

Debate & Analysis

Follow the yellow brick road:

integrated care — can we do better?

PATHS OR PATHWAYS OF CARE?

'Follow the yellow brick road'. That's what patients are supposed to do. Embark on a pathway, follow it and reach their destination, medical care achieved. Well, doctors have difficulty with this concept. Pathways often become rigid and prescriptive, sometimes the actual path taken is a winding convoluted yellow brick road, with multiple stops and deviations. Patients deserve better. A quick smooth route, where each step in the actual pathway is linked together, where the destination of health and recovery is reached directly and efficiently. Enthusiasts point out that improving patient care by providing a pathway based on national guidelines, has clear advantages. Others would state that pathways are simply a crude guide for the inexperienced, a basic map for the unfamiliar? Fixed pathways should deliver gold standard health care, through best practice. Local areas adapting to achieve the ultimate safe, efficient, and cost-effective goal of patient care. This is integrated health care. But is this actually happening?

PATIENTS LOST WITHOUT HELP?

Gaps exist within healthcare systems, which prevent patient pathways from being smooth and direct. Patients can disappear off the pathway for days, deviating from the path, lost in the system. Examples are daily.¹ Mrs Smith, admitted by default with a treatable at home chest infection, on a Friday night, has a delayed discharge because of the absence of social care and physiotherapy access, then picks up a urinary tract infection, leading to a DVT on the ward, followed by problems with coordinating INR management at home.

While the pathway may be good in principle the practical organisation and implementation is not always smooth.¹ Issues occur in both primary care, secondary care, social care, private care, and voluntary care. Each sector can see the problems. However sectors are not, as yet, consistently working effectively together in an integrated way to share these problems and to attempt to prevent future recurrences.

How many consultations across the NHS are wasted, handling the frustrations, anger, and morbidity arising from the barriers and gaps in the paths of patient

care? Complaints are but the tip of this iceberg. Absorbed and then ignored, there is often no process to funnel these frustrations and to convert them into a feedback process to improve the pathway locally. Complaints are actually the goldmine of advice, which used on a bigger collated scale as feedback could and should improve local pathways, tailor them to local needs, and result in financial savings.

MISSING AN OPPORTUNITY FOR INTEGRATED HEALTH CARE?

There remains a genuine wish and impetus to move forward. All those involved in health care, without exception, want to see processes work better. More seamless, more integrated care. Clinical commissioning still remains an opportunity to improve practice across primary and secondary care. The risk is that the evolutionary process becomes derailed. Instead, focusing on reorganisation of regional administration and management rather than improvements of local clinical care and the education of clinicians in service provision and pathways.² Most examples of good practice, involve bringing everyone in the whole care pathway together in a multiprofessional approach.³⁻⁷ The hiccups in a patient's care pathway are often organisational, a delay to get an X-ray, a CT scan, access to physiotherapy, obtain a walking stick.¹ The key is having a practical way to bring the lead clinicians together for a short focused period to highlight problems in the care pathway and to solve them together so that another problem elsewhere in the system does not result.

DRIVERS FOR CHANGE

In many cases the drivers for change are actually the marked reduction in budgets. Organisations are forced to actively look at practical ways to make savings. At times of austerity there are clear benefits in

collaboration and pooling of resources. The health and wellbeing boards are an obvious vehicle for this if used effectively.⁸ The concern is that these are being underutilised. The incentives for improvement of care are actually more now than when the NHS was in receipt of greater investment. More efficient, community-based services can be achieved through discussion of complex cases, risk stratification, shared case planning, and comparison of outcomes across multidisciplinary groups using a reporting of metrics.³⁻⁵

WHO'S IN THE DRIVING SEAT?

GPs are said to be leading this, but they must retain a dispassionate overview of the processes. GPs must avoid a GP-centred approach by looking at the whole service across all sectors of care.² Primary care is well placed to provide feedback on systems and to facilitate improvements. Success can be achieved via collaborative working across bundles of clinical pathways, while still retaining a focus on patient care. But clinicians need to actively seek the wider view. Applying Mintzberg's principles of reflection, analysis, collaboration, action, and worldliness⁹ could help to prevent clinicians becoming entrenched in the narrower perspective of their individual clinical silo.

WHAT IS NEEDED?

Well, easily accessible, local fact management databases are essential, but they are as yet, embryonic in their evolution. 'Map of Medicine' is a national project, which lays out clinical care pathways and has brought clinicians together in teams to discuss pathway patterns as clinical reference groups.¹⁰ Map of Medicine is a good begin, starting to establish local information and local guidance. Adding in a more effective 'wiki' element may empower

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local healthcare workers further by allowing them to edit and add local relevant information directly. Whatever system develops, what is clear is that rapid retrieval of user specific information during each consultation is essential.¹¹ Clinicians cannot possibly remember everything. A fact management system, that rapidly indexes summary points, linking to more detailed documents would be a major innovation. ‘Local Linked Addresses Management and Advice’ is such an example, reviewed by the University of Winchester and the Wessex Deanery.¹² It is tailored and focused, with local user input, but is not as yet in a format that can be applied nationally.

KEYS TO SUCCESS

‘Integrated care’ is now part of the national outcome framework for the first time and a focus of one of the four main work streams of the second phase of the Future Forum Phase.¹³ Sharing and analysing models of success rather than reinventing the wheel can only be good for national development. Successes invariably involve a lead clinician and a lead administrator.⁴ When the patient is stuck or lost in the system, the lead clinician and administrator are available to tackle the issue. They are a focal point of coordination and feedback, essential to the future success of clinical care pathways.

FEEDBACK

There is a need to find an easy route of feedback to improve care pathways. Nationally there is currently no clear mechanism in place for local patient and clinician feedback. What we have is either labelled as ‘patient complaints’ or is ‘feedback on whole organisations’ such as that undertaken by Dr Foster.¹⁴ A website portal which can collate information related to a particular bundle of care pathways may provide the answer. This could be linked to sites such as Map of Medicine.¹⁰ There is a risk that the sheer volume of comment could simply overwhelm, but it is the pattern of feedback more than the detail, that will guide lead clinicians on where to focus. Examples of good practice are beginning to

emerge. One is a clinical dashboard updated on outcome measures of patient care¹⁵ which has been applied in several specialities at Salisbury NHS Foundation Trust. Other examples of integrated care are described where there has been improved health care with significant cost savings. Examples include care for older people in Torbay, COPD care services in Somerset, and diabetes care in London which have been described at the King’s Fund conferences and in the King’s Fund reports.³⁻⁵

EDUCATION

Education underpins the whole process. Education about the key contacts, education about how to access the information, education about who is available to provide care, education about how to refer. Education for all members of the care pathway and in particular for those involved in commissioning of care should be at the forefront of all planning. Information needs to be provided in easily recalled concepts, nuggets, and bytes of information. What were first called skills networks and are now known as local education and training boards (LETBs) could be pivotal in this and have the potential to provide a multiprofessional approach with a focus on education related to pathways of care in each specialty.¹⁶ LETBs could bring together trusts, deaneries, colleges, and medical committees, plus medical, non-medical, public, and private stakeholders. Concerns exist however that primary care representation on LETBs is vastly overshadowed by secondary care representation. Sitting alongside health and wellbeing boards,⁸ with the right encouragement, LETBs have the potential to improve the care of the whole population.

IS IT ACHIEVABLE?

Good examples do exist. The King’s fund ‘GP Whole Systems Leadership’ approach helps doctors to focus on a specific path of care and facilitate improvement.⁶ The London Deanery has set up education for integrated care in specific specialities.¹⁷ The RCGP has

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a network of Clinical Commissioning leads. Improvement Science Fellows and Service Improvement Fellows are all being trialled in Deaneries such as Wessex. What makes a difference is meeting together and working face-to-face in localities. It is this bottom up rather than top down approach, using the principles of action learning and action research, that produce lasting change. The review, feedback, change, and review approach⁵ needs to be embedded in clinical commissioning contracts at local levels. Clarity on routes of feedback and a requirement for named clinical and administrative leads is essential for success. Listen to those along the yellow brick road and in so doing undertake to continually improve the route.

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Provenance

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