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Integrated Care Pathways - Re-engineering the NHS for Clinical Governance

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Abstract

With the introduction into the discourse of the UK National Health Service (NHS) of the term Clinical Governance in the 1997 Department of Health White Paper, *A New NHS, Modern and Dependable,* arguable a new and distinct phase in the relationship between the government of the day and the providers of health care was begun. As a concept Clinical Governance is difficult to define, its very ambiguity aids the ability of different stakeholders to, rhetorically at least, accept it in principle. In its ability to appeal to a strengthening of professional self-regulation on the one hand, whilst simultaneously stressing the need for a greater visibility of accountability and

enforcement on the other, the concept can appear to offer a 'win-win' outcome for health professionals, managers, auditors, politicians and patients alike.

This paper, uses insights, gleaned from early empirical research within a large NHS Hospital Trust to produce a narrative account of the efforts of a group of medical and technical support staff to introduce a series of Integrated Care Pathways (ICPs), which to many of the actors involved, would stand as a concrete example of clinical governance in action. In striving to make a reality of these conceptual notions, many of the tensions inherent in implementing ICPs and clinical governance came to the fore. As such it makes an ideal precursor and pilot project for highlighting some of the problems facing the introduction of clinical governance into the everyday 'culture' of the NHS.

Introduction

> "An Integrated Care Pathway is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes. Variations from the pathway may occur as clinical freedom is exercised to meet the needs of the individual patient." (Middleton and Roberts, 2000).

> "An Integrated Care Pathway *determines* locally agreed multidisciplinary 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 Pathways Association, 1998).

Two definitions of Integrated Care Pathways (ICP) - a closer look at each and one begins to see the potential for the generation of change and tension with the introduction of ICPs into the workings of the NHS. The first definition, offers a view

of ICPs as patient centred, as focused upon the individual patient and with the locus of control, i.e. clinical freedom, defined as a variable that stays if not with the clinician, then with the clinical team involved. The second definition views the ICP itself as *determining* practice and facilitating *evaluation* of 'multi-disciplinary practice' for improvement - not much discussion here of patient centred practice and clinical freedom. The tension created by the ambiguity as to the nature and/or role of an ICP comes into much sharper focus when efforts are made to bring the abstract notion to life.

This paper provides empirical evidence from an ongoing study of the efforts of a NHS Hospital Trust (referred to here as NorthTrust) to introduce ICPs into a number of its clinical interventions. The research begins to show that while the notion of the ICP is seen by the majority of health professionals involved to be beneficial and in the interests of the patient, the reality of 'integrating' the care given by the various professional groupings is not at all straightforward. The difficulties faced by managers and health professionals alike in attempting to make a reality of what the government has outlined as being necessary in order to create the 'new NHS' is clearly seen in their efforts to introduce ICPs. The centrality of the idea of integration within government thinking for the future of the NHS is well presented in the 1997 White Paper, *The New NHS, Modern and Dependable* (Dept. of Health Cmd. 3807, 1997) where it says:

> "This White Paper sets out how the internal market [instigated by the previous government] will be replaced by a system we have called *'integrated care'*, based on partnership and driven by performance. These changes will build on what has worked, but discard what has failed."

A major criticism of the attempts to instigate changes via these sorts of management techniques, what one may call Human Resource Management (HRM) is centred around the underlying assumption held and espoused by the consultants and gurus alike, that an organisation, any organisation, can and should be conceived of as a unitary entity. Under this assumption it is held that all members of a particular organisation, either as individuals, groups, departments or functions, view the role and

the object of the organisation as particular, unified and unambiguous. The notion that an organisation may well, quite legitimately, be thought of as plural or heterogeneous in its make-up would be viewed by the aforementioned consultants as, pathological and in need of attention. Without this assumption of unity many techniques espoused by advocates of HRM for example, empowerment, commitment and continuous improvement become difficult to envisage and even more problematic to operationalise.

The introduction of ICPs into the provision of medical treatment within the NHS can be viewed as an effort to 're-engineer' the delivery of care and treatment within NHS. This is particularly the case when ICPs are placed within the context of the Electronic Patient Record (EPR) and become eICPs. The proposed date for this within the NHS Plan for **all** acute hospitals is 2005. Once an ICP becomes electronic, an eICP becomes more than just a passive route map for guiding a particular intervention, it becomes, in the words of the NHS Information Authority Guidelines (2000): "not simply a question of computerising existing practice ... [but] should be seen as a *business process re-engineering* tool." (emphasis added)

The introduction of ICPs into the NHS as a tool for re-engineering places their introduction in to different category. Within management and organisation studies there has been a good deal of work undertaken to evaluate and analyse the effects of re-engineering processes. The significance of their introduction and the scale of organisational change that is potentially entailed is not necessarily fully appreciated by many members of the NHS. In particular the relationship between HRM and re-engineering has been explored by Willmott (1994) and some of the implications, particularly for the human resources are highlighted:

> "Making the transition from function-centred to process-oriented organising practices necessarily depends upon the 'human resources' who enact, and are also (re)constituted by BPR. Given BPR's focus on business *processes,* it remarkable how little attention is given by BPR to the *human* dimensions of organising." (Willmott, 1994: 35).

Integrated Care Pathways

a) The patients perspective

> "An Integrated Care Pathway is a timetable of events which will happen to
> you whilst you are in hospital. All your tests, medical treatment and nursing
> care are noted inside of this leaflet. The pathway is a guide, for you and your
> family."

The above quote is taken from the front page of the leaflet given to patients as they
begin their treatment for Dento Alevolar Surgery (the surgical removal of wisdom
teeth) within NorthTrust. Patients receive this leaflet after their clinic meeting with
the Maxillofacial Consultant following referral from either their dentist or GP. The
leaflet is entitled - "Integrated Patient Care Pathway" and consists of lists of
information for the patient regarding their time within the care of the hospital. Some
of this information tells the patient what they can expect from the hospital service, e.g.
'You will be nursed on a trolley/bed. A nurse will assist you when its time to get up.'
Other items tell the patient what the service expects of them, e.g. 'You should
shower/bath prior to admission'. This information is organised in three sections,
Before Operation, Day of Operation and After Operation. It is supplemented by
General Information regarding post-operative care and treatment and what to do if
certain events transpire.

From the perspective of the patient the ICP is a set of instructions, outlining what
will/should happen to them during the course of treatment for particular affliction. It
is a four page leaflet, written in clear and precise language and as such is quite an
unremarkable, if useful source of information for patients and their families. This then
is the patients view of an ICP. It is worth mentioning at this point that this
information was given to patients prior to the move to ICPs - but was not labelled in
the same way.

From the perspective of the patient the pathway, as a document, can be conceived of as reflecting very much the ideology of New Labour. It sets up a particular expectation within the patient as to what the *deal* is. It begins to establish the relationship between the patient and medical service providers as a form of implicit contract - a reciprocal arrangement where by the rights and responsibilities of each are made clear. This emphasis on the rights and responsibilities of both consumer and provider can also been seen to lie at the heart of New Labour encapsulated by Tony Blair, who in talking about the welfare system in 1999 said, 'our welfare system must provide help for those who need it, but the *deal* that we are trying to create in Britain today is something for something.' (cited in Fairclough, 2000: 39, emphasis added).

b) The medical staff perspective

For the medical staff, nurses, surgeons, anaesthetists, theatre staff, etc. an ICP is a booklet containing, in detail, the expected trajectory of a patient through their engagement with the hospital. This booklet, and by definition, the pathway is instigated by the Consultant at the outpatient clinic (that is the appointment generated by the referring letter of the dentist or GP).

On the front of this booklet it tells medical staff:

> *'This ICP is intended as a guide to clinical care and the document on which to record the patient's progress through an episode of care, but at any time clinicians/practitioners are free to exercise their own professional judgement. All deviations from this pathway (positive or negative) must be recorded as a Variance.'*

The booklet begins with a list of questions for the consultant to ascertain answers to, from the patient, with regard to their medical history. This is supplemented by a further list of points with regard to the consultants examination and ends with space for a brief written diagnosis and boxes to tick with regard to further treatment, operation with general anaesthetic, local anaesthetic or no operation required and a

space for the consultant to sign. The next page, picks up the patient's journey as they enter the Day Case Unit (DCU) for their operation. (Given the waiting lists at the time of the research the gap between outpatient examination and a bed in the DCU could well be six months).

Page four contains the Anaesthetic Room procedures, page five Operating Theatre procedures, pages six and seven contains the Consent Form, page eight is a largely blank page entitled Operation Record, page nine lists the concerns of Recovery. Page 10 details Post Operative Care protocols. Page 11 is the Variance Record, this is where the clinicians or practitioners record their reasons and responses to the patient being removed from the 'pathway'.

For those medical practitioners involved in the care and treatment of patients requiring Dento-Alveolar Surgery, this booklet stands as the ICP. At one level a collection of the paperwork that stands as a representation of their work - at another level, a representation of the correct pathway along which a patient *should* progress through Dento-Alevolar surgery.

It is immediately obvious is that for the two most intimately concerned groups of people within this medical encounter, the patient and his or her family on the one side and the clinicians and NHS practitioners on the other, the ICP is a very different object.

Moving away from a description of the ICP as an artefact born ahistorically and locally, how else can this object be described? According to a booklet, produced in the late 1990s by the Clinical Pathways Reference Centre for use within the NHS by staff seeking to 'overcome common problems others have already faced' (quote taken from back of booklet). The story of ICPs begins in 1983 and grew out of a nursing and case management initiative in Boston's New England Medical Centre. They produced a one-page 'tool' that contained clinical interventions and a timeline - they labelled this a critical path, a term borrowed from industrial and engineering project management. They proceeded to add to this various 'tools', (their language), e.g. intermediate goals, variance analysis and further documentation which they trademarked as CareMap. As

efforts in the US to monitor and manage health care continued, so the use of ICPs has grown, by 1993 it was claimed that 57% of health care providers in the US have 'a formal initiative for monitoring and managing clinical processes' (Lumsden and Hagland, 1993).

Clinical pathways were introduced into the UK in the late 1980s, as part of the Resource Management Initiative (RMI), an effort to increase the 'emphasis on cost effectiveness, efficiency, the critical examination of clinical practice, and the use of evidence-based medicine.' (Middleton and Roberts, 1998). In essence the pathway should provide a multidisciplinary template for the clinical governance of a group of patients who share a diagnosis or set of symptoms. Ideally, the pathway leads each patient towards a desired objective and ensures that specific interventions are delivered at the right time, by the right professional, in the right way. These pathways are not intended to compromise clinical judgement and any member of the care team can move the patient from the pathway providing there is a valid clinical reason for doing so. These reasons are collated as part of the variance recording and as such become part of the audit process leading to continuous improvement of patient care.

Care pathways, it is claimed can further add to guidelines drawn up by government to improve the quality of health care including evidence based medicine, clinical audit and clinical effectiveness. Though well publicised by government there is little if any information available to local practitioners as to how these initiatives are to be embedded within everyday practices. ICPs are seen by some members of the various health professions, nurses and doctors, as well as managers and administrators to be the way forward. They are welcomed by commissioners, that is purchasers of health care, who see them as an opportunity to become *a currency* for their contracting negotiations and compliance reviews.

Integrated Care Pathways and particularly in their electronic form as eICPs can also be discussed in a very different way. If we view ICPs within a different context, one that views the NHS, not in anyway different from any other major organisation, not as a public service, not as in anyway unique but simply as one of the major employers of human resources in Europe, and as such within the context of a global marketplace

and therefore open to all the pressures of competition that such a marketplace contains, then the role of ICP can be constructed with a very different outcome.

Within this context the need to achieve market responsiveness and at the same time reduce labour costs is seen a paramount. A particularly popular strategy aimed at bringing this about is Business Process Re-engineering (Hammer, 1990; Hammer and Champy, 1993) and within BPR a central role is ascribed to Information Technology (IT). The ability of modern computer technology to facilitate a major re-engineering of corporations, allowing for a stripping out of levels of managers and workers, in taking advantage of IT and its ubiquitous nature to rid an organisation of duplication and therefore inefficiency has seen a proliferation of re-engineering during the late 1990s. The particular strong selling point of BPR as highlighted by advocates is the radical nature and scale of the changes that can be brought about. This is summed up in a famous quote from Hammer:

> "It is time to stop paving the cow paths. Instead of embedding outdated processes in silicon and software, we should obliterate them and start over." (Hammer, 1990)

Is it possible to see the introduction of ICPs into the NHS as part of a strategy of re-engineering? As the quote above shows, there is a certainly a rhetoric within some aspects of the NHS that this is a role that ICPs are capable of - if this is so, then what is the prospect for the NHS? Are we about to see huge numbers of doctors, nurses and paramedics being made redundant? Probably not, but the numbers of managers and administrators may well fall - brought about by the ability of IT to allow these tasks to be done in very different ways. As Hammer again tells us:

> "we must challenge old assumptions and shed the old rules that made the business under perform in the first place." (Hammer, 1990)

Within the literature and strategic intentions put forward by the government for the modernisation of the NHS do we find this sort of language? A couple of examples from *"The New NHS - Modern and Dependable"*.

"These changes will build on what has worked, but discard what has failed."

"The government will work with Health Authorities to streamline their administrative functions."

It is not surprising to find such language within the discourses of the government. The pressures being exerted upon the NHS, from government particularly, but also from its customers (nee patients) to radically change role continue to increase. The changes demanded, it is argued, are driven by a government with a much more overtly managerialist agenda than previous administrations of either political hue. A point emphasised by Norman Fairclough in his recent book, 'New Labour, New Language?'. Fairclough sees government being conducted in the UK, as:

"a discourse and rhetoric of government as political and dialogical but where the processes are in fact overwhelmingly managerial and promotional." (Fairclough, 2000: 124).

For those of us from an organisational studies background who are concerned with understanding and theorising, amongst other things, the managerial efforts and technique's of major corporations this point, well made by Fairclough, would seem to present an opportunity. The idea that the NHS as part of UK plc is being governed and managed in line with models of HRM, or managerial techniques of re-engineering much criticised over the last decade by our community, is maybe not comfortable but maybe one worthy of consideration. The relationship between government and those charged with the management and administration of public sector organisations and the subsequent effects on the services delivered would appear to be open for a reassessment. The traditional view that there still exists some fundamental differences between public and private sector management would appear to come under pressure, when the government of the day attempts to re-configure itself as the board of UK plc.

A pointed example of the managerialist rhetoric with reference to the NHS can be seen from this example taken from a speech by Alan Milburn MP, Health Secretary in March, 2000.

> "My contention is that the UK's health service - modernised and reformed - will be better placed than most other systems of health care world wide to fulfil these conditions. [Of economically efficient health gains both upstream (preventative services) and downstream (sickness services)] In other words, the Government's modernisation programme for the NHS has positive economic benefits for UK plc."

This reconfiguration of the relationship between government and the NHS in particular, but the public sector in general, is one that can usefully be compared to the relationship between senior management of major corporations, and the various sites of business of that corporation. Senior management, with their concerns for strategy, and driven by the imperative of sustaining visible stock market success, have over the last two decades distanced themselves from the day to day activities of their organisations. Relying more and more on their ability to manage at a distance via advances in the power of information technology.

The use of such strategic managerial techniques as BPR and Total Quality Management (TQM) has allowed the inclusion of concepts such as empowerment, flexibility, self-managed teams into the discourse of management. Within this discourse they have allowed for a rhetoric of de-centralisation to become widespread. At the same time, and in a paradoxical fashion, the use of targets and the generation of visible accounting procedures have through the very same information technology, seen a corresponding move towards a greater degree of centralisation. None of this is new to those of us with interests in the management of contemporary private sector organisations, but the impact on the public sector is less well known and would appear to warrant further investigation. As such, the delivery of health care services within the UK becomes a site of interest for an exploration of the way in which managerialist techniques, imported from the corporate world, are practised within the context of the NHS.

It would appear that there is some, all be it limited evidence that the development and use of ICPs can be viewed, by certain stakeholders as a tool for re-engineering the NHS. The rhetoric that surrounds ICPs and the contested way in which their use and efficacy is constructed would appear to leave their implementation as a somewhat precarious undertaking. In the final section, the paper turns toward implementation. In so doing it will report on the efforts of a group of medical, managerial and IT staff to introduce ICP into NorthTrust, an Acute Hospital Trust in the North of England.

NorthTrust was formed in the spring of 1998 with the amalgamation of three former hospital Trusts. The guiding principles for the newly formed NorthTrust are enshrined within in the government White Paper - *The New NHS - Modern, Dependable,* published in 1997, which saw the government announce the end of the 'internal market' and introduce as its replacement the notion of - 'integrated care'.

In the summer of 1999 a Steering Group was set up in NorthTrust to oversee the introduction of Integrated Care Pathways into the Surgical Directorate of the Trust. The Surgical Director had become interested in the notion and wished to begin pilot projects as soon as possible. The director, informed the Lead Clinicians of the various specialities, that he wanted them to set up at least one ICP within their area and to seek to have this in place by the end of the year. The empirical research in this paper is the story of the efforts of one clinician, (from now on referred to as John Smith), to carry out this task and pilot an ICP for Dental Aveolar Surgery or the surgical removal of wisdom teeth.

The author, through a number of interviews with the main protagonists and via observations of meetings and working practices has endeavoured to represent the efforts of the people charged with producing this ICP. The research is ongoing and is planned to continue into the foreseeable future as a collaborative effort between the researcher and NorthTrust.

The surgical removal of wisdom teeth is a routine surgical intervention. The typical route taken by a patient would normally begin with either the patient's GP or more

likely their dentist. Patients usually contact their dentist or doctor complaining of endogenous pain in the jaw. Following examination of the patient the dentist or GP would refer the patient to the Maxialfacial Surgery department by letter. This letter would be considered and if deemed necessary an appointment would be made at the weekly clinic held in the department. Following an examination at the outpatient clinic, during which time a medical history would be taken, a diagnosis would be developed, stating that the patient required the removal of one of more of their wisdom teeth. If they were deemed physically able the usual course of action would see the patient receive an appointment to attend the Day Surgery Unit in the 'near' future. The patient would turn up on the appointed day and could look forward to spending 6 hours on the Day Surgery Unit before begin discharged, during which time they would have their troublesome teeth removed. Following the discharge of the patient the surgeon would write to the referring dentist or doctor outlining the procedure and seeking to inform them of any post-operative care they maybe called upon to deliver.

The straightforward, relatively standard, routinised and short passage of treatment and care made it an obvious choice for the department when they were asked to produce an ICP to pilot. A second, more interesting reason was to do with a possible side-effect that can occur in a very small number of patients upon the removal of the wisdom teeth. Rare though this side-effect is, the number of patients having this treatment (120,000 pa) means that the numbers of patients affected is quite large. The total amount the NHS pays out in compensation to patients when this happens is the single biggest negligence outlay, currently in the region of £6m pa. The ability of the Trust to show that it was not negligent and that it had followed 'best practice' procedures and protocols was a central concern of NorthTrust and the Maxillafacial department. The production of an ICP in this area was seen as an excellent choice to begin the process of introducing a system of 'managing the care of patients'.

The process of construction of the ICP for Dento-Alveolar Surgery, began with discussion between John Smith, Head and Neck lead clinician, and Mary Brown (a former nursing Sister now attached to the IT department of the trust, who was responsible for the production of the actual form). At this meeting, it was decided that

the removal of wisdom teeth would make a suitable case for the construction of an ICP given the criterion laid down by the steering group. It was at this meeting that the start point for the pathway was decided and the different professional groupings that the pathway would seek to integrate were identified.

Mary Brown held meetings with each of the groups identified from the first meeting to give information of the project and to listen to their views. When the ICP was operational it was planned to operate in two different hospitals where the intervention was regularly conducted. What quickly came to light, was that the two hospitals, formerly two different hospital trusts before their merger into NorthTrust, had very different work practices for the same surgical intervention undertaken by the same surgeon. The surgeon, who had been in post for only two years had adapted his practice in order to fit in with the nursing regimes operated by the two different hospitals. It was only with the beginnings of notions of integration via the introduction of the ICP that he began to question.

Mary Brown, working from material she had acquired from the National Pathways Association had spent time talking too the nurses who work in the Day Surgical Units and the operating theatres of the two hospitals and are responsible for the care of patients during their stay in the hospital. After so doing, she produced the first draft of the ICP and a meeting was held, where representatives of the different groups of nurses and doctors were present. (There was no representative from the anaesthetists as they as a group had decided not to join in the ICP as a matter of principle, but this is another story) This first draft was only four pages of A4! The previous paperwork the ICP was replacing ran to almost 16 pages, here was clear proof that re-engineering worked. Was this not a major step forward for the nurses - just look how much duplication had been cut out, was this not marvellous.

The meeting was a mild affair with a fairly low-key response from most of the people there. Mary Brown and John Smith were enthusiastic and sold the ICP quite hard to the nurses, there was some discussion about changes in the order of events and other things missing, but there was also a sense of resignation. The nurses were being asked to pilot the ICP for a couple of weeks and then evaluate the outcome. This was agreed

to by the nurse's representatives and the following week was earmarked. With this agreement the meeting ended.

The pilot day arrived and the nurses began their attempt to use the ICP paperwork. There were obviously some teething problems, but the nurses tried, Mary Brown was hand to take notes and collect observations from the nurses as to what was proving difficult and if it could be altered and changed for the next draft.

What quickly became obvious was that the relationship between the paperwork, and the actual practice, or the doing of the work of nursing these patients was much more complex than first appearances had led Mary to believe. The ICP with its 'pathway' and prescriptive tone, exemplified by the removal of 'blank spaces' to write and its replacement with a set of 'tick boxes' had a profound effect on the way in which it allowed the nurses to represent their work.

The efficiency of the pathway to be the 'one best way' for a patient to move through a treatment for the removal of wisdom teeth, left no room for the nurses to represent the skills and competencies they saw themselves as providing. Instead they saw the ICP as representing an engagement between a patient and some sort of uniformed, automated response. The fact that all they had to do by way of recording and representing their work was to tick boxes, gave them a strong sense of only 'following orders'. They were not allowed to 'explain in nursing language' what had occurred. Indeed, the only opportunity they got to do this was when something went wrong, when they filled in the variance record that stated when and for what reason the patient had not followed the pathway. 'It is only at these times that I feel that I am showing myself to be a nurse'.

The pilot lasted for one day, rather than the couple of weeks and further meetings were going to be held in an effort to overcome some of the problems. These discussions are still ongoing after six months. The ICP as a document is now 12 pages in length and many of the features that were cut out in the first draft have been re-incorporated. They are currently working on Draft 4/5 and as Mary Brown said, 'It

is no longer a pathway, it is simply a collection of the original paperwork pulled together into a booklet.'

The interest for the author in this story is not really about who is winning the battle in the contest over the shaping of the ICP, though that is one that will run and run. The central interest is in the relationship between the practices of the nurses and the records that they keep.

Records are kept for various reasons and a judgement about how 'good' they are depends on the 'reader' being able to 'read' authoritatively the records. What this group of nurses were demonstrating was the differences in the ways each 'read' the records of their colleagues. As one of the central tenants of the ICP is the removal of duplication with regards to note-taking and record-keeping, i.e. getting rid of red-tape, this little case begins to show that this is not a straightforward process.

Records that attempt to span different disciplines or communities, in this case, nursing and none nursing become problematic, because a 'reader' from one community may not have the necessary authority to 'read' the record, generated in a different community. The potential for the ICP becoming a 'boundary object' exists, that is as a 'tool' to facilitate the coming together of different groups may well be desirable, but, I would argue that in order for this process to begin a different vision or image of the process of integration is necessary.

What has been outlined in this working paper, is the opportunity for a better understanding of the problematic processes of 're-engineering' medical interventions and the translation of tools and technologies from product focussed organisations and corporations into the NHS. The implications for ideas of Clinical Governance being introduced into the NHS in practical and resourceful ways is also perceived to have a difficult passage. The relationship between the work of nurses and the modes of representing that work to themselves and others is complex and potentially very important for the future working of the NHS and the governments 'third way' managerial approach to running it.

The research that has begun to show the difficulties faced by the different stakeholders involved in the ICP at NorthTrust will hopefully shift focus in the near future and will take on a more action research focussed intervention. Using ideas from Cultural Historical Activity Theory, a different vision of the process of integration can be developed. One that builds on and develops the metaphor of a 'network of activity systems' rather than the straightforward, mechanical and linear view of the 'pathway' that is inherent within the Integrated Care Pathway.