Integrated Care Pathways: a case for development

1. **Background & Rationale:**

1.1 The modernisation agenda for acute in-patient mental health care provision considers the integration of acute in-patient care with other mental health services – and, notably, Crisis Resolution and Home Treatment Teams (DoH 2002). Integral to the modernisation process, ‘care pathway arrangements are seen as a formula for ensuring that care experiences are built around the needs of service-users, their families and carers (Hall 2004).’ It is particularly important that a service-user’s journey across services is negotiated, managed and agreed, and incorporates planned and coordinated therapeutic intervention and well-organised care systems.

1.2 Integrated Care Pathway (ICP) development offers a continuous quality improvement approach to distinct quality issues that have been well-recognised within the acute mental health setting:
   - poor coordination of care
   - lack of collaborative working – for example, the multiple times that a service-user is asked to go through their story in moving through various stages of the existing route to accessing care
   - care-plans of variable and, sometimes, questionable value and purpose
   - lack of therapeutic intervention and evidence-based practice
   - the increasing need to demonstrate the implementation of national guidance – for example, the NIMHE Guidance on Suicide Prevention, and the growing body of NICE Guidelines and Technology Appraisals
   - audit findings that confirm that key elements of important care processes are sometimes missed (for example: Suicide Prevention Baseline Audit (BLPT 2005))
   - ongoing concerns over the service-user experience of care

1.3 As considered in this short paper, it is proposed that the ICP development approach has much to offer the service, practitioners and service-users in directly responding to the above challenging quality issues.

2. **Integrated Care Pathways:**

2.1 Increasingly used in the UK as a tool for managing clinical processes and patient outcomes (Currie & Harvey 1998), integrated care pathways are multi-professional care plans that provide detailed guidance for each stage in the care of service-users with specific conditions over a period of time (Riley 1998, Ellis & Johnson 1999), and are used for day to day monitoring and quality assurance (Hall 2004). They are known by a variety of names: Integrated Care Pathway; Multi-disciplinary Pathway of Care; Critical Care Pathway; Anticipated Recovery Pathway; Care Maps; Care Profiles; Care Protocols. Originating in New England, USA, in the mid 1980s, ICPs have now been successfully developed and implemented within many general health settings and, more recently, within mental health settings within the UK – for example: Lincolnshire, Gloucestershire, Newcastle & Carstairs.

2.2 **Accepted Definition:** ‘An integrated care pathway determines locally agreed, multi-disciplinary practice based on guidelines and evidence where available, for a specific
patient / client group. It forms all, or part of, the clinical record, documents the care given and facilitates the evaluation of outcomes for continuous quality improvement.’ (National Pathway Association 1994)

2.3 **Integration:** A care pathway is integrated only when it: recognises the contributions of all professionals & those who support professionals, all care sectors, all component parts of the patient’s journey, and begins & ends with the GP / Primary Care Service.

2.4 **Care Pathway Document:** Whilst the content of ICP documents are highly variable, it will always include basic information in chronological order, with events grouped under key headings & organised in time, stages or phases – for example: daily / weekly; assessment / intervention.

2.5 **Variance Monitoring:** An ICP will always clearly record deviations from planned care in the form of variances (*when what is expected to happen does not happen*). Variances are deviations or variations from an activity set out in the pathway. They are the one element that is unique & essential to all pathways and are recorded by the caregiver during the course of care. They allow you to review and update the process of care delivery, with attention to the service-user and other outcomes. Variance will usually be due to (Currie & Harvey 1998):

- *the service-user* e.g. a behavioural problem
- *the care-giver* e.g. an omission or delay in providing the intervention
- *the system* e.g. practice patterns, policies or procedures
- *the community* e.g. transport problems, lack of placements

2.6 Reviewing variance, which may be positive or negative and avoidable or unavoidable, clearly contributes to quality improvement (Currie & Harvey 1998, Hampton 1993, Petryshen & Petryshen 1992).

2.7 In summary, an integrated care pathway aims to have: *the right people, doing the right things, in the right order, at the right time, in the right place, with the right outcome, all with attention to the service-user experience, and to compare planned care with the care that is actually provided.* Pathways are both a tool and a concept that embed guidelines, protocols and locally agreed, evidence-based, patient-centred, best practice, into everyday use for the individual service-user. They are much more than merely a pathway flowchart attached to an operational policy document, but represent a common summary record for care documentation and concurrent audit. A recognised continuous quality improvement tool, the latter sets ICPs apart from the myriad of other tools supporting best practice (NHS Modernisation Agency / NICE 2002, Integrated Care Pathway Users Scotland 2003).
3  Stages of ICP Development:

3.1 There are a number of key stages in the development of ICPs, as highlighted in Fig. 1, below.

**FIG. 1**

![Care Pathway: development stages](image)

3.2 It is important to note that development activity could stop at various stages of the ICP development process – for example, after the process mapping stage, the care matrix analysis stage, or following the development of a service-user pathway element (*such as the development of a specific tool e.g. a service-user information sheet for self-monitoring the admission process*), if the original quality issue has been addressed and it is felt that further activity would be too time-consuming for little further gain (Comment at: ICP Development Workshop, The Health & Social Care Quality Centre, October 2005).

4. Reported Benefits of ICPs:

There are many reported benefits of developing and implementing ICPs as an approach to addressing identified quality issues – these are generally accepted as (Currie & Harvey 1998, Middleton & Roberts 2000, Brett & Schofield 2002):

a. enhanced professional practice – due to an increased use of the evidence / research base
b. streamlined care documentation that enables real-time recording of the actual care that is given – this involves simplifying the process of multi-disciplinary care documentation & reducing duplication
c. improved multidisciplinary communication, collaboration & team-work
d. reduced patient distress
e. the increased involvement of service-users, relatives, non-registered staff-members, volunteers etc...
f. increased consistency with explicit expectations about assessment, treatment and care
g. reduced variations in the care that is provided
h. reduced length of stay & associated costs
i. enhanced clinical outcomes
j. efficient auditing – the ICP document with its integrated variance tracking represents a concurrent audit tool, which promotes quality improvement
k. provides an infrastructure that supports clinical governance

5. Responding to Reported Concerns:

A number of concerns have been expressed within the literature on ICPs:

a. a fear of litigation – although it is argued that practitioners are better protected if able to show that their decision-making was based on an ICP or clinical guidelines (Tingle 1997)
b. that following a standard protocol may conflict with personal judgement, resulting in the loss of spontaneous clinical assessment and intervention, and threatening the therapeutic, intuitive nature of professional practice (Lynan 1994) – ICP implementation in fact incorporates high quality assessment and intervention, and, if used as intended, the purpose of the ICP and variance tracking is merely to guide the timely implementation of evidence-based care and to quickly identify and action-plan any variation from the agreed time pathway
c. the ICP development process is lengthy – however, it is recommended to commence with less complex issues and to view the development process as a series of clear stages, which may help to address the identified quality issue before or even without progressing to the full completion of an ICP document

6. Moving Forward with ICP Development:

The Health & Social Care Quality Centre highlight a number of critical success factors for ICP development and implementation, which would require that:

a. ICPs are included as a recognised part of the Trust’s quality improvement programme
b. professionals groups / practitioners actively collaborate in developing and implementing ICPs
c. the Trust’s Directorates of Medicine and Nursing give their strong support for ICP development
d. priority areas are agreed for ICP development, incorporating agreed SMART goals
e. the Trust agrees for sufficient time and resources to be devoted to ICP development and implementation
f. there is an ongoing education programme to support the development and implementation of ICPs

7. ICP Development – Initial Activity:

7.1 A number of key areas, linked to well-known quality issues, have been identified for initial ICP development activity:

a. ICP for the Acute In-Patient Journey
b. ICP for people presenting with deliberate self-harm
c. ICP for people presenting with dual diagnosis (mental health problem + substance misuse) (this is a NIMHE Eastern priority)
Since late September 2005, a small group of interested mental health practitioners have met on three occasions, to commence and progress work on the first of these issues – the acute in-patient pathway. Following a short educational presentation about ICPs, which covered the stages of development and implementation, this small group has begun to create a visual high level process map of the acute in-patient pathway. As this becomes more detailed, the group are beginning to consider possible changes to the pathway for improving quality. In providing an illustration, a representation of the initial high level pathway is shown in Fig. 2 – this is now being significantly modified to show greater detail.

8. Gaining External Support for ICP Development:

8.1 NIMHE Eastern Acute Care Collaborative
The regional steering group will be engaging in a collaborative approach to redesigning an integrated care pathway for clients with dual diagnosis in collaboration with Paul O’Halloran, Director of Training, Education and Development Team. Assistance will be given to interested teams from several Trusts within the region to develop an ICP, which it is hoped would become a blueprint for the region on best practice pathways for this group of individuals.

8.2 The Health & Social Care Quality Centre, London, which have provided guidance in using a series of CD-ROM based tools to support ICP development – these include:

a. The European Framework for Quality Management – a tool for project planning
b. High level Process Mapping Worksheet
c. Care Analysis Matrix
d. Examples of completed ICPs from around the country
9. Recommendations:

9.1 It is recommended that the Trust supports ICP development and implementation as an approach to addressing known quality issues and providing continuous quality improvement.

9.2 It is recommended that the Trust provides active support in meeting the success factors for ICP development (refer to Section 6).

9.3 It is recommended that the Trust supports the continuation of initial ICP development activity by interested mental health practitioners.

9.4 It is recommended that the Trust becomes actively involved in the NIMHE Eastern ICP development initiative, which will commence in 2006.

10. Key References:


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