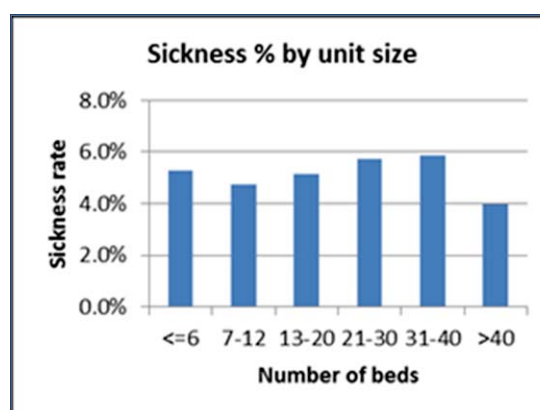
There appears to be a relationship between the size of the unit and sickness absence levels. This mirrors the data provided for vacancies and unit size (Graph 4). The average sickness rate for the critical care units (Band 2 - 8) is 5.1%

Between January and March 2015 the average sickness absence rate for the NHS in England was 4.44 per cent, an increase from the same period in 2014. Nursing, Midwifery and Health Visiting Staff had an average of 5.19%.
(Data taken from the Health and Social Care Information Centre).
http://www.hscic.gov.uk/catalogue/PUB17903/sick-abs-rate-jan-mar-2015%20rep.pdf

Graph 4

Sickness % by unit size

There were 785.84wte staff on maternity leave during the period surveyed. Taking the denominator as 14,828.97 (funded wte for bands 2 through to Nurse Consultant), gives a figure of 5.3%

Agency Usage

Growing shortages of qualified clinical staff have led providers to make increasing use of agency and other temporary workers to fill vacancies. This has led to financial challenges for services and poor use of resources. The recently introduced capping rules are having a significant impact on units dependent on agency nurses to keep rotas afloat.
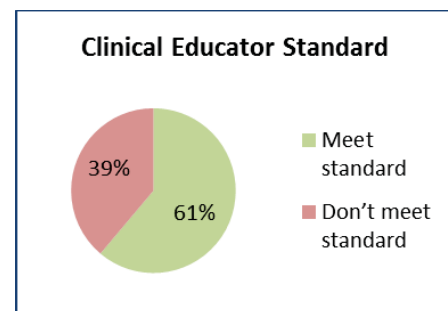
Of the units surveyed 83% who answered the question stated they use agency / bank staff who are not their own staff. 46% of units are using greater than the standard 20% on any one shift; 54% do not. 37% reported using agency/bank staff who are not their own staff on a regular basis. Of those who answered the question (n188) 82% had systems in place to provide a formal induction when staff arrived for a shift. 63% of units had competencies in place for agency/bank staff who were not their own staff. 94 0f the 188 units have been in a position where they have on occasion had to raise concern about agency/bank staff; 1.6% stating this was a frequent occurrence.

Clinical Educator Posts

Recommendations in both GPICS and the Adult Critical Care Service Specification require all critical care units to have a in the region of 1WTE Clinical Educator Posts for every 75 nurses. 139 units provided an answer to this question. At the time the survey was undertaken a wide variation in compliance was reported in the provision of Clinical Educator posts.
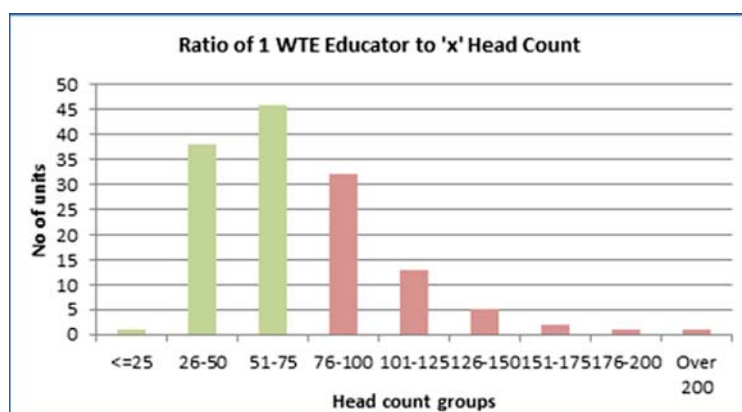
61% (n 85) of units are meeting the standard required; 39% (n54) fail to meet the standard.

Graph 5 shows the ratio of Clinical Educators per head count of staff which gives an indication of the number of staff each Clinical Educator covers.

Chart 2

Clinical Educator Standard

39%   61%

■ Meet standard

■ Don't meet standard

Graph 5

Ratio of 1 WTE Educator to 'x' Head Count

No of units

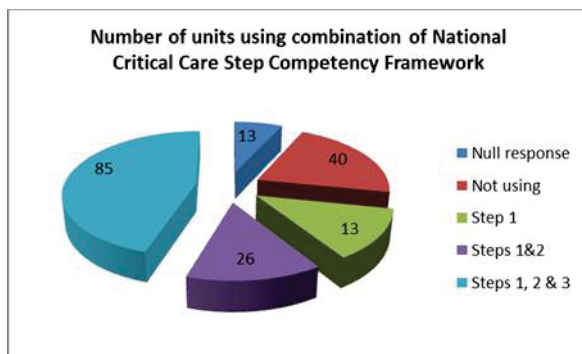<=25 26-50 51-75 76-100 101-125 126-150 151-175 176-200 Over 200

Head count groups

Adoption of National Critical Care Competency Framework

Following the introduction of the National Critical Care Competency Framework (CC3N, 2012) anecdotally there appears to have been a gradual move towards adopting the framework for assessing registered nurses in practice and underpinning academic courses. The framework is broken down in to 3 steps:

- Step 1 for use when staff commence on critical care
- Step 2 & 3 are for use in assessing the competence of staff in clinical practice when undertaking academic critical care modules
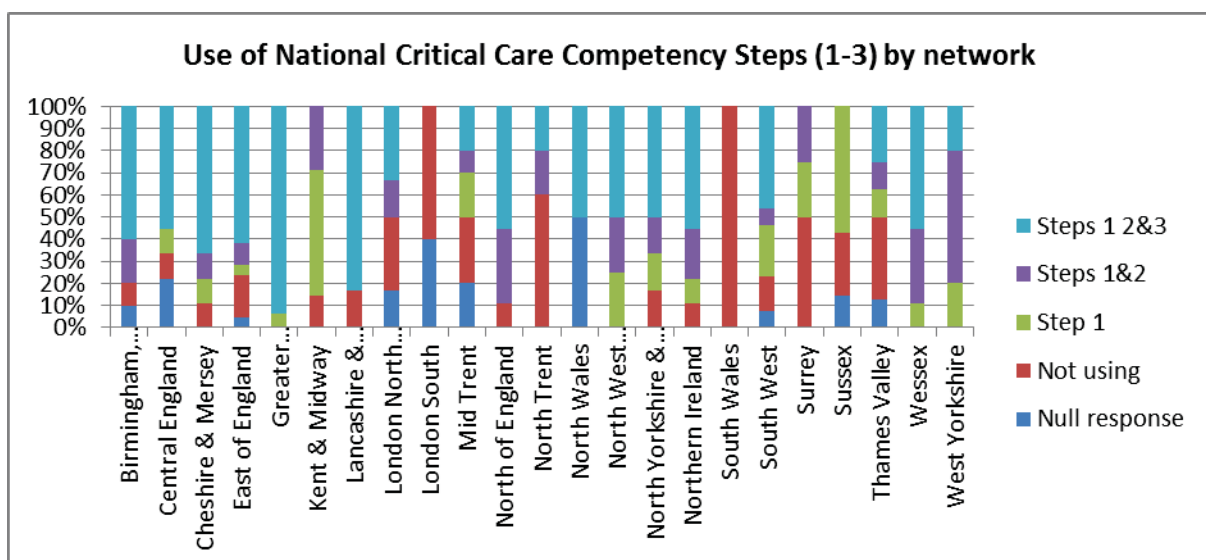
Chart 3

Of the 175 units who gave an answer (13 null values), 85 are using all three Step Competency Assessment documents. 135 units surveyed were using a combination of the framework, leaving only 40 units where adoption had not taken place at the time of answering the question. (Chart 3)

Adoption of National Critical Competency Framework by Network (Chart 4)
Chart 4

Trained Critical Care Nurses

The GPICS standards & D16 require a minimum of 50% of critical care nurses to be in possession of a post registration award in critical care nursing. The figures vary across England, Northern Ireland and Wales. Some networks reporting 0 % compliance to this standard whilst others are demonstrating 90% compliance. This in part is due to the interpretation of the standard, but more importantly the lack of resources and provision of courses for critical care nurses.

The core standards for critical care nurses states all nursing staff appointed to critical care will be allocated a period of supernumerary practice. For newly qualified nurses the supernumerary period should be a minimum of 6 weeks; this time frame may need to be extended depending on the individual. Of the 188 responses 87 (46.2%) provided ≥ 6 weeks, however due to the way the question is asked it is unclear how many of the 81 units providing 4 - 6 weeks do in fact allocate a 6 week period (chart 10).

Table 10	
Period	Number
2-4 weeks	16
4-6 weeks	81
6-8 weeks	72
8-10 weeks	7
>10 weeks	8
Null	4
Grand Total	188

Assistant/Advanced Practitioners

Due to the perceived challenges ahead for the critical care workforce, the survey was keen to obtain an understanding of where role development had or was planned to occur.
Of the 188 returns, 180 gave an answer, with 21 (11.6%) reported already having introduced the role of Advanced Critical Care Practitioners (ACCP); 31.7% have plans in place to introduce the role; 56.7% stated they had no plans at the current time.
The survey demonstrated the Assistant Practitioner role (Band 3 - 4) has been introduced in 14.3% of units who responded to the question; it would appear there are a smaller number of units planning to introduce this Band 3/4 role with only 12.6% have plans, leaving a further 73.1% with no plan.

Administration & Clerical Support

There was a high non-return rate for the Administration & Clerical fields therefore the data has been omitted from this report.

Critical Care Outreach

Out of 160 responses, 136 had outreach teams in situ; 23 did not and 1 null response. Of these, 115 teams formed part of the critical care service where 21 didn't. 114 provide outreach on a single site and 21 provide the service on multiple hospital sites.

The data in table 11 highlights which teams actually provides the outreach services.

Table 11	
Provision of Outreach	**Number**
CCOT (stand alone)	87
Critical Care with H@N	27
H@N	1
Hospital 24/7	13
Medical Emergency Team	2
Patient at Risk Team	3
Null	3
Grand Total	136

Table 12 provides a breakdown of the hours covered by outreach services.

Table 12	
Hours CCOT Service Provided Number	**Number**
24 / 7 service	76
Monday - Friday 24 hour cover	1
Monday - Sunday 07.30 - 21.00	35
Monday - Sunday 07.30 - 17.00	9
Monday - Friday 07.30 - 21.00	2
Monday - Friday 07.30 - 17.00	9
Null	4
Grand Total	136

The GPIC Standards state that:

Each hospital should be able to provide a Critical Care Outreach/Rapid Response Team that is available 24/7.

Of the 160 responses received, 136 had Critical Care Outreach Teams, and 76 of these (56%) provided 24/7 cover.

23 had no CCOT

[13]

Table 13		
Funded Establishment	**WTE**	**Head Count**
OutreachFundedWTEB2	8.84	8
OutreachFundedWTEB3	40.20	41
OutreachFundedWTEB4	8.32	11
OutreachFundedWTEB5	74.21	66
OutreachFundedWTEB6	347.80	373
OutreachFundedWTEB7	443.14	479
OutreachFundedWTEB7AP	47.01	33
OutreachFundedWTEB8Clinical	26.20	31
OutreachFundedWTEB8AP	14.30	28
OutreachFundedWTEB7Physio	6.28	8
OutreachFundedWTEB8Physio	0.50	0
Total	**1016.80**	**1078.00**

Table 13 identifies the number of staff working within outreach teams and their funded establishments. This demonstrates that 34% of staff working in the teams are band 6 and 44% staff is band 7 which means that 78% of team members are band 6 or 7.

7 (n136) teams currently have band 3 /4 assistant practitioner roles with another 7 teams considering implementing the role. However there is a resounding 102 teams (75%) who have no plans to introduce the role.

Regarding the introduction of advanced practitioner roles, 77 (n136) (56.6%) of the teams have no plans to introduce the role, whilst 7 teams are considering. 7 teams already have advanced practitioners.

87 (8.6%) outreach staff out of a total of 1018 are over the age of 50 which is slightly less than the staff working within critical care.

Turnover of staff appears to be lower than for critical care staff with 65 of the 136 teams having below 0.4% staff turnover and 11 teams having between 5 to 10% turnover. There are a total of 5.97% vacancies with 3.85% of the vacancies being band 6 and band 7.

Sickness absence rates for critical care outreach showed that 77 teams (57%) have a sickness absence rate of 0 to 4% and 15 (11.1%) have a rate of 5 to 10%

88 teams (n136) (64.7%) acknowledged having gaps in their duty rotas which are covered by 30% utilising additional hours, 21% using overtime and 20% using critical care staff to fill the gaps. Where other alternatives were indicated a range of other options were used like specialist outreach bank rates, flexible rostering and the use of other staff like consultant nurses or anaesthetic SPR. 14.7% of the teams have to support staffing gaps in their organisations.

90.4% (123) (n136) of outreach teams are trained by utilising competencies which team members are assessed against (table 14).

Table 14	
Competencies	**Number**
Trust Competencies	63
NOrF Competencies	34
Other	10
Network competencies	8
University competencies	7
Null	1
Grand Total	123

Dietetics

Description (returns = 169)

These data suggest that 86% (145/169) of critical care environments have access to a dietitian.

The majority, 70% (102/145) of dietitian are band 7 or above which compliments the range of critical care experience. The majority, 60% (90/145) had at least five or more years of experience in critical care with nearly a third of this cohort (32%) having ten or more years of experience.

Delivery of dietetic services is predominantly over a three to five day model (83%, 140/169) with the majority of these units reporting a 5 day service cover (67%, 114/169). Only three units reported having a seven day service model.

Two-thirds of the units only have between 0.1-0.5wte of dietetics resource allocated to critical care activity (111/169). 21% (35/169) had more than 0.6wte, and only 11% (18/169) of units have 1 or more whole time equivalent (wte) staff allocated to critical care activity.

Supervision for junior staff (band 5-6) does occur in 62% on units (104/169) with 20% of units reporting that no supervision occurred; the remaining units never gave an answer.

Speech and Language Therapy

Description (returns = 145)

These data suggest that only 30% (43/145) of critical care environments can identify a Speech and Language Therapist.

Of these the majority, 70% were band 7, 14% were band 6, and the remainder were band 8

Only 38 units gave a response to the question around resource wte allocated to Critical Care. Of these, 27 reported between 0.1-0.2wte, with only 4 returns stating they had 1.0 wte.

The data around the service delivery model suggests that critical care units have between 3.75- 7.5 hours of Speech and Language Therapy provision per week.

Occupational Therapy

Description (returns = 146)

These data suggest that funded staffing for Occupational Therapy in critical care is very low with 14% (20/146) of units reporting any form of Occupation Therapy input.

This provision covers all banding from band 5 – 8a, with only five units reporting 1.0 - 2.0wte band 7 Occupational Therapist provision.

Only one of the band 7 Occupational Therapists was trained to Masters level.

The proportion of Occupational Therapists involved with follow-up services is only 5.5% (8/146) with only 13.7% (20/146) providing vocational rehabilitation services.

The range of interventions provided by the Occupational Therapists is set out in table 15:

Table 15	
Intervention	**Percentage**
Splinting	42%
Wheelchair /Seating advice	39%
Discharge planning	38%
ADL Rehabilitation	32%
Cognitive Strategies	28%
Communication Strategies	23%
Patient Relaxation	12%

Psychology

Description (returns = 135)

These data suggest only 17% (23/135) of units in the country have a service offering psychological support to patients and families in the unit, with the majority (65%) of these units having access to only one psychologist (15/23).

Psychology services are provided by an identifiable clinical, health or other psychologists in 66% cases. Other titles are used by practitioners providing psychological support including, CBT therapist; counsellor; psychotherapist; nurse with psychological training; psychological support practitioner; follow-up sister and bereavement counselling nurse.

The majority of Psychologists reported were in the band 8 range with band 7 providing the next largest service provision (12/29). Support worker posts were identified as two band 6 positions.

The service provision for psychology was limited with 83 units saying they had no dedicated time, and 14 units saying they had between 5 and 37.5 hours per week. The most frequent provision was 0.2wte with three units reporting one day per week of service.

Psychological follow-up on general wards is provided by 15 units (11%) with the most frequent provision being only 2 hours per week.

Psychological follow-up in follow-up clinics is provided by 17 units (13%) however provision is most frequently only 1 hour per week. Only 1 unit provides psychological follow-up to critical care survivors in the community (4h/week).

The interventions provided by Psychologists are described as percentages in table 16.

Table 16	
Intervention	Percentage
Psychological support of patients and families	9%
MDT consultation about patients psychological welfare	10%
Staff training in providing psychological support	7%
Provide/supervise psychological assessment of patients	3%
Psychological follow-up on general wards	6%
Psychological follow-up post hospital discharge	7%
Provide staff support	10%

Physiotherapy

Description (returns = 169)

These data suggest that:

Band 5: 70% of units (118/169) have between 0.13 – 7.45wte (whole time equivalent) band 5 Physiotherapists. The most frequent staffing level at this band is 1.0wte (48/118) with 38 units reporting 2.0-7.45wte.

Band 6: 73% of units (124/169) have between 0.13- 6wte band 6 Physiotherapists. The most frequent staffing at this banding is 1.0wte (48/124) with 35 units reporting 2.0-6wte

Band 7: 80% of units (135/169) have between 0.13 – 5.0wte band 7 Physiotherapists. The most frequent staffing level at this band is 1.0wte (55/135) with only 13 units reporting 2.0-5.0wte

Band 8 and above: 25% of units (42/169) have between 0.13 – 1.82wte band 8 and above Physiotherapists. The most frequent staffing level at this band is 1.0wte (15/135) with only 3 units reporting 1.6 - 1.82wte.

Band 4 and below: 17% of units (46/270) have between 0.1-2.28wte band 4 or below members of staff. The most frequent staffing at these levels were 1.0wte (15/46) with 4 units reporting 2.0-2.28wte band 2 or 3 staff. Three units reported having 1.0wte band 4 staff members; no units reported having more than 1.0wte at this banding. It is important to note that these bandings (2-4) represent unqualified staff.

There were 562 WTE posts reported for bands 5 to 8, with 77 physiotherapists undergoing post-graduate training to Masters level. The majority (62%) of the Masters qualifications were held by band 7 physiotherapists (48/77).

Service delivery for weekend, bank-holidays and on-calls was predominantly provided by physiotherapists who "don't routinely work in ICU" with an average of 76% of units reporting this mixed approach to service provision.

On-call services were not provided in 6% of units, though this data is difficult to interpret without the identifiable clinical areas to inform this.

The majority of units reported a rehabilitation assessment in the first 24 hours (85%), around half (53%) reported having a rehabilitation prescription tool.
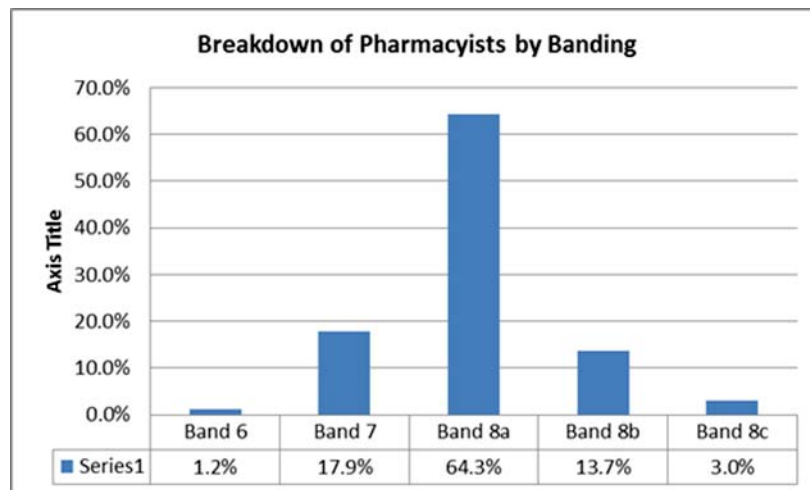
On-going physical rehabilitation was limited, with only 29% of units reporting physiotherapy contributing to follow-up clinics and only 19% reporting the provision of outpatient based services when discharged.

Pharmacy

Description (Returns = 186)

Of the 186 units who responded 165 (89%) had a dedicated critical care pharmacist; 21 (11%) did not. For the units who report having a critical care pharmacist graph 6 provides a breakdown by banding.

Graph 6

Breakdown of Pharmacyists by Banding

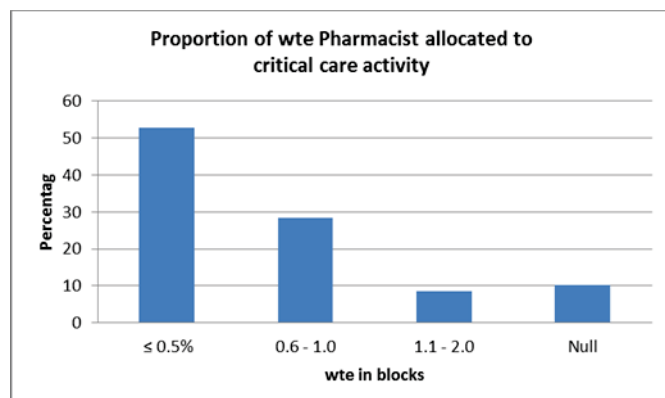|	Band 6	Band 7	Band 8a	Band 8b	Band 8c
■ Series1	1.2%	17.9%	64.3%	13.7%	3.0%

The provision of routine Clinical Pharmacy for Critical Care Services is shown in table 17.
4% (n=7) of units have 7 day plus bank holiday cover. 70% of units (n = 129) have 5 day cover which includes some level of cross cover at weekends.

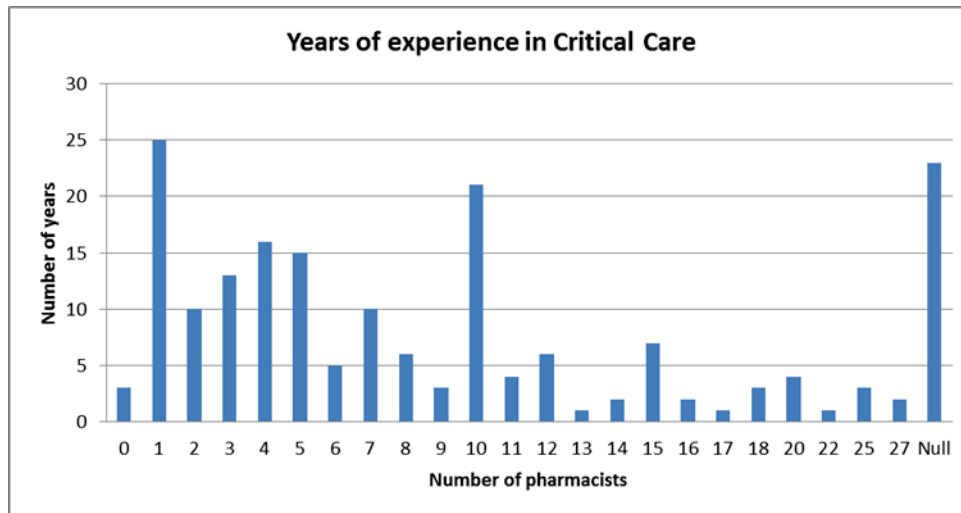| Table 17	
7 days per week including bank holidays	7
5 days per week including cross cover for leave	129
At least 3-5 days each week	35
Ad hoc up to 3 days per week	10
Null	5

Graph 7

The proportion of WTE pharmacy time allocated to critical care varied widely across services, this would need to be understood in terms of unit size (graph 7).

- ≤ 0.5% = 52.6%
- 0.6 - 1.0 = 28.48%
- 1.1 - 2 = 8.61%
- Null = 10.22

Proportion of wte Pharmacist allocated to critical care activity

[18]

There is a wide spread relating to the number of years and experience of the Critical Care Pharmacists. 106 (56%) report having ≤ 10 years' experience; 59 (31%) have ≥ 11 - 27 years' experience; 10.22% did not respond to the question (graph 8).
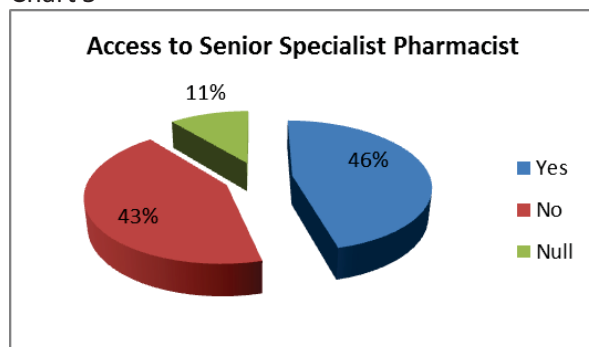
Graph 8

Years of experience in Critical Care

Table 18	
Mastery	11
Excellence/Advanced Stage II	76
Foundation/Advanced Stage I	60
Does not meet Foundation/Advanced Stage	18
Null	21

The level of education for Pharmacists who provide critical care cover ranges from not meeting Foundation /Advanced stage to Masters level study (table 18).

The survey revealed that in terms of practice assessment, the vast majority of Pharmacists (71%) are assessed against local competency frameworks. Only a small proportion use nationally agreed tools UKCPA Critical Care Assessment (9.6%); Royal Pharmaceutical Society (6.3%) (table 19).

Table 19	
UKCPA Critical Care Assessment Group	18
RPS Faculty	12
Own Assessment	133
Null	23

Chart 5

Access to Senior Specialist Pharmacist

It was reported that formal access to a Senior Specialist Pharmacists (accredited Advanced Level Practice in Critical Care Pharmacy) was varied, at best this was available only 46% of the time.

[19]