All improvement requires change, and improving quality in healthcare involves changing the way that things are done, changes in processes and in the behaviour of teams and people. This is reflected in recent government policy in the area of healthcare, which emphasizes the need for change and bemoans the pace of change in the past.

There is a requirement that managers and clinicians across the NHS make change happen and the Modernisation Agency was established to ensure this occurred because rapid, effective service improvement requires targeted expert support to spread best practice and stimulate change locally. It mirrors the change management approach taken in much of the private sector.

Yet such exhortations appear to be based on an assumption that change is a straightforward process that is amenable to being “managed”. In reality the situation is considerably more complex than that conveyed in policy documents and much of the management literature.

Some argue that if teams in healthcare focus on the patient using the framework of a care pathway change can occur without the overt need to “manage” it directly. This approach also provides a means for addressing difficult professional and organizational issues that are often unresolved in broader projects of organizational change. However, there is no simple prescription for managing sustainable change and it is vital that the organizational context is considered. Care pathways represent a useful tool, which teams can use to work through the contextual and practical issues involved in changing practice.

**Origins and development of Care Pathways**

Historically a number of Integrated Care Pathways (ICPs) were developed in specific locations, often following an incident or in response to a perceived local need within a particular group of patients or users. A range of titles have been used to describe this way of organizing care including collaborative care pathways and patient focused pathways. They are designed to standardize care, shorten in-patient stays, reduce costs and involve the patient in decision-making. Their development in the UK has arisen primarily to improve the quality of patient care and the standards of associated documentation by systematically managing the processes of clinical care. The following definition of Integrated Care Pathway (ICP) is taken to include the key features of ICPs:

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.

Some of the impetus for the development of care pathways has also come from the USA and can be seen as part of an international trend towards “managed care”. In order to drive down costs care is “managed”, in that providers have to adopt protocols, specialty by specialty, to control costs. In the early 1990s the NHS funded a patient focused initiative to explore this approach to care organization and as part of this fact finding tours were undertaken by a range of managers and practitioners to the USA where ICPs were already in operation. The ultimate outcome of all this activity was that a need for a national coordinating group to oversee the process in the UK was identified. This led to the establishment of the National Pathways Association (NPA) in 1994. Since 1992 ICPs have been developed and implemented across the full range of healthcare settings in the UK including
NHS acute, community, primary, and mental healthcare, as well as the private sector.

There is also an increasingly international dimension to work in this area. The European Pathways Association (EPA) has been established as a forum for sharing expertise and evidence relating to ICPs across Europe. This indicates that this approach to the organization and management of patient care is becoming widespread and so requires systematic monitoring and evaluation.

ICP development

In 2001 the Royal College of Nursing carried out a survey of all NHS Trusts within the UK. The results of which highlight the widespread use of pathways. A total of 1,069 questionnaires were sent and 405 were returned, a response rate of 37.8 per cent. Of these responses 79 per cent reported care pathway activity, with 89 per cent being in the acute sector. In total 2,879 care pathways were identified.

“ICPs can be used to bring about improvements in care and treatment if applied appropriately. They can serve as a specific tool to achieve change in healthcare.”

However on further analysis it emerged that only 11 per cent of trusts accounted for 50 per cent of care pathways reported with 59 per cent employing a facilitator to promote this. Given that ICPs are intended to improve quality and standardization of care it is surprising to note that only 19 per cent had been subject to a formal evaluation and that a mere 5.9 per cent were integrated with the Electronic Patient Record/Care Record System. On a more positive note 85 per cent expressed a willingness to share the details of the pathways they had developed with others and it was clear that significant activity was being undertaken in areas of priority identified in government policy.

There have been many smaller studies which have investigated individual ICPs and the accumulated evidence regarding ICP has also been examined in systematic reviews. These reviews, reporting on ICP development, produce a useful summary of their strengths and weaknesses, some of which include.

**Strengths:**

- Facilitates the introduction and use of local guidelines, protocols and evidence based-practice as an integral part of clinical practice and in a useable format.
- Excellent prompt for healthcare professionals.
- Encourages multidisciplinary communication and care planning.
- Promotion of patient-focused care and improvement of the provision of information to patients by identifying what care is planned and what progress is expected.
- All patient information recorded by the multidisciplinary team (MDT) in one place in chronological order.
- Less staff time spent on paper work.
- Provides a common language and framework for multidisciplinary patient care.
- Enhances patient education and patient involvement.
- Facilitates change management, evidence based practice, clinical audit and clinical risk management.
- Outcomes such as length of stay, readmission rates and mortality rates are reduced.
- Fewer things missed or overlooked.
- Smoothes transition of care between nursing units.
- Care plan variability decreases.
- Reduces the size of case notes.
- Precipitates agreement in previously debated areas.
- Identifies unnecessary tasks, for example duplication.
- Helps to establish and define the skill mix required for particular patient groups.
- Supports the development of electronic patient records.

**Weaknesses:**

- Time-consuming and costly to produce.
- Medical staff wary of replacing traditional medical notes.
- Documenting and signing off ICP, perceived as an extra burden.
- May discourage clinical judgement, stifle innovation and progress. Concerns regarding cookbook medicine.
- Compliance with documentation difficult to establish.
- Have the potential to be misused if factional healthcare interests have undue influence, in particular health managers may misuse them to reduce patient care costs inappropriately.
- Lack of support, commitment and willingness to change.
Collective solutions

The development of ICPs can be regarded as a fortunate fusion of managerial and professional concerns. The systematization of care through the use of ICPs provides a means for managers to better plan and evaluate the care process, whilst the central focus on the patient at the heart of the process is valued by professionals as an appropriate model for practice. This combination means that, in this area of healthcare, bringing about change has not been as difficult as might have been anticipated. Change management is thus seen to involve professional groups interacting among themselves to invent collective solutions.

Working groups, joint committees, planning task forces, and especially pilot projects are identified as mechanisms that can lead to learning and change in the systems of ideas that guide professional action, yet appeal to a “clan” style governance logic. This principle can be applied more widely in healthcare as it can be seen to be successful. Moving the focus away from an explicit “change management” agenda and more towards working together on more patient-centred projects can bring about the required change. Combining patient and management concerns is vital to this process and helps to facilitate joint working. The evidence suggests that ICPs are successful in this respect, however they will not be the appropriate “tool” for all situations. Rather the need is to consider why they work and seek to mirror the approach in other settings in order to bring about other forms of change.

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