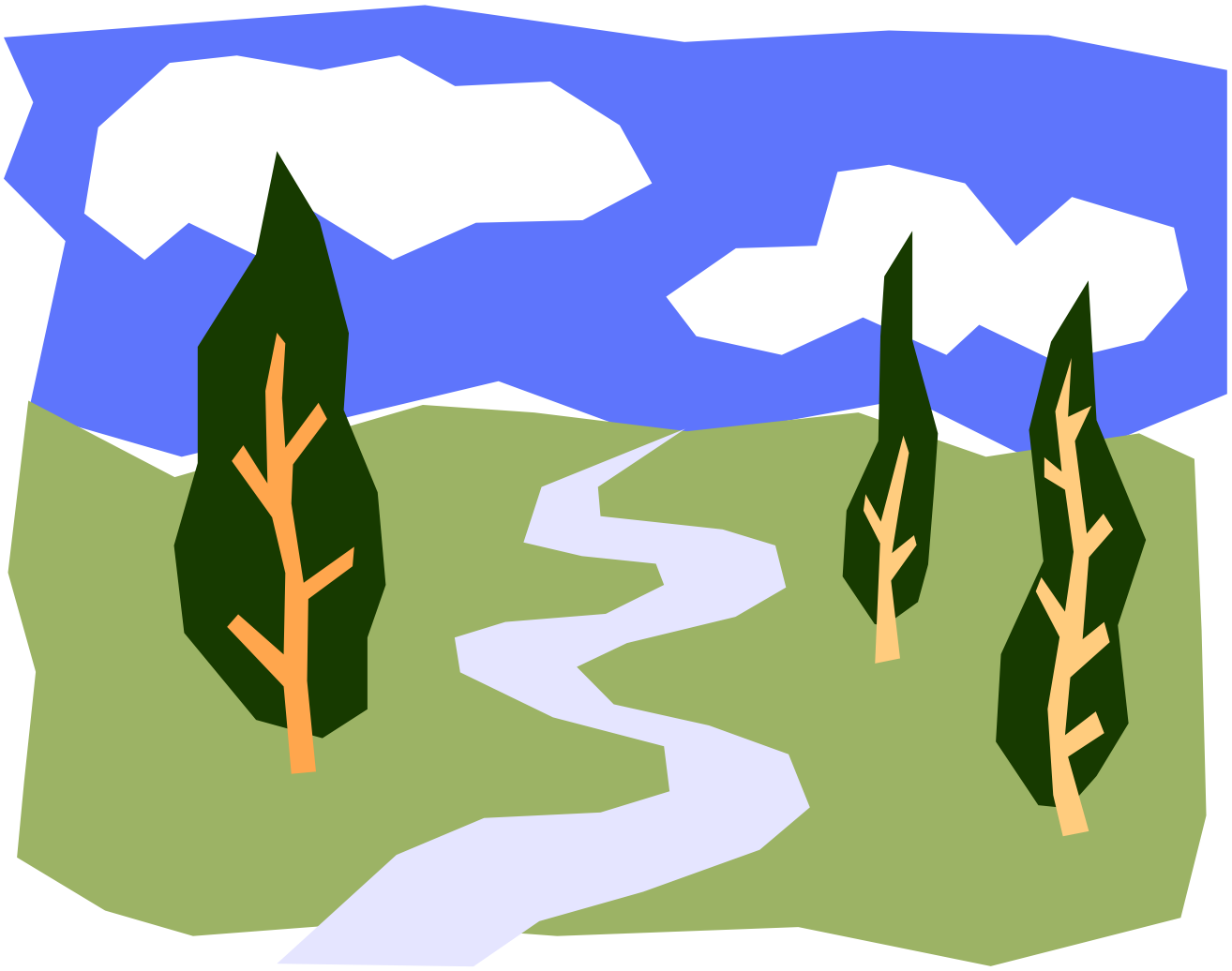
Great Ormond Street Hospital for Children NHS Trust

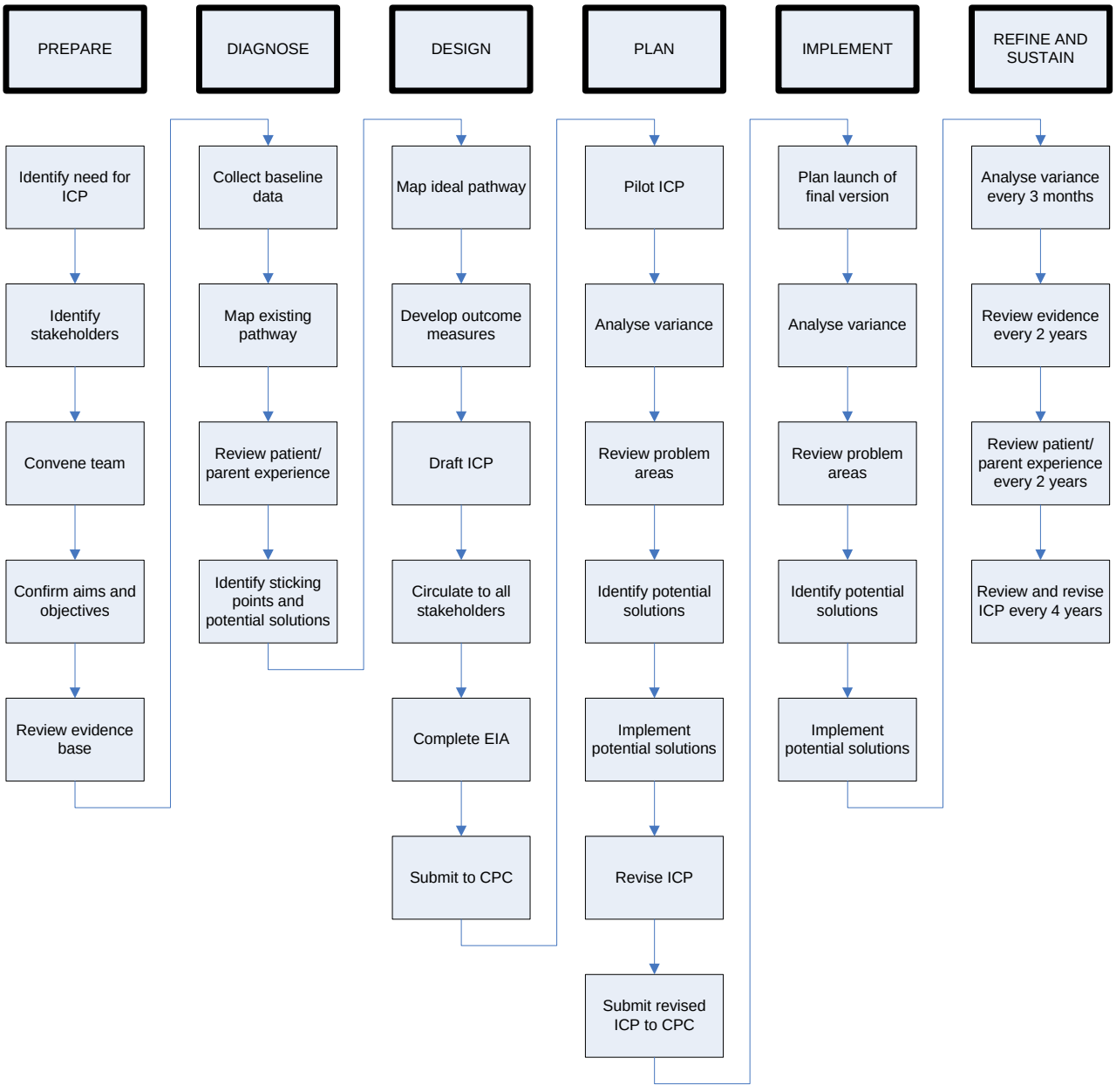


How to produce and evaluate an integrated care pathway (ICP): information for staff

August 2010

A clear process for developing integrated care pathways is used at GOSH. Adhering to the following overview flowchart will ensure that all our integrated care pathways are consistent and of high quality.

Overview of process



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Introduction

Integrated care pathways are one way of managing, monitoring and recording a child's care. They can also be referred to as 'clinical pathways' or 'critical pathways', 'care plans', 'care paths' and 'care maps'.

The European Pathway Association (EPA) defines an ICP as 'a methodology for the mutual decision making and organization of care for a well-defined group of patients for a well-defined period'.[1] Another definition is that an ICP is a 'multidisciplinary management tool based healthcare plan for a specific group of patients with a predictable clinical course, in which the different tasks by the professionals involved in the patient care are defined, optimised and sequenced'.[2]

In addition, an integrated care pathway must contain the following:

- An explicit statement of the goals and key elements of care based on evidence, best practice and patient expectations
- The facilitation of communication, coordination of roles and sequencing the activities of the multidisciplinary team, patients and their relatives
- The documentation, monitoring and evaluation of variances and outcomes
- The identification of appropriate resources[3]

It can be argued that a document that does not contain the above is not an integrated care pathway.

Integrated care pathways at GOSH

In many ways, the use of integrated care pathways at GOSH follows the above definition. However, integrated care pathways used at GOSH should not include GOSH documentation such as the Family Forms, Patient Assessment Form, Immunisation history or Birth History forms.

Observation charts can only be included in ICP documentation if fewer than 10 sets of observations are to be taken within four hours. If more are likely to be required, the GOSH standard A3 observation chart should be used as an accompanying document.

Consent forms may be included if they contain the exact wording used in the GOSH consent form and are 'pre-completed' with standard definitions of the procedure and its associated risks and benefits.

All integrated care pathways should be submitted to the Clinical Practice Committee for ratification before they are used, even for the pilot phase. More information about this follows later in these

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[1] European Pathway Association. (n.d.) Clinical/care pathways. Available at www.e-p-a.org/index2.html. Last accessed 1st October 2008.

[2] Rosique R (2009) Care pathways: methodology and implementation. Presented at Integrated Care Pathways 2009 conference.

[3] Massimiliano Panella (2007) Variance analysis for integrated care pathways in Europe: methodologies, results, outcomes for patients and lessons learnt. Presentation to Change Champions, Melbourne. Available at http://www.changechampions.com.au/resource/Massimiliano_Panella.pdf [Last accessed 24th August 2009]

guidelines. Once ratified, a watermarked copy of each integrated care pathway is made available on the GOSH/ICH website at www.gosh.nhs.uk/clinical_information/care_pathways/index.html .

About these guidelines

This document has been written to guide members of staff at GOSH in developing integrated care pathways as part of an improvement project. It follows the outline of *Improving the patient pathway* published by the NHS Institute for Innovation and Improvement and is split into six phases: prepare, diagnose, design, plan, implement and refine. While it is not compulsory to follow all these phases or the order in which they appear, it should be noted that this is the framework that supports the process of improvement and results in a high quality and truly multidisciplinary integrated care pathway.

PREPARE

Key tasks for 'prepare' phase

- Convene team and identify project lead ☐
- Select topic for integrated care pathway ☐
- Identify aims, objectives and desired outputs ☐
- Recording progress ☐
- Find the evidence base ☐

Convening the team

For an integrated care pathway to be truly multidisciplinary, it should never be developed by one staff group. At the outset, all staff groups involved in the patient journey should be identified. Each group should endeavour to have representation on the development group. A typical working group should include doctors, nurses and allied health professionals, with input from administrative and managerial staff where required. If the pathway is likely to cross boundaries of care, for instance, discharging patients to local services, representatives of these groups should be involved wherever possible.

Patients and parents should also be regarded as key members of the development group. Development of an integrated care pathway without patient/parent input could lead to changes in the pathway that disadvantage certain groups. GOSH is moving towards 'co-design' with patients/parents and these guidelines for integrated care pathway development support this move.

Decisions about how to run the development group meetings lie with the group itself. The frequency of meetings can only be decided in the light of clinical priorities, but it may be helpful to schedule meetings more frequently at the start of development, becoming less frequent as the integrated care pathway is in use and being assessed. All groups should have an overview document stating the membership of the group, the group's aim and objectives and also their desired outputs (see next section) and it is also helpful to take minutes of meetings, recording decisions made and actions required.

Identifying your project lead

All projects, whether improvement projects or not, should have a designated 'project lead'. This should be a member of the development team who agrees to take an overview of the development and check that all tasks are completed before moving on to the next phase. This person should be ultimately responsible for delivering the final product and will be required to report regularly on progress.

Selecting the topic

An integrated care pathway works best where a child has a defined 'journey', including a clear start and end point. A suitable topic for an integrated care pathway could be a condition or a treatment.

There should be input from a variety of groups at various stages of the journey, possibly including different clinical teams.

The decision to develop an integrated care pathway may arise from particular issues occurring in the patient journey that lead to differing outcomes; it may come about because a number of different teams are offering the same treatment in different ways (with or without differing outcomes); clarification may be required around different staff groups' roles within the journey; or it may simply offer a consistent way of doing things that frees up staff time to devote to caring duties.

Integrated care pathways can be used as a tool for improvement, as the stages of development will inevitably identify issues or areas where problems can occur. Development of an integrated care pathway may solve these problems without further work or may be just one of a variety of improvement methods used. However, integrated care pathway development and use rarely involves a 'change of culture' therefore cannot be regarded as 'transformational'.

Identifying the membership, aims, objectives and desired outputs of the development group

Once the membership of the development group has been confirmed, the group should start by identifying what each group member hopes to achieve through the development of the integrated care pathway. This will identify any particular issues in advance and clarify what the group will cover and what they will not. It is also helpful to identify the 'end products' or outputs for which the group is aiming at the outset.

Recording your progress

It is important to record how you developed the integrated care pathway, noting how decisions were made, who was consulted and their responses. One way of doing this is to add your project to the Business Tracking System (BTS) at GOSH. This enables project milestones and regular notes of progress against these to be recorded, along with information such as group membership, financial implications, and relevant documentation. If you have not used the BTS before, please contact the Planning and Performance Manager for a quick teaching session.

Finding the evidence base

A good integrated care pathway should acknowledge the evidence base for the selected topic. The Clinical Support Librarian in the Education and Training department can help teams to locate and appraise research to provide this evidence. In some circumstances, the evidence may have been appraised previously and recorded in the Cochrane database. Again the Clinical Support Librarian can help with access to this and other evidence databases. Once the evidence has been found, the team should discuss it with reference to current practice, identifying areas where practice is different to the evidence base. There may be good reasons for doing things differently, but these should be discussed, acknowledged and noted.

DIAGNOSE

Key tasks for 'diagnose' phase

- Baseline data collection ☐
- Mapping the existing pathway ☐
- Finding out your patient and staff experience ☐
- Issues and solutions ☐

Baseline data collection

If you are developing an integrated care pathway as part of an improvement project, it is vital to be able to measure that the work you are doing and the changes you are making are having an effect. One of the best ways of doing this is to collect baseline data before implementing any changes and then collect the same data at various stages of the project after you have implemented a change.

The types of data to collect can vary depending on the result you are trying to achieve, but a basic data set would include:

- Number of patients being treated
- Average (mean) length of stay
- Minimum and maximum length of stay
- Waiting time for treatment
- Patient/family experience

Other datasets that could have an impact on your integrated care pathway include:

- Clinical outcomes
- Patient reported outcomes
- Incidence of side effects
- Number lost to follow up

Whichever type of data set you collect, remember the rules on using patient identifiable data, available from the Trust's Caldicott Guardian.

You should submit your request for a data report to the Information Services and Planning department. You should also give ample time to run the report and will need to be as specific as possible with your request including:

- Time period to be covered
- Clinical codes for the procedures or conditions to be included
- Data about episodes (for instance, admission and discharge dates)

Data reports are usually provided in an Excel spreadsheet, so if you feel you need training on using spreadsheets, please contact the Education and Training department for advice.

Mapping the existing pathway

It may not be immediately clear why process mapping is a central part of integrated care pathway development. However, mapping existing processes can

- Help each member of the team understand the complete process, including those steps that may not involve them directly
- Identify areas where the process does not work well from either the patient or staff viewpoint
- Show how complicated the process could be for patients
- Allow all members of the team to have a say in designing or re-designing the process
- Provide an end product (the process map itself) that is a useful record for future developments

Before you start to process map, you should identify the scope of your pathway, in terms of the patients it will affect. An example could be: patients having an MRI scan without sedation or anaesthetic. Once you have agreed the scope, this will enable you to map the journey only for this group of patients and not get diverted into addressing other areas. You should also identify the start-

point and end-point for your patient journey, although be aware that process mapping may in fact show that the process starts or ends earlier or later in the patient journey than you imagined. Once you have these parameters in place, you can start to process map.

Process mapping may seem like a complicated skill but we all do it in everyday life, working out what we need to do first, decisions we need to make and actions to take as a result. All you are attempting to do when process mapping is to draw a picture showing the various steps and stages, interactions and tasks associated with a patient's journey. The key is to keep it as simple as possible so that it is meaningful to all members of the group.

A good process map should contain the following components:

- A start point and an end point (scope)
- A defined group of users (patient slice)
- The outcome has a purpose (aim)
- Quality rules for each stage (criteria)

When you are working as a group to map the processes involved in the patient journey, ask yourself some standard questions as you go along:

- Why are we doing this [stage or step]?
- What will happen as a result?
- Is the right person doing this [stage or step]?
- Could anyone else do it?
- Is this being done twice?
- Are we doing this [stage or step] for the benefit of the patient or to make life easier for us as members of staff?

Process mapping can take time to do properly so schedule a two- or three-hour session at a minimum or more frequent one-hour sessions. It is important not to lose momentum at this stage, so it is preferable to schedule all the mapping sessions and notify the team at the same time.

There are three main types of process mapping used at GOSH: simple process mapping, role-lane mapping and value stream mapping. More detail about each type follows:

- Simple process mapping literally records the step by step process followed for a procedure and contains little extra detail. It is helpful to record each step in an 'active voice', that is '[person] receives referral' so that it is clear if a particular person or group of staff carries out a step.
- Role-lane mapping records the process followed but the resulting diagram shows which person or group is doing which step and the way in which the process switches from one person to another throughout.
- Value stream mapping follows on from simple process mapping and role-lane mapping and focuses only on the steps that 'add value' to the patient. These should include each time the patient receives something or does something, or generally has contact with the team.

For more detail about these types of process maps and how to use them effectively, please see the Transformation website at gosweb.pangosh.nhs.uk/transformation/.

When you are designing your process map, you will need plenty of large sized paper, pens and sticky notes. A flip chart or roll of lining wallpaper works well but remember to make sure you have enough space either on the wall or the floor to be able to spread out sufficiently. Your process map will not be

a static document, so you need to be able to amend it as you continue development of the integrated care pathway.

When you have finished the mapping, you will next need to transfer the map into a format that can be stored easily, displayed easily and circulated to the entire group easily. There are two options for transferring your process map into an electronic copy.

- PowerPoint is probably the most widely available programme and is reasonably simple to use. The 'drawing' toolbar gives you the option to draw shapes and arrows so should contain all the components you will need.
- An alternative is Visio, which is a specific programme for drawing flowcharts and similar diagrams. You may need to purchase a licence to access this programme – further details are available from the ICT department.

Once you have made an electronic version of your process map, it is good practice to circulate it to members of the development group for checking and proofreading.

Finding out your patient and staff experience

At GOSH, we practise 'family-centred care' so all pathways should be developed with the intention of improving the patient journey. It is easy, however, to make assumptions about what is important to our patients and their families. An essential part of developing an integrated care pathway is to find out what patients and families experience with the current process, how they feel about it, and how they think it could be improved.

One method of capturing experience that fits well with the process mapping mentioned previously is 'emotional mapping'. The basic principle of emotional mapping is to map the patient/parent emotional journey as well as the actual steps taken. Every journey involves 'touch points' where the patient comes into contact with the service either in person, on the telephone, by reading written material or receiving letters. Understanding the emotions felt by patients/parents at each stage in the journey can help to 'bring the process alive' and often throws up potential issues and solutions. For more information about emotional mapping, please see the Transformation website at gosweb.pangosh.nhs.uk/transformation/.

As well as emotional mapping, there are many other ways you can find this out, the simplest of which is just to ask. However, it is helpful to follow a proven methodology and record all feedback, so it can be compared with future experiences. Examples of potential methods to use are explained in the *How to carry out patient/public involvement and engagement at GOSH* guide, available from the Pals Office, which also gives guidance on how to propose, organise and report your patient/public involvement and engagement activity.

Most of the methods used to record patient/parent experience can also be applied to staff. For instance, mapping the staff member's emotional journey can be useful. Whatever method you use to record both staff and patient/parent experience, it is important to record your findings so that future comparisons can be made.

Issues and solutions

Once you have your basic process map completed and checked by all members of the group, it may become clear that certain areas could potentially cause problems ('sticking points'). An example could be that a patient has to see another clinician within the hospital before a certain procedure can be carried out and appointments cannot always be arranged in the right order. These sticking points may well have cropped up previously but it is helpful to list these separately.

When you have reviewed your patients' and staff experience of the process as it stands, you will probably identify further 'sticking points' to add to the list above. For example, your patients and

families could well report that they have not received a key piece of information or been visited by a member of the team. Equally, community teams may report that they are not being told when a child is being discharged. All of these 'sticking points' should be considered with others identified and potential solutions identified.

Once you have identified the sticking points, you need to work out why they are happening. It is useful at this stage to have a grid showing the issue, root cause, potential solution and way forward. You can then work backwards from the issue to identify the root cause.

For example, an issue could be that afternoon theatre lists rarely start on time. The group thinks about why this happens, which could be that surgeons rarely finish their morning lists on schedule so overrun to the afternoon. The group then considers why the morning lists rarely finish on time, which could be that they rarely start on time. The reason that the morning list rarely starts on time should then be considered, which could be that there are not enough nurses to accompany patients to theatre at the start of day shifts, which causes delays to list starts. So, after some discussion, the root cause could be that there are not enough nurses to accompany patients to theatre in the morning, which has a knock on effect of delaying the afternoon list. A potential solution could be to have a 'float' of nurses taken from several wards, whose only duty at the start of day shift is to take patients to theatre.

For more information about analysing sticking points and identifying potential solutions, please see the Transformation website at gosweb.pangosh.nhs.uk/transformation/.

DESIGN

Key tasks for 'design phase'

- Develop outcome measures ☐
- Draft pathway document ☐
- Circulate for comment and proof reading ☐
- Equality impact assessment ☐
- Sign off from clinical leads ☐

Developing outcome measures

There is an increasing need for services to be able to provide quantifiable measures about the clinical effectiveness of their interventions. This follows Lord Darzi's Next Stage Review and is evidenced at GOSH by the work that is being undertaken to develop specialty- and service-level Quality Accounts. When pathways are being developed, it will be beneficial if thought can be given to the kind of measures that could be used to assess whether the care being given is effective.

Drafting your pathway document

Integrated care pathways can have many different appearances. There is currently no standard template for integrated care pathways at GOSH, but there are certain elements that should be included regardless of the layout and content.

- **Document reference details** – The title page contains details of the scope of the pathway and instructions for its use, which should not be amended. Please see appendix 1 for the text. The footer of the title page should contain details of version number, status of document (draft, pilot or final), production and review date, and document lead.
- **Signature sheet, abbreviations and glossary** – Each member of staff using the pathway should sign this page and then use their initials for the remainder of the document.

Abbreviations should be avoided wherever possible, but where unavoidable should be noted on this page. A glossary of terms used can be helpful, particularly if re-definition of terms forms part of the pathway.

- **Outcome measures** – Outcomes from procedures are starting to be measured at GOSH for inclusion in the Annual Quality Account, which has to be submitted to the Department of Health. There are two types of outcome that we measure: clinical outcomes and patient-reported outcome measures (PROMs). Wherever possible, outcome measures for each part of the journey should be developed alongside the integrated care pathway and included after pathway tasks.
- **Variance tracking** – The simplest way to include the facility for variance tracking is to include a sheet at the back of the pathway document, with space to record:
- The task number
- What occurred?
- Why?
- What did you do about it?
- Outcome
- Initials

An example variance recording sheet is in Appendix 2. For more information on variance recording and reporting, please see later in this document.

Circulation for comment and proof reading

Once you have finished the draft integrated care pathway, you should circulate it for comment to the rest of the development group. They should check that each task in the integrated care pathway is correct and scheduled in the correct order and no tasks have been omitted.

Following review by the development group, you should circulate the draft to all wards and departments who will be using the integrated care pathway. As with the development group review, they should check that the integrated care pathway contains all tasks completed in the correct order, which may also identify any variation in practice between wards. Once you have received comments back, these should be discussed with the development group and the pathway document amended as needed.

A final proof read for errors and mistyping is essential before submitting the integrated care pathway for permission to pilot.

Equality Impact Assessment (EIA)

An equality impact assessment is a method of ensuring that any policy introduced does not affect one or more groups of people (staff, patients, families) in an adverse way. It also helps to identify discrimination and unmet needs. One of the organisation's objectives is to recognise diversity within different patient, family and staff groups, so that everyone can have a positive experience and get the most from their time at GOSH. Equality Impact Assessment (EIA) is just one of the ways we can ensure our work does not discriminate against any one person or group of people and helps promote equality. All integrated care pathways need to have an EIA form completed before submission to the Clinical Practice Committee. Further details about how to carry out an assessment are available at www.gosh.nhs.uk/about_gosh/equality_diversity/downloads/EIA_policy_form.pdf

Sign off from clinical leads

The final stage before submission to the Clinical Practice Committee is to have the signed approval of the clinical leads for each area involved in the integrated care pathway. In many cases, they will be

part of the development group, but it is good practice to have their signed approval in case of issues at a later stage. A specimen approval form is available in Appendix 3.

Submission to Clinical Practice Committee for piloting

All integrated care pathways should be submitted to the Clinical Practice Committee (CPC) for ratification before they are used, even for the pilot phase. This group meets on a monthly basis and includes representatives from all areas of the hospital. You will be expected to send the submission form in Appendix 4, along with the draft integrated care pathway, a completed equality impact assessment and a summary report of how the integrated care pathway was developed. In most cases, you will be asked to attend a CPC meeting to explain the pathway and answer any questions.

The CPC will use an assessment tool adapted from one developed by NHS West Midlands to review the integrated care pathway and its development. Please see Appendix 5 for the evaluation tool used at GOSH. Once the pathway has been discussed by the committee you will either be given 'permission to pilot' or asked to amend the pathway and bring it back to a future meeting.

Printing your pathway

You should arrange for your pathway to be professionally printed before piloting. Copies printed from an office printer and stapled together will not be suitable for inclusion in medical records. Medical Illustration will be able to print copies for you, usually with a quick turnaround time, so email the pathway to them at gdesign@ich.ucl.ac.uk. They will send you a design proof as a PDF to approve before printing the final version. Make sure that the pages appear as you want them, with each episode of the pathway on a new sheet. The final version will be produced as an A4 stapled and hole-punched booklet ready for insertion in medical records.

PLAN

Key tasks for 'plan' phase

- Organising the pilot ☐
- Variance analysis ☐
- Organising and reporting variance analysis ☐
- Implementing potential solutions ☐
- Post-pilot amendments ☐
- Second stage pilot ☐
- Progress reporting ☐

Organising the pilot

Ideally, your pilot should be on a small scale, so that the pathway can be completed by a small number of patients and amended according to the variance recorded. In most cases, a small scale pilot with 10 patients will be sufficient. If your integrated care pathway covers a long period of time, for instance from referral to follow up, it can be helpful to focus initially on the inpatient stay part of the episode and then expand with later pilots to cover earlier or later stages. Remember that pathway development is a continual process and you will need to build in amendment time into your development plan.

Once you have received permission to pilot from CPC, identified your pilot cohort and had a small number of pathway documents printed, you should nominate one person in the team to lead the pilot. This person will be responsible for noting which patients are on the pathway and collecting the medical notes after the pilot for variance analysis. The variance analysis can be done by one or more people but it is helpful to have one person 'administrate' the pilot.

Variance analysis

Variance analysis is a critical part of developing and using integrated care pathways. It could be argued that without variance analysis, a pathway document is just another piece of documentation. Variance analysis is used to measure what happens to the patient on the pathway, whether they deviate from the expected pathway and if so, for what reasons. The resulting analysis can be used to amend the integrated care pathway itself (if, for the majority of patients, the practice is different to the pathway) or the processes followed (if a certain task is persistently not met or not met at the expected time).

It is helpful for more than one person to carry out the variance analysis to arrive at a consensus for the reasons for variance. Once the medical notes have been collected, the pathway documentation should be photocopied for each person carrying out the variance analysis. Each person should then independently review the variance section. If there are any differences in opinion, the group should discuss each occurrence and arrive at a consensus for the reason it happened.

Implementing potential solutions using PDSA cycles

PDSA cycles (or small cycles of change) are a central theme in improvement work. Whenever a potential solution is identified, you should introduce it following a Plan-Do-Study-Act cycle. Ideally, you should introduce one potential solution at a time, so that you can clearly measure whether it is having a positive effect. Introducing more than one potential solution is confusing for those involved and will cause problems with data analysis as you will have difficulties identifying which solution is having an effect. When you have identified the potential solution you wish to implement, you should aim to introduce it and evaluate it on a fairly short timescale, perhaps within four to six weeks. This will enable you to continue using this solution or identifying another way of tackling the sticking point. For more information about PDSA cycles, please see the Transformation website at gosweb.pangosh.nhs.uk/transformation/

Post-pilot amendments

Once you have carried out the variance analysis, you will be able to see where amendments need to be made. It may be the case that a particular task is not being carried out, so improvements need to be made to this section only. Alternatively, a whole section of the pathway may not be working well, in which case, more in depth improvements may be needed. For more information on carrying out improvement work following your pilot, please see the Transformation website at gosweb.pangosh.nhs.uk/transformation/

Second stage pilot

Ideally, your second stage pilot should follow the same process as your initial pilot. This will allow you to make direct comparison to see whether improvements you have made, either to the documentation or the process itself, have led to any reduction in variance. It is also helpful to repeat the patient and parent experience survey carried out in the initial pilot, again to confirm whether improvements have made a difference.

Once you have completed your second stage pilot, you should again present a report along with any amendments to the pathway document to CPC for ratification. Once they have reviewed and approved the report and the final pathway document, you are ready to implement it across the Trust. Suggestions for how to best achieve this follow in the next section.

IMPLEMENT

Key tasks for ‘implement’ phase

- Printing your integrated care pathway ☐
- Telling people about your integrated care pathway ☐

- Training colleagues to use the integrated care pathway ☐
- Uploading your integrated care pathway ☐

Communication

Integrated care pathways only work if they are used consistently for all patients within the scope statement. You will already have identified all the stakeholders during the 'prepare' phase and you should make every effort to include them in the review process. Once the integrated care pathway has been piloted and approved for implementation, the team will need to meet stakeholders to tell them about it.

Training

Telling colleagues may not be enough if they are unfamiliar with the concept of an integrated care pathway. A short teaching session has been developed to explain the concept and how integrated care pathways should be used in clinical practice.

Launching the final version

You will already have identified the number of patients who will follow the pathway in the 'diagnose' phase and you should aim to have around two years' worth of the document printed. Depending on the numbers involved, this can be through Medical Illustration for small numbers (fewer than 200 patients per year) or through the Trust's printers for larger numbers. The CPC can help you arrange printing through the latter.

Once the pathways have been printed, they need to be circulated to every member of staff who will be starting patients on the pathway. This may be the clinical nurse specialist if your pathway starts at pre-admission, consultants if it starts with an outpatient appointment or ward staff if the pathway starts at admission.

Uploading your integrated care pathway

You should also submit your pathway document to the GOSH/ICH Web Manager for inclusion on the GOSH/ICH website. A watermarked version will be made available for information, but should not be used in clinical practice, as the GOSH standard is to have pathway documentation commercially printed.

REFINE AND SUSTAIN

Key tasks for 'refine and sustain' phase

- Variance analysis ☐
- Updating evidence and patient/parent experience ☐
- Reporting on quality, safety and experience ☐
- Updating pathway document ☐

Variance analysis

Once the integrated care pathway has been implemented, variance analysis should be completed every three months or so, analysing the pathways of patients discharged in the previous month. It can be helpful to nominate one person to carry out the variance analysis for a set period, after which the baton is passed to another team member. The Clinical Audit team may also be able to offer help and support. Variance analysis reports should be submitted to the Clinical Practice Committee and Clinical Unit Lead with details of action to be taken to reduce variance in future. If actions are not reported within six months, details may be added to the Clinical Unit's risk register.

Updating evidence and patient/parent experience

New evidence may also come to light or new policies introduced in the Trust which mean that the pathway needs to be amended. It is good practice to review pathway documentation regularly. Clinical guidelines are reviewed every two years, so it is sensible to search for new evidence every two years and repeat the patient/parent experience activity every two years as well.

Reporting on quality, safety and experience

As part of the updating process, you should make regular reports on quality, safety and experience to the relevant clinical unit board(s). This information should also be copied to other relevant members of staff or groups, for instance outcomes for inclusion in the annual Quality Account and experience to the Patient/Public Involvement and Engagement Advisory Group.

Updating the pathway document

As you are carrying out variance analysis, it may become clear that some parts of the pathway need amendment. You can amend the integrated care pathway following these activities, but it is advised that you then carry out a large scale review and revision every four years. Some pathway documentation may need more frequent reviews and updates than this, particularly if the field of medicine is new and developments are being made. You should decide the review period for your pathway during the design period, document this and then review it within that timescale.

Further reading

Organisations

- Health Information Resources – www.library.nhs.uk – You will need an Athens username and password to access the collections – further information from the Library on ext. 2424
- European Pathways Association (EPA) – www.e-p-a.org/
- EPA England branch – contact c.l.whittle@bham.ac.uk

Journals and articles

- The *Journal of Integrated Care Pathways* is published by the Royal Society of Medicine and indexed in Medline. Unfortunately it is not available from the National Library for Health or via UCL, so individual articles will need to be ordered through the ICH library.
- What is an integrated care pathway? article from Bandolier journal – www.medicine.ox.ac.uk/bandolier/painres/download/whatis/What_is_an_ICP.pdf
- Evidence of whether integrated care pathways work article from Bandolier journal – www.medicine.ox.ac.uk/bandolier/Extraforbando/Forum2.pdf
- Hyett KL et al (2007) Valuing variance: the importance of variance analysis in clinical pathways utilisation. Australian Health Review 31(4) pp565-570. Available through the National Library for Health.
- Campbell H et al (1998) Integrated care pathways. BMJ 316 pp133-137. Available at www.bmj.com with your Athens username and password.

For more information

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Ref: 2009S0016 March 2010
www.goshfamilies.nhs.uk

Appendix 1 – Standard instructions for use

Instructions for using this ICP

- The ICP incorporates the detail and information required for this patient journey/episode together with specific activities and variance tracking, which compares planned and actual care.
- When activities are completed the practitioner should initial in the “met” box and enter the date and time in the adjacent boxes.
- In the event of variance from the plan or if an activity is not met, the practitioner should initial the “not met” box, enter the date and time and complete the variance tracking at the foot of the page.

Important

- Each professional making an entry in this record must complete the signature sheet on page 2, after which they should use only initials when making an entry.
- In using this ICP the practitioner should refer to trust policies, clinical practice and procedure guidelines and protocols, which provide evidence and support the activities contained herein.
- This document complements rather than includes existing stand-alone documentation in use at GOSH.
- The integrated care pathway forms part of the legal record of care received so must be completed fully.

Appendix 2 – Example variance tracking record

Instructions for use

- Each time a task is not met, the variance should be recorded in the table below.
- This page should be photocopied and used for variance analysis

Date	Time	ID	What occurred?	Why?	What did you do about it?	Outcome	Initials
Example							
31/11/08	10am	0013	Parents not given written information	Computer network down	File copy requested	Parents given written information	JB

Appendix 3 – Submission to CPC

Name of person submitting	Click and add details
Job title	Click and add details
Contact details	Click and add details

Title of integrated care pathway	Click and add details
Status of integrated care pathway	Draft ☐ Pilot ☐ Final ☐

This integrated care pathway has been developed

- involving all members of the multidisciplinary team ☐
- involving representatives from all relevant units ☐
- using the best available evidence ☐

Funding has been allocated for printing the integrated care pathway documentation ☐

A named person is responsible for maintaining the integrated care pathway ☐

Name and job title Click and add details

Resources for carrying out variance analysis have been identified ☐

Details Click and add details

The following documents are included in this submission

- Integrated care pathway document ☐
- Completed equality impact assessment ☐
- Summary report of integrated care pathway development ☐

Date submitted DD / MM / YYYY

Appendix 4 – Approval form

Title of integrated care pathway	Click and add details
Status of integrated care pathway	Draft ☐ Pilot ☐ Final ☐

☐ Approved for publication without change

☐ Approved for publication with amendments – please send amended version for approval

☐ Approved for publication with amendments – no further version required

☐ Approved for publication on the GOSH/ICH website

Document lead	**Head of Department**
Signed _____	Signed _____
Name _____	Name _____
Ward/Dept _____	Ward/Dept _____
Date _____	Date _____
Other team members	
Signed _____	Signed _____
Name _____	Name _____
Ward/Dept _____	Ward/Dept _____
Date _____	Date _____
Signed _____	Signed _____
Name _____	Name _____
Ward/Dept _____	Ward/Dept _____
Date _____	Date _____
Signed _____	Signed _____
Name _____	Name _____
Ward/Dept _____	Ward/Dept _____
Date _____	Date _____

Appendix 5 - Integrated care pathway appraisal tool

Note: This appraisal tool is adapted from the integrated care pathway appraisal tool (ICPAT) developed by NHS West Midlands in 2006.

No.	Question	Yes	No	Comments
Section 1 – Is it an integrated care pathway?				
1	Does the integrated care pathway have an identified start and end point?	☐	☐	
2	Does the integrated care pathway reflect the patient's journey?	☐	☐	
3	Does the integrated care pathway outline the anticipated process of care?	☐	☐	
4	Does the integrated care pathway act as a plan for staff at the point of care?	☐	☐	
5	Does the integrated care pathway reflect the input of all those who contribute to care/treatment, that is, all members of the multidisciplinary team?	☐	☐	
Section 2 – Document content				
6	Does the document layout comply with the GOSH template for integrated care pathways?	☐	☐	
7	Is the integrated care pathway going to be professionally printed as an A4 stapled and hole-punched booklet?	☐	☐	
8	Where guidelines or protocols are referred to in the integrated care pathway, are these readily available at the point of care?	☐	☐	
9	Does the integrated care pathway refer clearly to GOSH patient assessment documentation?	☐	☐	
10	Do the integrated care pathway entries on discharge planning comply with GOSH policy?	☐	☐	
Section 3 – Development – see development summary supplied with draft integrated care pathway				
11	Is there a record of who was involved in the development of the integrated care pathway?	☐	☐	
12	Is there a record of other stakeholders consulted during the development of the integrated care pathway?	☐	☐	
13	Are there records of progress achieved in the development of the integrated care pathway?	☐	☐	
14	Was pre-existing practice reviewed before development of the integrated care pathway?	☐	☐	
15	Were patient and family views of existing processes sought during the development process?	☐	☐	

16	Were staff views of processes before and after development of the integrated care pathway sought?	☐	☐	
17	Has the integrated care pathway been piloted?	☐	☐	
Section 4 – Implementation				
18	Has a budget been set aside for printing the integrated care pathway professionally?	☐	☐	
19	Have arrangements for stock control of printed integrated care pathways been agreed?	☐	☐	
20	Have all members of staff been informed about the integrated care pathway and received training in its use?	☐	☐	
21	Have resources (staff and time) been allocated to carry out variance analysis and report back to members of staff?	☐	☐	
Section 5 – Maintenance				
22	Is there a named person responsible for maintaining the integrated care pathway?	☐	☐	
23	Are there plans in place for reviewing the evidence on which the integrated care pathway is based every two years?	☐	☐	
24	Are there plans in place for seeking patient and family views of the process every two years?	☐	☐	
25	Are there plans in place for reviewing and revising the integrated care pathway every four years?	☐	☐	

Final decision	
Major revision required ☐	Further information required ☐
Permission to pilot with amendments ☐	Permission to pilot without amendments ☐
Permission to implement with amendments ☐	Permission to implement without amendments ☐
Date of decision _____ / _____ / _____	Chair of CPGC _____