A CASE STUDY: USING INTEGRATED CARE PATHWAYS IN MENTAL HEALTH CARE

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ABSTRACT

Background: Integrated Care Pathways (ICPs) are prearranged processes of care which are being increasingly used to deliver mental health services. The literature reveals difficulties in their development and implementation, and a lack of empirical evidence to support their use.

Aims: The aim of this research was to investigate how an ICP has been used to manage mental health care in one selected mental health Trust in England.

Methods: A case study approach was adopted with several units of analysis. The views of healthcare professionals using semi structured interviews; the experiences of service users and carers using focus groups; contrasting hospital episode and performance statistics with a comparison Trust and documentary analysis of the ICP.

Findings & Discussion: Of the healthcare professions, only nurses used the ICP. No professionals used the ICP to support clinical decision making and risk management. However, just over two-thirds (67.2%) of the interventions described in the pathway were delivered. There was no statistically significant difference when comparing performance indicators for an equivalent episode of care between the ICP Trust and non ICP Trust. Service user and carers' experiences revealed that people did not feel that their care was individualised to them, although amongst them they had different perceptions of the care process.

Conclusions: Mental health ICPs need to reflect the relationships between stakeholders, variability of illness and individual ways of living if they are to provide a framework for managing care in the future that accords with the needs of people using mental health services.

CONTENTS

CHAPTER 1

INTRODUCTION

This research focuses upon an Integrated Care Pathway (ICP) used in acute inpatient mental health care. In health and social care the expression 'Integrated Care Pathway' has been applied in a variety of ways. The term has been used for general descriptions of a patient journey and high level process maps of services and processes of care. Responding to this ambiguity it is important to define at the outset what an ICP is for the purposes of this research, and in relation to the literature that is discussed. For clarity, many authoritative definitions concur that an ICP is a multidisciplinary plan of care that provides detailed guidance for care delivery at each stage of a patient journey, often considering a specific health problem or need, over a given period of time (Riley, 1998). The ICP exists as all or part of the clinical documentation and deviation from the plan is documented as a variance. This information is then used for the day-to-day monitoring of care and periodic analysis for quality improvement.

It is this specification of an ICP that has become widely used in United Kingdom (UK) mental health care from the mid 1990s onwards and is the focus of this research. ICPs were originally developed in the United States (US) (predominantly in general medicine) before being used in mental health services in the UK (Jones, 1997; Jones, 1998). Their use has received a growing commentary of anecdotal reports of reduced length of stay, economic gain, improved service user experience and positive clinical outcomes (Thornton, 1997; Brett and Schofield, 2002; Nott, 2002). However, in contrast, there are critics who voice negative affects upon professional judgement, longer term outcomes and patient autonomy (Olsen, 1994). Despite these criticisms, the described difficulties of development and a lack of robust evidence about their use, ICPs are now widely used in mental health care. For the purposes of this research the terms service user and patient are used interchangeably throughout the literature review, findings and discussion. This research began by a proposal in 2003 and received subsequent support by a subject specific grant from the Economic and Social Research Council. Medical Research Ethics approval for the study was received in September 2006. Data collected to complete the research relates to a period of four years between 2004 and 2008. Described in more detail within the methodology, this research focuses upon the use of an ICP used on 6 wards in 3 geographical locations within a United Kingdom (UK) mental health National Health Service (NHS) Trust. This care pathway has been used from 2003 onwards, and is now in a fifth updated version. The ICP details the anticipated inpatient care for those aged between 18 and 65 years old with acute mental illness. The ICP is used for people who have a variety of mental health needs and diagnoses, when their needs cannot be met without inpatient care.

The literature review which underpins this research was first conducted in 2003 and refreshed in 2006 and 2009. The main focus of the literature is the topic of mental health ICPs. Although wider literature about developments in mental health care and the relationship that ICPs have with other processes are also considered. Therefore, secondary themes which supplement the literature include clinical guidelines, care plans, case management and the Care Programme Approach (CPA). The literature highlights that much is known about the development of ICPs in mental health care (Jones 2003; 2004), whilst little is understood about their use and impact. Limited research has been conducted into the topic whilst significant investments have been made developing ICPs within mental health services. Where research has been conducted papers often lack detail about sample size and selection, confounding variables and limitations. Therefore to date there is little convincing evidence to support their use despite the impetus and activity. Overall, the literature provides a mixed commentary about ICPs as an approach to pre-formulating mental health care.

Whether an ICP approach adds value beyond other accustomed approaches to managing care is questionable. The literature highlights philosophical issues about the use of ICPs and whether they may compromise individualised approaches, which is seen as a prized facet within care delivery (Peet and Wakefield, 2002; Raynor, 2005). Linked to this it is a notable weakness that there are no detailed investigations of how healthcare professionals use ICPs on a day to day basis. Whether they do use ICPs as a basis for decision making and a way of managing pre-formulated care is unknown. Indeed, how professionals incorporate individualised care and patient choice into a pre-formulated approach to managing care is unclear. Arising from the literature is a strong sense that not enough is known about how mental health ICPs are used to manage care or about the consequence or experience of using ICPs. These issues have been raised but have remained unanswered for over a decade. The anecdotal claims about the benefits of mental health ICPs are largely unsubstantiated. Therefore the need to determine whether ICPs are an effective and acceptable way to organise mental healthcare delivery, and whether the continued investment in ICPs is justified poses the following principle research question. How is an ICP used to manage mental health care?

The principle question suggests a research approach that considers the interpretative investigation of how an ICP is used and experienced. Whilst allowing for a corresponding position about the effects of an ICP. As a consequence of the literature review the following four research questions were developed to cumulatively answer the principle question.

1. How do healthcare professionals' use ICPs as an approach to managing mental health care?
2. What are service users' and carers' experiences of care that is managed using an ICP?
3. How does the care described in the ICP compare with what is actually provided?
4. What is the impact of using an ICP upon key performance outcomes?

This approach gives a holistic view of the care pathway as a case and offers new knowledge in the field. This would be an original contribution to knowledge reflecting important international policy and practice issues. At the centre of the research are the philosophical debates that have begun to emerge in the literature, driven further by the need to match the allocation of investment into mental health ICPs with a corresponding level of knowledge.

CHAPTER 2

LITERATURE REVIEW

The main focus of this review is the topic of mental health ICPs, although wider literature about how mental health care is managed is drawn upon. Debates are supplemented with theories about other approaches to managing mental health care i.e. clinical guidelines, care plans, case management, care management and the Care Programme Approach (CPA). These topics have been included due to their associations with the topic that is under research. By way of illustration, clinical guidelines are often used as the content of an ICP, and there are similarities in that both are attempting to pre-formulate the interventions used to meet particular health needs (Dykes, 1998).

Similarly, there are links between the CPA, care plans, case management and ICPs. Each of these is a means of managing care used either discreetly or collaboratively (Floersch, 2002). It is not uncommon for healthcare teams to use all of these approaches in their day to day work. Nor is it unusual for ICPs to be used as a mechanism to underpin the Care Programme Approach (CPA), to incorporate care plans and include case management principles (Wakefield & Peet, 2003). Including these secondary topics develops a literature review that encompasses the wider structural, process and outcome issues about managing mental health care. This places the ICP literature in a wider context which provides a more thorough understanding of the issues arising from the study.

This literature review was conducted using the general principles for a systematic review (Weightman, 2004). Steps were taken to identify the relevant sources to answer the questions, assess the quality of the included sources, summarise the evidence and interpret the findings. The main digression from a systematic review is the scarcity of primary empirical studies investigating the impact of ICPs.

The inclusion criteria for sources used in this review include qualitative and quantitative studies about the use of ICPs, models of nursing, care plans, case management, clinical guidelines and the CPA within mental health care. Also included are non research peer reviewed papers and texts by leading authors. Excluded are sources which did not have any reference to mental health care or psychiatry. It was not intentional to exclude sources in languages other than English, although none were found using the search process described. Sources prior to 1980 were generally not included due to the extensive sources available from beyond this date and the relative scarcity of scientific literature.

Nine electronic databases were searched (see table 1) with the keywords; case management, care management, nursing models, care plans, the Care Programme Approach and ICPs. Several terms that are used to refer to ICPs such as care maps, care pathways, critical care paths, clinical pathways, anticipated recovery paths, critical care maps and managed care were also used. The searches which revealed vast sources were limited to methods, standards, utilisation, trends, evaluation and history. To operationalise the inclusion criteria the search filter mental health and/or psychiatry were applied to each of the searches. All the sources that met the inclusion criteria were retrieved and reviewed, and then a decision taken to include or exclude the source. As suggested by Rowley and Slack (2004) it was the intention to include sources with a firm theoretical base and critical commentary. The reference lists of all the sources were considered for their relevance and a number of secondary references also contribute.

Table 1 – Database searched and dates covered

Database	Dates covered
British Nursing Index	1985 - December 2008
CINAHL	1982 - Week 2 2009
Embase: Psychiatry	1980 - Week 2 2009
Psychinfo	1985 - Week 2 2009
International Biography of the Social Sciences	1951 - Week 2 2009
Ovid Medline (R)	1950 - Week 5 2009
Cochrane Database	Issue 1 2009
UK National Research Register	Issue 2 2009
NLH Evidence Based Reviews	January 2009
British Library Catalogue	1985 – January 2009

The review begins with describing the structures that are used to manage mental health care and how these have developed over time. There is an introduction to the concept of mental health care pathways and details about how they have been adopted. There follows sections which specifically discuss ICP development and implementation, the contrast of ICPs with other approaches to managing mental health care, evaluation of the impact of ICPs and finally the main philosophical debates about their use. Throughout, the researcher considers the literature critically and elaborates on the concept that has become known as a mental health ICP. A summary of the ICP literature included is shown in Appendix 1. Where appropriate, the limitations of the literature are indicated and the associations with this research highlighted. Three peer reviewed papers have been published arising from this literature review (Hall and Callaghan, 2008; 2009a; 2009b).

1. Developments in managing Mental Health Care

Care plans, care management, ICPs, case management, the Care Programme Approach (CPA) and clinical guidelines are commonly referred to in discussions about how mental health care is managed. Each can be associated with developments in mental health care and traced back over decades. Considering these approaches, health policy and organisational changes over time reveals how mental health services have come to the point of using ICPs to manage mental health care and consequently why this has become a topic for research.

Many writers have documented the history of psychiatry and the social history of mental illness (Ramon, 1985; Porter, 1987; Jones, 1993; Shorter, 1997). Sociological perspectives focus upon the dialogues associated with power, religion, genius and gender (Porter, 1987). Others concentrate upon the profession of psychiatry, the establishment and features of asylum care, biological psychiatry, psychoanalysis and treatment approaches (Shorter, 1997). These texts set out the historical and philosophical understanding of mental illness. They make known the ways in which those experiencing mental health problems have been cared for over time moving from institutional to community care.

The literature reveals how mental illness is perceived and the roles that different groups have adopted in relation to mental health care. Specific approaches to managing care like care plans and case management do not feature in history, even though they pre-date the period which includes community care. During the 1950s the majority of psychiatrists remained focused upon neurology and physiology (Ramon, 1985). Other professional groups involved in mental health were developing an interest in conceptual frameworks and professionalisation, while the social dimension of care was still absent at that time. Ramon (1985) describes how Dutch and American movements towards psychological factors drove thinking towards community care in mental health.

Theory development and mental health nurse training in the United States (US) preceded developments in the United Kingdom (UK) (Nolan, 1993). Postgraduate training for nurses in the US was common by the 1920s and saw publication of the first psychiatric nursing textbook – 'Nursing Mental Disease' by Harriet Bailey. Around two decades later moves away from the disease model could be seen in the work of Nightingale, Peplau, Henderson and later Orem, Johnson and Roy (Fitzpatrick and Whall, 1996). These theorists, and others, through the mid and late twentieth century heralded the development of nursing models representing the purpose, philosophy and theory of nursing. These models went on to be used as sources of research, templates for practice and as guides for further knowledge development.

During an era of positivism in 1952 Hildegard Peplau's Interpersonal Relationships in Nursing described a conceptual framework that continues to influence mental health nursing today, this has been particularly significant in a field that has become more professionally diverse (O'Toole and Welt, 1989; Peplau, 1988). In their relationship to nursing practice, Chinn & Kramer (1995) report that many early conceptual nursing models were accompanied by descriptions of the nursing process, replacing illustrations of the subordinate helper of doctors, the role of the nurse became more valued and credible.

Early texts about medicine outweighed those of other professions working within mental health (Ramon, 1985). Nolan (1993) reports that in the UK that mental health nurses were long seen as the psychiatrist's lowlier helper. Theoretical developments in the profession appeared later than within general nursing. This was supposedly due to an inability to transfer medical approaches into mental health in the way that had been achieved in general nursing. Nolan (1993) illustrates this telling how in the early 60s a Staff Nurse returned from general nurse training and began to introduce individual care plans for patients on a mental health ward. This practice was supported by nurse tutors and soon caught on. However, when nurses asked if these plans could be filed in the doctor's notes, a psychiatrist tore up the plans and said that only doctors were able to make such plans for patients. Nolan (1993) reported that the doctor's stance was supported by hospital managers and consequently, the staff nurse left the hospital soon after. This echoed Goffman's (1961) earlier asylum studies where access to case records were restricted to medical staff and higher level nurses. Nursing notes were kept merely to chart the course of illness and keep a record of the patient's conduct.

References to care plans grew during the 1960s as nurses continued to develop their own understanding of the people for whom they cared and how their needs could be met (Aggleton and Chambers, 1992). The use of care plans as part of the nursing process was seen as part of the move from care given based mainly upon intuition towards a more systematic approach to assessment and meeting needs with an equal emphasis upon the physical, psychological and social. Primary nursing features alongside the nursing process and use of care plans in general and psychiatric nursing texts (Hally and Hardy, 1997; Thomas Hegyvary, 1982; Maddison and Kellehear, 1983). Hally and Hardy (1997) reported that primary nursing is the interaction between a nurse and a patient, within which a particular nurse provides most of the care (as opposed to other nurses). This nurse takes responsibility for implementing the nursing process, helps make decisions about care, works with the patient's family, is responsible for providing advocacy and communicates with other healthcare professionals. Manthey (1980; 2002) has been a longstanding advocate of Primary Nursing reporting how responsibility, authority and accountability for decision making needs to be de-centalised for primary nursing to succeed. More recently, Manthey has reflected this as a relationship approach to care framed around intentional humanism, caring and professionalism.

In the UK the term primary nurse was superseded by named nurse during the 1990s following publication of the Patients Charter (Department of Health (DH), 1991). This emphasised a patient's right to have allocated to them a registered nurse to manage their care, with a view to improving standards. Named nursing remained underpinned by the concepts of primary nursing and the nursing process. At the same time as these developments were occurring in the UK, community care was being implemented in the US (Rohde, 1997). To underpin this, the US health care system organised care using a case management approach. As the social aspects of care became prominent, Rohde (1997) reports case management as the method by which mental health service users gained access to services, training, housing and rehabilitation in order to meet their needs. Its growth in the US began during the 1960s and the term began to emerge a decade later in the UK (Rodhe, 1997). Many of the features of case management can be found within the nursing process, although in the US there has been an emphasis on brokerage, where the case manager procures services and does not become therapeutically involved with the patient. More recently in the UK the term case management has been used to describe different models of services, the interventions that are offered and particular ways of working therapeutically (Onyett, 1998).

In summary, the last century has seen a shift towards a less medicalised approach to mental health care, during which the contribution of nurses and allied health professionals have grown. The range of interventions and care settings involved within mental health care has grown rapidly. Similarly, there has been a growth in theory development and (in what is theoretically), more individualised needs led care. In practice this has seen the development of care planning, primary nursing and case management. The latter is a reflection of the expectation that a wider range of needs will be met, more complex interventions will be delivered and the activities of different contributors will be coordinated effectively. Looking back over time there have been few attempts to systematically evaluate these developments – although this has changed more recently with the focus on evidence based practice. Therefore, it is primarily case management that has been subject to systematic review, and has a suitable evidence base to allow comparison with ICPs.

1.1 Structural Change

Over the decades that saw patients in the UK increasingly cared for in the community (from the 1970s onwards), Community Psychiatric Nurses (CPNs) took primary/named nursing and the nursing process into community settings (Burford, Hobson and Sayer, 1997). Mental health policies from the 1960s onwards focused upon deinstitutionalization and community care provision struggled to cope with demands (Simpson, Miller and Bowers, 2003). Care became add-hoc and there was a lack of clarity about responsibilities and resources. Hence, the Care Programme Approach (CPA) was introduced in the early 90s with a view to ensuring that those with severe mental health problems received the right level of help and support from specialist mental health services. The activities described previously (care plans, nursing process, primary/named nursing) were refocused within the CPA (DH, 1990a). Under the CPA a keyworker of any profession assumed the role of coordinating care and maintaining a close therapeutic relationship with the patient. Several serious failings had been highlighted as the consequence of poorly coordinated care and the CPA was viewed centrally as a means to securing supervision for patients and improved communication amongst those involved in care delivery (Warner, 2005). Since its initial inception, the CPA guidance has become more specific, and has been followed by performance management to monitor adherence with the process.

The CPA emphasizes that care and supervision outside of hospital is best undertaken by a combination of professionals, and it is essential to have a planned system in place to provide high quality and consistent care (DH, 1990a). It is generally agreed that in order to achieve effective community care, teamwork is critical. Texts over the last decade have built upon the experiences learnt from the implementation of the CPA, with continuing examination of the tensions, paradoxes and inconsistencies with policy and practice (Fawcett and Karban, 2005; Lewis and Glennerster, 1996). There is now an observable and growing focus upon service users and carer involvement, models of recovery, achieving social inclusion and effective multi-agency working (Fawcett and Karban, 2005). Later reforms have stressed greater choice, flexibility and responsiveness for service users and this sits against a backdrop of managerial and organizational change, which now resembles something like the re-engineering associated with transformation in large scale industry (McNulty and Ferlie, 2004).

Simpson et al (2003) report how the CPA has been poorly implemented in the UK and that it has failed to achieve its intentions. Some of this has been attributed to the failure to adopt within CPA some of the practices that have been central to effective case management, and have a supportive evidence base. Important to this, is an understanding of the influence and practice between the different styles of case management i.e. standard, rehabilitation orientated and intensive case management. Whether it is the size of case load, the content of delivery or the service user – case manager relationship that influences effectiveness is debated by Simpson et al (2003) who argue that CPA has not given sufficient guidance on the practice of case management and the therapeutic approach that is expected, and as a consequence, the CPA has become administratively focused, rather than an active therapeutic vehicle. Later Simpson (2005) reported that the community psychiatric nurses who act as care coordinators have, due to workload burden, been unable to provide evidence based therapeutic interventions and have not always recognized signs of relapse amongst the individuals on their caseload.

The literature gives a sense that each profession bases its theories and practice upon a different philosophical basis. Whilst successful community care for those with mental health problems hinges upon integrated working and effective communication, this has not always been evident in people's experiences (Fawcett and Karban, 2005). More recently 'Refocusing of the Care Programme Approach' (DH, 2008) has emphasized the requirement for a more personalized approach to mental healthcare, the use of recovery principles and closer more integrated working. At the same time the wider modernisation agenda within the UK NHS has brought about an increased focus upon improving the delivery and effectiveness of services. Economic pressures have brought about increased concerns about efficiency and economy (DH, 1999a). In response to these conditions, UK mental health services have followed practices in the US to implement ICPs (Jones, 1996; Wilson, 1997).

In 1997, the National Pathways Association in the UK held details of six mental health NHS organizations in the UK developing or using ICPs, whilst in 2004 the National Electronic Library for Health showed that this had increased to 23 (Hall, 2004a). In a pre-formulated approach these specify how interdisciplinary care is organized over a patient journey, often incorporating evidence based guidelines. Such an approach if effective could help stem the commonly reported failures within care delivery, contain costs and enable the implementation of evidence based guidelines.

Looking back over time it has been difficult to evaluate the impact of different approaches to managing mental health care, as each has existed within whatever was the context at that time. Now the context is described variably depending upon the philosophical perspective. One might suggest that mental health care is still highly medicalised, others believe it is now more focused upon recovery and inclusion, some say it is risk averse and controlling (Fawcett & Karban, 2005). Clearly approaches to managing care have operated with changing dynamics; they have evolved with the developments in services and policy, and have experienced varying degrees of opposition, impact and success.

In summary, the literature shows how alongside community care there has been increased regulation around care coordination. Issues around resources and risk are factors that have been, and continue to be influential. Reports about the use of the CPA highlight continued shortcomings in systems in practice (Sainsbury Centre for Mental Health (SCMH) and Mental Health Act Commission (MHAC), 2005; Simpson, 2005).

1.2 ICPs

Over recent years the term 'care pathway' has been used in a variety of ways with various intentions. It has been adopted by policy makers and healthcare professionals to describe concepts similar to ICPs, such as guidelines and protocols. The term has also been used for general descriptions of a patient journey or high level process maps of services and processes of care. However, within the literature a relatively common description emerged from the late 1990s onwards. Definitions are mainly based upon Riley's (1998) proposition that an ICP is a multidisciplinary plan of care that provides detailed guidance for each stage in the care of a patient with a specific condition, over a given period of time. The pathway exists as all or part of the clinical documentation and that any deviation from the plan is documented as a variance. This information is then used for day-to-day monitoring and periodic analysis for quality improvement.

In 1998 Patricia Dykes published the first text dedicated to mental health care pathways. It describes how they were developed during the remodelling of US health care and that their aim was to improve effectiveness without compromising quality (Dykes, 1998). For example, by reducing unnecessary tests, interventions and duplication within the care process – ceasing activities that will not negatively influence clinical outcomes. The ICP approach used in US mental health care involved defining a schedule of interventions to be followed by professionals to achieve stated clinical outcomes for a particular patient group. Initially the concept had been used in acute medicine and was adopted into mental health when managed care was introduced into the speciality. Managed care aims to reduce costs whilst achieving desirable outcomes. The primary provider (i.e. the psychiatrist or case manager) does not control treatment decisions these are predetermined and any variations are monitored by insurers (Olsen, 1994). At the time this presented a change in dynamics within clinical decision making and the amount of control that healthcare professionals exerted. This development attracted criticism for being finance driven and not clinically centred (Olsen, 1994).

Dykes (1998) reported that US mental health teams had been experimenting with mental health ICPs since the early 1990s most notably at the New England Medical Centre in Boston headed by Karen Zander. After the US government capped revenues related to inpatient cases and introduced set rates, most stakeholders involved in mental health care became cost conscious consumers. Zander's team trialled ICPs working on the premise that the misuse of nursing care and technology drove up the cost of hospitalisation (Dykes, 1998). Their fieldwork suggested that ICPs could concentrate nursing care on the interventions which contributed to desired outcomes and reduced length of stay. The noticeable focus upon finance and reducing length of stay did attract criticism from healthcare professionals.

Iglehart (1996) drew attention to the fact that the benefits of mental health care pathways were being forwarded without case study and rigorous investigation. He argued that very little consideration had been given to the experience of service users, the impact upon their autonomy and choice, and the longer term consequences of reduced length of stay. He suggested that the measures of success cited were restricted to the empirical i.e. to curtail admissions and reduce variation in treatment programmes rather than any felt experiences or longer term consequences. Performance and benefits had been measured by payers or professionals, rather than from the perspectives of patients (or service users). Iglehart (1996) concluded that the alleged benefits were not supported by rigorous evaluation. Apparently supportive statements were emerging about the benefits of mental health ICPs, without any empirical evidence. To date ICP literature particularly in mental health is generally restricted to opinions, with few examples of robust systematic investigation.

Following implementation in the US the use of ICPs began to grow in the United Kingdom (UK). Despite the lack of evaluation, the work at the New England Medical Centre attracted replication (Chan & Wong, 1999). The consciousness of UK mental health services were drawn to the potential benefits of ICPs. The main commentator about their use in the UK was Adrian Jones (then a PhD student at the City University, London) who led action research developing and implementing an ICP for patients experiencing psychosis. He published a series of papers critiquing ICPs as a mechanism to structure care delivery within the changing structures of the UK National Health Service (NHS) (Jones, 1996; 1997; 1999a; 1999b). He questioned on the grounds of differing fiscal structures whether the benefits espoused could be transferred from the US to the philosophy and context of UK mental health services.

Given the lack of substantial evidence about effectiveness, there has been debate around why ICPs have been championed by UK mental health professionals. Jones (1999a) argued that modern health policies emphasise clinical and fiscal responsibility and these may have increased the motivation for ICP development. The suggestion is that whilst the healthcare systems differed, the drivers for ICPs in the US apply equally in the UK. The NHS was and remains increasingly concerned with methods to reduce costs, improve the quality of care and implement clinical guidelines (DH, 2009). ICPs were already viewed as a popular vehicle to achieve this in acute medicine (Pearson, Goulhart-Fisher and Lee, 1995). So at a time when mental health provision was sporadically characterised by depressing portrayals of fragmented care (SCMH, 1998; DH, 1999b) any approach to improvement seemed to warrant consideration by those charged with modernising services. Hall (2004b) noted that ICPs were becoming increasingly linked to initiatives that occupied the agenda of mental health trusts i.e. clinical governance, assurance, quality, clinical effectiveness, evidence based practice, risk management, integrated working and resource management. The association between ICPs and these activities probably fuelled the impetus of their development in the UK. Despite concerns about the concept and their effects not being fully substantiated, many UK mental health Trusts continued with development and implementation of ICPs.

2. Care Pathway Development and Implementation

Most of the literature about mental health ICPs is narrative accounts of their development and implementation. Those using ICPs have described their experiences, the processes they have undertaken and expressed viewpoints about development and implementation. Some commentators have extended beyond anecdotes using action research and qualitative methods to gain a deeper understanding.

The literature about how ICPs have developed within mental health care raises issues about individualised care, how the course of mental illness can be replicated in the format of an ICP, their perceived impact upon multidisciplinary teams and the accessibility of evidence for care pathway content. Cited within the literature about the development of ICPs and discussed in the following section are two books dedicated to mental health ICPs, one UK health policy document, four book chapters and fifteen peer reviewed papers. A further thirty-one papers and chapters discuss the process of implementing ICPs in mental health care invariably outlining the benefits of the implementation process itself or the difficulties experienced. About half of these sources are accounts based purely on anecdotes whilst the remaining uses audit or non-experimental research to underpin discussions about implementation.

2.1 Development as an approach to Service Improvement

From 1998 onwards there has been a steady stream of healthcare professionals documenting the process of mental health care pathway development. Dykes (1998) and Hall and Howard (2006a) contributed two texts of edited chapters which outline the process of ICP development for particular patient groups. Both rely mainly upon narrative accounts. Other reports of ICP development are provided by Anders, Tomai, Clute and Olson (1997), Thornton (1997), Lock and Walsh (1999), Wilson, Tobin, Ponzio, Moffit, Hudon-Jessop and Chen (1999), Burgess (2002), Nott (2002), Hall (2004b), Hall (2006) and Gunstone and Robinson (2006). All these sources propose a similar process of care pathway development generally described as establishing a group of stakeholders who will be involved in developing the pathway, agreeing the patient group who will use the pathway and determining the timeframe for the pathway i.e. where the pathway begins and ends. They map care and evidence based practice along that patient journey in hours, days, weeks or in phases or stages.

The main types of pathways described are for people diagnosed with depression, dementia or schizophrenia and less common examples for perinatal illnesses, acute inpatient care and child and adolescent mental heath problems. A few authors describe service user involvement within the development process aided by patient diaries, focus groups and reviews of patient experience (Hall, 2004b; Gunstone and Robinson, 2006; Fleming, 2006; Rawdon, Oldham and Lambert, 2006; National Institute for Innovation and Improvement, 2006). Many report that once the ICP has been developed, staff are trained to use the ICP before it is piloted and fully implemented (Hall, 2004b; Fleming, 2006; Rawdon et al, 2006).

There is a tendency within accounts to suggest that if the accustomed process is followed then few difficulties are experienced (Wilson et al, 1999; Burgess, 2002; Nott, 2000; Nott 2002; Hall, 2004b; Wakefield and Peet, 2003; Gunstone and Robinson, 2006). Authors describe how ICPs have been introduced for the purposes of service improvement. For example, Nott (2002 p13) describes how a pathway for acute inpatient care was introduced to 'empower service users and their carers/relatives by promoting collaborative care planning'. Care pathways for attention deficit hyperactivity disorder (Burgess, 2002), psychosis (Emery, 2004), dementia care (Gunstone and Robinson, 2006), self harm (Harrison, Hillier & Redman, 2005) and depression (Wilson et al, 1999) were all introduced to improve the delivery of care, either by reducing variations, improving the way professionals work together or to give clarity about roles, interventions and outcomes for the particular patient group. It has been asserted that the development process itself can accomplish a great deal, 'It identified the individual components of comprehensive inpatient treatment of major depression, and included elements of the existing model of clinical practice in the service as well as elements expected within a broadly agreed concept of best practice which was derived from the consensus opinions of the group (Wilson et al, 1999 p17)'.

Given the supposition that developing and implementing an ICP can contribute towards service improvement, this has often been associated with practice development in the UK (Emery, 2004; Harrison et al, 2005; Wylie, Faid, Nash, Fletcher and Barber, 2007). Emery (2004) describes developing an ICP for psychosis through staff training. The care pathway development process was used as a means of training staff in aspects of assessment and recovery principles to ultimately ensure that there were processes in place for the comprehensive assessment of service users presenting to the service with psychosis. Emery (2004) evaluated practice development using questionnaires completed by staff concluding that care pathway development had positively changed staff's knowledge, attitudes and working practices with patients with psychosis.

A similar approach to Emery was used by Harrison et al (2005) in the development of an ICP for self harm and by Wylie et al (2007) for perinatal mental health. Both used care pathway development and incorporated in this an emphasis upon staff ownership and involvement, to allow professionals to improve their practice in areas of healthcare that are complex. These activities are reported to have taken place in services where professionals had previously expressed dissatisfaction about current practice and felt that the services could be improved. Within each local context there was a willingness among staff to be involved in ICP development.

2.2 Complexities and Difficulties

Not all accounts of ICP development have portrayed the process being completed with ease. The most prominent exception is narrated in an action research project by Jones (1999a; 2003; 2006) and Jones and Kamath (1998). Jones led the development of, and research into a care pathway for the inpatient care for people with schizophrenia within a UK NHS Trust. Jones (1998; 1999a) describes how action research principles were used to facilitate the development of the ICP. Participant observation and unstructured interviews were used to gather data about experiences of the process. Jones and Kamath (1998) give an account of staff perceptions about the ICP at the contemplative stage where the project was first introduced to a working group. They report that staff raised early concerns that an ICP would devalue the interpersonal aspects of care and that care would become task orientated. A further anticipated difficulty staff raised concerned the possibility of describing the course of schizophrenia within the format of a care pathway. Much debate was given to how to capture the individual, variable and complex nature of schizophrenia in a standardised way.

Jones and Kamath (1998) noted how individuals in the working group talked about the roles of their professional groups within the anticipated care pathway. How there were difficulties and tensions around articulating the role and contributions of different professions, and apprehensions in expressing professional boundaries. As the ICP development process involved questioning the appropriateness of interventions and who undertakes particular roles, tensions were raised between the drive for efficiency and the ideology of particular professional groups. Jones (1999a) describes that as the process of ICP development continued, attendance at the working group varied and the process of agreeing the content of the ICP became fraught. After arguments and debates an ICP used in the US was introduced for discussion to move development forward – seemingly successfully as Jones (1999a) describes that a draft ICP was eventually developed.

Although an ICP was eventually produced Jones (1999a) reported there had been many barriers to the process including resistance from clinicians and a perceived lack of evidence base about schizophrenia and its treatment. The most significant setbacks were, 'related to professional and interpersonal issues and disputes' (Jones, 1999a p196). These focused mainly upon the feeling that the ICP would directly conflict with individualised care, the reliance on local practice in the absence of a firm evidence base and each professional groups' attempts to preserve their role and functions, as well as interpersonal tensions, disagreements and general lack of consensus. Unlike earlier descriptions of ICP development the action research described by Jones and Kamath (1998) fell short of adopting a strong integrative philosophy, deliberate use of teamwork and shared belief systems.

Three further papers went on to discuss the findings of the action research particularly focusing on the evidence base for the ICP and multidisciplinary team working (Jones, 2001a; 2003; 2006). These papers used data collected during the ICP development sessions via participant observation, the ICP itself, field notes and unstructured interviews with staff. In the first of the papers Jones (2001a) interviewed six staff who described being unaware of the evidence base for much of their practice, basing their practice upon hunches and where evidence was available they questioned the nature, validity and reliability of this. This was significant to the extent that some staff disengaged with ICP development, there was a complete lack of consensus about the effectiveness of most treatments and the eventual ICP in the authors' view illustrated little that was unique to psychiatric care.

The nurses, psychologist and occupational therapist interviewed during Jones' research discussed the lack of evidence to support their contributions to the pathway. The lack of evidence for occupational therapy interventions has also been acknowledged in a paper by Duncan and Moody (2003) identifying similar difficulties. The psychologist it was suggested was adamant that particular therapies should be included in the ICP primarily based upon 'blind faith as opposed to any professional judgement (Jones, 2003 p673)'. Consequently, Jones (2003) went on to report that the process had led to a questioning of the ideology of the professional groups and the ethos of what they were trying to achieve, as well as considering that developing an ICP in the absence of evidence may not be practicable.

The later paper written by Jones (2006) about the same action research, included data from 29 semi-structured and unstructured interviews, participant observation of 15 working group sessions and field notes. The findings focus upon the conflicting interests within the multidisciplinary team developing the ICP. The development process and its requirement to define contributions to care, caused resentment and hostility as individuals responded defensively and felt threatened by the requirements of the process. Some individuals felt that their role was ambiguous and that their profession had little value or status. In the ICP it was suggested that barriers would be broken down between professional groups, the opposite effect was reported. Individuals perceived a need to protect their uniqueness, and it seemed that the lack of consensus within professions about the effectiveness of interventions and desired outcomes did little to assist.

In addition to these issues, Jones (2006) suggests there was little enthusiasm for a standardised approach to care, some respondents felt that during ICP development they had been placed in the position of having to defend their role and that the process had been very stressful. Some professional groups felt less powerful than others (to the point of being excluded from decision making) and that as a consequence the ICP had become medically dominated. The interventions of other groups perceived as less powerful meant that psychological interventions were not well articulated in the ICP. It is suggested that the ICP development process became the vehicle by which staff played out group conflicts, disengagement and dissatisfaction. This leads to questions about the appropriateness of undertaking the development of an ICP at that time, with that group.

Jones did acknowledge the limitations of the methods that he used in terms of sample size, and generalisibility (Jones, 2004; 2006). Although little is made of how his observer participant role within the research may have influenced the data and findings. Despite the depth of the findings it is unclear that if the dynamics during ICP development had not been so detrimental, whether the difficulties related to lack of evidence base and perceptions of individualised care would have been overcome, or how the eventual ICP might have differed. However, what is clear is the complete contrast to the illuminating, teambuilding and collaborative experiences cited previously. Critically, had this not been part of an action research project then there might not have been the motivation to persist with the ICP development.

Simpson (2007) studied the impact of team processes on psychiatric case management using a multiple case study approach of seven United Kingdom community mental health teams. The study reported that several factors impacted the ability of care co-ordinators to act effectively. Care co-ordination was enhanced when team structures and policies were in place and where team interactions were respectful. Where members felt disrespected or undermined, communication, information sharing and collaboration were impaired, with a negative impact on the care provided to service users. Simpson's (2007) findings were similar to those reported by Jones (2004; 2006) suggesting that 'consultant psychiatrists would frequently and understandably attempt to impose solutions to the perceived difficulties through their professional status or force of personality. Such actions tended to create resentment and resistance, rather than agreement and co-operation that are essential to the provision of co-ordinated care. When new procedures were established, they provided team members with a joint focus and prevented strong personalities from dominating proceedings Simpson (2007, p411)'.

This and Jones' critique offer an insight into the culture in which ICPs are being applied. In a broader context Miller, Freeman and Ross (2001) also raised concerns around interprofessional practice within health and social care, suggesting that applied to clinical settings not all individuals consider themselves to be part of a team or engaged in teamwork. Miller et al (2001) acknowledge that organisations, individuals and group processes all impact upon teamworking. Where team working is limited the focus of efforts can shift away from the primary focus (the patient), to dealing with interprofessional problems, where there is an absence of a shared understanding about what is to be achieved, reduced clinical effectiveness and poor care coordination (Miller et al, 2001). The implications of this upon the concept of ICPs as an integrated form of practice are potentially highly significant.

2.3 Anecdotal experiences of ICP implementation

The process of implementing mental health ICPs and the perceptions of this have been widely discussed. Many authors report that after the content and the format of the ICP is agreed it is common to undertake a pilot, then refine the pathway and fully implement it (Smith, Embling, Price and Lyons, 2000; McQueen and Milloy, 2001; Hazell, 2003; Chave, Painter, Peet and Wakefield, 2004; Hall, 2000; Sims and Iphofen, 2003; Hall, 2004b; Hall, Grant and Pritlove, 2005; Hall and Connelly, 2006; Hendricks and Mahendran, 2006; Repper-DeLisi, Stern, Mitchell, Lussier-Cushing, Lakatos, Fricchoine, Quinlan, Kane, Berube, Blais, Capasso, Pathan, Karson and Bierer, 2008). Some accounts like Hazell (2003) and Repper-DeLisi et al (2008) describe a plan for evaluating the ICP, establishing how its use will be monitored and the measures that might be used to determine its impact.

Hazell (2003) used an audit to establish whether an ICP for young suicide attempters was implemented and how it was followed, and supported this by narrative accounts of experiences implementing the ICP. For example, 'working within hours the pathways were working smoothly. Outside of office hours there were some difficulties (Hazell, 2003 p57)'. It was said that this highlighted the need to further educate accident and emergency staff about the ICP. It is common in the literature to find accounts of lessons learnt from the process of implementation. Repper-Delisi et al (2008) audited 40 episodes of care both pre and post ICP to establish that the implementation of an ICP for alcohol withdrawal led to a shift in practice congruent with the content of the ICP. It was their view that timely assessment and staff education had contributed to changes in prescribing patterns, improved patient monitoring and reduced costs. The authors acknowledged that they could not establish the exact clinical decision making that staff used when following the pathway due to the retrospective nature of the audit. Nor could they control variables like the change in mental health status of the patients whose care was studied.

Brett and Schofield (2002) described a number of difficulties in the shift from traditional care plans to an ICP in an older people's service. They found the experience of beginning to use the ICP too time consuming for staff who were not wholly convinced about the benefits of using the ICP. Training was seen as a key aspect of successful implementation. After persisting with implementation Brett and Schofield (2002) report that as a consequence of using the ICP staff expressed several benefits: an improved consistency of care, assurances that care is evidence based, improved team work, involvement of families had become more common place and staff became familiar with the new form of documentation. The authors conclude that the process of implementing the ICP had brought about many benefits in terms of governance and risk management (as well as the benefits already cited by staff), although all reports remain anecdotal. Browning and Hollingberry (2000) alleged similar benefits around increased patient involvement, the implementation of evidence based practice and improved standards of care. Forsyth (2006), Jackson (2006), Jenkins (2006) and Roberts (2006) also outlined these benefits for particular patient groups.

Baker, O'Higgins, Parkinson and Tracey (2002) discussing the implementation of an ICP in low secure inpatient services in the UK report similar positive impressions, 'The impact upon client care cannot be underestimated, as we have seen the development of more focused care that is planned in greater detail (Baker et al, 2002 p739).' Baker et al go on to show that the process of care planning had improved and that staff were working more collaboratively. Similar findings were reported by Zacharias, Rodriguez-Garcia, Honz and Hopper (1998) in their implementation of an ICP for alcohol withdrawal. They suggest that the staff using the ICP were very positive about the impact of the ICP. They viewed it as a consistent and objective framework for directing care and used it proactively for risk management. The nurses particularly reported that the ICP helped them control the levels of sedation used and led to more consistent clinical judgements. The medical staff using the ICP were less positive; they viewed using the ICP as a 'cookbook' approach (Zacharias et al, 1998 p17). The perceptions reported by both Baker et al (2002) and Zacharias et al (1998) remain anecdotal accounts from the perspectives of the authors and are not supported by formally gathered data.

Smith et al (2000) describe using several mental health ICPs and receiving positive feedback from staff. Reporting that the ICPs were easy to follow, they reduced paperwork and improved patient involvement. They report that in their experience the ICPs have been used to monitor whether interventions have been provided and standards met. Overall, the experience in their view was very favourable giving a shared understanding of the care process which had not undermined professional autonomy or individualised care. In accounts of implementation, the format that the ICP takes be, it a flow chart, form or spreadsheet varies considerably. Its relationship with other documentation is referenced in a number of accounts (Brown, Griepp, Buckley, James and Vandermolen, 1998; Zacharias et al, 1998; Keys, 2001; Brett and Schofield, 2002; Moos, 2004). In the case of an ICP for post natal depression, Moos (2004) questions whether there should be one copy of the ICP. Who should keep it the patient, the midwife, the health visitor or the GP and should it be electronic? A study by Goddard, Alty and Gillies (2001) found that the record keeping and health information systems typically used in UK mental health NHS Trusts pose many barriers for the advancement of ICPs. Their use is impeded by poor system integration, high likelihood of duplication of information and a general reluctance to embrace technology.

Other accounts describe having learnt lessons from previous projects using ICPs and recommend that the process of change can be tailored accordingly. Chave et al (2004) report that overcoming the barriers to implementation warrants careful consideration. It is suggested that work still needs to be done to reduce the negative preconceptions about pre-formulated practice and its perceived impact on staff time and professional judgement.

Brown et al (1998) considered what are viewed as the obstacles to the implementation of ICPs. They acknowledged that clinicians view ICPs as extra paperwork and believe that they are not a suitable alternative to other forms of documentation. In their experience staff tended to continue to supplement the ICPs with written narratives which are no longer required when the ICP is fully utilised. It was suggested that many of these perceptions could be addressed via training, external review of the ICPs for assurance, better integration with other key documents and further improvements to the ICPs in use. Brown et al (1998) stated that they had failed to fully consider staff learning needs and that instead of streamlining documentation, the lack of training had consequently led to duplication which could have been avoided.

Similarly working with ICPs in Singapore, Hendricks and Mahendran (2006), like Chave et al (2004) were keen to reduce the obstacles to ICP implementation and the involvement of staff in the development of the ICP was important in their view. They worked to ensure that their ICPs were informed by feedback from clinicians and they ensured that staff were trained each time a new ICP was implemented or revisions made to existing ICPs. Like Chave et al (2004), Hendricks and Mahendran (2006) described these responsibilities as falling within the role of a dedicated person to help ensure robust ICP implementation. This, in their view, meant that there was sufficient buy in from staff to ensure that the ICPs were well received and used.

Little has been written about how patients progress through care pathways when they are implemented. One exception is a study by Peterson and Michael (2007) who considered 170 patients admitted to acute inpatient care. They sought to investigate whether an initial assessment might predict a treatment response that could be measured as patients moved through different care pathways. It was found that there was a negative correlation between symptom severity and progress through the care pathways, i.e. those with more severe symptoms progressed through the pathways quicker and, together with co-morbidity, these factors explained 52% of the variance in progress through the ICPs. Peterson and Michael (2007) went on to suggest that rapid progress through the care pathway for people with more severe symptoms may be associated with their response to antipsychotic medication and the increased distress they experience. This discomfort may motivate these patients to engage in treatment more promptly than patients with fewer severe symptoms. Peterson and Michael argued that some co-morbid conditions might have a differential impact upon progress through an ICP and that some diagnoses like psychosis may be more responsive to a care pathway approach than others.

2.4 Perceptions about ICP implementation

Hendricks, Mahendran and Vaingankar (2008) sought the opinions of staff about the implementation of 11 ICPs in a Singapore psychiatric hospital. They considered staff opinions via questionnaires which focused upon whether the ICPs had impacted upon the effectiveness of care, professional autonomy, quality of care and collaboration. All members of staff involved in using the ICPs were invited to participate. With a good response rate of 78.4%, 137 respondents from a variety of professional groups returned answers based on ordinal scales (although it is not known how many questions were asked). A number of respondents (35.8%) said that they were against the compulsory use of ICPs. However, more than three quarters of respondents (76.6%) suggested that the ICPs were 'useful as a checklist (Hendricks et al, 2008 p27)'. Around 45% reported that they used ICPs on a daily basis to support clinical decision making and 31.4% reported that they would eradicate variations in treatment. Interestingly those with more than 15 years clinical experience reported that the ICP had a greater impact upon clinical decision making than those with less experience. Eight percent of respondents reported that the ICPs had a detrimental impact and 16% felt that they adversely affected professional autonomy. Just over half of respondents proposed that the ICPs had helped to improve care delivery and that the care was appropriate to meet people's needs. Again training features, as almost 60% of respondents reported that the implementation of the ICPs would be improved by more education.

A qualitative study of a care pathway pilot in older people's service in the UK by Hall (2001) discussed the perceived impact of an ICP upon professional autonomy, care delivery, team performance and practice development. Interviews with five staff from different professional groups and subsequent content analysis suggested that the ICP had helped structure the different contributions to care and that care continued to be responsive and individualised. All respondents reported that they felt able to deviate from the ICP should this be warranted. Respondents reported, in line with Hendricks et al (2008), that the ICP could be used as a structure to monitor care and check that interventions had occurred within required timeframes. There was a consensus amongst those interviewed that as a consequence of developing and piloting the pathway people were more aware of each others roles and that teamwork, communication and access to information had improved. Those interviewed expressed concerns about the content of the ICP. They perceived a conflict between incorporating what care could be offered within the resources available, as opposed to what should be offered according to the available evidence. Also, it was reported that although the ICP had encouraged practice development, it had not in any way influenced resource allocation in the way that individuals had hoped.

Using a similar methodology, Chan and Wong (1999) studied nurses' perceptions of using an ICP for schizophrenia used in a hospital in Hong Kong. They gathered data via semi structured interviews - although the sample size or selection criteria are not stated in the paper. Nurses reported that the main benefits of the pathway were that care had become more systematic and it helped them adhere to agreed timeframes. It reduced the likelihood of duplication, had improved accountability and enhanced their professional status and feelings of autonomy. Nurses also expressed concerns about whether the ICP content (developed by the nurses themselves) was correct and reported that some staff had resisted using the ICP. It was suggested that the ICP had increased their workload, whilst some nurses did not accept that leading the ICP should be the responsibility of nurses and there had been some resistance to this from other disciplines.

With regard to resistance to using ICPs, a key aspect of implementation is described as staff engagement. Wilson et al (1999) reported that an important part of ICP implementation is achieving an ICP that is acceptable and useful to staff. Staff involved in ICP development often work to achieve the development of the ICP based upon a group consensus approach. These are the same staff who worked with others using the ICP during a pilot, and as Wilson et al (1999) reports, are then involved in an evaluation of the pilot. In their case they considered an ICP for depression piloted over 8 months and found a wide variation in standards of completion. Focus groups with staff found that those involved in developing the ICP were more positive about its use than staff who had not been involved. The latter perceived the ICP as being remote from practice – a theoretical project that they did not feel supported in its implementation. Many perceived the ICP as an additional burden, that it was not particularly useful and did not support or guide practice. Comments about increased documentation were similar to those described earlier by Brown et al (1998), who reported that the ICP was an administrative burden. Whilst the number of participants in the focus groups is not stated, the authors describe gathering views on ways to make the ICP more acceptable and robust.

The study of the implementation of an ICP for schizophrenia in the UK by Jones (2000) highlighted similar difficulties to the negative perceptions described by Chan and Wong (1999) and Wilson et al (1999). His study did not report the benefits that previous authors describe. Using data from interviews, focus groups and observation, Jones' research showed that the team implementing the ICP changed considerably. During implementation many staff left the service. Consequently, because of low staff morale, poor engagement, the way that the care process was managed and poor levels of documentation, the implementation of the ICP was stopped after use with seven patients. Jones (2000) reported that staff had a lack of commitment towards using the ICP, staffing levels militated against implementation and there was no energy or support for a new development. Jones (2000) concluded that at the very least, for the ICP to succeed, it required commitment both organisationally and within the team, as well as stable staffing conditions.

Similar problems were found in the study of an ICP for community mental health teams in Scotland (Rees, Huby, McDade and MacKechnie, 2004). Impressions of staff about implementation were sought via interviews and focus groups. The aim being to investigate staff perceptions and views of implementation and generate learning for others implementing ICPs. The qualitative data from interviews with five managers and three focus groups involving 15 clinicians from different professional groups were analysed using the constant comparison method. Findings suggest that whilst the participants agreed to the philosophy of the ICP, in practice it was not being used. The authors suggested that the integrated working needed for the ICP to work had not been signed up to at an organisational level and that there had not been enough resources available to provide the support, team development and change management that was needed for implementation. The ICP required the involvement of other agencies and there was a lack of agreement about how that should be operationalised. There were also tensions expressed around some of the roles described in the ICP and conflicts had arisen when individuals felt it important to protect their professional roles. The authors concluded that not enough consideration had been given to the organisational change for integrated working across agencies, and the time and support required for ICP implementation.

More recently interviews were used to establish patient perceptions about the use of an ICP for Occupational Therapy in a Crisis Resolution and Home Treatment Service (Rigby, Hannah, Haworth, Molloy and Scutts, 2007). Four patients were interviewed using a semi structured format and their experiences suggested that they had received the interventions described in the ICP. This was interpreted by the authors as verification that the ICP had led to the implementation of evidence based practice. It was reported that using the ICP had enabled the occupational therapists to be explicit about their role within the service and that this had become apparent to other stakeholders.

Beardsall, Gough and Pringle (2002) also considered the implementation of an ICP from the perspective of patients. They studied an ICP for electroconvulsive therapy (ECT) gathering the impressions of patients and staff after a 16 week trial when the ICP had been used for 15 patients. Data was gathered by audit of 14 ICPs, questionnaires, group discussions and interviews with staff and semi-structured discussions with patients. In an action research approach they described that following the audit changes to the pathway were made. In the main this was due to the fact that staff had not been recording variances and this was being continually overlooked. Also, other parts of the ICP were not completed and further investigation indicated that it was not clear to the team under whose responsibility some aspects of the ICP fell. Encouraging findings reflected improved communications between staff and the development of the ECT ICP as a multidisciplinary record of care. Staff perceptions were that the ICP had provided a beneficial structure for the care process, although it had raised concerns about levels of knowledge and training within the team. Further work needed to be done about roles and responsibilities. Patients reported that they were given sufficient information prior to their treatment and that care was satisfactory, although they were kept waiting too long on the day of treatment. These perceptions were used to make relevant changes to the ICP before fuller implementation. In a similar way, Warr and Hoyle (2007) used the views of women prisoners to make improvements to a mental health ICP in a women's prison. Two focus groups were held to gather women's perceptions about the ICP and how their experience of it could be improved. It is evident that several studies in this section lack detail about sample size and selection, and rarely give consideration to their limitations.

3. Contrasting ICPs with other approaches to managing care

This section describes the contrast between mental health ICPs and approaches to managing mental health care, particularly care plans, case management, the Care Programme Approach and clinical guidelines. Contrasting each approach reveals what ICPs are able to offer beyond the other frameworks, whilst acknowledging how they may impact upon what are seen as accomplishments to date in terms of the organisation of care delivery.

3.1 Comparing ICPs to Care Plans

Care plans originate from the nursing process, and are described as a well established sequence of planned steps and actions designed to help nurses treat and evaluate responses to health problems and care (Fortinash, 2000). The process itself is a five or six step activity involving the

assessment of needs, the identification of outcomes, planning the care and interventions required to meet the outcomes, implementation of the planned care and evaluation of the outcomes in light of the care given. This approach to managing care is typical of those found in mental health texts during the 1990s (Boyd & Nihart, 1998; Shives, 1998) although research has raised doubts about the effectiveness of care plans (Aidroos, 1991; SCMH and MHAC, 2005).
Descriptions of care planning can be contrasted with Riley's (1998) definition of ICPs. Both approaches have an underpinning logic based upon meeting people's needs by offering planned activities and interventions. Due to their similarities, the value of either combining or replacing care plans with ICPs is arguable. This can be explored further by examining differences between care plans and ICPs. The most obvious variation is that care plans generally allow for narrative freedom in the development of forward plans and what interventions will be offered (Shives, 1998). This implies that within a care plan there is scope for discussion, variation, negotiation and flexibility. The product of the care plan is said to be patient centred care as well as meeting stated outcomes. However, ICPs include mainly pre-determined interventions, suggesting fewer opportunities for flexibility and individualisation (Iglehart, 1996).

Pre-formulated ICP content is often referred to as a method for securing the implementation of clinical guidelines whereby specific interventions are defined (Hall and Howard, 2006b). This is the main rationale for the structured nature of ICP content, and therefore it is seen as an approach to securing standards, equitable care processes and risk management. Whereas it can be assumed supposedly that interventions described in care plans are more likely to be based upon individual professional judgement, the therapeutic relationship and clinical decision making which could vary widely. Unlike a care plan, an ICP states exactly the type of intervention to be offered, how often it should occur, and at what point in the patient journey. Theoretically, this means that a uniform pattern of interventions is offered to most patients with a particular health problem accessing a particular service (Hall and Howard, 2006). Overall, a care plan does not include this level of specificity and what is offered is more random (Shives, 1998).

The freedom to vary interventions within a care plan gives a perception of professional autonomy and being able to individualise care around a person's specific needs and situation; some of these assumptions are disputed (Duncan and Moody, 2003; Aidroos, 1991; SCMH and MHAC, 2005). However, the detailed guidance provided in an ICP (Riley, 1998) has been interpreted in both the US and UK as conflicting with individualised care, choice, and impeding therapeutic relationships (Iglehart, 1996; Jones, 1997). In contrast to the ICP, theoretically a care plan is reached by collaboration between the service user, carers and the interdisciplinary team involved.

A further distinction between care plans and ICPs is that the latter set out to be interdisciplinary in nature and consciously map the interventions offered by different professionals. It is acknowledged that early texts about mental health care plans are predominantly aimed at nurses (Doenges, Townsend and Moorhouse, 1995; Schultz and Videbeck, 2002; Krupnick and Wade, 1993). These texts originate in the US and describe the practice of care planning and provide examples of plans to meet particular needs. The focus of these texts upon nursing appears restrictive in the growing climate of interdisciplinary care. Wood and Green (2006) note that many parties contribute to clinical practice and that a positive experience of care should involve a synchronization of all activities which contribute to the experience of care. Their view being that using an ICP as a basis for integrated working introduces a common process framework upon which care can be based, as opposed to a fragmented content driven approach which bears little relation to overall outcomes.

Some success in using ICPs for integrated working has been reported by Sims and Iphofen (2003) who outline their use of an ICP for service users with a dual diagnosis. Their impressions are based upon embedding joint working within ICP content which helped a service progress from a position of poor coordination for a group of service users with particularly complex and fluctuating needs. In contrast, Duncan and Moody (2003) report that it was possible that some professional groups feel that their philosophical basis is compromised by the ICP development process. They particularly reflect upon the perspective of Occupational Therapists who they suggest have not readily embraced the use of ICPs, explaining that this may be attributed to the lack of evidence base for the interventions provided by this professional group, or the view that standardisation is not compatible with their profession's view of individualised care.

The final significant difference between ICPs and care plans is that the former can be used more rigorously to monitor care that is not offered or delivered. This involves a mechanism for continual monitoring of variation, often referred to as variance analysis (Riley, 1998). This does not usually exist within the care planning process. As ICPs are developed upon the basis of meeting the needs of most people, most of the time the variations in patient journeys have to be accommodated and acknowledged. A variance occurs when activities described in the pathway do not happen or when interventions not described in the pathway are given (i.e. those you would not usually expect to offer) (Hall, 2006). Capturing this information affords potential benefits within the areas of clinical governance and performance management (Soltysaik and Millward, 2004), However, there is no present evidence suggesting that mental health ICPs are used effectively in this way. There are continued suggestions that service users are not fully involved within decision making about their treatment via the use of traditional care planning methods (Care Quality Commission, 2009). There is no evidence that mental health ICPs will improve this situation.

3.2 ICPs and Case Management

Surprisingly little has been written about how mental health ICPs are used on a day to day basis to manage care delivery. There are no in-depth accounts about how they are used as a form of case management, by a named person who is responsible for care coordination. Nor are there any descriptions about how they are used in interactions with service users and carers, or how they influence decisions about activities and treatments. Providing more detail than most, Brett and Schofield (2002) wrote an account of their experience of using an ICP in the mental health care of older people. They give rare details about how an ICP was used to monitor and evaluate care. However, in their account it is noticeable that the ICP appeared remote from day-to-day practice. For example, they describe using variance information only once a month, rather than on a concurrent basis to inform case management. They suggested that the ICP was integrated into their model of case management although it was difficult to interpret how this was achieved along the patient journey.

It is possible that conflicts exist between the use of ICPs to manage care and well established theories about case management. To consider this further, the literature about case management is explored to examine compatibility. Case management, like care planning, makes a feature of the individual nature of managing and arranging care. This is notably different to ICPs where interventions and care are mainly pre-agreed for large groups of service users (patients). Pre-agreement suggests that there is already arranged access and availability of services (and possibly interventions), as well as the requisite funding that is required. Using ICPs in addition to case management, it is practicable for an organisation to know about the resources required ‘on mass’ based upon ICP content, and therefore better manage the re-numeration and services required to provide care. This is different to estimating the resources required to follow highly individualised care plans based purely upon case management.

Onyett (1998) reports how case management in the UK was driven by health policies wishing to improve the coordination of community care and target resources towards the severely mentally ill. In support of the point made previously about the resources required for highly individualised care, Onyett (1998) describes how the implementation of case management was not accompanied by the required funding or structures. Subsequently, the multi-agency and multidisciplinary working needed particularly during the 1990s was lacking. Providers operated services in diverse geographical locations, with poor lines of communication, thus, increasing discontinuity. During this time UK services and policy makers were looking beyond current approaches to managing care to reduce the inadequacies and inequalities within existing practice. Clearly, having an agreed integrated patient journey within an ICP offers a level of regulation and clarity around activity and the provision of services that is otherwise lacking.

Case management often has a psychodynamic inclination, and the helping relationship between the case manager and the service user is prominent (Onyett, 1998). The emphasis is upon flexible and continuous care, the therapeutic effects of the relationship as well as growth, participation and recovery. A possible conflict between case management and ICPs is evident in the differing degrees of individualised care that are offered according to each approach. The therapeutic relationship has been problematic to represent within ICP content (Jones, 1998). Peet and Wakefield (2002) consider what happens to the quality of the therapeutic relationship when using ICPs. They concluded that the ICP was useful for focusing on technical procedures whilst the human elements, the therapeutic relationship and interpersonal aspects were potentially overlooked. They proposed that emotional care, empathic interviewing, education regarding diagnosis, reassurance, consultative style, negotiated treatment, shared goals, collaboration and the therapeutic alliance all need to be built into ICPs.

These concerns were also supported by Hall (2004a) who also found few interpersonal interventions within ICPs. Content analysis of a sample of mental health ICPs in the UK revealed a preoccupation with assessment and administration. This could be verification of what Olsen (1994) described as care processes which are influenced more by the priorities of commissioners and providers rather than service users and carers. Whilst UK mental health Trusts are required to measure compliance with processes like CPA, there is no such external demand to measure the interventions offered. Hall's (2004a) findings also revealed an absence of direct therapeutic interventions within ICP content. The ICP content hence lacked the exact activities which are the direct actions to meet needs, which could impinge upon the inclusion and recovery of those experiencing mental health problems. This level of specificity and individualisation appears lacking within ICP content. The level of personal detail that is implicit to case management poses a significant challenge to the concept of ICPs, and therefore also how the standardisation associated with care pathways fits within an individualised clinical case management approach.

There are currently different models of case management in operation and disputes about what elements of the different approaches are producing benefits in terms of outcomes (Simpson et al, 2003). If increased contacts, or particular therapeutic approaches are determined to be of benefit, an ICP could be used to manage the implementation of these locally. Whilst there is some emerging evidence that ICPs increase the likelihood of interventions being delivered (Bultema, Maillard, Getzfrid, Lerner and Colone, 1996; Grant Hall and Pritlove, 2005) – these are far from conclusive. Presently, therefore, there is no significant evidence to support the use of ICPs as a means of coordinating care when compared with a standard case management approach.

3.3 ICPs and the UK Care Programme Approach

Variations in how mental health care is managed and what it comprises have been considered within two specific health policy approaches in the UK; the Care Programme Approach (CPA) and the implementation of clinical guidelines. The CPA was first introduced in a joint health and social services circular entitled *Caring for People* (Department of Health (DH), 1989). The arrangements described were aimed at reducing worrying failures in the care of people with mental health problems in the community and arrangements to underpin the reorganisation of hospital and community care (DH, 1990b). The CPA was offered as an approach to case management which focused upon assessment of need, care planning, review and provision of a designated key worker. Professionals and academics began to comment on the use of the CPA with irregular implementation and failures in community care being widely reported (North, Ritchie and Ward, 1993; Schneider, Carpenter and Brandon, 1999; Simpson et al, 2003).

Debates which continued through the 1990s included whether the CPA should apply to all patients using mental health services and whether it would inhibit other favoured approaches to managing care such as Assertive Community Treatment (Cornwall, Gorman, Carlisle and Pope, 2001). Reservations about the CPA continued as randomised controlled trials suggested that clinical case management as described in the CPA failed to be effective (Cornwall et al, 2001). Not surprisingly, at this time professionals were looking towards alternative approaches to managing care. ICPs were then considered as a substitute to traditional care plans. The aims of ICPs were to standardise integrated arrangements, reduce the duplication of administration and develop processes to more accurately resemble the patient journey (Page and Sorribas, 2006).

Simpson et al (2003) reported that the CPA is dependent upon leadership, interdisciplinary working and role clarity; and that not all these prerequisites have been in place. Interestingly, many of these issues are reportedly settled by the use of ICPs (Jones, 1997; Brett and Schofield, 2002). ICPs have only recently been mentioned as a concept in UK policy (NHS Institute for Innovation and Improvement, 2006; NHS Quality Improvement Scotland, 2007; Department of Health, 2008). Page and Sorribas (2006) have written about the relationship between the CPA and ICPs. Their discussion considers how we know whether care offered using the CPA is of a good quality or effective, and how an organisation can obtain the information to answer these questions. They suggest that ICPs can be the basis for information processes which highlight whether high standards and best practice are implemented. It is proposed that the CPA is, in their opinion a care pathway in itself and that moving away from a traditional view of CPA methods and moving towards an ICP approach can provide links to other activities and promote a whole systems approach rather than the CPA framework existing in isolation. Page and Sorribas (2006) argue that this offers some of the positive benefits of standardisation, possible reduction in paper work and limits the amount of personal risk experienced by clinicians.

In summary, the use of the CPA has been set as a policy objective for over 10 years. As this is a key mental health policy in the UK there is no question of ICPs replacing the CPA. Although, whether ICPs can be used as a framework for improved implementation of the CPA has drawn some speculation (Page and Sorribas, 2006). To date there is no evidence to suggest that mental health ICPs can increase service users' contacts with care coordinators, reduce the likelihood of the service user losing contact with services, reducing the symptoms of illness, improving social functioning or increasing service user satisfaction. Whilst there are studies of case management suggesting some increased effectiveness can be attributed to specific case management features, there is a question arising about the delivery of interventions within the confines of CPA and the potential for increased inpatient bed use. This suggests that the CPA approach does have weaknesses especially in an environment where the use of resources is stretched (Simpson, 2003).

3.4 Contrasting ICPs with Clinical Guidelines

The use of clinical guidelines has been prompted by the challenges of healthcare systems, most notably rising costs and variations in treatment. Whitty and Eccles (2004) suggest that underlying variation in treatments and standards are concerns about inappropriate care and under or overuse of resources. Both ICPs and clinical guidelines are seen as a strategy for reducing variations in standards and closing the gap between evidence and practice. ICPs, unlike clinical guidelines, involve mechanisms to monitor variation (variance analysis). In contrast to ICPs which are locally developed, clinical guidelines are authoritative statements often endorsed by a college, university or institute (Moss and O'Connor, 2001). Moss and O'Connor (2001) suggest that clinical guidelines are often seen as remote and so clinicians fail to own them. ICPs which are developed locally rely upon the ICP development process to help safeguard against scepticism (Emery, 2004).

Berghmans, Berg, Van Den Burg and Meulen (2005) investigated issues related to resources and clinical guideline development experienced in the Netherlands. They report that clinicians were cynical, seeing guidelines as a vehicle for rationing scarce or expensive treatments by restricting treatment to specific diagnoses and shortening the length of such treatments. These are similar to concerns raised about ICP use (Olsen, 1994; Jones, 1998). In relation to ICPs, there was caution about the impact of reducing length of stay upon longer term outcomes for service users, and also to what effect decisions were led by finance and the impact this would have upon therapeutic relationships. How cost data is used in guideline development has been discussed by Mason, Eccles and Freemantle (1999) who note the difference between effectiveness and cost effectiveness and conclude that there has been no satisfactory method to incorporate economic factors within guideline development.

Given individualised care, choice for service users and the ethical context within which mental health care is provided, Berghmans et al (2005) argues that the legal position of clinical guidelines is similar to that of ICPs (Irons, 2006). Justified clinical discretion is accepted, and guidelines are seen as assisting decisions and cannot be viewed as mandatory (National Health Service Executive, 1996). Similar to observations during the development of ICPs, Berghmans et al (2005) outlined the difficulty defining the goals of treatment and obtaining a consensus view. They found differing views from psychiatrists, psychotherapists and service users. There was a lack of consensus about achieving a diagnosis, and some stakeholders placed more emphasis upon biology and others upon social circumstances. There then follows varying views upon efficiency, symptom reduction and the available evidence. These issues were mirrored in Jones's (1999a) observations about ICP development.

Like early suggestions about ICPs, Berghmans et al (2005) report that clinical guidelines may adversely affect the autonomy of professionals as well as service users. It is proposed that guidelines pressure professionals to comply when it may be thought inappropriate to do so. Variation from guidelines could be viewed negatively and any restriction of practice frustrating. In the same way that a patient's individual values and circumstances are not considered in guidelines, this can also apply to professional intuition and experience. In Berghmans et al's (2005) research, the psychiatrists stressed the importance of individualised care and raised concerns that professional autonomy will become restricted. This is similar to Olsen's (1994) views about ICPs.

There is concern regarding the evidence base of mental health guidelines as many everyday interventions have not been researched by randomised controlled trials, the favoured evidence base for testing effectiveness (Torrey, Drake, Dixon, Burns, Flynn, Rush, Clark and Klatzker, 2001). Politically, it is suggested that should the use of guidelines become more dominant, power will shift from doctors to policy makers and managers. This model alone does not account for the role that service users may have in decision making and gives rise to concerns. Berghmans et al (2005) reported that the service user appears to sit outside of guidelines and argue a great deal more needs to be done to integrate shared decision making, patient focused outcomes, autonomy and responsibility. The pertinent question would be whether ICPs are able to integrate professional autonomy, individualised care and choice for service users in ways that clinical guidelines have failed to do.

The process of developing ICPs is similar to the development of clinical guidelines. Hall and Howard (2006) describe the care pathway development process which begins by selecting a case type or client group that will access the pathway. Like clinical guidelines, development involves collaboration and representatives of all stakeholder groups working together, joining an ICP development or authoring team. During development the timeframe and parameters act as a framework that enables care to be mapped in hours, days, weeks or in phases or stages of treatment. This can involve bridging the primary and secondary care interface and often spans organisational boundaries, which adds to the complexity of the task. The development team review the aims and outcomes of the care process and often these are identified in terms of service user and process outcomes (Dykes, 1998). Roberts (2006) argues that all stakeholders are involved in process mapping; identifying major steps and activities through the ICP. Also contributing to this are patient diaries, focus groups and review of medical records to establish practice patterns. This activity is quite different to clinical guideline development where local and qualitative information are not generally used.

After mapping activities in the ICP there is enough data to identify keywords and search for evidence-based interventions (Hall & Howard, 2006). It is here the relationship between ICPs and clinical guidelines is obvious. A thorough and critical review of the literature is completed

(Roberts, 2006). Established guidelines, systematic reviews, meta-analyses and national recommendations which influence the expected ICP content are identified. Roberts (2006) describes how the pathway development team then critically review the process map. Each step is evaluated for appropriateness and timeliness – determining roles, duplications, delays, and added-value. This enables the care pathway to be re-conceptualised, identifying key areas for development and the incorporation of clinical guidelines into the content. The process is then redesigned around the experience of receiving care and this 'localisation' is not generally associated with clinical guidelines.

4. Impact and Evaluation

As those using ICPs have become conscious of the lack of formal evidence about their effectiveness, there has been an increase in attempts to evaluate their impact. The most common methods used have been pre and post ICP comparisons, whilst true randomisation has not been attempted. Fifteen studies have considered the impact of ICPs upon either clinical outcomes, length of stay, service user experience or the interventions offered. Often these studies have combined quantitative measures with qualitative methods which have considered the views of staff using the ICP and their perceptions of its impact. Six of these studies are based in acute inpatient care and eight in other mental health settings. Ten of the studies are from outside the UK.

4.1 The likelihood of care being given

One of the most common approaches used to ascertain the impact of an ICP on the delivery of care has been to compare the completion of interventions for a particular patient group prior to an ICP being used, and then for a group of patients after an ICP has been introduced. For example, Bultema et al (1996) compare activities and interventions delivered using an ICP for inpatients with depression, with a pre ICP group of matched patients. They found that patients on the ICP were more likely to receive the interventions that were identified as pre and post measures. The measures included activities like medical consultations, family involvement, physical examinations and discharge planning, although it is not clear how many activities were compared in total. Comparing two groups of 12 patients it is proposed that the increase in the interventions provided in the ICP group was a marked improvement compared to pre ICP. For example, examination by an intern or a nurse practitioner within 24 hours of admission increased from 8% to 92% for the ICP group. Interventions that involved contact with families and aftercare agencies also improved significantly. The limitations of this study are the relatively small sample, whether the measures were in fact the expected standards of practice prior to the ICP being implemented and whether they would be identifiable in the health record if that were the case.

In a similar pre and post ICP comparison Grant, Hall and Pritlove (2005) reported on measures that were the interventions within an ICP for acute inpatient care used for two years on six wards. Again using a relatively small sample they compared the care of 23 patients before the pathway was implemented, with 23 patients after the ICP had been implemented. The outcome measures were a range of interventions from admission to discharge although the total number of measures is not stated. The findings suggest that the likelihood of receiving interventions for patients on the pathway compared to before the ICP had increased on average from 18.4% to 73.6%. However, the ICP had little effect on patients receiving information about their levels of observation and being given a copy of their care plan. Studied as a discrete group of interventions, those completed by medical staff showed a consistently high rate of completion pre and post ICP (always completed for 80% of patients or more). When studying whether interventions had been completed in a timely manner between the groups, there was little difference with a decline in the timeliness of interventions towards the latter stages of the inpatient stay (for both the pre ICP and ICP groups).

In a further pre ICP and post ICP comparison Repper-DeLisi et al (2008) reported on the implementation of an alcohol withdrawal pathway in a general hospital. Contrasting the health care records of 40 patients pre the ICP being implemented with 40 patients cared for using the ICP, the findings suggested that of the six measures of pathway compliance compared, five had increased significantly in the ICP group. The differences were tested using ANOVA and were statistically different at the level p=<0.05). They also examined the differences in the prescribing of benzodiazepines using Mann-Whitney tests, which showed no significant differences (at the level p=<0.05) in the dosages prescribed between the groups. Later in the inpatient stay patients on the ICP were more likely to receive medication based on fixed or standing prescriptions rather than PRN (as required medication) when compared to the pre ICP group. An interesting aspect of this study is that this is a pathway that is mental health based but delivered in a general health setting and it is noticeable in the account, that it was developed with ease, implemented without difficulty with seemingly successful outcomes. In an earlier evaluation of a similar ICP, Morgan, Kofoed and Peterson (1996) reported that dosages of benzodiazepines decreased by a third following ICP implementation when by comparing 66 pre and 131 patients post ICP.

Again claiming an increase in activities and interventions being achieved with the implementation of an ICP, Hanson, Grypma, Tee and MacEwan (2006) describe the impact of an ICP used in Australia for early intervention in psychosis. They compared care between a pre ICP group and a group of patients cared for using the ICP. It was proposed that the ICP group of 33 patients received interventions at a much higher rate than had the pre ICP group of the same size. Comparisons between the groups were made using Mann-Whitney U-tests for non-parametric data and t-tests for parametric data. The use of the ICP significantly increased the frequency of client and family contact, provision of psychosocial interventions and family work. These differences were statistically significant at the level of $p<0.05$. However, the authors suggest caution in attributing these improvements to the ICP when they could possibly be explained by other factors such as improved standards of documentation.

Two studies describe the level of interventions achieved using an ICP without comparison with any other group. One of these is Hendriks, Mahendran, Su, Thambyrajah, Choo and Krishnan (2007) who describe a retrospective study of 307 patients who have been cared for using an ICP for schizophrenia in the US. As well as considering the socio-demographic profile of the patients, and the length of their hospitalisation, the study considered whether psychoeducation had been offered to patients who had been cared for using the ICP. The findings suggested that 98% of patients received the programme of psychoeducation that had been built into the ICP, and that these patients had a low likelihood of rapid readmission and better uptake of aftercare. Unfortunately there are no pre ICP measures or a non-ICP group for comparison, although suggestions are that the ICP had prompted essential components of care to be delivered systematically which appears to be the case for the psychoeducation in this ICP.

Another study by Hazell (2003) described the use of an ICP for young people who presented to services with suicidal ideas in Australia. He reports a 'good' level of adherence to the ICP studied over a three month period, although there is sparse detail to support this claim. The most significant exception to the ICP he reports relates to the review of the young person in accident and emergency by a mental health professional. It is suggested that the reason for this only occurring in 62% of presentations was that the young person had often been admitted to hospital before this happened. A possible consequence of this being that the patient had not been fully assessed.

The final study which considers the impact of an ICP on the likelihood of interventions being given is reported in a controlled evaluation of an ICP for acute episode psychosis (Mynors-

Wallis, Rastogi, Virgo, Kosky, Howard and Brake, 2004). Mynors-Wallis et al (2004) compare the delivery of 45 care standards between a group of patients cared for using the ICP (n=30) and a control group of patients (n=27) who received care by traditional management (not based on an ICP). The comparison includes 21 standards for assessment and 24 concerning treatment, all of which were specified in the ICP. Comparisons showed that there were few statistically significant differences in the delivery of the care standards between the groups, and on some occasions the non ICP group of patients were more likely to have had the interventions described in the standard. Patients in the ICP group were more likely to have plans for substance misuse management, whereas in the non-ICP group patients were more likely to have received education about their illness, psycho-education, contact with voluntary agencies and plans for unmet needs. It is noted that the results for only 31 of the 45 standards are shown.

Interestingly when comparing the delivery of the interventions for psychoeducation in the study by Mynors-Wallis et al (2004) (2 standards achieved for 43% and 27% of ICP patients) to that in the study by Hendriks et al (2007) at 98%, the difference is vast. The study by Mynors-Wallis (2004) does use a much smaller sample, and it is acknowledged that the ICP had only been in use for 6 months and that it could possibly have been implemented more robustly. Other differences are that Hendriks et al's (2007) study is based in the US and Mynors-Wallis et al (2004) in the UK and the latter is a much longer ICP which considers outpatient as well as inpatient care. Inpatients are more likely to be available for treatment, but are also more acutely ill. Both factors may have had an impact on the likelihood of the interventions in an ICP being achieved.

4.2 Length of Stay, Readmission Rates & Follow-up

Many of the studies which report the likelihood of care being given also consider length of stay. Five studies report a shorter length of stay as a consequence of implementing an ICP, two report no difference and one reports a longer average stay. Reporting a shorter length of stay, Kazui, Hashimoto, Nakano, Matsumoto, Yamamura, Nagaoka, Mori, Endo, Tokunaga, Ikejiri and Takeda (2004) consider the impact of an inpatient ICP for older people with dementia used in Japan. Comparisons were made between two groups of patients, one a pre ICP (n=20) and the other an ICP group (n=23) admitted to the same service a month after the ICP was implemented. The difference between length of stay of the two groups was analysed using t-tests, Fisher's exact test and analysis of covariance (ANCOVA) considering other possible variables between the groups that may have impacted length of stay. T-Tests were used to consider differences in the means between the two groups, and ANCOVA to test the differences of means between the groups on a dependant variable whilst controlling other variables. As a consequence of this analysis, Kazui et al (2004) determined that average length of stay in the ICP group was 25.3 days which was 5.9 days shorter and significantly less than pre ICP ($p<0.005$). It was found that the factors that might influence length of stay i.e. gender, age, mental state, medication and aetiology did not vary significantly between the non ICP and the ICP group. Although, there was the tendency for patients in the pre ICP group to be older, and after considering age as a covariate, the effect of using the ICP upon length of stay remained statistically significant.

Also reporting a reduced length of stay in the case of an acute care pathway, Nott (2002) described an evaluation based in a UK NHS inpatient unit. The length of stay was compared for 203 patients admitted in the year before the implementation of the ICP and was on average 28.72 days. This was compared with the average length of stay for 179 patients who had been cared for using the ICP during the following 9 months when the ICP had been in use. The patients in the ICP group had an average length of stay of 12.46 days indicating a 56.5% reduction. Pre ICP, 20 patients stayed in hospital longer than 10 weeks, compared to five during the time the ICP was used. However, there was no discussion about confounding variables like diagnosis, access to accommodation and severity of illness.

In different settings three other studies report reduced length of stay as a consequence of using ICPs. Repper-DeLisi et al's (2008) study of an alcohol withdrawal pathway suggests a shorter length of stay using the ICP group reducing from 5.4 to 4 days. Morgan et al's (1996) study of a similar ICP reported that average length of stay reduced from 7.35 to 4.77 days for patients who completed the full ICP. They reported no increases in people leaving treatment early or clinical complications. Bultema et al's (1996) study of an inpatient care pathway for depression for older people compared a pre path group of 153 patients with 58 patients cared for using the ICP. The authors reported that average length of stay reduced by 9 days and that 58% of patients were discharged within the 14 day timeframe of the pathway.

In contrast, an acute inpatient ICP used in Australia by nine inpatient teams had no perceived impact on length of stay (Emmerson, Frost, Fawcett, Ballantyne, Ward and Catts, 2006). In this study there are no details about sample sizes, and pre ICP data about length of stay is limited to patients only in the quarter prior to the ICP being used. The authors reported that the average length of stay when the ICP was used is 16 days, but no pre ICP data was available. Questioning the validity of the conclusion about the ICP having no impact on length of stay it can only be assumed that the ICP was adhered to. There is no evidence in the paper as to whether this was actually the case and the conclusion asserts that the lack of impact is due to the fact that mental health problems are too difficult to represent in an ICP – which seems to be unsubstantiated. This may be the case, although as a conclusion it cannot be logically drawn directly from the method and results that are published in the paper.

As the ICP reported by Emmerson et al (2006) covers a significantly different timeframe to the acute inpatient ICP reported by Hendricks et al (2007) - the length of stay findings cannot be directly compared. Hendricks et al (2007) described that with the inpatient pathway they studied; ICP patients had a shorter length of stay, than before the ICP was used. In their retrospective study of the ICP for schizophrenia 307 patients 65.7% had been hospitalised for less than 21 days and 20.8% had stayed over 28 days. Just over a third of patients (34.2%) were not discharged within the 21 day timeframe of the pathway. Unfortunately there are no average lengths of stay given for the pre ICP and post ICP groups. In contrast, the longer ICP for acute episode of schizophrenia which includes both inpatient and community care studied by Myers-Wallis et al (2004) reports an average of 81 days were spent in inpatient care out of the total 24 weeks of the ICP. This was not significantly shorter than for the non ICP control group they also studied. There is no indication of whether the 81 days reflects multiple admissions – although it is possible that it could.

Hendricks and Mahendran (2007) published pre and post ICP comparisons of length of stay for a total of nine different diagnoses-based inpatient pathways. The largest reduction in length of stay was found for patients on the ICP for dementia reducing length of stay by 4 days. The patients on pathways for major depression, first episode of schizophrenia and mania had an average length of stay 2 days shorter than patients pre ICP. Length of stay for those on pathways for alcohol dependence or opiate dependence did not significantly reduce. Conversely, Lock's (1999) study of the outcomes of a care pathway for anorexia nervosa for adolescents in the US revealed an increased length of stay following the introduction of the ICP. Although clinical outcomes were achieved, patients had experienced more medical problems resulting in longer stays during the time the ICP was used. Further examination revealed that the ICP patients had been admitted with significantly lower body weights and more serious physical problems.

Two studies consider the influence of ICPs upon readmission rates. The retrospective study of the ICP for relapsed schizophrenia by Hendriks et al (2007) reported a shorter length of stay suggested that patients who had received care on the pathway had a reduced likelihood of readmission to hospital within 28 days (14.3%) and more likelihood of attending follow-up appointments (80.5%). All that can be done with this information (as there is no pre ICP data) is to compare it to Emmerson et al's (2006) findings related to the ICP for acute inpatient care which suggests no impact of the ICP upon unplanned readmission. Pre and post ICP readmission rates range between 11 and 17% (both lower than in Hendricks et al's (2007) post ICP group). As suggested previously, and disappointingly, there are no details in this paper about the sample size, and pre ICP measures are limited to patients only in the quarter prior to the ICP. Hence, from both these sources it is not possible to discern any firm impressions about the impact of an ICP upon readmission rates.

It should be noted that a reduced length of stay is generally perceived as a positive outcome. This is more likely to be explained as a benefit in terms of reduced cost. It is not considered from the perspective of patients or carers, nor are any longitudinal effects taken into account. Jones (1996; 1997) suggested caution about considering length of stay as an indicator of quality. He argued that progress towards discharge in mental health care is a continually negotiated process between individuals. The point is also made that shorter length of stays may leave people ill prepared for the time after discharge whereby they may require more resource intensive care than had they spent longer as an inpatient. At the time of Jones' writing there was concern in the UK that community mental health care and particularly care after discharge was inadequate.

In these studies it is generally assumed that it is the effect of the ICP that is the cause of change in length of stay or quantitative performance indicator. Critically however, there are no indications that authors considered confounding variables that may have impacted upon the measures selected. No reference is made to reactivity or the Hawthorne effect i.e. the impact of solely the research taking place (Sim and Wright, 2000). The care environment, service users, professionals and their interactions inherently have many individual features that influence the outcomes being studied. No attempts have been made to allay doubts about internal validity and reflect the considerable emphasis that is placed upon the determination of causality. The design of the evaluations has excluded randomised controlled trails or true experimentation. Studies to date still raise prospects of rival interpretations for the change in outcomes suggested.

4.3 Clinical Outcomes and Cost

The impact of ICPs upon clinical outcomes is rarely reported. One example is the Mynors-Wallis et al's (2004) controlled study of an ICP for acute episode psychosis that compared clinical outcome measures. They compared outcomes and needs between an ICP group of patients and a non ICP control group using the Brief Psychiatric Rating Scale, the Clinical Global Impression Scale and the Camberwell Assessment of Need. These were completed on entry to the study, and again at 4, 12 and 24 weeks. Throughout the pathway there were no significant differences in any outcome measures between the ICP and the control group. Perhaps the ICP was not well implemented, a view substantiated by variances not being tracked across the ICP. The comparison did take place very soon after the implementation of the ICP. The authors also raise the issue previously argued by Emmerson et al (2006) that care for those with schizophrenia may be too complex to detail and manage via an ICP approach.

Emmerson et al (2006) considered the impact of the acute inpatient ICP on absconding, suicide attempts and minor self harm. Their findings also suggest there was no discernable difference between the incidence of these between the pre ICP and ICP group. Acknowledging again that this paper contains no information about the sample size, limited conclusions can be drawn from this. The results show what may be an interesting spike in the percentage of patients absconding, their length of stay and self harm in the first quarter that the ICP was used. This is not acknowledged in the discussion, nor is it considered if this may be linked to other variables or is explainable in any way. Considering this alongside Mynors-Wallis et al's (2004) study suggests the possibility that ICPs have no effect upon clinical outcomes.

However, in different care settings Repper-DeLisi et al's (2008) evaluation of an ICP for alcohol withdrawal showed that the patients cared for in an ICP group were less likely to experience delirium (12% less than for the pre pathway group), although the chi-square result for this suggested that the difference was not statistically different. Also, Lock (1999) evaluated the outcomes of an ICP used in the US for the care of adolescents with anorexia nervosa for three years. It is highlighted that a major indicator of the clinical success of the pathway was the weight gain of patients on the pathway. In the 20 months that the ICP was studied 100% of patients had achieved the target of increasing their weight by 1kg per week, compared to 85% during a four month comparison period pre pathway.

In a different patient group Hazell (2003) describes the impact of using an ICP for young people who had attempted suicide in Australia upon follow-up rates. It was found that 74% of the 115 people cared for using the ICP had attended for follow-up outpatient appointments, which the authors claim is higher than other studies of follow-up for that patient group. It was found that the likelihood of attendance was not influenced by gender, length of hospitalisation or the time to the follow-up appointment. Multiple presenters were less likely to attend (74% compared to 91%) and this was statistically significant ($x^2=10.84$, $df=3$, $p=<0.05$).

With regard to the impact of ICPs upon costs, only two studies contribute knowledge on this. Bultema et al's (1996) evaluation of the ICP for depression for older people suggests that the costs per case by implementing the ICP had reduced by an average of 40%, which they consider as relative to the reduction in length of stay previously described. It is suggested that the reduced length of stay reduced the cost per case by $5,770. For similar reasons stemming from reduced length of stay, Kazui et al (2004) reported the cost of the inpatient episode reduced from $5425.5 to $4766.7, and claimed that this was due to the use of the ICP for dementia.

4.4 Patient and Staff Experience

Few studies describe patients' experience of receiving care organised by an ICP. Nott's (2002) evaluation of an ICP for acute inpatient care is an exception which compared patient experience prior to and after the implementation of an ICP. He used a postal questionnaire with a sample of 36 patients pre ICP and 26 patients who had received care using the ICP. The eventual sample size was a consequence of low response rates. The findings from the questionnaires suggested that 90% of respondents felt satisfied with their care in the ICP group (which was 15% higher than prior to the ICP). Also there was a 15% increase in people understanding why they were admitted and 17% more felt that their expectations about their stay had been met (for the ICP group). Eight percent (8%) more respondents felt they were actively involved in their care in the ICP group and 11% more were satisfied about the information they received about their medication and side effects. It needs to be acknowledged as the author states, the sample size is small and there was no attempt to control other variables that might have impacted upon patient satisfaction.

Two further studies describe the patient experience of care delivered using ICPs. Frazer, Hanson & Wakefield (2006) gathered the views of patients who had received care organised by staff using an ICP for the treatment of depression in UK primary care services. It is suggested that patients had been satisfied with the service they had received, that they found the service accessible and been able to monitor their own progress through the pathway. Frazer et al (2006) reported there was a positive impact upon outcomes, although there were no data to substantiate this claim. Unfortunately, the sample size or the methods used to gather the views of patients are not clear, and subsequently it is difficult to determine the validity and reliability of the conclusions drawn.

Beardsall et al (2002) and Pringle (2006) are the other authors who have reviewed service users' experiences of a mental health ICP. Mentioned previously in this review, they evaluated an ICP for Electroconvulsive Therapy (ECT) by audit, staff questionnaires and semi-structured interviews with service users. Interviews with eight service users revealed that when the ICP was used they felt that they were informed, helped, reassured and that their care was satisfactory. However, negative views were expressed about the timing of treatment and the level of anxiety experienced. No pre and post ICP comparisons were made, or attempts at randomisation, although Beardsall et al's (2002) account is more comprehensive than most.

Whilst there are many anecdotes about developing and implementing ICPs, systematic research into perceptions about the impact of ICPs is less common. Three of the more systematic investigations generally suggest that staff report that the ICPs have improved their contribution to care. Staff perceptions about the use of an ICP for acute episode for schizophrenia reported that 90% felt that the ICP was a good idea (Myers-Wallis et al, 2004). Eighty-six percent (86%) of the 29 healthcare professionals giving their views in semi-structured interviews reported that the ICP had benefited patient care. The aspects that were viewed positively were that the ICP offered a structure to care, it was interesting and beneficial. Negative impressions were that it was time consuming to use, too long and difficult to use. It is interesting that this is the same ICP that had had no discernable impact upon length of stay and clinical outcomes.

Similar impressions were suggested in a study of primary care Graduate Mental Health Workers (GMHWs) experiences of working with an ICP for the treatment of depression in UK primary care services (Frazer et al, 2006). General Practitioners (GPs) and GMHWs suggested via questionnaires that the ICP had improved the organisation of services, clarified roles and improved communication. The GPs did suggest that it had not changed their own practice but added clarity about onward services and how these should be accessed, and that overall the ICP represented best practice. The GMHWs suggested that the ICP had helped to clarify their role, gave them a guideline for practice and helped them collaborate with others involved in the care process. There is again little detail about how these views were analysed or the sample size used.

Kazui et al's (2004) evaluation of the care pathway used in Japan for the care of inpatients with dementia included a questionnaire to gain staff impressions of the ICP. Like the previous example, the sampling strategy or process of analysis are not described. Although there is detail in the findings which suggest that doctors and nurses report that the care was of good quality whether the ICP was used or not, whilst interestingly other care givers believed that the care was of better quality using the ICP. Kazui et al (2004) describe findings that suggest the care process using the ICP was much better understood, and that planning and communication had vastly improved. There were however concerns expressed by doctors and nurses that the ICP restricted their practice and increased the amount of work they were expected to do in a day.

5. Emerging Critiques

There is a specific philosophical debate that underpins discussions and critiques of mental health ICPs. This relates to the issue of whether people (be they patients, carers or health professionals) are viewed as individuals or as potential homogenous groups. That latter assumes that each group can have a shared understanding about health and health care, and whether a care process is something that can be viewed collectively for significant numbers of people. This relies upon the assumption that patients and carers' needs can be met uniformly and that healthcare professionals are prepared to act homogeneously (and not themselves be seen as unique). Either perspective, be it individualist or collectivist, may be seen as good, or more beneficial in some way than the other.

Claeys (1986) describes individualism as the outlook that stresses the moral worth of the individual, explaining that the human individual is of primary importance as the central unit of analysis. Natural rights, independence, autonomy and freedom are the substance of theories about individualism and there is an emphasis towards humanism as philosophical position. Whereas collectivism is defined as the theory and practice that makes some sort of group rather than the individual the fundamental unit of political, social, and economic concern. In theory, collectivists insist that the claims of groups, associations, or the state must normally supersede the claims of individuals. Claeys (1986) describes how theorists such as Frederich Hayek, Michael J. Sandel, Amitai Etzionni, and Robert Wolff have examined modern political and social issues using their own individualist or collectivist theories, continuing historical philosophical debates.

Within the context of this research, the debate around individualism and collectivism has become a preoccupation that is manifested in critiques about how ICPs clearly work towards a collectivist approach when so many other dominant influences are espoused as individualist; for example, individualised and interpersonal care, professional autonomy, choice and patient involvement. Subsequently, this final section of the literature review considers these issues further.

5.1 Patient journeys, individual perspectives and interpersonal care

It has already been described in the section on ICP development that problems have been experienced in establishing care pathway content that is acceptable to a range of stakeholders (Jones, 2004; 2005). Difficulties have been experienced in some settings and not others, and these have been explained by a number of factors, i.e. the mental health patient journey is too complex to represent in an ICP, there is a poor evidence base and lack of agreement about what should constitute the best care, and that care should be individualised and not standardised. Not wishing to generalise, these impressions which are based mainly upon 2 cases, and contrasts with other sources are used to further the debate (Jones, 1999a; Emerson et al, 2004).

For example, the helping relationship between healthcare professionals and patients and its psychodynamic inclination have long been prominent features in discussions about how mental health care is managed (Onyett, 1998). Emphasis on flexible and continuous care has increased, as has the therapeutic effects of the relationship as well as growth, participation and recovery. These features have been rarely considered in the ICP literature and are difficult to represent as collectivist concepts (as applied to large numbers of people in an ICP) when they are inherently individual. This suggests a possible conflict between ICPs and traditional case management which is popularly viewed as a highly effective and individualised approach to delivering care. Should the assumptions about case management be correct then ICPs as an approach to managing care can be seen as less individualised, more directive and potentially offering a less positive experience. The control associated with ICPs appears to be poorly regarded by professionals with the view that the highly valued therapeutic relationship is problematic to represent within ICP content, and at worst could be lost if an ICP is used (Jones, 1998). The patient journey itself is assumed to be and is described by healthcare professionals as highly individual and complex. With a poor ability to predict the course of illness gaining a representative view of this is difficult. It is one view that the care required is different between one patient and another, and the therapeutic relationships central to this are unique.

Peet and Wakefield (2002) considered what happens to the quality of the therapeutic relationship whilst using ICPs. They suggest that ICPs are useful for focusing on technical procedures whilst the human elements, the therapeutic relationship and interpersonal aspects are potentially overlooked. It was felt that human processes and the placebo effect needed to be included in ICPs and that these are more difficult to articulate. In their view, ICPs need to consider enhancing patient expectations about interventions, the role of self management and patients' ability to communicate their health problems. Peet and Wakefield (2002) proposed that emotional care, empathic interviewing, education regarding diagnosis, reassurance, consultative style, negotiated treatment, shared goals, collaboration and the therapeutic alliance all need to be built into ICPs. The literature examined in this review show that these aspects have not been exploited within ICPs and if they had been, potentially some of the difficulties experienced in Jones's action research may have been reduced. Wakefield and Peet (2003) argued that to exclude these essentials results in neglect of interpersonal factors, in pursuit of a technical approach.

Peet and Wakefield's (2002) concerns were supported by Hall's (2004a) findings of few interpersonal interventions within ICP content. Content analysis of a sample of ICPs in the UK revealed that there were similarities in the content and a notable preoccupation with assessment and administration. This could be verification of what Olsen (1994) describes as care processes which are influenced more by the priorities of commissioners and providers rather than patients and carers. Whilst organisations are encouraged in a collectivist approach to measure compliance with administration processes like the CPA, there is no such demand to monitor the individualised interventions that are required. This encourages a degree of homogeneity which has not focused on the interpersonal aspects of care despite drives towards choice and placing the patient at the centre of care. Hall's (2004b) findings reveal an absence of direct therapeutic interventions within ICP content, suggesting that content potentially lacked the exact activities which are the direct actions required to meet the needs of patients. So either the ICPs have not achieved a true representation of the patient journey or such interventions are absent from care processes which is probably more concerning. The former may be the case as political processes have influenced ICP content, or as suggested previously, such interventions have been too difficult to represent. Either way, an absence of therapeutic interventions in ICP content may have direct implications for inclusion and recovery of those experiencing mental health problems.

There are indications that ICP development has sought to overcome some of the concerns about the integration of the views of service users and carers and the interventions required to meet the most pressing needs. Overcoming these issues is described during the use of an ICP for adolescents experiencing an eating disorder (Rawdon et al, 2006). Rawdon et al (2006) describe how adolescents and their carers were substantially involved in developing the ICP, which meant them becoming familiar with the research and literature. The ICP development group wanted to combine the perspectives of young people and their families with local clinical expertise and available evidence. The young people asked for specific issues to be considered in the ICP like attending school and the development of their skills to cope with the problems they experience. The activities required to meet these needs were purposefully included in the ICP. So a collectivist approach to managing care sought to ensure that interpersonal aspects were built in.

Similarly, Fleming (2006) describes using an ICP to implement the Scottish schizophrenia guidelines and overcome the limitations of traditional approaches to managing care. Whilst the clinical guidelines were the significant focus for the content, the ICP was heavily influenced by service users and carers. Fleming (2006) suggests that developing the ICP was about giving service users and carers greater choice in the services planned and confidence that these services are efficient, effective and high quality. There was acknowledgement of the need for cost effective as well as clinically proven practice. Going one step further than clinical guidelines, Fleming (2006) describes using the ICP not only to consider the outcomes of individual care but also exploration of the overall performance of the care delivery process within the ICP. The key aim in his experience was to streamline tasks and structure them in a way which reduces repetition, minimises delays and simplifies the care process. The involvement of different stakeholders ensured that service users and carers were fully involved in redesigning the care process.

These exceptions aside, contrasting ICPs against care planning and case management reveals to professionals the potential weaknesses of ICPs. Comparing previous approaches to managing care with ICPs there is a new form of external influence and oversight. Such regulation has long been resisted on a number of levels. Assuming that theories of care planning and care management are congruent with practice, case management can deliver highly individualised care and specifies interventions and activities. Stepping away from this perceived degree of individualisation into a more collectivist approach like ICPs potentially stirs thoughts of depersonalised care that mental health care has sought to avoid. This perception is further reinforced when the level of specificity and individualisation is not properly addressed within ICP content. In this way care pathways fail to represent complex care processes and meet their own espoused definition (Hall, 2004a).

5.2 Standardised Care

Debates about individualised and collective mental health care can be traced back through the history of psychiatry and mental health care. Goffman's (1961) study of the social world of a mental hospital inmate described these as an oppressed group, with in a culture overwhelmed by the exploration of professional interests and collusion by the system, as features of collective institutional care. The day to day regimen of the institution included group daily activity and days that are scheduled, sequenced, prearranged and governed by inflexible predetermined rules. This may be relevant in considering the use of mental health ICPs in the present day, where with some variation standardisation of care is anticipated.

Rogers and Pilgrim (2001) describe the fall of the institution and rise of conversational treatments and the focus of self within mental health treatment. The debates about the self and individualised care continue in the response of healthcare professional to ICPs. Some later experiences in the UK have suggested that a loss of an individualist ideology need not be the case when using ICP, although this warrants further clarification and evidence particularly from the perspective of service users and their families. If ICPs were seen as operating in an ethnocentric way, as to order care in a disciplinarian system developed for the organisation's interest this may well be seen as being in direct conflict with the ideology of individualisation (Jones, 2005).

However, progress has been made in incorporating a form of therapeutic individualism and choice for service users within ICP content. It is suggested that ICPs have gone beyond clinical guidelines and case management in an approach to managing care that does not see individuals in isolation from the context within which they exist, and the interventions that may be available to help them. Who and what is driving ICP content is certainly significant. Service users and their families have been involved in treatment decisions and the development and implementation of ICPs. The care process clearly requires an active partnership between all stakeholders (Stuart, 2001). How all of these perspectives then manifest themselves within the ICP content and how this influences the reality of care giving and the experience of receiving care warrants further research. Engaging in this debate raises the consciousness about why ICPs have developed and the structures which have influenced this and how they (ICPs) are being used.

The literature has broached the dynamics between how care is managed and how it is influenced by the partnership between healthcare professionals, patients and carers. It has been suggested that level of individualised care and choice can be compromised by standardisation and reduction in variations arising from the implementation of both clinical guidelines and ICPs. Although some authors for example, Rohde (1997), have questioned how consumers (service users) can really exercise choice, even within case management which is inherently patient centred. The same question can be asked about the use of ICPs. The literature does not yet reveal how ICPs accommodate choices made by service users and carers. If care is individualised as it should be, this would indeed be a common occurrence that can be explored. Rohde's (1997) discussion highlights how it could be difficult and complex for ICPs to respond to the drivers of consumers, policy, organisations and finance.

Related to choice for patients and the decision making involved within managing care, it would be remiss not to consider the influence of resources. Floersch (2002) reports that case managers and care co-ordinators propose that choice is exercised through budgeting and goal setting which are often morally situated. It is proposed that the context includes prevailing policy which sets the parameters about what care can be offered. For example, the prevailing policy towards deinstitutionalisation has seen a reduction in inpatient services and subsequently alternative ways of meeting particular needs have to be considered. Relevant to any study of mental health ICPs is what influences are dominant within the care pathway content and the way the ICP is used. If any particular policy is prominent it is important to understand how this has developed, and how it manifests itself in the delivery and experience of the ICP.

More recently there has been a move towards a psychosocial approach, based upon a philosophy of recovery (Onyett, 1998; Floersch, 2002). This means the development of consumer based outcomes and a shift from a system dominated by other ideological perspectives such as cost containment and professional dominance. This may be a strike against ICPs if they are viewed as having a focus upon the fiscal (or medical) and have been centred upon organisational needs rather than those of service users. For example, it would be particularly significant if modern mental health ICPs and the care formed by these do not incorporate aspects of recovery and social inclusion. As suggested previously, a review of the ICP content suggests that these aspects are weak and how this operates warrants further investigation (Hall, 2004a).

Raynor (2005) acknowledged that the current body of literature about mental health ICPs does not readily address issues about language, effects of the therapeutic relationship and individualised care. She bases her discussion upon the experience of using an ICP within mental health residential services in a UK mental health Trust. Raynor (2005) argued that there had been a tendency to develop ICPs with a medical bias, the ICP itself based upon diagnosis and formulated solely upon the activities of professionals, potentially the service user becomes a passive recipient. The choice made in relation to their ICP was to omit the diagnostic label, which was viewed as unhelpful and its omission was seen as a way of ensuring that types of intervention other than those of a medical nature could be incorporated. As a consequence of this, Raynor (2005) reported that the ICP content became largely based upon the strengths model of case management, rather than focusing upon illness and problems. Concurring with Peet and Wakefield (2002), Raynor (2005) used this approach to ensure that the therapeutic relationship was well represented in care pathway content and it included case management in the ICP in the form of individual assessments and personal plans.

Also, Jones (2004) reflected upon the relationship between individualised mental health care and ICPs. To describe individualised care he uses terms like involving the service users in care planning and goal setting, and being able to recognise individual signs of relapse and response to treatment. In addition to these aspects, those involved in the action research he conducted noted that although they often respond to needs in a structured pattern, they felt that they offered care in a more personalised way than could be articulated in ICPs. Describing the amount of time professionals spent with service users, it was suggested that issues like trust, humanism and intimacy were difficult to express. Jones (2004) proposed that individualised care seemed to be influenced by each clinician's own values, style and ideology, and seemingly they were viewed as part of the ideology of the professions, and therefore this may be the basis for the opposition to standardising care.

6. Relevance to further Research

In the 1990s Denton, Wentworth, Yellowlees and Emmerson (1999) asked two questions about mental health ICPs. The first, are clinical pathways applicable in a mental health setting? At the time they suggested yes, there is a need to work more efficiently and effectively in delivering mental health care. Clearly due to the wealth of development that has taken place in different continents others have agreed. Subsequently over the past decade a body of knowledge has emerged about the process of developing and implementing ICPs in mental health care. However, this is heavily reliant upon individual accounts and limited research. Evans-Lacko, Jarrett, McCrone and Thornicroft (2008) recently acknowledged that where empirical research methods have been used in studies about ICPs, papers often lack detail about sample size and selection, confounding variables and limitations.

Overall, the literature provides a mixed commentary about the application of ICPs as an approach to preformulating mental health care. Whether the ICP approach adds value beyond the other accustomed approaches to managing care is open to question. Given the philosophical issues that have been highlighted in the literature it is a notable weakness that there are no detailed investigations of how healthcare professionals use ICPs on a day to day basis. The retrospective nature of most documented studies has inhibited this type of investigation. Whether healthcare professionals use ICPs as a basis for decision making and specifically how they incorporate individualised care and choice into this approach are unclear and needs further investigation.

Denton et al (1999) also questioned, is the mental health patient journey too complex to use this approach and is that why mental health professionals resist the challenge of using ICPs? They anticipated problems defining content and outcomes, articulating the care that was cognitive and not being able to engage staff. These predictions have been experienced and are well documented. Denton et al (1999) also queried whether it is too difficult to design ICPs for mental health. They considered if the process of care is too complex or individualised, or whether there are commonalities in progress and interventions. Therefore would it be possible to engage with clinicians on a local basis to develop and use ICPs? These issues have remained persistent in the literature, and have been seemingly overcome in some cases.

Linked to this is the possibility that ICPs may fail to account for interpersonal care and this would seem a critical area for further investigation. Their acceptability in mental health care seems to link strongly to this and individualised care. Questions are raised in the literature and are unanswered about whether the content of an ICP is what patients (service users) actually do experience. If, as the literature suggests, there are possibilities that ICPs impact upon how care can be individualised and choice exercised, then the experience of patients and carers is highly important and appears as a gap in the present knowledge base. If more were known about the effect of ICPs this would provide a new dimension to the existing philosophical debate. Whilst the impact of mental health ICPs, upon what are considered to constitute performance outcomes has started to be tested, this area of investigation is still under-represented in the research/literature.

Denton et al's (1999) issues have been rehearsed by commentators, but are still without clear and substantiated conclusions. Sources to date are restricted mainly to anecdotes and poorly documented studies and there is still a lack of theory upon which to base future decisions about the use of ICPs as an approach to managing mental health care.

In summary, the literature describes how the use of mental health care pathways has developed under the guises of governance and efficiency. Mental health professionals have been sceptical about their use and particularly this has been expressed in difficulties developing ICP content and then variable implementation. The benefits about their use are in the main focused on improved governance and service development. These are restricted to anecdotal accounts with little evidence beyond this. Whether ICPs have reduced unhelpful variations in practice, benefited service user experience, improved outcomes or have impeded individualised care has not been fully established. Evidence remains lacking, especially in relation to whether they are effective in achieving any form of outcomes. Despite this limited empirical evidence base, the use of ICPs is growing internationally. It is timely therefore to consider, through empirical research how ICPs are used, how they are experienced by staff, service users and carers, and what are the differences in clinical outcomes between services using ICPs and those using standard forms of care.

6.1 Research Questions

The literature review suggests there has been a growth in the use of ICPs in mental health without a robust evidence base about their use. There is adequate description of the care pathway development process. The extent of success in both development and implementation is mixed. Accounts of implementation fail to discern if and to what extent healthcare professionals actually use ICPs. Other aspects that have seldom been investigated systematically are patients' and carers' experiences of ICPs. There are suggestions that patients as a consequence of the using ICPs are more informed about their care, more involved and have a better experience of receiving care. However, these claims are largely unsubstantiated. There have been few studies of whether the standards of care within ICPs have been achieved and limited data about their impact. Where standards and outcomes are considered, there is a lack of supporting data about the use of the ICP. Most sources lack details about methodology, data collection, sampling, ethical issues and limitations.

As well as the lack of methodological rigor and reliance upon anecdotes what also contributes towards a sense of doubt about the impact of mental health ICPs is the lack of examination of the ICPs in use. ICPs themselves vary between organisations. Some are lists of interventions; others are based upon either diagnosis or a part of the patient journey. Many ICPs are displayed as a matrix of interventions (grid like) whilst others encompass the whole healthcare record. Some are paper based others are electronic, and several but not all include exception reporting. It is often unclear in published accounts what style of ICP has been used, and so it is difficult to establish whether a particular formula or approach is successful. The contributions of the most prominent authors do not describe in detail one ICP, how it is used and experienced, and its impact. The need to determine whether ICPs are an effective and an acceptable way to organise mental healthcare, and if continued investment in ICPs is warranted, justifies further research.

The theoretical framework for this study considers whether the advantages of ICPs experienced in acute medicine have been translated into mental health care, suggesting the following principle research question.

How is an ICP used to manage mental health care?

The principle question considers the interpretative side in how an ICP is used and experienced. Whilst allowing for a corresponding position about the effects of the ICP that may be knowable from a materialist stance and less influenced by the researcher. This approach is able to add new knowledge in the field and will examine the anecdotes about ICPs within an empirical framework. The following four specific research questions enable explanation about how healthcare professionals use ICPs, how they are experienced by service users and carers, whether ICPs reduce variation and offer benefits beyond traditional care planning.

1. How do healthcare professionals' use ICPs as an approach to managing mental health care?
2. What are service users' and carers' experiences of care that is managed using an ICP?
3. How does care that is described in the ICP compare with what is provided?
4. What is the impact of using an ICP upon key performance outcomes?

These research questions collectively offer the possibility of understanding one ICP in detail from different perspectives. The first question aims to describe how healthcare professionals use an ICP, how it exists as part of their working practice and its effects upon the therapeutic relationship and individualised care. The second question allows similar issues to be explored from different perspectives. It allows the opportunity to study concerns about how ICPs have been developed from the perspective of service providers, potentially not accounting for issues around choice and service user involvement in decision making. With the pre-formulated nature of ICPs it is not clear how variations in care delivery are practiced and how individualised care is accommodated. Having data from healthcare professionals, service users and carers allows for a contrast of impressions.

The third research question seeks to establish whether the content of the ICP reflects the actual patient journey in that whether the interventions in an ICP are actually provided. This offers a view that may differ from the impressions gained in answer to the previous questions. It allows for the possibility that the ICP (or parts of it) may or may not be implemented and whether any types of activities and interventions are more likely to be offered. This draws upon the issues in the literature that the course of mental illness is too unpredictable for using an ICP to manage the interventions and activities along a patient journey. The final research question considers the effect that an ICP has upon performance outcomes. Presently, there is a lack of evidence related to the effect of mental health ICPs upon effectiveness. A particular deficiency is that research which describes outcomes omits details about the nature of the ICP and its use. As there are currently wide variations in the use of clinical outcomes measures this research question will focus upon established and widely used performance outcomes so that contrasts can be made with data from other services.

Collectively these questions answer the principle research question. This research is an original contribution to knowledge reflecting an important international policy and practice issue. At the centre of the research are the philosophical debates that have begun to emerge in the literature driven by the requirement to match the allocation of investment into mental health ICPs with a corresponding level of knowledge.

CHAPTER 3

RESEARCH METHODS

This chapter outlines the research methodology and describes the research methods undertaken. It gives an overview of the research design, sample, data collection, analysis, ethical issues and matters of reliability and validity. There is discussion about the philosophical framework for the study and how the view of the researcher has influenced the research approach.

The literature review showed that the use of ICPs within mental health care is complex and poorly understood. Establishing this as a topic for research begins from the premise that from a number of perspectives there is a case for studying the use of ICPs as means of organising and delivering health services. At the very least, as Fulop, Allen, Clarke and Black (2002) suggest, without this kind of examination there is a failure to understand the efficacy, impact and benefits of new systems of care delivery.

Under the auspices of health service delivery and organisation research (Fulop et al, 2002); it can be argued that increased understanding of ICPs as a phenomenon could further knowledge and service development. Equally, Clarke and Dawson (2003) describe the need for this type of research under the guise of evaluation research whereby there is a need to assess the merits of using ICPs in mental health, determine their impact and contrast the care delivered with other methods. In the context of health service delivery and evaluation research, the systematic and formal investigation of mental health ICPs has the potential to reduce uncertainties about their use, improve their effectiveness and make decisions about their future use (Clarke and Dawson, 2002). On that basis a research methodology that will contribute to this was adopted.

7. Research Methodology

Ontology and epistemology are the philosophical building blocks that underpin this research. Blaikie (2000, p8) describes ontology as

> 'claims and assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up and how these units interact with each other. In short, ontological assumptions are concerned with what we believe constitutes social reality'.

The key question that ontology poses is whether there is a real world out there that is independent of our knowledge of it. If the answer is yes then one takes a foundationalist position that regards the social world as a foundation of reality that exists independent of the observer. This can be measured in an objective way, taking one towards epistemological positivism. Whereby the answer is no, one takes an anti-foundationalist position ontologically, suggesting there is not a reality that exists independently of the observer, but rather that the milieu is entirely socially constructed. If this is the case, it is concluded that there is not a social world out there that exists independent of our knowledge of it. Thus we would not be able to observe it, not expect to measure it and we would not consider positivist theories or methods. The researcher's own position on this is primarily that we can establish real relationships between social phenomena via direct observation, although there are those which exist that are not directly observable.

Leading on from this, epistemologically these two questions represent a tripartite taxonomy (March & Furlong, 2002). Logically there are three epistemological positions that can be taken, positivism, scientific realism and intrepretivism. It is the scientific realism that seeks an explanation of observable phenomenon and yet an understanding of the non-observable that appeals to the researcher. Rather than assuming the polarities of objectivism and positivism which emphasise quantitative analysis, and subjectivist interpretivism, this research builds on realism which assumes objectivism for observables, subjectivism for non-observables and employs both qualitative and quantitative approaches. This is particularly relevant to the four specific research questions proposed, each composing of a separate and defined unit of analysis. The experiences of using the ICP and of the care delivered by it are about human experiences best studied through interpretive approaches. Whilst other ways of knowing about the ICP studied through the documentation of the care given and performance information are units of analysis that can be studied by positivist and more objective approaches. In particular, the use of performance information as a unit of analysis can be deployed in a comparative or quasi-experimental approach. In terms of underlying epistemology this takes the view that positivist methodologies, theories and approaches are available for use in this research as part of a scientific realist approach. There is a close alliance to the interpretivist stance which concludes that there are deep social structures and influences that exist around the functioning of the ICP which cannot necessarily be directly observed.

The development of this research process began by recognising the relationship between the researcher, the research and the reality being studied. In this research the perceptions, feelings and impressions of the different stakeholders involved in the use of an ICP are highly valued but alone (in the view of the researcher) would fail to explain a phenomenon that may be better understood by a more holistic understanding (Mathison, 1998). Similarly, an alternative and purely materialist view suggesting that people, objects and living things can be explained by the organisation of matter would provide an equally inadequate understanding (Benton & Craib; 2001). It is argued that a materialist stance would ignore critically important aspects in the field. These include the possibility of service users experiencing high levels of distress or dissatisfaction, whilst particular quantitative outcomes are still being achieved. How an ICP is used and experienced cannot be weighed, diffused or subjected to laboratory conditions (Hospers, 1997). Acknowledging that ICPs are a complex phenomenon, the lack of prior theory and the research aim, there is an emphasis on selecting a methodology that is practical, and yet allows for a greater understanding to be widely accessible.

Given these influences and the requirement to study ICPs within the context of mental health care, case study has been selected as the most suitable research approach. As Yin (1981) suggests, case study research does not seek to extract the phenomenon away from its context. Yin (1981, p97) argued for the need to use a case study arises when

> 'An empirical inquiry must examine a contemporary phenomenon in its real-life context, especially when the boundaries and the phenomenon and context are not clearly evident.'

In later definitions Yin (2003, p1) relates that case studies use multiple sources of data and that they are the preferred research strategy,

> 'when 'how' or 'why' questions are being posed, when the investigator has little control over events, and when this focus is on a contemporary phenomenon with some real life context.'

Much of the early theory about the success of ICPs has been based upon general medicine and not within mental health. The literature indicates difficulties in establishing the extent to which they have been implemented and their impact within mental health care. Acknowledging this, it is particularly important for mental health ICPs to be studied within their context, to assist in understanding the complex inter-relationships about how they impact upon individualised care. In answer to this, case study methodology allows for a severely restricted focus and the construction of a detailed and deep understanding of how one ICP is used (Hodkinson and Hodkinson, 2001). This will enable opportunities to consider fully within the confines of a case the philosophical issues that have been highlighted in the literature review, and how these factors may now be influencing the use of mental health ICPs and their impact.

There is a need to understand how ICPs are used in mental health, and their complexity, and placing this alongside the requirement for findings which are holistic and meaningful. Stake (1995) considers the facets of a case and the disciplined enquiry that forms a case study, with an emphasis upon the context and wholeness. Mental health ICPs are very similar in their nature to the many cases of interest like the studies of communities, organisations and systems that have been subject to case study (Stake, 1995; Bergen and While, 2000; Hodkinson and Hodkinson, 2000; Yin, 2003). These researchers have successfully used case studies to develop understandings about the workings of individual departments within an organisation through to studying the effects of policy implementation and transformational change within the confines of a particular case. The contexts in which these case studies have taken place are complex and influenced by many variables and conditions, in the same ways as the operation of ICPs.

As Yin (2003) describes, there are the alternatives of an experimental strategy, archival analysis, historical studies and surveys. Many of the factors associated with mental health ICPs, like how they are perceived and experienced, are not easily accessible to direct measurement. Also, as the researcher is not able to control the behavioural events associated with the ICP this excludes a solely experimental approach. Given the research questions, using multiple approaches within an overall case study methodology suits the conditions of the researcher being unable to control what is being researched and ensures that the findings are contextual. As the nature of mental health care managed by an ICP is a contemporary set of events which cannot be externally controlled, it is therefore the researcher's view overall that case study methodology will most suitably underpin future knowledge development.

7.1 Research Methods

Considering the literature, the ontological and epistemological approach and the research questions, the research methods for this study were chosen to provide a comprehensive picture of a complex phenomenon (Morse & Field, 1996). In terms of research methods many writers differentiate between positivist, quantitative and interpretive, qualitative knowledge acquisition (Sarantakos, 1998; Bryman; 2001; Robson, 2002). Qualitative research focuses on the illumination of the interpretation of events rather than identification and construction of facts; quantitative research tests relationships between predetermined variables. Given the research questions, this research called for an integration of these approaches arranged through a case study. This is indicated particularly as the research questions engage with the inputs, processes and outcomes within the field of study (Fulop et al, 2002).

Case study research is the naturalistic investigation of an individual, group or system as a circumscribed unit (Stake, 1995; Adelman, Jenkins and Kemmis, 1996; Yin, 2003). Examining a phenomenon in this way acknowledges that the boundary between the ICP and the context itself may not be clear. As Yin (2003) reports, a case study is able to cope with multiple influences, uses several sources of data and is appropriate where there is a benefit of prior theory. Case study design makes use of a wide range of social research methods (Stake, 1995; Yin, 2003). Clarke and Dawson (2003) discuss how it is easy for researchers to become restricted to one particular research method and the importance of selecting methods determined by the nature of the research questions. As a methodology, a case study offers the possibility of achieving the research aim which is to understand how an ICP is used to manage mental health care, whilst acknowledging the multiple and subjective realities of the major stakeholders which include healthcare professionals, service users and carers. Individuals construct their own version of reality and using mixed methods within a case study approach helps ensure that any differing versions are captured.

7.2 Selection of the ICP for Case Study

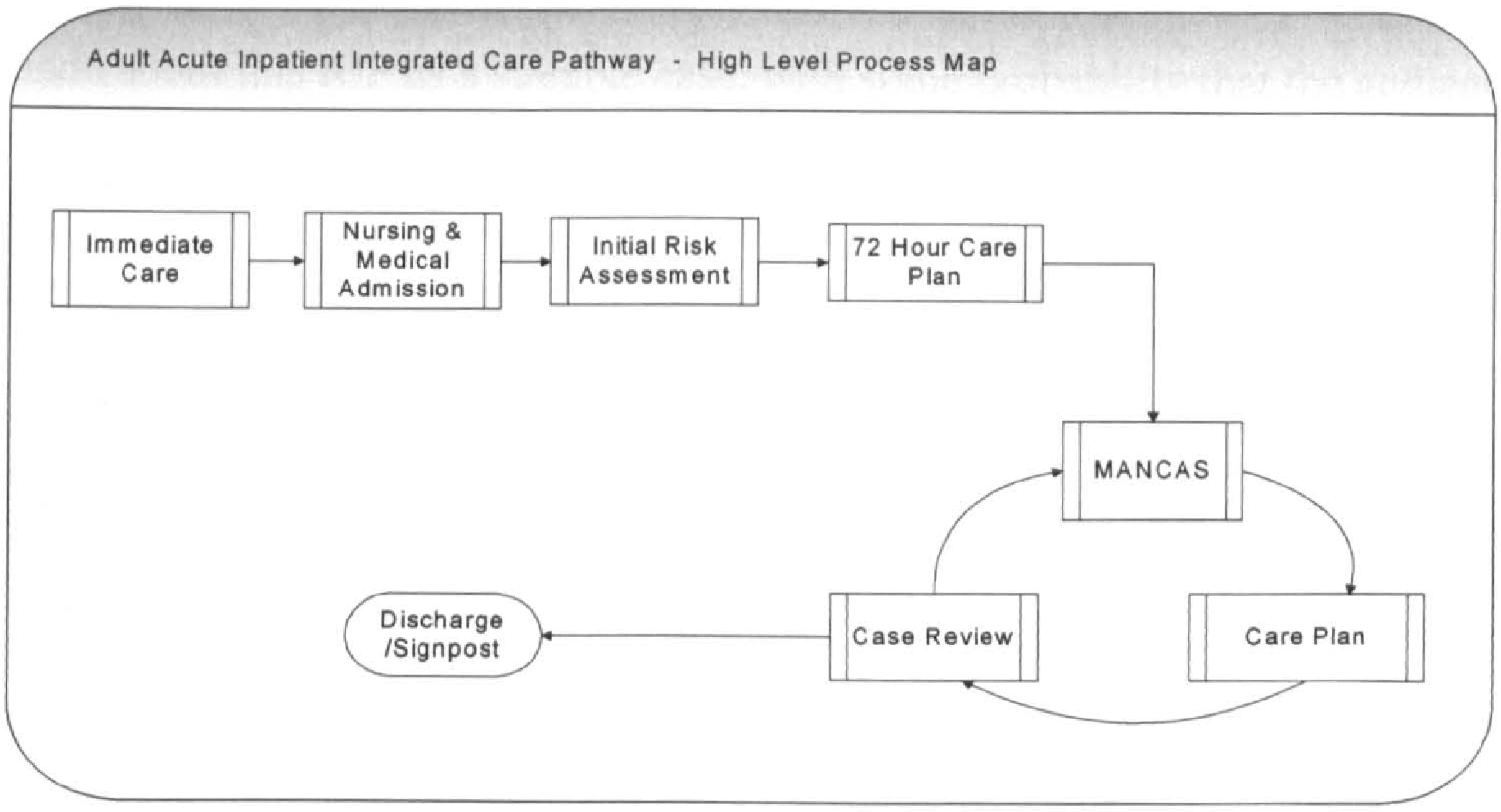
Hussey and Hussey (1997) suggest that suitable attention should be given to selecting the case within a case study with a view to understanding it as a single entity over a stated period, be that in terms of time or activity. Therefore the ICP selected for this research needed to meet specific criteria, firstly that it met the definition of an ICP as described by Riley (1998). This definition suggests that ICPs 'determine locally agreed, multidisciplinary practice based upon 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 (Riley, 1998 p30).' A further criterion was that the ICP was in current use and had been established for at least two years so as to provide sufficient data to answer the research questions. The literature review and UK National Electronic Library for Health indicated that a small number of organisations in the UK use ICPs which meet these criteria. To narrow selection further few ICPs could be directly linked with retrospective or current performance data. On this basis acute inpatient care was selected as the focus of the ICP with the added benefit of limited prior research into this type of ICP.

Of four contributors to acute ICP guidance provided by the NHS Institute for Innovation and Improvement (2006) one Trust known to the researcher, was accessible in terms of location and had used an ICP for acute inpatient care since 2003. This particular ICP was selected as the case, and was being used in 6 inpatient wards in 3 different geographical sectors of the Trust. Acute inpatient care as organised in the ICP is provided for people aged between 18 and 65 years old with a variety of different mental health problems. The degree of illness they are experiencing is serious enough to warrant inpatient care (Department of Health, 2002). Use of the ICP began in 2003 and in 2009 the ICP was in its 5th version. As described in the literature review, the ICP content had evolved over time in response to new developments, variance analysis and service change.

Version 3 of the ICP issued in 2004 (when this research began) was a 30 page paper document which began by detailing on the front cover that the ICP is for acute inpatient care, giving a place for recording the personal details of the patient, detailing the evidence base for the pathway and giving instructions for the completion of the ICP. Each time a patient is admitted the care pathway is commenced and the ICP then forms part of the patient record, bearing the version number of the pathway and the date that the version is issued. The pathway shows a high level process map of the pathway (shown in figure 1), details of abbreviations used throughout, a register of the signatures of staff using the ICP and notes about other records used in conjunction with the ICP. The content of the ICP begins with detailed personal and demographic information about the patient, their carers and agencies involved in their care. There is a record of the physical description and any needs related to cultural or religious practice. The pathway then details the expected interventions and activities that make up immediate reception and care. This involves gathering details about the circumstances which led to admission, agreeing the purpose of admission, advance directives, needs for an interpreter and so forth.

Throughout the document there are requirements to indicate whether activities are completed, including signatures by patients and healthcare staff, and recording the reasons for variations, as well as detailing narrative information required at the particular stages of the patient journey. Also incorporated are the assessments, activity programmes, care programme approach reviews, risk management plans, record of observation levels and individual care plans. A list of the content of the ICP by page is shown in Appendix 2.

Figure 1 - High level process map of the ICP



MANCAS – refers the to the Manchester Care and Assessment Schedule

Throughout the ICP are guidelines which describe the expected interventions and activities at particular points of the inpatient stay, based upon an anticipated timeframe. Each activity or intervention is identified by an activity code, and it is expected that these are recorded by exception if they are not completed. The care pathway ends with discharge from inpatient services and includes arrangements for aftercare. Parts of the ICP are used to trigger electronic data entry, referral to other agencies, and there is a cumulative register of variances at the end of the ICP which is sent to the Trust's audit department for analysis.

Using a case study methodology enabled in-depth study of this ICP by the detailed and intensive analysis of it as single case, using several units of analysis (Yin, 2003). As Stake (1995) reports, it is important to maximise in a case study what can be learnt and access is an important factor. This case has the breadth, volume and duration of use to allow sufficient fieldwork to answer the research questions, given that the ICP has been used in the way in which early information suggests.

Sufficiently describing the case, and continuing this through with detail and depth in the reports of the findings it is possible to consider the uniqueness of the case. At the outset an assessment was made about this ICP as a suitable case, with some probability that the audience for this research would find commonality in the characteristics of the ICP and the process of care that it is being used within. Commended by the National Institute for Mental Health (England) (now referred to as the National Mental Health Development Centre) and the NHS Institute for Innovation and Improvement this ICP is not typical of the way in which acute inpatient care is managed. The same episode of care is managed in most other organisations without the use of an ICP, allowing possible but cautious contrasts to be made.

It was the intention of this study to explore how this ICP is used as situation rather than develop new theory about what ICPs are (Yin, 2003). One of the inherent characteristics of case study as Yin (2003) describes is that it operates with a restricted focus and this ICP as a case has described parameters. In this case the parameters are the scope of Riley's (1998) definition; the ICP focuses on a particular care episode which is acute inpatient care and is used within one organisation. Rich description about the use of the ICP is of value in its own right, especially considering the lack of information about the success of different models or formats of ICPs. Engaging with this case means that it can be studied in depth using qualitative and quantitative approaches to investigate the complexity of how the ICP operates, and its effects.

7.3 Mixed Methods

Quantitative and qualitative approaches have often been described as opposing, each with various merits possibly outweighing the other (Sarantakos, 1998; Bryman; 2001; Robson, 2002). Some authors have suggested that as research methods they should not be mixed, whilst others have suggested that they can be complementary (Reichardt and Rallis, 1994; Hussey and Hussey, 1997). Using a case study approach for this research does support the use of mixed research methods (Yin, 2003), and data to answer each of the research questions was gathered using the described mixed methods.

Morse (2005; 2008) reports that mixed method design has become increasingly common, but they raise methodological issues that have not been resolved. She argues that there has been the urge to design either primarily qualitative or quantitative studies, then into these incorporating strategies of the other method. It is described that for example, qualitative data is integrated with forced choice questionnaires, which Morse (2005) considers to be inappropriate. The other approach that Morse (2005) describes is transposing numbers from interview data i.e. how many people referred to the same item in response to questions – using non-parametric analyses to enhance the qualitative description. The approach taken in this study does not apply both qualitative and quantitative approaches to a single dataset, and so does not have to overcome issues like, whether the qualitative data is consistent enough to quantify.

There is a wide and complex debate that sits behind whether the application of either a qualitative or quantitative approach is based on a rejection of the opposite epistemology (Avis, 2003). In this debate there is a view around pragmatism and holism. Avis (2003, p999) reports how decisions about what beliefs to accept are shifting towards pragmatism as a consequence of the 'collapse of positivism'. From this, there is a view that individual beliefs are fashioned by a background of thinking and interactions, and that these influence any claim to knowledge. This poses dilemmas about knowing what is true, and any desire for neutrality. Avis (2003) reports that qualitative research offer a way forward in this respect, in revealing the beliefs and values that are inherent, and not assuming any prior understanding. It can be considered that the mixed method approach taken in this research looks towards theory based on attempted pragmatic totality. Using the different methods allows some challenge about the knowledge assumed, to take place in a critical and transparent way.

7.3.1 Qualitative Methods

Qualitative approaches were used to gather data for research questions 1 and 2 which emphasise the individual and complex nature of people's experiences of ICPs. Importance was placed upon understanding the ICP as it happened by the collection and analysis of narrative accounts (Polit & Beck, 2007). Previous research has not explored in depth the perceptions of different stakeholders and where little is known about a case, an exploratory approach can be productive (Murphy, Dingwall, Greatbatch, Parker & Watson, 1998). The strength of this approach means that the findings are contextual and give clear detail about the case. Consideration was given to the sequence of data collection which was completed in the order suggested by the numbering of the questions. This was purposeful to elicit whether the ICP was used to such an extent as to answer subsequent questions.

Semi-structured interviews were used to gather verbatim data to answer question 1. The interview process, with face to face contact allowed opportunities for a full response, and outweighed the limitations of a questionnaire (Barker, 1996; Murphy et al, 1998; Too, 1996). Interviews were a favourable option to access the perceptions and experiences of healthcare staff and develop insights into how they use the ICP. This method enabled an approach which was both conversational and emergent (Holloway & Wheeler, 1996). The interview guide that was used (after being piloted) is shown in Appendix 3. Thirteen interviews were conducted, recorded and transcribed by the researcher and each lasted between 35 and 65 minutes.

To consider the perspectives of service users and carers as suggested in question 2, focus groups were used. The purpose of the focus groups was to obtain data about the experiences and impressions of patients and carers who have received their care managed through an ICP. Stewart and Shamhasani (1990) describe focus groups as a research method widely used for understanding consumer attitudes and behaviour. They have been successfully used for involving 'hard to reach' stakeholders in development, planning, and evaluation (Webb and Kevern, 2001). In this situation it was felt that focus groups may be more effective than other methods as participants might not have thought previously about the subject and discussion with peers may prompt fuller description. A guide for the focus groups was developed and reviewed by patient and carer representatives from an established group before being used (see Appendix 4). The researcher facilitated the two focus groups, the content of which were tape recorded and transcribed.

7.3.2 Quantitative Methods

Research question 3 was answered by data provided by documentary analysis. The aim was to investigate whether the interventions described in the ICP were actually offered. Patient records and copies of the ICP include data about whether the interventions and activities in the ICP were offered. As a source of data these originate in the research setting and as such are able to contribute as contemporary primary sources (Mann, 1985). Following Mann's (1985) interpretation, such records fall within the scope of official records where errors or falsification are unlikely. An advantage of using these data is that an aspect of the ICP can be studied without obtrusive observation or direct contact. These data could be collected without being influenced by the researcher and provide a suitable source in terms of truthfulness and accuracy (Robson, 2002). A schedule was used to collect this data and its content reflects the patient journey described in the ICP (see Appendix 5).

Finnegan (1996) highlights the significance of how documentary sources come into being. It is noted that sources which are written and numerical 'do not just arise automatically through some natural process, as if they could not have been produced in any other way. But in effect, all these sources are the results of human activity. They are produced by human beings acting in particular circumstances and within the constraints of particular social, historical and administrative conditions (Finnegan, 1996 p143)'. In the case of the documented ICP the recording on this as a document, relies on a series of human decisions and may be imprecise. There may be occasions for example when the ICP has recorded care as given – and this may not have been the case. The recorder's interpretation may be the result of a taken for granted routine, or influenced by inner feelings without awareness of these. Therefore it is important to acknowledge the series of choices that are made around recording the care that is on the ICP, and for example, to acknowledge any outside influences on this, i.e. organisational pressure to record actions as completed. The consequence of this Finnegan (1996) describes, is that the ICP as a source should be considered as relative rather than absolute, and that as a source it should be subject to interpretation.

To answer the final research question about performance outcomes, within-case and cross-case examination was used. This involved using existing data from patient administration systems (PAS). To support between case examination, data was introduced from a NHS Trust which offers the same episode of care but does not use an ICP. The episode of care is acute inpatient mental health care for people with a range of diagnoses whose needs can not be met without admission to hospital. The comparative Trust is one which resides in the same strategic health authority, and is subject to the same performance management framework and achieved equal scores in its rating for the national assessment of acute inpatient care (Healthcare Commission, 2008). Yin (2003) reports that using a second case can make findings more robust than being constrained to a single case, and using larger samples and incorporating quantitative techniques can help to increase external validity. This relates to a social experiment approach where whole groups of people i.e. the non ICP group and the ICP groups represent service users who received care under different conditions (where the condition is the ICP).

The PAS data was used to consider the characteristics of both samples and whether any extraneous variables may impact upon length of stay as a possible outcome. This data originates from the Trusts submissions for the national Mental Health Minimum Dataset which is collected for each mental health inpatient episode; this includes the patient's

- date of birth,
- gender,
- marital status,
- ethnic group,
- religion,
- source of referral,
- place of residence,
- legal status,
- diagnosis
- and start and end dates of ward stays (NHS Information Centre, 2008).

Both Trusts supplied these for stays in acute inpatient care. Other numerical data included summary information about the incidence of readmission within 28 days of discharge, and the provision of 7 day follow-up. Seven day follow-up is when inpatients have been in contact with services within 7 days of their discharge from inpatient care. The numerators for both these indicators are published by the Healthcare Commission (2005).

8. Sampling

The overall sampling strategy reflects the study of this ICP as a bounded case, in that all the qualitative data are gathered from individuals who had experience of the ICP, in its different geographical locations. The quantitative data was gathered from a criterion based sample and offers good representation within the confines of the case. The criterion base has the experience of the ICP at its centre, be it the experience of using the ICP, or the acute inpatient care in the organisation as a consequence of the time that the ICP was in use. The specific sampling strategies for each method are described.

8.1 Interview Sample

Research question 1 indicates the eligibility criteria for the interviews i.e. the healthcare professionals involved in using the ICP. These were medical staff, nurses, physiotherapists, occupational therapists and social workers. To make up the sample volunteers were sought from staff who worked on the 6 wards using the ICP. In total 13 staff volunteered and were interviewed. They included 5 qualified nurses, 3 occupational therapists, 2 consultant psychiatrists, 1 senior house officer, 1 physiotherapist and 1 social worker. Generally this sample size is viewed as sufficient for this nature of enquiry (Streubert & Carpenter, 1999) and justified by the requirement for description and depth rather than hypotheses testing. Data can be appropriately gathered via interviews and focus groups using small non-random samples (Streubert & Carpenter, 1999; Holloway & Wheeler, 1996). Over the sequence of interviews the findings were concurrently analysed in order to develop subsequent interview schedules and assess at what point the research question was sufficiently answered. The intention was to achieve a quality and quantity of data that allowed the research question to be addressed without drawing upon a vast sample which belied thorough analysis. Three of the healthcare professionals had used the ICP since it was developed in 2003 whilst the others had joined the service more recently. The interviews were completed in December 2006.

It is considered that there may be a distorting effect associated with a sample drawn from volunteers – this applies equally to the interviews and the focus groups in this case study. Murphy et al (1998) highlight that in qualitative research this is not uncommon, and that particularly in health research clinicians engage in research that they find interesting. Some pragmatic issues influence this kind of sampling, ranging from geographical to interpersonal ease of access. In this case (for the interviews) there was an ambition to represent all disciplines and geographical areas so as to represent a slice of the case. Although it is understood for example, that the viewpoints of two psychiatrists, cannot be generalised and assumed to represent the experiences of all the psychiatrists using the ICP. There is a potential that their motivation for joining the study may impact upon the data. This issue is considered throughout the discussion, where the perceptions of the interview and focus group respondents are contrasted with the other units of analysis and with existing knowledge.

8.2 Focus Group Sample

It was the intention to hold 2 focus groups each with up to 10 service users and carers. This size of group is reported to allow individuals opportunities to participate sufficiently (Kingry, Tiedje & Friedman, 1990). The NHS Trust where the ICP was used agreed to send invitations to join the study to the last 60 patients discharged from acute inpatient care and recruitment began in December 2006. The letters also included an invitation for carers to participate, with reply slips and stamped addressed envelopes to the researcher. The initial response rate was poor (only 1 service user responded) and it took a further 90 invitations and the introduction of a small incentive e.g. £10 in addition to the original travel expenses to achieve a total of 20 potential participants. In response to the invitations one service user sent a typed letter of impressions about his care and another sent a diary that he had kept about his deceased wife's care (this is discussed further under the ethical considerations). After agreement from these individuals these sources were included with the focus group data.

Despite confirmation of attendance only 10 of the 20 volunteers attended (5 at each group) the two focus groups which took place in June 2007. This included 3 carers, 6 service users and 1 person who considered himself to be a carer and service user. Whilst people's latest admission to acute inpatient care pertained to the period between December 2005 and March 2006, all but one service user had had multiple admissions during the time the ICP was in use. This achieved a sample that met the eligibility criterion for focus group participants i.e. people that had received care organised via the care pathway or being a carer of that person. Having service users and carers participating together allowed for consideration of whether similar information emerged from the two groups of respondents.

This purposive sample allowed the capture of views from both groups and as with the interviews a small non-random sample can be used legitimately in this situation (Streubert & Carpenter, 1999; Holloway & Wheeler, 1996). Crawford & Acorn (1997) and Reiskin (1992) agree that in certain circumstances only a small number of focus groups (one or two) can be sufficient. With the low uptake and high drop out rate consideration was given to whether to continue to recruit further participants and have a third focus group, although evaluation of the data suggested that this was not warranted. It was the researcher's assessment that further focus groups were unlikely to unearth new information and the data gathered was sufficient to answer the research question. The focus group participants were reflective and willing to share their insights and experiences. Indeed the small numbers in the focus groups appeared to aid discussion and allow a depth of description that might not have been achieved with larger groups. All those present were able to participate.

8.3 Sample of ICPs and Healthcare Records

The sample of care pathways and healthcare records used to gather data for question 3 were shaped by specific criteria, i.e. the care had been managed using the ICP and within the timeframe which corresponded with the other data collected. The sampling frame included all service users admitted to acute inpatient care during the 2 years that version 3 of the ICP had been in use. The rationale for selecting this timeframe was the requirement for consistency. The population of service users that had been admitted during this time was split into lists for each

Trust locality and sorted using excel randomiser function. From each locality list, the notes of the first 20 service users were selected. From the total quota sample of 60, four sets of records were unavailable and replaced by the next on the locality lists. Reasons for notes being unavailable were that patients had died, or the notes were being used for current inpatient care or outpatients appointments. The Trust used separate notes for community care, so patients currently receiving community based care were included in the sample.

During data collection it was found that 3 sets of notes did not include an ICP and these were replaced by the next on the randomly generated list for the relevant locality. The final sample of 60 met the eligibility criteria for patients who had received care via the care pathway in the timeframe. It gave a sample that was representative of geographical spread and offered a low likelihood of bias in terms of the patient's age, gender, consultant, for example. A sample size of 60 was manageable in terms of data retrieval and provided sufficient data for descriptive analysis of the interventions in the ICP. Data collection using the tool in Appendix 5 took between 30 and 50 minutes per case and was completed in the medical records departments. Bryman (2001) and Robson (2002) support the use of quota sampling when looking to obtain representation determined by a particular element and that smaller numbers are adequate when a non probability sample is acceptable.

8.4 Hospital Episode and Performance Data

The sample used for the within case and between case comparison was based upon 2 types of datasets the first being hospital episode data for 200 patients in the ICP Trust and 200 in the non ICP Trust. A sample size of 200 patients per Trust is sufficient for within, and between cases, comparison. This is supported by Borg and Gall (1989) who propose that 100 subjects in each of the major subgroups is sufficient, and Mertens (1998) who notes that 15 participants per variable are sufficient in non experimental relational designs. Further support for this size of sample is found in similar studies of mental health care delivery (Barr and Huxley, 1999; Galvin and Baudendistel, 1998).

All data referred to patients admitted to acute inpatient care between November 2004 and November 2006. Data from the Patient Administration Systems was extracted by staff from the Trust's Information Departments, and a random sample was requested. The protocol given asked that a sample of 200 be extracted using excel random number generator from list of all the patients admitted to acute inpatient care between the November 2004 and November 2006. Deviating from this slightly, the first sample received which was from the ICP Trust was split evenly by gender – which was not what had been requested. However, after consideration and given the time taken to gain access to the first sample, the second Trust's data was requested by protocol to match this sampling strategy and include the gender split. Manual checking of the sample confirmed admission dates within the timeframe, admission to acute inpatient care and no obvious patterns that might indicate bias, such as clusters related to age, ethnicity etc.

The second dataset included performance data which is not available in PAS data, and the 2 Trusts provided summary statistics for readmission rates and 7 day follow up which are key performance indicators for mental health services. Readmission rates were counted as a % of people readmitted within 28 days from discharge and 7 day follow-up (the % of patients seen within 7 days of their discharge from acute inpatient care). This was available from both organisations for the timeframe May 2004 to February 2008.

The inclusion of the comparison with a Trust that offers the same process of care but does not use an ICP, allows consideration of whether the ICP offers benefits beyond traditional care planning. Bryman (2001) outlines the benefits of comparative designs and contrasting two or more cases in order to understand a social phenomenon better. The aim is to seek explanations for similarities or differences in performance ICP and non ICP Trust and to gain increased awareness or a deeper understanding. There is awareness that differences found may not be down to the ICP as the distinguishing factor and this will be considered. Yin (2003) outlines the possibilities of using 2 cases because they offer contrasting situations and that this can increase the external validity of case study findings.

9. Data Analysis

Sarantakos (1998) suggests that the aim of data analysis is to make sense of the information gathered during the process of the research and identify its meaning. Processing and converting the data into meaningful statements is integral to analysis and interpretation. For the purposes of this case study qualitative and quantitative analysis were used and the relationship between the data and how this was managed is outlined.

9.1 Qualitative Analysis

The qualitative data from the interviews and focus groups having being transcribed from recordings was analysed using a process of content analysis. Content analysis is described by Burnard (1991) and Silverman (2001) as a way of organising the data to capture its features using words, phrases, categories and coding to identify themes. The transcripts were read by the researcher, and the words, phrases, sentences were assigned with analytical categories (known as codes). Strauss & Corbin (1990) call this process coding and a gradual process of refinement is involved. The codes were seen as an aid to fragmenting and retrieving the text as well as organising it into broader themes and an organised structure. Although there were no specific predetermined categories at the outset, the interview and focus group schedules influenced the data in that it focused upon the experience of using the ICP or care formed by it. Subsequently the data and codes reflected this, although as Silverman (2001) suggests, the codes reflected what was actually said as opposed to what might have been anticipated.

During data collection each interview and focus group was coded as soon as the transcript was typed. The categories and codes were constantly reviewed in their relationships with others to build up themes. Field notes were taken throughout to record interpretations and consider how categories were connected and any broader phenomenon. During this process categories are labelled, revisited, joined and divided until the data was presented in a structured form. Analysis continued throughout the data collection, data reduction, data organisation and interpretation (Morse and Field, 1996; Sarantakos, 1998; Silverman, 2001). Although this was not a linear process at its simplest Bryman (2001) describes it as turning the qualitative data into fragments moving from the basic attributing of codes to the data, developing an awareness of what is being said, and identifying the issues and themes that are seen in the language of the respondents. The next stage was moving to consider these in broader analytical themes. To assist data retrieval and storage the software NVIVO version 2.0 was used. The data from the interviews and focus groups were analysed and are presented separately.

9.2 Quantitative Analysis

Analysis of the data for questions 3 and 4 was conducted using descriptive and inferential statistics. Data from the documentary analysis included levels of measurement that were mainly but not exclusively nominal variables. The level of measurement primarily considers how the categories within a variable are related to each other. In this case many of the variables include categories which have no rank or order, for example within the variable marital status, either being single, married or divorced. This allows a difference to be distinguished, but there is no rank attributed to these categories. As De Vaus (2002) acknowledges this does preclude the use of the most powerful statistical methods and restricts the methods of analysis. After data cleansing and reducing the amount of data to be analysed, analysis began with the use of descriptive statistics to investigate the characteristics of the samples (Munro, 2001; De Vaus, 2002). Using SPSS (Statistical Package for Social Sciences version 12.0.1) nominal and ordinal data were presented in tables and bar charts. Measures of central tendency were used depending on the nature of variables. Kolmogorov-Smirnov Z test was used to evaluate the distribution of the sample (De Vaus, 2002).

Much of the data describes the extent to which the ICP had been used to manage the patient journey and what interventions and activities had been completed. Given the data available, analysis considers relationships between ICP use, and other factors, i.e. gender, age, detention under the mental health act and so forth. Cross-tabulation was used to show relationships and allow for the search of associations. Bivariate tests of statistical significance were used to consider whether there was a variation in the percentage of interventions/activities completed in the ICP according to the gender of the patient, their Consultant Psychiatrist and the locality that they were an inpatient. Mann-Whitney and Kruskal-Wallis tests were used due to the small sample size, the nature of the variables and the non-normal and non parametric distribution of the percentage of interventions/activities completed (which could not be corrected by adjustment). Statistical significant differences were acknowledged at the level $p=<0.05$. To consider variation in the percentage of interventions/activities in the pathway completed according to the age of the patient and their length of stay a one-tailed Kendalls Tau test was used. Where findings were of statistical significance, the direction and size of these relationships were determined. It is acknowledged as Field (2000) and Black (2003) suggest that non-parametric tests are less powerful than parametric tests and there is an increased chance of type II error, i.e. falsely accepting the null hypothesis.

Similar approaches were taken with the data used in question 4. Descriptive statistics and analysis were used to review any differences in the characteristics of the samples between the ICP Trust and the non ICP Trust. The purpose of this was to consider whether the samples were similar enough for comparisons to be made about length of stay, 7 day follow-up and readmission rates between the two Trusts, and whether any differences were statistically significant. T-Tests and chi-square tests were used for this purpose (Field, 2000). Then non parametric statistical tests Kendals Tau and Kruskal-Wallis tests are used to consider the relationship between length of stay and other known key variables.

10. Ethical Considerations

The main ethical issues related to this research are the interaction between the researcher and third parties to obtain the data during interviews and focus groups, obtaining data from health records and the Patient Administration Systems, the use and storage of the data involved, gaining access to participants and obtaining consent. Before the study began approval was gained from the relevant Local Research Ethics Committee (LREC) and the 2 participating NHS Trusts as described in the Research Governance Framework for Health and Social Care (Department of Health, 2005). The confirmation of approval is shown in Appendix 6.

As described by Morse and Field (1996) and Silverman (2001), measures were taken to ensure that participants in the interviews and focus groups were fully informed of the nature of the research, the demands placed upon them and how the data is utilised. This information was given in writing and verbally prior to interviews and focus groups. Participation was voluntary and informed consent documented. The information and consent forms used were those approved by the LREC. Realising that the data collection process may be a rare opportunity for individuals to discuss sensitive and complex issues, the researcher made clear the circumstances in which information would be communicated to others. As suggested by Holloway and Wheeler (1996) and Silverman (2001) it was planned that where issues of concern emerge, or apprehension over the wellbeing of the participant or others occurred, data collection would cease. The welfare of the participant would take precedence, and details of support agencies were given to all participants.

Data from healthcare records and Patient Administration System information were used in this research. NHS Trusts are required to have mechanisms to ensure that patients, who do not wish to participate in research, have their wishes followed. The Trusts were asked to ensure that these individuals were excluded from all samples. These arrangements did fail to be effective but were outside of the control of the researcher. Access to health records and PAS information was authorised by the Trusts' Caldicott Guardians. PAS data was anonymous and no personal details were gathered from the health records. The researcher had an honorary contract of employment with the relevant NHS Trust for the period of the data collection and it is acknowledged that access to the sample of healthcare records falls outside of usual access.

During the recruitment of the participants for the focus groups an ethically challenging situation arose. The NHS Trust which sent out the invitations to participate to service users (and their carers) based on their own patient information, sent invitations to 2 service users who had died since using the Trust's services. Both had carers who made this known by contacting the researcher, who sincerely apologised for the distress caused by the correspondence. For one of the carers this was particularly distressing as his wife had committed suicide and indeed this study pertains to the mental health care she received. Subsequent to telephone conversations and a written apology from the researcher the carer released diaries that he had kept of his wife's care for inclusion in the data, his considered view being that this information would benefit the research and future care delivery. This did highlight in a very real way the personal costs of conducting this type of research. The Trust was formally made aware of these incidents and that deceased service users were being used in sampling for research (and other Trust correspondence). As a consequence they agreed to take action to safeguard against this in the future.

The qualitative data collected was anonymised and identifying information omitted during transcription of the tapes which will be destroyed when the research has been reported. Transcripts will be kept for 5 years following the completion of the study. All the data is labelled by codes instead of personally identifiable information. As this research was conducted as part of academic study, anonymous data were shared with the academic supervisor for purposes of supervision and improving reliability. By accessing interview and focus group participants via Trust staff, details of only those who wished to participate were accessible to the researcher. Personal contact details were used only for arranging appointments, validation of transcripts (where agreed), for receiving a copy of the research report (where agreed) and for reimbursing expenses. At the point that these activities are completed and the research reported all personal details are to be destroyed. Such details will not be stored electronically, but on paper securely at the applicant's place of work (NHS premises) until they are destroyed.

11. Validity and Reliability

Yin (2003) describes the four tests that are commonly used to evaluate the quality of social research which are equally applicable to case study research. The basis of this focuses upon trustworthiness, credibility, confirmability and data dependability. Each of these has been considered in the development of the research strategy and is outlined in terms of the individual research methods and the overall research process.

11.1 Construct Validity

Construct validity emphasises the need to establish correct operational measures for the concept being studied. In general terms this has been considered by the use of multiple methods, different sources of evidence and having key informants review the findings. Whilst it is noted that it can be difficult to establish a set of valid measures in case study research. Where these are used it is difficult to reflect that it is the ICP as the critical event alone that impacts upon these measures. Length of stay and key performance indicators has previously been associated with the evaluation of ICPs, and patient satisfaction to a lesser extent. Therefore, importance is placed upon acknowledging other influencing variables upon the measures used in the analysis and discussion.

Within quantitative research reliability is concerned with the consistency of measures. Most commentators consider stability, internal reliability and inter-observer consistency as the main features (Black, 1999; Bryman, 2001; Field, 2000). In this study some measures arise from the content of the ICP translated into the questionnaire. Having no influence upon the data collected these can be considered as stable measures and reliable in this context. It would have been possible to consider the stability of a measure by a test re-test method (Kelly & Long, 2000) although this was not applied. Inter-observer consistency was not problematic as the quantitative data is factual and barely required categorisation (Avis, 1995). Conscious thought was given to improving concurrent and construct validity and this is shown in the discussion when contrasts are made with data from other sources (Kelly and Long, 2000; De Vaus, 2002).

With regard to the qualitative data respondents have taken the opportunity to review the findings and comment on these. A common criticism of qualitative research is the subjectivity of the data collection and analysis process (Appleton, 1995). Critics of qualitative methodology describe a retreat from rigour, whilst supporters believe that quantification is not the sole form of assurance (Good and Watts, 1996). Related to this are criticisms about sample size and generalisibility. As the data is gathered from a range of health care professionals working in 3 geographical areas of a UK mental health trust, it needs to be considered in this context. An interpretive perspective acknowledges that professional experiences of using an ICP cannot be value free and separated from the cultural, social and political context of their work. Therefore rigour in the composition phase of the study is established through specific measures to improve the trustworthiness of the data. The aim being to ensure that the findings accurately represent the experience of using the ICP (in the case of the interviews). It is to a degree inevitable that the researcher influences the qualitative data, although truth-value, applicability, consistency and neutrality are scrutinised throughout. Particular measures to improve the strength of the qualitative findings were;

- Cumulative validation to establish whether findings are supported by other studies.
- Review of the transcripts by nine participants who confirmed that they captured an accurate record of their interview.
- Samples of transcripts and codes were reviewed by the academic supervisor and this was used as an opportunity to safeguard against subjectivity arising from the researcher's own experience (Appleton, 1995).
- Including verbatim data in the findings.
- Using field notes in supervision to make known and set aside the researcher's personal perceptions. This allowed the provision of an audit trail for examining with others the processes which contribute to the conclusions drawn.

There was awareness throughout that the researcher has experience of developing ICPs and the organisation where the research took place, and arising from this is a potential for bias. Supervision provided a safeguard against this throughout data collection and analysis. The importance of guarding against errors in translation and interpretation, as well as the awareness that qualitative research is susceptible to the researcher's influence, is acknowledged in the limitations that are reported.

11.2 Internal Validity

Internal validity generally is more pertinent to explanatory and causal studies however the researcher has been attentive to the need to incorporate this into explanation building and considering rival explanations which are made explicit in the discussion. It is acknowledged that specific tactics for improving internal validity are difficult to apply in case study research (Stake, 1995). The most stated safeguard is the use of pattern matching. In this case study the multiple sources of data were used to consider rival propositions and alternative explanations rather than relying on single sources.

During analysis it was the intention to gather each set of data as individual units but then look purposefully for contrasts and patterns across the sources. As Yin (2003) describes, this approach was intentional to avoid circular reasoning and never ending data collection. The selection of the case study methodology for this research included a framework for incorporating mixed methods and multiple sources of data. Then in line with Stake (1995), looking for correspondence and patterns whilst using the different data as more than one way of describing the case. Analysing the qualitative data before gathering the quantitative data was intentional to explore the extent to which the ICP was experienced and whether the quantitative data would be available and have meaning. Data from the interviews and focus groups looks at the ICP at a micro level (Stake, 1995). Widening this with data from a larger population within the case and another case develops this further and includes a wider perspective. The degree by which the unobtrusive quantitative data shores up the qualitative findings as a form of triangulation is debated.

Particularly relevant to internal validity in case study, Yin (2003) describes three general approaches to analysing findings which have been applied in this research. The first is the theoretical propositions that led to this case study, and which have shaped the research questions and data collection. For example, the thinking that ICPs as a form of standardised care leads to improved efficiency and reduce length of stay. Then as Yin (2003) suggests, considering alternative explanations. Indeed there is a possibility that healthcare professionals may not use

ICPs to manage day to day mental health care and any reduced length of stay may be incidental. The third strategy Yin (2003) outlines, is to develop a descriptive framework for organising the case study and to an extent this has been promoted throughout the research process. That is embedded within the intention to describe the experience of using the ICP, impressions about care, the extent to which the ICP is delivered and how it impacts upon performance. The management of these multiple sources is the most relevant aspect of internal validity in this study.

11.3 External Validity

External validity is about establishing the domain to which the study's findings can be generalised. It is acknowledged throughout, that this research is primarily the study of one ICP. No deliberate consideration has been given to the composition of the sample groups to purport generalisability outside of the case, but instead into giving sufficient details of the case and ensuring that there is sufficient depth in the findings. The findings are contextual and due regard has been given to allowing the best representation of the case that could be achieved. It can be argued that these staff, patients and carers represent a typical group of participants that could be found within acute inpatient care. Indeed though, they were selected as they have associations with an approach to managing care which is atypical.

There is no direct evidence that with the exception of the ICP that there were any other variables which would have a significant influence on the results. The data collection was completed between December 2006 and November 2008 and in the context of case study, no extraordinary events were reported. There appear to be no particular circumstances in the services studied which could be considered as significantly influencing the results of this study. Yin (2003) describes that within case study research the aim is to achieve analytic generalisation where the findings can be contrasted with existing theory. In order to achieve this, the theory on which the research design is based becomes the main vehicle for generalisation.

It is acknowledged that the samples used in the quantitative elements of this study are based on quotas and cannot be considered as random or sufficiently large to generalise any conclusions to the wider population. The samples however do represent the case and therefore the findings can be conservatively considered in that context rather than inferring general principles. In relation to the sample it is acknowledged that limited conclusions can be drawn from small sample sizes like 60 cases and the findings have low statistical power. This is why the findings place primacy on what is described and explained, rather than likelihood of correlations and so forth.

In terms of the hospital episode data from two mental health Trusts, these rely upon the mental health minimum dataset, which is generally considered to be an official and valid source. Those reviewing this study will recognise this as a source of data which has not been contaminated by the researcher during data collection. Care has been taken before comparisons have been made between the samples from the two NHS Trusts to ensure that the characteristics of the population are similar and that non-ICP related variations that may exist between the organisations have been explored. It has been necessary to consider whether factors like length of stay, follow-up and readmission rates are influenced by other factors, for example the availability of other services. Possible confounding variables are acknowledged and in terms of construct validity, (Kelly & Long, 2000; De Vaus, 2002) the discussion reflects that efforts have been taken to contrast the data with other sources.

11.4 Reliability

Yin (2003) describes that the goal is to minimise bias and errors in a research process that can be adopted by others. In order to support that level of detail a prerequisite is rigorous documentation and detailed description of the methods used. To that effect, measures have been taken according to the different research methods used and these are briefly outlined. How accurate any replication of the study may be will be influenced by the researcher's influence on the participants in the qualitative elements of the study. It is therefore acknowledged that the interview and focus group data were influenced by participants' perceptions of the research and the researcher. It is possible that participants were influenced by the investigator effect, i.e. imparting a particular impression that is not reflective of their reality. The potential for this effect was unlikely although three interview respondents were known to the researcher prior to the research starting. The most likely potential for the investigator effect was in the focus groups if the researcher was viewed as a healthcare professional, rather than being perceived as an independent individual. Focus group participants were aware from letters of invitation that the researcher was employed within the NHS, but not by the organisation being studied.

The focus group data were treated in similar ways to the interview data with regards to reliability. Three participants agreed to review the transcripts and confirmed that they were a true record of their input to the groups. There are impressions in the literature about how focus groups need to be considered differently in terms of reliability (Carey and Smith, 1994; Stewart and Shamdasani, 1990: Webb and Kelvern, 2001). It is the group effect that offers extra complexity and there are suggestions that methods of analysing focus group data are not well developed. In addition to the measures taken with the interview data there was a conscious intent to consider how the data may have been inhibited or censored. As Carey and Smith (1994) describe, analysis has to consider the responses of group members and how perceptions within the group may have influenced the data. Disclosure is influenced by what is said prior and subsequent attempts were made during transcribing to add details about tone, pace, non verbal communication (transcribed from field notes) and add the subsequent meaning i.e. humour, emotion etc.

Although the researcher is experienced in facilitating groupwork these were the first research focus groups that the researcher had moderated, and was therefore inexperienced as a moderator. Keeping focus on the research topic was at times difficult and as Stewart and Shamdasani (1990) acknowledge the amount of direction provided by the moderator does influence the data that is gathered. They also highlight difficulties in striking the balance about what is important to the members of the group to express and what is imperative in the view of the moderator to enable the research question to be answered. The phenomenon of ICPs from the perspective of service users and carers is not well understood and this increased the likelihood of response categories that were not anticipated at the outset (Stewart and Shamdasani, 1990). As with the interviews, participants in the focus groups had experience of the ICP in the 3 geographical areas of the Trust. In addition were the two narratives provided from people who did not attend the focus groups. Kevern and Webb (2001) acknowledge that focus group data should be considered in context without trying to generalise beyond this. For the purposes of this case study that premise is well suited. Indeed the nature of the volunteers and their numbers limit generalisations to a wider population (Stewart and Shamdasani, 1990).

CHAPTER 4

FINDINGS

12. Findings

The findings begin with a presentation of the case, including description of the setting in which the care pathway is used and how it was developed. Following this are four sections each focusing on the specific research question and they arise from the use of the described research methods. At the end of the chapter there is a brief review of the limitations of the findings.

13. Description of the case

Yin (2003) outlines the requirement in case study research to use multiple sources of evidence and rich description of the case. The rationale for this is triangulation and by way of former employment in the ICP Trust the researcher is able to add to the case study database details about the research setting and how the ICP was developed. It is described that participant roles are not uncommon within case study research (Yin, 2003) and previous employment as a Care Pathway Manager and facilitation of the care pathway development allows the researcher access to data that would be otherwise unavailable. The researcher's prior involvement however does raise issues around potential bias (Yin, 2003), and these are considered within this section.

13.1 The Research Setting

The research setting where this research took place is a medium size mental health NHS Trust in the UK with an annual income of over £100 million. It provides mental health, learning disability and substance misuse services over a largely rural population. The Trust offers crisis, community and inpatient services across the entire age spectrum. The inpatient services in this study include 6 wards in 3 geographical locations – which equate to the 3 main towns within the

Trust's area. The characteristics of the wards are similar in culture and practice to those described in acute wards studied by Berg and Hallberg (2000), Whittington and McLaughlin (2000) and Hummellvoll and Severinsson (2001).

The Trust began to work with ICPs in 2002, and the care pathway subject to this case study was one of three implemented early in 2003. The Trust had an agreed strategy for care pathway development which intended for ICPs to be widely used in different services (X NHS Trust, 2002). The aim of this strategy was to improve the experience of receiving services by using care pathways as a tool for monitoring, coordinating and improving standards of care. It was the intention that this approach would help secure a culture of practice development and a pursuit of improvement in outcomes which places service users at the centre of care (Hall and Howard, 2006). It was agreed that all care pathways developed and implemented would:

1. 'Be a consequence of rigorous review of existing practices and involve all stakeholders in development.
2. Adopt an integrative philosophy and deliberately use team-working and shared belief systems from the outset. Collaboration will be visible during development, within pathway content and in subsequent feedback of variance.
3. Form all or part of the patient record and describe a seamless pathway of care that articulates expected interventions. The document in conjunction with others will satisfy existing standards of record keeping and be multidisciplinary in nature.
4. Describe effective interventions targeted to affect the greatest clinical benefit. This will incorporate evidence-based practice and clear reference to available clinical guidelines, outcome measures, benchmarks, research and expert opinion.
5. Identify through variance analysis; clinical deterioration, variation in care delivery and clinical outcomes. This specific information is used to facilitate clinical decision-

making, risk management, individualised interventions and continuous quality improvement.

6. Focus upon benefits management – reviewing service availability, 'gate-keeping' arrangements and reducing delays, duplications, hold ups and deficiencies (Hall and Howard, 2006 p19)'.

In 2002 the selection of acute inpatient care as a priority for care pathway development was a response to local and national desire to secure improvement in the quality of acute inpatient care. Hall (2004a, p111) described how 'following decades of mental health policy reform and directives to redress longstanding criticisms of institutional care - acute mental health services still face these same challenges'. Organisations, service users, carers and professionals were engaged in dialogue about a perceived decline in therapeutic interventions, bed management problems, an absence of evidence based practice and subsequent concerns over care experiences (Sainsbury Centre for Mental Health (SCMH), 1998). This ICP development came at a time when acute inpatient services were facing transformation, fully supported by mental health policy (National Inpatient Task Group (NITG), 2002).

As described in 7.2, acute inpatient care is provided for people aged between 18 and 65 years old with a variety of different mental health problems. The degree of illness they are experiencing is serious enough to warrant inpatient care (Department of Health, 2002). Over the period that the ICP has been in use there have been small reductions in bed numbers on the acute wards in this study, and they have moved towards providing gender specific provision. Bed numbers at the time of report writing vary between 9 and 22 beds per ward, with the highest staffing establishment standing at 24 whole time equivalent staff. When the ICP was developed a full Crisis Resolution and Home Treatment (CRHT) Services was available. These services according to their operational policy were Policy Implementation Guidance Complaint (DH, 2001). Having a close association with acute inpatient care the CRHT gate-keep inpatient admissions and are suggested to support early discharge. This means that the CRHT are actively involved in all admissions, mental health act assessments, providing assessment before admission and are central to decision making about admission to inpatient services. They also have a role in facilitating early discharge by the provision of intensive home treatment.

The following was provided as rationale for the acute care pathway development. 'Few would argue against the need for professional development and social transformation in acute mental health inpatient services. Characteristics of this situation can be seen as socially rooted, manifesting themselves in low morale and decline in therapeutic interactions (professionally known as acute concerns). These social issues are not unlike those which underpinned Lewin's (1946) early action research theories. Similar to action research, care pathway development requires a process of collaborative investigation, which develops knowledge to solve problems and bring about change (Hart & Bond, 1995). Care pathway development is situational and firmly rooted in human values and behaviours. The social nature of change required to respond to acute concerns is consistent with how care pathways are developed. It is known that economic strains, re-organistion and cost cutting have increased demands upon nurses (Hummelvoll & Severinsson, 2001). Resulting from drives for increased efficiency and lack of organisational support - burnout, professional inadequacy and exhaustion amongst nurses is high. Nurses in acute services require support to develop practice and frameworks to support this have been lacking. Studies of acute inpatient care indicate that nurses do want to develop their practice (Bray,1999; Hummelvoll & Severinsson, 2001). Perhaps lacking has been the focus, direction and structure to engage with the optimism and enthusiasm that are evident.

Care pathways offer nurses in acute care the opportunity to increase their understanding the nature of their situation and validate their practice. This approach is rooted in culture, group process, democracy and collaborative change (Adelman,1993). Development can therefore be grounded in the context of acute mental health services. Process mapping identifies problems, innovations and solutions rooted in everyday practice. The underlying causes, assumptions and beliefs which influence current problems are revealed and analysed and change often means challenging basic assumptions (Hendry, 1996). Care pathways whilst having managerial driven ethos enable nurses to have a voice in changing acute mental health services through a more contextual approach. For the necessary changes to occur, organisations and professionals are required to reconstruct their reality and take responsibility for their role in the situation (Hall, 2004a, p137-138)'.

To provide particular insight into the inpatient areas the ward philosophies are précised as being able to provide inpatient care during a time of mental health crisis, which is safe and gender sensitive. Interventions are provided to enable people to understand and more effectively manage their difficulties through an individual programme of care and treatment. There is an ethos of optimism, respect, focus on strengths, inclusion and recovery. Particular policies associated with inpatient care include those related to discharge and transfer – which is seen as a joint responsibility between ward staff and Care Coordinators (X NHS Trust, 2003a). The Assessment and Care Planning Policy, incorporating the Care Programme Approach (X NHS Trust, 2001) outlines expectations related to the core principles and standards of CPA. This states that everyone admitted to an inpatient service will receive care and treatment through the CPA process. The named nurse on the ward is expected to act as the care coordinator until one in the community is in place. The Clinical Risk Assessment and Management Policy (X NHS Trust, 2003b) states that on admission to inpatient services a clinical risk screening will be completed, and also on transfer, leave or discharge from acute inpatient care. All of these policies have been updated during the time the ICP has been in place.

Acute inpatient care has recently been subject to a national review (Healthcare Commission, 2008). This talks about how inpatient care is a critical part of mental health provision, supporting people during crisis, relapse and ill health. Nationally the report claims that improvements have been made to the quality of acute inpatient care whilst there is still significant variation in quality and some unacceptable practice. From the survey of 69 NHS Trusts during 2006/07, the ICP Trust scored 3 (good) for their overall assessment. With a score of good (3) for the effective care pathway criteria and for individualised whole person centred care. The Trust's acute inpatient services were also rated as Good in the 2009 national survey of acute inpatient care (Care Quality Commission, 2009).

13.2 ICP Development

In accordance with the Trust Strategy it was agreed at the outset that the ICP would meet Riley's (1998) definition of a care pathway in that it would 'determine locally agreed, multidisciplinary practice based upon 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 (Riley, 1998, p30).' Deviation from the pathway would be documented as a variance and this information used for day-to-day monitoring and periodic analysis for quality improvement. Arrangements were put in place to record variances on the pathway and to collate these at the point of discharge. Then this information would be feedback to teams to allow them to consider change and quality improvement. The pathway was developed initially on paper with possible electronic use to follow, as the service made its transition to electronic CPA (equivalent to an electronic patient record). To develop the ICP the following steps were followed to secure the involvement of all stakeholders and to detail sequential multidisciplinary interventions based upon emerging guidelines and evidence.

1. 'Establish, develop and educate the authoring team; Determine staff interest and secure support from the clinical setting, multidisciplinary team and service user /carer representatives.
2. Select the Timeframe and Parameters; This determines where the pathway begins and ends. The timeframe enables the care to be mapped in hours, days, weeks or in phases or stages of treatment/intervention.
3. Determine the Goals and Outcomes of Care; The pathway team must determine the goals and outcomes of care within the chosen parameters. These can be identified in terms of patient and process outcomes.
4. Process Mapping; All stakeholders mind-map the major steps and activities through the timeframe. Review of medical records to establish practice patterns. Consider problems and issues at each step. Include approximate time periods and parallel processes. Establish loops, complexities, roles and relationships.
5. Search for evidence-based interventions; Review the literature, established guidelines and national recommendations which influence the expected integrated care pathway
6. Analysis; Critically review the care process mapped and steps for appropriateness and timeliness – determine roles, duplications, delays, and added-value. Compare current practice with established clinical guidelines and benchmark across other organisations. Identify key areas for pathway/service development.
7. Redesign; Redesign the process around the experience of receiving care. Revise processes in terms of co-ordination, preplanning, and removing steps with no added value. Incorporate evidence-based interventions, extend roles and match capacity to demand. Develop, consult and review a sustainable, feasible vision based upon best practice.
8. Map the anticipated care and write the pathway; Mould together the corporate care pathway template, variance analysis system and prevailing clinical documentation.

9. Review, consult and revise; Pathway development team, clinical staff and organisational approval.
10. Develop implementation plan; Dissemination/consultation, staff education, establish champions in the clinical areas, pilot (3 to 6 months), monitoring to assess the level of completion and variance analysis (after 30 cases).
11. Review the pilot, revise and fully implement; Monitor and evaluate usability, content and influence upon outcomes. Revise where necessary and fully implement.
12. Quarterly variance analysis; Present data to identified members of the multidisciplinary team and organisation. Consider in light of the analysis review of clinical activity and care processes. Develop action plans and the pathway to address adverse variances.
13. Annual Review; Revise and upgrade pathway content according to emerging evidence, variance analysis and organisational developments (Hall, 2004a, p132-133)'.

The authoring team was made up of the multidisciplinary team from one inpatient ward, the Care Pathway Manager (the researcher), service user and carer representatives. The following groups were represented; medicine (Consultant Psychiatrists and Senior House Officers), nurses, social workers, care coordinators (community staff), occupational therapy, psychology and physiotherapy. Also to gain a wider involvement in the mapping, drop in sessions were arranged to involve more participants in step four of the development process. The parameters of the pathway were agreed as ranging from admission to discharge from the ward. The care pathway states; 'This integrated Care Pathway is for individuals admitted to acute inpatient services. It is untended to guide activities ensuring that a service user's journey is negotiated, managed and agreed. As inpatient care is implicitly a request for urgent/intensive intervention there needs to be clarity regarding inputs and interventions required and how they will be delivered. Wherever possible, interventions are based upon evidence and best practice. It is essential that the expectations of the individual service user are addressed as part of the overall care plan (X NHS Trust, 2003b, p1)'.

The aims of the pathway were agreed as;

- 'To initiate a therapeutic relationship and provide prompt expert assessment of individual needs.
- Ensure effective care planning, co-ordinated care and risk management; user and carer involvement and communication.
- Provide effective, evidence based interventions to help recovery.
- Establish effective liaison and ensure that appropriate and necessary treatments and services are offered (X NHS Trust, 2003, p1).'

Examples of the evidence base for the ICP included – Getting Better Together (Dale, Dempsey, Ellis, O'Hare, Stanbury, Stoddart (2002), the Mental Health Policy Implementation Guidance for Acute Inpatient Care (DH, 2002) and Mental Health Nursing – Addressing Acute Concerns (Standing nursing and Midwifery Advisory Committee, 1999). As described by Hall et al (2005) the most significant tasks involved in the development process were a review of the literature and engaging all stakeholders in the mapping and redesign. This involved defining the interventions to be incorporated into the pathway and asking clinical questions, then searching for and appraising the evidence. Interventions were compared with the research and opinions offered by respected experts. This process enabled the authoring team to critically review what was already offered. Then plan the integration of professional expertise, evidence based practice and service user perspectives.

Once a redesigned and detailed process map was agreed, this was translated into the corporate care pathway document – and the main steps of the pathway are described in Appendix 5.

During an 8 week pilot, the pathway was circulated for further consultation and was submitted through an agreed validation process. Following a pilot, the content was modified and then the pathway rolled out to the other wards. Rollout involved identifying 2 pathway leads per ward to take responsibility for implementation in these areas. It may be relevant in relation to other findings that the pathway was designed by one team and then implemented in another five areas.

13.3 Implementation and using the ICP

Hall et al (2005) described that implementation of this ICP was framed around making improvements to acute inpatient care and hinged on the delivery of anticipated benefits. It was anticipated that arranging care using a predetermined philosophy may seem impractical or inappropriate to some stakeholders. Whilst this was contrasted with the widely reported quality problems already cited. Implementation time for this pathway required commitment of resources to the change process and it took approximately 3 months to put into full use. Implementing the ICP had to contend with the context of acute inpatient care and its competing priorities (Hall et al, 2005). It was important that implementing this ICP should not appear as a burden, and implementation had to be flexible in an environment where meaningful change can be difficult to sustain. Each ward had two identified champions to lead the implementation of the ICP, and its level of completion was regularly audited. These individuals supported other members of staff to follow the process of recording care on the ICP.

The ICP included the following guidance about recording care. 'Before writing in this Integrated Care Pathway, please ensure you have signed the signature sheet. When using this document please ensure that you date, time and sign against each activity when it has been completed. It is important to remember that the aim of the Integrated Care Pathway (ICP) is to ensure the most appropriate care is given at the correct time.

If an activity outlined in the ICP has not, for whatever reason, been completed then this must be shown as a variance. The variance record sheet at the end of the pathway should then be completed. If further action needs to be taken, e.g. the intervention needs to be repeated, then use the blank spaces in the appropriate time frame of the ICP to record this. To view an example of a completed ICP please read the ICP file which is in your ward/area. These blank spaces can also be used to add interventions which are deemed appropriate for that person but are not already in the ICP. These additions should also be recorded as a variance. It remains each professional's responsibility to ensure that practice is safe. This ICP is not a replacement for experienced clinical judgement and inter-disciplinary discussions. If you require further information please contact your Care Pathway Lead or Care Pathway Manager (X NHS Trust, 2003c, p1)'.

ICP champions were asked to encourage implementation on the following principles. As Campbell, Hotchkiss, Bradshaw and Porteous (1998) describe that 'professionals using care pathways are encouraged to:

- Follow the integrated care pathway.
- Complete the ICP documentation, signing for key elements of care provided as they are carried out.
- Be free to deviate from the care specified in the integrated care pathway provided they justify this and enter this in the variance record.
- Take appropriate action when the ICP identifies service users whose progress is less positive than expected or faster than expected.
- Ensure that service users understand the ICP as it relates to them, and allow them access to the integrated care pathway.
- Use variance information to regularly to identify common reasons why the ICP was not followed (Campbell et al, 1998, p135).'

One of the most significant changes to existing practice involved variance reporting (Hall, 2006). As integrated care pathways define expected interventions a variance can be defined as when activities described on the pathway either do not happen or when interventions not described on the pathway are delivered (i.e. those you would not usually expect to offer). A variance is digression from the planned pathway. For example, in this care pathway a service user should have a physical assessment within three hours of admission. If this did not occur, e.g. due to the doctor not being available or the service user being too unwell, this would be a variance. Kitchener (1997) describes that it is important to understand why variances occur. These may be due to a system type cause, or it could be a matter of individual choice or an exacerbation of illness.

A sample variance report for this pathway is shown in Appendix 7. This details the variances reported over 3 months for one ward and this suggests that the incidence of reported variances is extremely low. As part of the process of using the ICP variance reports are provided to teams quarterly. The information in Appendix 7 suggests significant problems in pre-discharge processes and working relationships between wards and community mental health services. The benefit of this information is that it is contextual and meaningful to those with responsibility for managing the service user journey across boundaries.

Systematically collecting variance data is a credible and reliable method for developing changes in practice which are clinically led (Kitchener & Wilson, 1995). Theoretically it enables organisations to identify interventions which are ineffective, or not delivered and the reasons why. The information is analysed to consider how omissions and errors can be minimalised. In the example of discharge planning and aftercare, it is possible to see how corrective action should be planned. Such omissions could have had significant consequences for vulnerable service users following their discharge from hospital care. Indeed, this is the basis for the current performance targets related to the provision of 7 day follow-up after discharge and reducing readmission rates and illustrates the close relationship between care pathways and performance.

13.4 Implications of Insider Research

Robson (2002) describes that it is not uncommon for researchers to carry out a study directly within their workplace. The advantages of this are described as having easy access to the site and an understanding of the context, including how it has changed over time and issues around politics and hierarchy. The disadvantages are however significant in that researching the practice of colleagues can be difficult, and they and the researcher are influenced by prior relationships. In this case the researcher was involved in developing and implementing the ICP being studied and this may have influenced the professionals who volunteered to be interviewed and the data they provided. The researcher can be viewed either as a supporter or critique of the ICP concept due to prior knowledge. The researcher did leave the employment of the ICP organisation over a year before the interviews were conducted. Whilst two of the nurses were known to the researcher prior to the interviews, this was not the case for any of the service users and carers. Neither were they aware of the researcher's role in developing the ICP. Interview data also suggested that some of the healthcare professionals were not aware of the researcher's previous role.

Hewitt-Taylor (2002) describes taking an insider research approach in the study of paediatric intensive care. Drawing from impressions of Kuhn (1970) and Wellington (1996) it was considered that immersion in the culture being studied can be an inherent benefit especially in relation to case study research. This enabled a level of engagement that would not have been possible had Hewitt-Taylor (2002) been an outsider. However, it did raise significant problems related to potential loss of objectivity, assumptions made about prior knowledge and the impact of existing relationships. In this study the researcher had access to data about how the ICP was developed and implemented without requiring additional time in the research setting, and had an appreciation of the context in which the ICP was implemented.

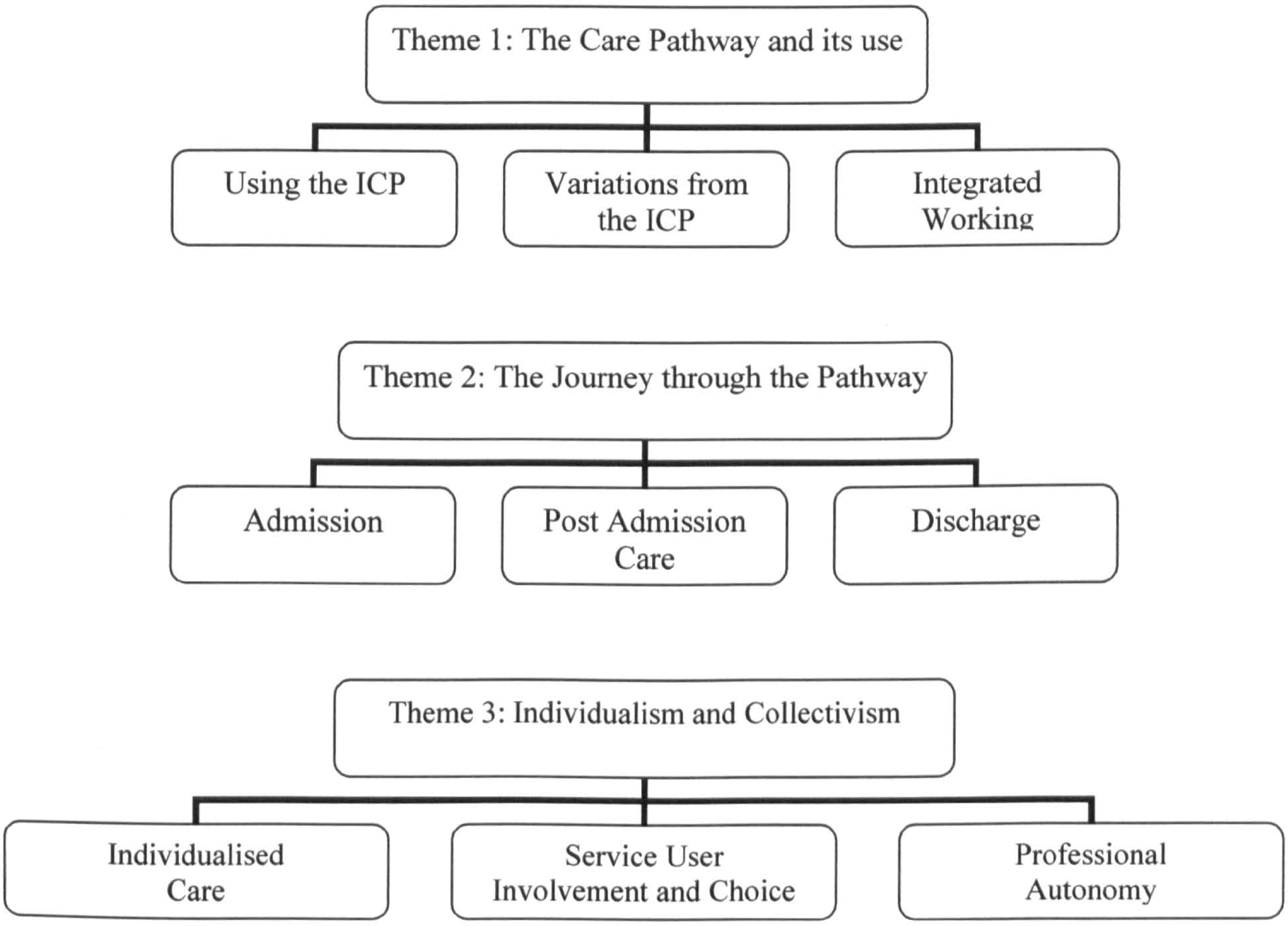
Involvement with the ICP prior raises questions about whether the researcher would be able to objectively view the situation. At the very least making this is made explicit and allows for readers to question possible bias. Throughout the research design stage, reporting of the findings and discussion there are conscious attempts to critically question assumptions and relationships. Tresch (2001) argues that it is possible to be highly engaged in a research context, and yet be able to stand back from the enquiry through the process of being both an informant and an analyst.

Yin (2003) describes that within case study participant observation can be a powerful technique, whilst it brings with it intrinsic problems others have suggested. He describes being a participant within the context can mean being able access data which might not otherwise be available. This is particularly relevant to the data describing the case in this chapter, offering extra evidence that would have been difficult for an external researcher to gather retrospectively. Whilst on the negative side, Yin (2003) reiterates the earlier views that this introduces an element of bias, and means that the researcher no longer has a role as an external observer. On reflection it is understood that the researcher's previous involvement with the phenomenon has influenced the nature of data collected to study this case, essentially around the use of mixed methods and integration of the quantitative data.

14. Interview Findings

The findings from the interviews with health care staff using the care pathway are summarised in 3 themes to answer the question 'How is an ICP used to manage mental health care?' The first theme focuses upon general perceptions about the care pathway and how it is used. The second theme focuses upon impressions about the patient journey, and whether this is viewed as standardised. Finally, are perspectives about individualised care, involvement and how individual professionals influence the care pathway. In the findings respondents fall into the following professional groups; respondents R1, R4, R5, R6 and R9 are nurses, R2, R8, and R12 are Occupational Therapists, R3 and R7 are Consultant Psychiatrists, R11 is a Senior House Officer (SHO), R13 a Social Worker and R10 a physiotherapist. The main themes in the interview findings are summarised in figure 2.

Figure 2 – Main themes in the Interview Findings



14.1 The Care Pathway and its use

The first theme is reported in three categories; using the ICP, care and variations and integrated working.

14.1.1 Using the ICP

All of the respondents knew that the pathway existed. They described that the pathway began when someone came into hospital and ended on their discharge. Nurses and the social worker describe in detail their knowledge of the pathway, for example,

> '*There are certain requirements within it (the care pathway). Certain things have to be done by a certain time frame, such as the assessment and risk assessment they are contained within it. They are done on an on-going basis. They are revisited and re-assessed and so on. You know, information that is missing initially is always added as and when we go along, when it's appropriate...... Well, I mean it's almost like a set of instructions really. Isn't it really? That this is what people will receive. This is what they (patients) will get at various points. Um everybody should get the same, you know so that there should be no sort of inconsistency, which is a possibility I guess. It's also sort of like sort of like check points if you like, that this has been done, this is being done. I suppose a way of auditing as well about how well we are performing (R9).*'

The medical staff, occupational therapists and physiotherapist however described more varying levels of involvement with the ICP. Suggesting that only sometimes they use it or they don't adhere to it accurately. Explaining this several respondents commented about how well the pathway was completed. It was viewed that much of the recording on the ICP was a nursing responsibility, and that the nurses tended to complete the activities required by other disciplines. Explaining the varying levels of completion respondents offered,

> *'There's so much paperwork for people to fill in I don't know that sometimes the care pathway gets the priority that it possibly deserves (R12).'*

A Psychiatrist added,

> *'I think that's about the care pathways not being sufficiently flexible. I think they're about box ticking rather than actually this is what really happens (R7).'*

How professionals perceived the ICP as an approach to managing care also varied. All but two respondents (both medical staff) suggested that they supported the ICP as a standardised approach to care. One nurse said,

> *'I like it as a concept. I've sort of liked it really from its inception.... 'It makes it certainly less complicated and sort of standardised (R9).'*

Another nurse echoed this,

> *'I think it's very easy for things to get woolly and I think at its heart it's a good philosophy, in keeping people on track if you like. From my point of view I can see where people are at with it (R2).'*

Another added,

> *'I think that it is a good idea. Oh yeah, because then you cover everything. As you are going along, then nothing is going to get missed. And I know things do get missed. But if you've got a set criteria, if that's the right word to use. Then you can follow that....... The benefits are that it's, it is clear. You can get all the information down that you need. I do think it is a good system (R5)'.*

One nurse described how the ICP can aid communication, using it to see what has been completed, what might have been missed and to gain information about treatment plans. Generally respondents made clear that the ICP could be a valuable source of information. The Physiotherapist described,

> *'it gives me a idea of people's physical condition. And the BP is normally recorded which is useful as well. And then also I will skim down the moving and handling assessment which is part of it..... So that's also useful. Because we don't attend all the handovers so we might have a little bit of a gap or need to know what's happening. So the, those sheets are very clear and concise, as to what's happening, what's changing or what might be planned in the coming week. Um, generally it gives a good framework for collecting information I can see (R10).'*

Despite the differing accounts about using the ICP it was generally proposed that the activities within the ICP were offered or did happen, only with a few exceptions.

> *'I would say pretty much they always happen. So things like people being settled and orientated to the ward nearly always, well always happens when I'm on. Um, but I would say on the whole these happen. Umm, observation levels and BP, and temperature are reported (R6).'*

Respondents described that sometimes interventions did not occur as service users were not well enough and that these activities were often returned to at a later stage. It was the impression of both medical and nursing staff that even if parts of the ICP were not used to record activities, the activities did still happen. Sometimes interventions were not necessary or inappropriate and so were not implemented. Some things were better delayed until staff had developed further their relationship with the service user.

However, again in contrast, one psychiatrist illustrated a much starker picture about some parts of the ICP.

> *'I've not yet seen a care plan for a patient, since we started admitting there a year ago....... The lack of adherence to the care plans from the Multidisciplinary Meetings is just so apparent on a regular basis (R7).'*

Yet in a different locality another psychiatrist reported,

> *'When a patient is admitted the admitting doctor fills in some proforma sheets which are urm blue.. so they're very easily recognisable. The ward rounds are documented also on separate sheets which are colour coded. So that you can refer quickly to the admission clerking and identify ward round decisions.. and so on. And if I see the patient in between the ward rounds I would write in the chronological notes (R3).'*

14.1.2 Variations from the ICP

It was reported that variances were sometimes used for monitoring the patient journey, although staff did not document variances each time they occurred. One Nurse described monitoring variances around discharge and care coordination, which he suggested highlighted the deficiencies in practice. Respondents described how the pathway is being used in an increasing climate of performance management. One nurse viewed that this was part of the drive to shorten the patient journey, reduce the amount of resources taken up by inpatient care and benefit the organisation from a business perspective. There was a consciousness about how this might accelerate,

> *'We're going to be in a situation in the future where we will only get paid for a period. Whatever is decided as an average length of stay, and anybody who stays over that period, ... we aren't going to get paid for. So we've got to look at reducing the length of stay with us being an acute facility, down to the bare minimums really (R1).'*

An Occupational Therapist described that in her view professionals felt a great need to have their profession's interventions acknowledged and that they need to be made more visible. It was acknowledged that being so explicit may have a negative side in that where targets were not met this information may be used in a punitive way by the organisation.

Another nurse described how the person's mental health can slow or speed up the care pathway. Describing how the severity of illness, higher levels of observation, suicidal ideation and challenging behaviour also impact upon the ICP. It was described that detention under the Mental Health Act may slow down the patient journey and people's willingness to stay in hospital was also an influencing factor. It was felt that sometimes circumstances might unexpectedly improve or relationships change, and this speeds up the care pathway. It was described that the stage at which professionals begin to offer interventions can also influence the length of the care pathway and be determined by individual assessment.

> *'My assessment will help me decide if it's too early. Or you know, because perhaps someone's agitated or whatever, they may need to wait a little bit longer. But I'll still monitor the records on the ward to see how that person is progressing and then when I feel that we can contribute again, um then become involved at a later stage (R10).'*

The physiotherapist described that she would generally be able to meet the standard in the pathway of assessing patients by the time that they have been in hospital for 10 days. Exceptions to this would be when she is on leave, and a waiting list can accumulate. She described that for many months staffing had been below the funded establishment which impacted upon readiness to offer interventions. In such instances the service may then fail to meet the standards in the ICP, for reasons which are explainable. The issue which needs to follow the measurement, the physiotherapist stressed would be to understand the reason behind the failure to reach the standard.

> *'I don't mind audit or being monitored so long as you've got the resources there to meet the standards. I think the difficulty comes when people start to get upset because standards aren't being met. But they're actually not looking why and it might be because there are there's a lack of resources during a certain period of time (R10).'*

One OT felt that the performance management within the pathway did bring some benefits.

> *'Every client should have the opportunity to access the different services that an acute care ward provides. And without that structure of a care pathway there may not be that might not be safeguarded (R12).'*

All three medical staff interviewed did not see this form of oversight as beneficial, believing that the individual nature of people's needs makes managing the care pathway within a standard timeframe impossible. Their view was that the pathway in mental health could not be managed like the pathway for a general medical condition.

> *'It's not like a hernia operation where you can right, we want them out of bed by, you know. Different people are different. You might have somebody with an early onset dementia and has no where to go and isn't safe. And until you can set up a suitable placement for them you have to keep them here... Some people with severe depression, the medication takes a while to work, so you're not going to have them better within that time. So I think it would be a disaster... I think it would be poor management. I think every stop should be pulled out to get people out as early as possible.......but that might be after three days rather than a week. It might be four months instead of five in another. You know you can't predict, people are different and they need different amounts of care (R3).'*

14.1.3 Integrated Working

All the Occupational Therapists expressed the view that occupational therapy activities did not feature highly enough in the content of the ICP, describing it as nursing and medically focused. One respondent suggested that the care pathway is very medically dominated, and that associated with this there was reliance upon medical interventions. She suggested that this limited the choices available to patients, and that as the ICP did not represent non medical interventions very well this seemed to reinforce and perpetuate this.

> *'I think in terms of where mental health, the mental health research is and mental health practice should be. It's not where we are here I don't think and I do think that the ICP potentially perpetuates that because it is so medical, it's a medical model really. (R2)'*

With specific regard to the pathway R8 added

> *'It's just the Nursing Staff and Consultants that kind of fill it in.... carry it out and follow it through (R8)'.* And R2 described, *'I think OTs are quite an overlooked profession and if we're not overlooked we are misunderstood. We just fanny around doing art things, don't we or jigsaws or whatever? And that's not you know where we are as a profession and I think that other disciplines and maybe NICE (National Institute for Clinical Excellence) don't always understand that (R2).'*

The seeming lack of integrated working was also highlighted in one nurse's impression that despite having the ICP in place there was still not an organised or agreed journey for some service users.

> *'Some admissions just go on and on and on, with absolutely no point to them whatsoever..... I know how it should be, but at the moment some of them don't seem to have a journey. You know some of them really don't. In fact most of them don't, because nothing is really planned or structured (R4).'*

One psychiatrist supported the concept of an ICP, but the reality of its operation seems more complex.

> *'I think the philosophy is great. How you do that, whether it's best done with a bit of paper or not I don't know..... Umm I think that it is important that you know well, all know, what each other are doing.........And that things aren't repeated or omitted. Umm so you know, I'm not saying it's a bad idea, it's just how do we get it to work smoothly? (R3)'*

Although one of the two medical staff who felt less positively proposed,

> *'I don't think it works. I've been familiar with care pathways since I first started in psychiatry in 1995. Um I've watched boxes not been ticked for the last eleven years (R7).'*

Despite having an ICP it seemed that individual professionals were inclined to act in isolation. One OT describes how she completes her own assessment, makes a decision about the prioritisation of that person's need for OT interventions, develops her own treatment plan and feeds this verbally back to nursing and medical staff. She describes her communication of this and that there appears to be a lack of awareness in the team about her role and how a more integrated approach would be beneficial.

> *'I think the onus is on me to liaise with people verbally and tell people what I'm doing. But I think a lot of the time people are not aware of what I'm doing or they're not clear (R2).*

Similarly one nurse talked about the absence of an integrated or multidisciplinary approach to care and how the team do not seem to have a collective understanding of a persons care. Managing care was seen as a nursing responsibility and the work of different disciplines seemed uncoordinated.

> *'I think the problem is actually within the MDT (Multidisciplinary Team) itself. You know, you know but we still haven't got that sort of working. Everybody is doing their own sort of thing. Like nurses work, you know within their sort of philosophy of care and so on and so forth, and it doesn't sort of quite really come together (R4).'*

It was suggested that the problem was not so much the pathway itself but the way in which the teams did not work together. It was described that there is little shared ownership of significant features of the ICP such as the risk assessment and care plans. Some of the nurses describe that discharge can seem '*all of a sudden (R4)*' or that '*some admissions just go on and on and on*

(R4).' Nurses felt that there was little consistency and a lot of variation in the way that medical staff contributed to the ICP, which meant that a shared view on a patient pathway that could be applied consistently was unlikely. Nurses viewed that the approaches of different Psychiatrists caused variations in the care pathway,

> *'At the moment some of them don't seem to have a journey. You know some of them really don't. In fact most of them don't, because nothing is really planned or structured. There's only one consultant here at the moment, you know, where you know, he has his patients. They do have a journey and this is what's going on. You know, and this is discussed on admission and this is how it should be. But for the others absolutely not. There's nothing that I could sort of you know put my finger on and say okay, this is you know the story of that patient's journey. It just doesn't happen (R4).'*

One nurse said that she felt that despite the pathway there was no clear agreement of what people were working towards. Each discipline is working to its own view or style, with a different outcome in mind. She described her perceptions about some patients who were ready for discharge, but the consultant felt that the person needed to stay much longer. She said that she felt little power to influence this and if the journey was pre-agreed then that should have an impact upon decisions that are taken. Her view was that the patient journey is influenced by so many professionals that there is not much likelihood of achieving consensus over one patients care, let alone a pathway for a mass of people. She felt that for standardised care to succeed that would have to change.

One of the consultants in another locality described the team as '*fragmented*'.

> *'The morale, the lack of integration of the staff, the lack of communication between one shift and the next is just so apparent. The lack of coordination of care plans (R7).'*

He described though how another team works so differently. '*It depends on the team you work with (R7).*' He describes how in another location a team successfully cared for some service users who had very complex needs and how their care plans were completely integrated, and signed up to by all the team. Whilst the Social Worker described that in his view more could be done in the team to have a shared understanding about treatment and a holistic approach to care.

> *'I think one thing is the actual definition of treatment and what that involves. I still think there are people out there that think of it as just medication, when it's a lot more than that. If we can make people understand that you know treatment does involve a lot more one to one involvement, more therapeutic stuff, more holistic stuff, then that's going to make life much easier for service users (R7).'*

Some of this he describes is evident in the care planning part of the ICP which does not often include the interventions other than medicine or nursing.

14.2. The Journey through the Pathway

The journey though the pathway was described by the respondents in the main stages of admission, post admission care and discharge.

14.2.1 Admission

When asked to describe the ICP all of the respondents described the first part of the pathway as admission. They talked consistently about the interventions offered, the assessments and the documentation that they completed. The descriptions were very clear and potentially conflict with the previous impressions about not using or having a collective view of the ICP. Several respondents acknowledged that sometimes activities had to be revisited when people were not well enough to contribute. It seemed fairly common for the non-nurses to gather information from the pathway then complete their own assessments. Where the patient was known previously prior agreements would generally inform the way forward in terms of care and treatment. One psychiatrist described

> *'It's very good if you can to have a sort of plan. Of right, this person normally gets well within you know three weeks, so we're looking at an ambition of that sort of length of time. We need to restart this medication, dah-di-dah-di-dah umm aim for weekly ward rounds with the care co-ordinator coming along. Umm and take the opportunity to address other issues that might be around...(R3)'*

Two nurses described that it was important to consider the reasons for admission from the patient's perspective. Greeting the patient and orientation to the ward were viewed as critical. Physical care and legal status were significant issues, as well as ensuring that the patient had a named nurse to carry their care forward. Sometimes where people were acutely disturbed their management would be different and there might be communication as well as behavioural issues to consider. Nursing staff described their interventions and timescales very specifically. For example,

> *'They should be allocated a Primary Nurse on admission which, which they are. Um and then, ... part of the admission process, risk assessment um is always done, that is Part 1 of the risk assessment is required so that is done more or less straight away (R9).'*

Often early care was confined to nurses and medical staff before the involvement of other disciplines. Although in one location the social worker completed the admission, this seemed a variation to the norm. The physiotherapist described,

> *'I'll get involved when I get a referral which is usually by phone call or if I happen to be on the ward someone will see you on there and start to say, we've got a patient (R10).'*

In a similar way one OT described that patients need to be at a '*certain stage*' to benefit from Occupational Therapy. She described that she would usually see people at the multidisciplinary meeting and see them following that, or after a verbal referral from nurses on the ward. She added that offering interventions when people were very acutely ill was not helpful.

14.2.2 Post Admission Care

Respondents generally described the next stage in the care pathway as the post admission stage which appears to span the remaining time of the inpatient stay prior to discharge. Respondents describe that this stage begins once the care plan has been formulated, and activities on the ward begin and referrals are made to OT, day services and physiotherapy. The physiotherapist described that her intervention would begin when a person is ready to engage and that she is usually alerted at this point by another member of the team,

> *'So it might be that I get a new patient and I find that they've only been admitted 2 or 3 days, and see them very early on. Umm other patients perhaps because of their presentation or they've been quite poorly or not motivated or there've have been safety issues or whatever. I might find they have been on the ward two, three, four months even before I get involved (R10).'*

The physiotherapist also described that sometimes patients have heard about the facilities and activities that are available, and refer themselves.

Nurses reported that the actual therapeutic interventions offered to patients vary. Sometimes it's about getting to know the patient and developing their skills. Often there is a primary need for observation, and liaison with other key individuals who are involved with the patient. One to one time between nurses and patients featured in descriptions, although there was no detail to suggest what actual formal therapies or interventions took place during this time. Nurses described information gathering so that decisions could be made about care and treatment. The Social Worker described the need to treat the illness and the importance of patients being involved in developing their own care plans. Several respondents described that care after admission involved structured activities, on and off the ward. There is also the involvement of people to give specialist advice and help around issues such as advocacy and housing. Monitoring and observing people were prominent in descriptions, as was trial leave before discharge. One OT described that she is heavily involved in preparing people for discharge, as often people had few social contacts or networks.

It was reported that ward rounds or multidisciplinary reviews were regular features of this stage of care and that these generally occur weekly. One respondent felt that this practice was outdated.

> *'The fact that the consultants come on the ward on such and such a day and such and such a time, is archaic for goodness sake (R12).'*

One respondent felt that such reviews were failing to address the need for early discharge planning and managing the patient journey more effectively, he suggested,

> *'Ideally I guess really that you know we should have CPA Meetings as soon after admissions as possible really. Um, you know to identify really what you know what we are working towards, what the discharge criteria are. And, and something that happens is you know sometimes people stay here for much longer than they should. Um part of the reason is, is poor organisation I guess, but also you know identifying what the threshold for discharge is, which should be somewhere roundabout what the threshold for admission was (R9).'*

One respondent felt that the constant focus on moving people on could be detrimental. He suggested that especially with service users who were very disturbed or difficult to treat, that the energy given to trying to find somewhere else to treat them took away from trying to care for and treat them.

14.2.3 Discharge

Most respondents suggested that planning for discharge generally begins on admission. An Occupational Therapist talked in detail about working with patients on issues around occupation, life stresses and building up the confidence needed to return home. Also, it was described how she would follow-up with service users after their discharge and continue with direct liaison with the care coordinator. Other descriptions of discharge were primarily focused upon how care would be organised, coordinated and planned. Despite preparation for discharge theoretically beginning on admission sometimes it still seemed disorganised.

> *'So preparation for discharge um I guess (laugh) is, is you know, is just through the ward round. Right! We'll discharge you next week!...It's not its not, to my mind it's not as organised as it could be (R9).'*

There was a noticeable variation in impressions about how well the pathway worked upon discharge. A different respondent stated;

> *'I think that on the whole things are done to make someone's discharge as best as possible, in terms of their discharge. CPAs, umm and letting various outside agencies know that someone's been discharged. Whether that's family or probation, housing whatever that might be. I think that we are quite good at communicating with people (R6).'*

Those activities that should be completed by staff working within services based off the ward seemed less likely to be completed and recorded as variances. Some of this was explained by what some respondents described as a difficulty in ensuring that community teams remain or become involved with inpatients. The variations were put down to the fact that,

> *'It takes an age to get referrals picked up. Often a patient has been discharged before they've actually been picked up by a community team (R1).'*

Some described trying to use the care pathway to improve this,

> *'It's obvious when they come in that they're going to need more input when they go home. So the staff would do a referral straight way. But it takes forever because they (the Community Team) only have a referral meeting now and again. They don't have regular ones. They don't pick up patients as soon as they get the referral through. It'll probably wait until their next referral meeting, which could be a week or ten days away. And then you also have the situation where the community teams are at their limits and there is a waiting list (R1).'*

The connections between the services using the pathway and others seemed to vary depending upon the individual care coordinators involved, the available resources, geographical location, waiting times and different perceptions about the criteria for accessing services. Whilst the ICP requires that Care Coordinators are involved in the discharge process there is no indication of this in the respondents' descriptions of the care pathway.

One variation around discharge that featured highly was lack of accommodation for people to move on to.

> *'It's a huge one (problem) for people when they lose their housing. Umm they often assume that the NHS services will provide and sort out new accommodation for them. Umm, which is exceedingly difficult to do particularly if people are in rent arrears um or debt. Which can be quite difficult to sort out and there's different benefits. So we have a lot of patients, more who are often, are stuck because of housing issues (R6).'*

Respondents felt that this variation was difficult to manage. Indeed one OT described that 8 people on her caseload were waiting for accommodation. It was suggested that this slows the care pathway to a standstill and that the situation was extremely frustrating. Not all respondents knew about how to record variances. One of the nurses described some difficulty in accounting for variations in the care pathway.

> *'People aren't sure what to do, umm because they don't have a CPN and you can't stop thinking. Is it a variance, do they have a CPN, what's going on? So I end up leaving it blank rather than putting something down (R6).'*

14.3 Individualism and Collectivism

The theme of individualisation and collectivism is outlined in the categories of individualised care, involvement and choice, and professionals as individuals.

14.3.1 Individualised Care

Respondents described whether they felt that there was such a thing as a standardised journey through the care pathway. An OT and physiotherapist similarly described that they tended to follow a routine process when people were admitted. They each would do an assessment, make a judgement about prioritising the need for OT or physiotherapy input and if needed arrange a treatment plan. The OT from her perspective felt that there was a very definite pattern that she followed but that '*there is no regular journey*'. She described,

> *'I think everyone is so different and I guess it's about working out what the difficulties are and then addressing them.....You know I've a lady at the moment for example that there's no way that I could ever sit down and talk to her about her life at home because verbally she couldn't communicate with me in that way. But I have spoken to her care co-ordinator and I've spoken to her brother. So I'm getting some sort of picture but she's not at the point where I can look at her cooking skills or whatever. She's just at the point of getting her out of bed. So from my point of view my focus is on those kind of volitional kind of issues. That's where my focus is, so in some ways I am following the pathway but it's just a lot slower obviously in her case (R2).'*

All the three medical staff felt strongly that the patient journeys are very individual. One described in a similar way to the OT,

> *'You might have somebody with a diagnosis of schizophrenia for example who is extremely unwell, extremely umm when I say difficult to treat. I mean treatment resistant. In and out of hospital a lot, urmm. Non-compliant with medication, dah-di-dah-di-dah and going to need a lot of input... You might have somebody else with a diagnosis of schizophrenia who's very well maintained on anti-psychotics. Sees their CPN once a month, hates coming up to the unit because of memories of when they weren't so well. They're working full time and I don't think it would be appropriate just because they have schizophrenia that they need to see a psychiatrist every ... and I think what we need to develop is being very flexible with regards to seeing people urgently when they need it. And not just doing a routine follow up that are a pain in the neck for the patients. Different people have different side effect profiles. One anti-psychotic or anti-depressant might work for one person but not for another. You need combination treatment sometimes.. umm. So it can't all be done by ooh let's go down by this flow chart yes, no, yes, no......... it's very important to have the flexibility. It's got to be tailored each time (R3).'*

The Senior House Officer (SHO) added that interventions varied greatly depending on the individual patient, their circumstances, their diagnosis, presenting symptoms, the medical interventions needed, their social circumstances and the severity of illness. He described,

> *'If someone comes in and they are very manic and very aggressive say. Then it's more important that you stabilise them. Than say someone with schizophrenia that's sort of socially withdrawn. But, it's probably more important that you get the other inputs like the day hospital say..... I think it's very hard to generalise. Um because obviously everyone is different and ... I think you need to have, I think you need to make sure that*

> *people get the right treatments obviously and the right inputs. So I think as long people know what services there are available to them. I'm not sure everyone needs a specific pathway though unless it is very generalised..... You can't, you can't do specific pathways I don't think, personally think. It's not like a medical condition where you say 'oh right you've got asthma', you give this treatment. You know, its not, everyone's different really (R11).'*

His own feeling was that guidelines were much harder to apply in mental health when there is much more of a social focus. The consensus view from all the medical staff was that having a detailed pre-agreed pathway for most service users was not possible.

Comparisons were drawn to standardised practice which may be achievable in other settings.

> *'It's difficult in psychiatry. I mean I have my ideas of patient journeys but different consultants have different ideas of patient journeys. Different other professions have different other ideas of patient journeys. And most ICPs have been designed along orthopaedic kind of inpatient plan, of patient comes in, there is a brief period of investigations, there is a procedure that takes place, there is a brief period of rehabilitation and then there is a discharge (R7).'*

Another respondent gave a contrast and described that having a standardised approach could be beneficial in implementing clinical guidelines and making sure that evidence gets into practice. Suggesting that people would be more likely then to receive the interventions that are considered to be more effective. Although that was counterbalanced by the possibility of offering interventions that were not appropriate for some people or not wanted, favouring a more individualised approach.

> *'When you're trapped in those kind of boundaries and you've got someone who isn't adhering to those. Or is unwilling to work, or perhaps someone who can't work*

> *necessarily cognitively to the level they need to. Ummm and you can end up feeling trapped, or maybe you can't do your job properly or you're not doing it properly (R6).'*

One view was that the ideal is a pathway that is specific enough to guide you but where there is sufficient freedom to individualise. Similarly one of the OTs added.

> *'You could say after 4 days the OT should do such and such or should engage with or have an initial interview. Or whatever it might be, it might not be 4 days it might be 4 hours, it might be 3 days, it might be 7 days, it might, it might not be at all. It's, you know that's the that's the sort of the, the downside of it. But if it's very, very rigid from a time frame. It doesn't allow for an individualised approach almost. But then if you don't have anything at all then you know, I don't know where the happy medium is (R12)'.*

One nurse described how he encouraged care to be individualised within the ICP.

> *'I work with the patient to find out what's best for the patient. What they expect from their admission and what they expect from me being the primary nurse and what's best, to work towards getting them discharged (R5).'*

Another nurse described how the pathway can help with individualising care.

> *'I think that the pathway particularly on admission is geared towards what that individual needs. I can't remember which page it's on but it just talks about the patient's reasons for admission and what's going on for them in their own words and I think on one of the bits um, it asks you to get the individual to describe what's going on for them in their own words. And for those kind of things, they are always used to kind of talk about what's happening with them (R2).'*

Similarly another Nurse described,

> *'there's the flexibility to have individualised intervention in addition to what's already there. But I mean I think the move towards you know patients writing their own care plans and taking responsibility for that makes it a little bit more individualised (R9).'*

14.3.2 Service User Involvement and Choice

Views about service user involvement within their care varied. One Nurse felt that the whole care pathway is about involvement and engagement.

> *'It's about finding out what their problems are, getting them involved in activities that will improve their way of life so we can move them out of the ward setting. A lot quicker than we have done in the past (R1)'.*

The Social Worker felt that service users could be more involved in their care on a day to day basis.

> *'There's a tendency maybe not to involve the service users as much as they should have been and it should be done over a bit of a longer, longer period you know. Over a week or so rather than just there and then, just at a specific meeting (R13).'*

His view was that decisions were often made at ward rounds which in his view seemed a very outmoded way of decision making.

> *'You know that that's one of the traditions that seems to have still, still have survived really. That um everything kind of tends to go, um sort of evolve around the ward round. So you know you sometimes wonder who the ward rounds for? Is it for the convenience of the staff or is it really a place where the service users can um you know sort of voice what their needs are? (R13)'*

Respondents were asked to what degree service users were able to exercise choice in relation to aspects of their care and the ICP. Impressions varied, one Nurse answered,

> *'Well there's choice to a degree, but it depends what's available. There isn't always something available that they need. (R1)'*

An OT seemed to expand further on this.

> *'I don't think there's that much available to them really. You know I am the only OT on the ward here. There isn't.... you never see a Psychologist ever. They're vaguely in the*

> *ether somewhere, but I've never known a psychologist on the ward and you know, the rumour is, it's a two year waiting list. I think it's very restricted and I think because of that it's a very medical model approach that's what you're left with. You know people going for ECT, when it's, you know the NICE guidelines holds it as a treatment of last resort and it's not here, I think. So things like that trouble me, so no I don't think there's a lot of choice for patients (R2)'*

One Consultant Psychiatrist explained,

> *'It's lovely to be able to give patient choice. But the trouble is I suppose a lot of people are detained under the Mental Health Act. If they are detained under the Mental Health Act that obviously takes away some of their choice. If they would wish not to be in hospital, but they're in hospital against their will. Also sometimes people do not have an insight into the fact that they are unwell and that they need medication. And then they're really taking medication when they'd rather not be. Because a lot of the drugs do have side affects and you do have to be... So I suppose in the acute phase you sometimes have to do things against the individual's wishes. Hopefully though as they get better and say Ooh I was very ill but I'm much better now. Urmm you've put me on this medication, I don't like it because .... And you'd talk about side affects and so forth and consider alternative medications or whatever. I would hope to give as much choice as possible (R3).'*

She further explained that,

> *'Obviously sometimes there are people on the ward that are feeling unwell, and don't want to participate in the group activities. But sometimes it's beneficial to do things even though they don't wish to. And there might for example, be someone who's actively psychotic. You know being in a discussion group or something might help distract from them from the voices. Or someone who's depressed, they lose confidence, they lose self*

> *esteem they would much rather hide in their bed space. You know getting them to be with other people and so on, is kind of getting back into every-day life. So I think if you did a kind of umm snap shot of people on the ward there would be people who are more or less happy with what they're getting. I would hope that people who are now discharged down track, would be saying - well actually it was horrible being in because of this, this and this and I was unwell. But I can see that I needed to be in there, you know (R3).'*

One of the Nurses added,

> *'I think patients... umm you know certainly have quite a lot of choice. I think in terms of the nursing staff they get offered regular sort of activities, a good choice of activities. They do have a say in their care, because they do their own care plans, more often that not (R4).'*

Another Nurse added,

> *'It's all centered around them (the patients). If they want a change, for example say they want to change their primary nurse, then that would be done. And if they're not happy with something that's being done. It is patient-centred........ Obviously with the way we do the care plans means that it's all about what they want and what they need. It means that they get a lot of choice, to say what they need and want rather than being kind of forced into a set category. And it's different from how we perceive things. It's more about what they want (R6).'*

One OT said about how patients exercise choice whilst their care is managed by the ICP.

> *'I think it, it completely depends on the patient sometimes. Because I can think of one patient that I've got who is very kind of um pro-active and will say well I want to do this. What do you think about this ... and but he's one of the few, one or two that I can think of at the moment who, so therefore he almost has more choice because he's being pro-*

> *active ..... And therefore he has more of a kind of input into his activities that he does. Whereas a lot of other patients kind of don't really know what's out there and in the end we'll have to give them options (R8).'*

The SHO acknowledged that there are occasions when people chose not to engage.

> *'there's a patient at the moment who doesn't engage and hasn't done for years and years. Um and I think you can just offer what you can offer. But at the end of the day you cannot drag someone along to something they don't want to do (R11).'*

Generally respondents felt that service users were able to exercise a fair degree of choice, although the point was often made about these being restricted to the therapies available and these might be insufficient. The Social Worker was clear that

> *'in terms of choices of what they can do on the ward, in terms of therapeutic activity, I think that's improved. So I think may be there is some choice there now (R13).'*

Nurses, the social worker and the physiotherapist had more positive impressions about the choice exercised by service users. However, medical staff were more likely to acknowledge the way that the patients legal status or their illness impacted their degree of choice.

14.3.3 Professional Autonomy

Many respondents reflected how professionals as individuals influenced the delivery of the care pathway. One nurse described that working with 12 consultant psychiatrists was problematic as they each had their own way of working. Another nurse reported that some nurses want to be individuals and have their own influence. One psychiatrist reflected that she would do her own risk assessment rather than use that done previously by others earlier in the pathway. She added,

> *'I think different clinicians are going to have different views about things inevitably... and have their own way of doing things that works for them. And hopefully for the*

> *patients they're looking after because umm you have to do with people what you believe in (R3).'*

She described that experience helped in her professional decision making more than centrally provided guidance. She was unhappy for her professional decision making to be reduced in any way.

> *'If NICE told me to use a drug that umm I don't agree has a robust evidence base. Umm you know NICE don't always get it right. Then I wouldn't feel very ethically happy doing what I didn't think wasn't the right thing for that patient. So I would be very unhappy for things to become more prescriptive. Because again as I say, individuals are individuals (R3).*

One respondent reported she thought that there should be agreed care pathways but that in reality '*everybody is doing their own sort of thing*' and *'it doesn't sort of quite really come together'*. In her view it was not a problem with the pathway, but the multidisciplinary team itself. In her view there is variation from the care pathway between individual consultant psychiatrists. She stated that most psychiatrists are risk averse and that few are consistent in their approach. One nurse reported how for example the approach to discharge varied between individuals.

> *'I've said before it comes down to when the Consultant thinks they're ready to leave. Um, so sometimes you get patients who are desperate to go. And the Consultant says I'd like another week - we'll just see how things go. To make sure things are going well. Whereas another Consultant would see someone and they would be like 'I feel like I need a bit more time'. But the Consultant would say, you are ready to go and there's just like a clash of wills. And kind of how much control they (patients) get over their journey is limited in that respect, I think here (R6).'*

One Psychiatrist described the difference between his own practice and that of his colleagues. He considered how it would be difficult to establish an estimate of length of stay across a large number of patients under the care of different psychiatrists.

> '*Now Dr Z, one of the other consultants at T Ward admits people for respite. He's got one schizophrenic young man who's been on the ward for two years. Now I would have had him in a flat on his own.*' Similarly '*my colleague Dr S, I did a ward round for him and not a single patient that I was doing a ward round for would I have had in if they were mine. So with that variability of management how are they going to decide what is the right length of stay? (R7)*'

He described his view that the difference in practice is quite deep rooted. His view is that this difference in practice is driven by the clinician's philosophy, their training and whether this leant towards a particular model of practice, their view of evidence supporting practice and the outcomes that they have had in their experience. He suggested the individual approach conflicts with essence of a pre-agreed care pathway.

> '*I think that's what gets in the way of ICPs. There's such a variability of practice. My practice and there's evidence for what I do and you know there is an evidence base, yes because I'm converted to it. It deviates in my favour. Umm there's, there's a belief and belief is very powerful. And there's a team that's signed up to it and I think that's why I do what I do (R7).*'

The OT seemed to support this reporting that to her it is obvious that despite the ICP the practice of different psychiatrists varies.

> '*Dr E, he has had a lot of experience with OT. Therefore he kind of encourages it with his patients, because of their individual need, like it's in his mind to think about it…… Whereas a lot, some of the Consultants don't even think about it until I come into the ward round, and they say, oh right, yeah that might be good (R8).*'

14.4 Summary of Interview Findings

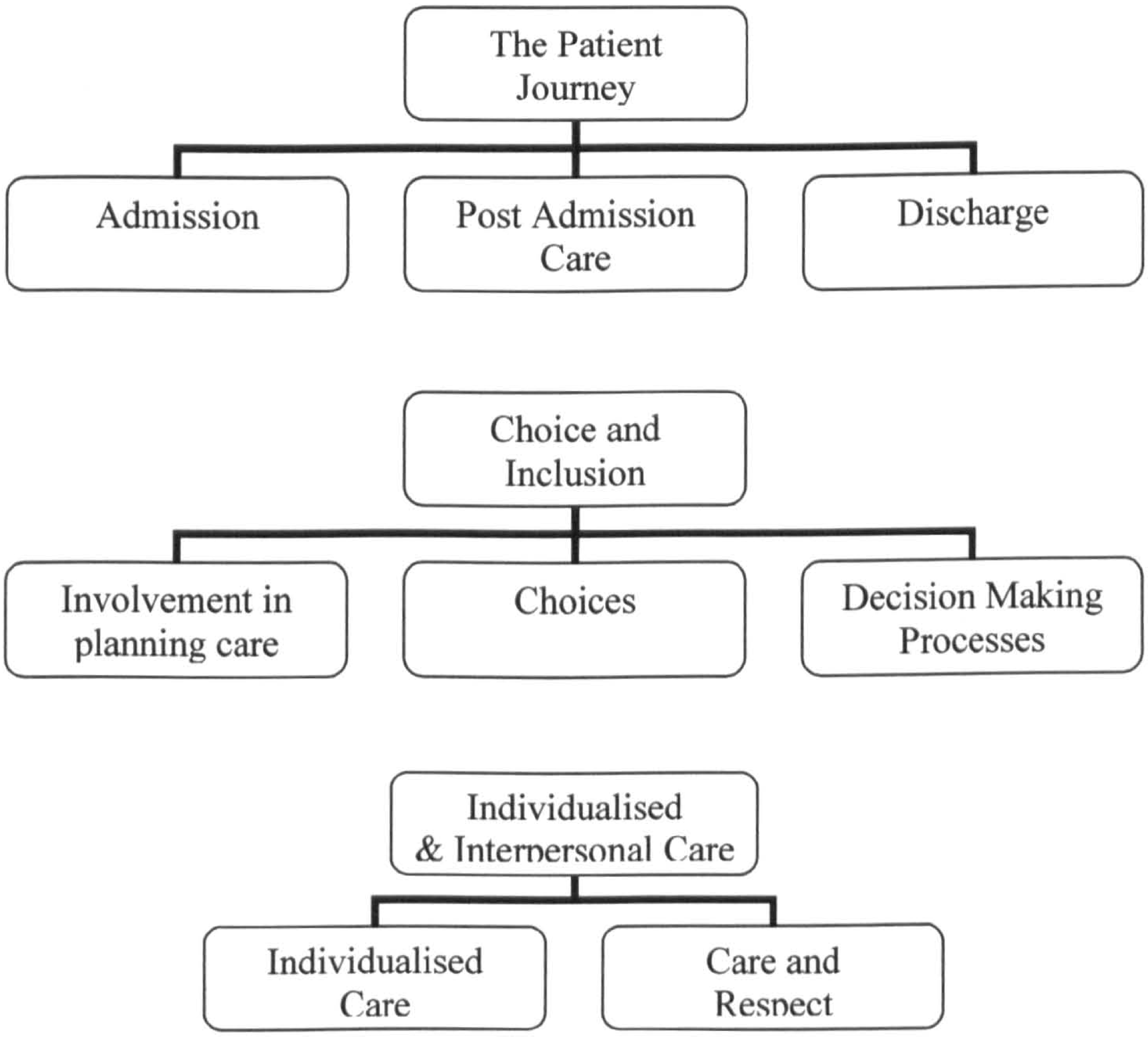
Respondents were all aware of the ICP, although it was primarily used by nurses as a checklist. Other professionals tended to use it only for the purposes of information gathering. There was little evidence the ICP was being used for actively managing the patient journey as in following pre-determined decisions or managing variances. However, it was suggested that most of the activities in the pathway did happen, although it appeared to have no obvious impact on reducing delays and improving patient experience. Medical staff in particular reported that decisions about care were made in discussion with service users, rather than being based on a pre-agreed approach. Although the sample for the interviews only included three medical staff, their opposition to the pathway was clear. Also it was evident that frequently there was no widely agreed or integrated view of a person's care pathway. Still some professionals act in isolation and this falls short of the close and integrated working, that ensures a coordinated approach to care delivery.

There was a view expressed that it is difficult to represent the needs of all the service users accessing the service using one care pathway. The needs of people varied considerably and many factors impacted upon this like people's social circumstances and their response to treatment. Despite this, when the respondents described the stages of the pathway and the interventions that are offered there was a high degree of commonality. The non nurses reported that they rarely used the ICP, but still their interventions appeared more uniform than individualised. This was at odds with descriptions of different professionals doing their own assessments, and then deciding upon individual interventions i.e. not following the ICP. Respondents felt that the ICP therefore, had not restricted their professional autonomy, or choices for service users.

15. Focus Group Findings

The findings from the two focus groups considered the question, what are service users' and carers' experiences of care that is managed using a care pathway? The findings are presented in 3 themes the first is a description of the journey through the pathway. The second is individual and interpersonal aspects of care and the final theme focuses upon decision making and choice. Extracts from the diary received from a carer were also integrated. Participants in the focus groups fall into the following groups P1, P3, P4, P6, P8 and P10 are service users, P5, P7 and P 9 are carers and P2 is a service user and also a carer. P1 is the wife of P5, P2 is the husband of P3, P7 is the wife of P6 and P9 is the husband of P8. Extracts from the diary are identified as P11. The main themes within the findings are shown in figure 3.

Figure 3 – Main themes within the Focus Groups Findings



15.1 The Patient Journey

People's experiences of the patient journey are outlined in terms of experiences of admission, post admission care and discharge.

15.1.1 Admission

Many participants described in depth their early experiences of the care pathway which focused on their admission. Also, the diary of the carer described his view of his wife's admission.

> *'Registration with a lady doctor took an hour to happen and another hour to complete. Questions about everything from her childhood and any abuse in her marriage, and more questions of abuse. To her medical history, sex life and recent sex drive, to how she felt about herself both now and over the years etc. We assumed that B's (name of wife) answers to such questions would assist them in their endeavour to get her back on track. After it was over, we spent an hour with her before a nurse took her to her bed-space. She had been given two tiny blue tablets to help her overcome her anxiety, but as she left us she still looked very frail and frightened...... Something after 10pm that evening B rang home. She sounded quite cheerful and told me that she had settled into her bed-space and had been for a bath (P11).'*

Service users in the focus groups described their admissions as a time when they felt distressed and being faced with intense and personal questioning.

> *'Being put in a room where you wait for ages and then they ask you millions of questions. How tall are you, what do you weigh, what colour are your eyes all the time and you're freaking out, and you're thinking what's this got to do with... Why aren't you calming me down? (P10)'*

Others agreed that the repeated questioning on admission felt unhelpful,

> *'I think what I find distressing is that you've got to repeat the same story..... About what's happened to you and why you've suddenly become ill again. You've got to repeat*

> *it in a short space of time to every new doctor or nurse, you know, that you're faced with in that hour, or two hours....That's really distressing (P8).'*

There was a general view that these details should already be available to those who were now caring for them.

Two service users reported that on admission there had been a clear definition of what would be achieved during their recent admission and that short length of stays had been pre-planned.

> *'I knew it was only going to be a very short one. There was a limited amount of work that could be done in 9 days. So I had very strong sense of what was going to happen, which means that I was going to discharged after 9 days. So if I was going to sort myself out - that's how long I had.'* She added, *'It did put me under a lot of pressure, because basically it was a short admission, you've got 9 days, sort yourself out (P1)'.*

Another service user said it made her think, *'When they said you're going to be here for so many days. So you feel, oh right best get myself sorted then (P4).'* The service user/carer (the man who was both a service user and a carer) in the group suggested that,

> *'That there is no need for that. Because there is not such a desperate shortage of accommodation now, as is being made out (P2).'*

There was no apparent consensus that pre-planned short stays were particularly positive. One participant suggested, *'I suppose it might help you think, maybe I'm not as bad as I think I am (P4).'* Whilst another added, *'But you're not in any state of mind to do that (P2).'* Others perceived it as *'just a quick fix (P4).'* And added that *'the suggestion is that, is you sort yourself and people can't always do that........because that's why they're there in the first place (P2).'* One service user who had a planned short length of stay described feeling under pressure to write her care plan on the first night. She stated she was admitted whilst feeling suicidal and as a result, she reported that the timing of doing the care plan on admission was wrong. Also, she stated she would have appreciated it if her husband had been allowed to stay to support her through her distress.

15.1.2 Post Admission Care

Service users and carers described consistently that care after admission was led by the named nurse. Work with the named nurse began on admission or shortly after. Although access to, and time spent with, the named nurse varied considerably, for example;

> *'I found out that my named nurse was somebody who did the night shift and only did the night shift, and who was also the main nurse on duty on these night shifts. So she would have 2 nursing assistants with her, which the chances of her spending any time with me was negligible, because her duties were taken to giving out medication and being the main nurse on duty.* Speaking on behalf of other service users, one service user reported: *'We all have very little contact with our so termed named nurses and the sense of anything like meaningful dialogue. We had to go and seek people out if you wanted a conversation. And then it was only in the communal area, mostly in the communal area, so not very private (P1).*

One service user reported that whilst arrangements seemed to be in place, much was left to the initiative of the service user.

> *'I had a care plan and I used to see my key worker for 20 minutes to half an hour every day. But I find that if you've been more than one or two weeks they don't seem to bother with you anymore..... You have to go and ask them in the office to see your key workers. They don't come and find you (P6).'*

Considering particular therapies and interventions that were offered as part of the care pathway, it seemed that these were sporadically provided and were often impacted by the staff available. Describing a programme of activity one service user suggested *'They have had the odd one but it* *is not like the timetable, because that member of staff was not on duty (P1).'* A carer noted that the facilities for providing activities are available *'They have got a fully equipped gym in there, which is used for ½ an hour a day, or ½ an hour a week (P5).'* Another carer suggested that patients who are viewed as more seriously ill take up the majority of staff time and that other service users *'just kind of get pushed to the side lines because these people are on a section 1 to 1 and require all the nurses' attention (P4).'* The service user/carer reported that staff often seemed preoccupied by administration or conversing between themselves and this reduced the amount of therapeutic interventions that were provided.

There were views about whether the interventions and activities provided were those that service users and carers find helpful. One participant explained that she perceived a shortfall in psychological interventions, *'I needed to talk, I needed therapy, and I felt it was just a holding station. Different drugs were being tried out and in my case ECT (P1).'* The diary of the carer outlined his wife's experiences of the interventions provided.

> *'I asked what support she (his wife) was receiving, she said none really, that 'they just leave you to it here'. There had been no more OT and no-one was counselling her its nearly now fully a month since her admission.'* And, *'With nothing forthcoming from the hospital, its time to start some DIY therapy it seems: I talked of things that may be feeding her guilt and causing her mind to crash down into depression (P11).'*

The carer's diary reported that he spoke with his wife's consultant about the apparent lack of therapeutic interventions provided. The diary stated that the Psychiatrist outlined,

> *'B had been a 'reluctant patient'. That she spent most of her time in and around her bed space, that she rarely got involved in any group sessions and that she showed no signs of WANTING (represented as capitals in the diary text) to be helped. I asked if he saw these things as her fault or as a failure of his service to offer the support and*

> *encouragement needed to develop such responses. B interrupted to correct him in that she had joined in with some of the group sessions, had gone to relaxation classes that others had walked out of, and had made an effort to attend occupational therapy sessions from time to time (P11).'*

In the focus groups similar impressions were voiced about the lack of interventions offered and therefore the amount of time when service users were not occupied. It was reported that a lot of time was spent sitting around just talking with other service users. *'People go to sleep in the chair and the main thing is the dinner time. It's like a big event because that's the only thing that happens, or coffee time (P10).'* A carer reported how he would be asked not to visit so that his wife could adhere to her programme. But in reality she had not been engaged in any activity during this time. Almost all the service users and carers agreed that the lack of other interventions meant reliance upon medication as the main means of treatment. *'I was just wondering do psychiatrists think that a chemical drug is the only answer. Are there not other things, combinations of other things that can help as well?'* Another participant added, *'I think there's too much emphasis on drugs (P8).'* Others suggested that more could be done by attending recreational activities.

However, these were not completely representative of everyone's experience, one service user described that during her recent admission all of these things had been put into place.

> *'They have always worked out a programme for me to go downstairs to the occupational therapy and do all sorts of things. I've done woodwork, I've done art. I've worked on a newsletter. I've tried all sorts of things and I have found that in a funny sort of way it's a funny thing to say this, but the more the experience you've had of the system the more you learn what works.... and to encourage that as part of your treatment... It's a sad*

> *thing to say that, really. If you are new to it and you're just going in, it must be horrendous (P8).'*

15.1.3 Discharge

The majority of focus group participants viewed the process of discharge and the preparation for this as adequate. One participant described it as

> *'staged process whereby you go home for a couple of days and then you come back on the ward. You go home for a couple of days and you eventually go home for a week and then you come back for ward round. So that is sort of a preparation in that you are going back out into the big wide world and if you've got a problem you come back on to the ward (P1).'*

However, two service users suggested that even if they felt unwell at this stage in their care they would be unwilling to delay their discharge once they had spent some time at home.

One of the service users who was critical about her planned and structured short stay said conversely that, actually knowing about the plan for discharge earlier had allowed her to plan for and accept this.

> *'Preparation that's obviously part of your care plan, as well and usually your care co-ordinator comes on board by then, to arrange whatever your care is going to be. I was advised about what was going to happen and I was shown a care plan of what was going to happen and they stuck to it.(P1)'* The service user/carer participant explained this saying '*I suppose one thing is that they don't want you to become institutionalised. There's not much benefit in doing that, but it depends on your individual circumstances (P2).*

Two service users and a carer outlined how their discharge and transfer of care was well managed.

> *'I must admit from what I have seen recently and that has only happened in the last couple of years I would have said, the transition of coming out of S (name of ward) Ward to go to the recovery team and back home again has certainly improved. When we did it the first time it was hell on earth. You come out of hospital and there were weeks before anyone called.'* His wife confirmed, *'Now I see somebody within days (P5).'*

This was not the experience of all the participants, one explained,

> *'I didn't have a care plan. I was just discharged and the crisis team came. God bless them. And I got a letter through the post about my next appointment with my Psychiatrist. That was it (P4).'*

Another different experience was outlined by the service user/carer and his wife who reported that their aftercare was too comprehensive.

> *'M (name of wife) and I were too busy trying the escape from the social workers (other participants laugh) and they didn't want to let us go. (laughter) For some reason they didn't trust in my level of care and of course there's always an emphasis on independence anyway for my wife so she was left to fend for herself anyway poor thing. But you know, to be fair. Yes it took some extricating one's self from that situation and I know they have a responsibility for us, our after-care. But you know sometimes it's overly imposed - when people do not necessarily require it or at least that's their feeling (P2).'*

A diary extract that considered a carer's perspective about assurances given about discharge arrangements stated,

> *'I was certain the service being offered would be far from adequate, that much as he assured me the crisis team would be there for her every day for as long as was necessary,*

> *that I know that before very long, they would make it every other day and then twice a week as soon as possible, that they would say that they are coming and wouldn't arrive and that B would continue to see a long line of different faces, none of whom would she feel able to get to know or trust (P11).'*

With regard to the decision about discharge, *'I told him that I was shocked beyond belief to hear that this was his decision.....(P11)'* The diary documents,

> *'Before we left B was approached by one of the CPN team. She reassured B that everything was going to be just fine and that they would take care of her. She asked what time of day it was that B felt most vulnerable to fear and bad thoughts. B replied that it was as she woke up. She asked what time she woke and B's answered about nine or ten o'clock because of her sleeping tablets. 'OK then, how about I arrange for someone to call about 11 in the morning for a while? Then maybe we can make it 11.30 for a while longer, and perhaps move it a long a bit as time goes by as you become more able to cope. How does that sound?' she asked. 'OK, I suppose' B replied. 'OK then I've made a note on your records and someone will see you in the morning at eleven'. Sat 11th - (the following morning) We wait for our promised 11am visit. Nobody came until 7.30pm, (!!) and arrived without an apology or explanation and asked of B could cope now until Monday (P11).'*

The diary goes on to describe that B was readmitted some days later.

15.2 The experience of choice and inclusion

These findings focus upon how people felt that that they were involved in making decisions about their care and what choices they had. These findings reflect particular questions about what choices people felt that they had and what mechanisms they used to influence their experience of care.

15.2.1 Involvement in Care Planning

Some service users described writing their own care plan during their most recent admission. One service user outlined how he was asked some questions and then a nurse going on from that to write the care plan without seeing or having a copy of the plan thereafter. Another service user who had written her own care plan acknowledged that not everyone might be able to do this. She described,

> *'It was the nurse who's my appointed nurse, who said she thought it would be a good idea if I wrote my own care plan and umm. So I sat down one evening, wrote it and as I say it's the first time I've encountered such a, umm a method. And I don't think it's a good idea for the average person to have to sit down when they've been admitted to an acute unit and write their own care plan.... It was entirely written by me (P1).'* She explained that it may not be possible for everyone, *'Not if you've been admitted to an acute unit and it's your first night at the unit. And you have to write a care plan and I don't think that everybody would have the strength within them to write a care plan... I'm not dismissing the idea totally out of hand. I just don't think it should be done on the first day on an acute unit...... There should be a settling in period (P1).'*

The service user/carer speaking on behalf of his wife and himself suggested that they did not have a care plan or had not seen one, nor had they been involved in writing it and suggested,

> '*In my instance they formulated a care plan of sorts, yes. But I wasn't really consulted over that and I was more or less asked to read it through and agree to it and sign it basically. I had no more involvement than that (P2).*' He went on to describe what he perceived as his wife's experience of being involved in planning her care. '*She was heavily manipulated by everybody concerned in her care and people didn't go out of their way to canvass her thoughts, feelings and emotions and views, to any great extent. She was just told basically from start to finish what she should be thinking, what she*

> *should be doing and how she should be doing it..... You know, I didn't quite have that experience but it's bordering on that and I think it alienates people from the outset. If you really want to seriously help them, you have to assess their personal needs and write it in their care plans (P2).'*

Participants described what they perceived as barriers to their involvement within the care process. One service user agreed that her husband was excluded,

> *'When I went in, they followed the same procedure every time. Which is my husband is got rid of as soon as possible. So he basically drops me off at the door, don't you? You're not encouraged to remain with me (P1).'* A carer added, *'They (meaning the staff) don't like relatives (P2).'*

One carer reported that at times he felt that staff thought he may be the cause of his wife's illness and this stopped him communicating with them. He went on to say that he felt that a lot more could be done to educate carers. The carer's diary outlined an example of his involvement, *'When I took B back on the ward, I was given a leave evaluation form to complete which I will fax back to them tomorrow (P11).'* The diary suggested that there was no acknowledgement of whether, and how, that information was used.

15.2.1 Choices

When asked about what choices people had during their inpatient stay the discussion tended to reflect restrictions in their personal activities, as opposed to choices about what their care should comprise, i.e. what treatments they might receive. This was expressed in statements like *'You can't even make a cup of tea when you want one (P4).'* Another participant reported, *'I wanted to get up early, because I felt like I needed drinks and the way my body was feeling I needed drinks (P3).'* The carer/service user (her husband) finished her sentence, *'And was sent back to bed with a ticking off (P2).'* Bedtimes and TV viewing appeared to be significant issues,

> *'Once I was staying up late at A (name of Unit) just watching TV that's all. I wasn't hurting anybody and I can't remember her name, came marching up to me and turned the telly off and sent me to bed and I'm like 'I'm a grown woman, I'm not tired.' 'Come on (raised voice), time to go to sleep now'. I was like 'what'.* Other service users added, *'Getting up and going to bed, no we didn't get any option on that.'* Also, *'You go to bed when you're told to go to bed and you get up when you're told to get up.' 'And you drink when you're allowed to have a drink (P4).'*

With regards to leave and discharge, different experiences were reported. The service user/carer described that at the point of his discharge he was very involved in the decision making about aftercare. Offered 2 residential placements and a family placement he said,

> *'I still appreciate the fact that I was offered the chance of a placement, with a family. Although somebody who'd been a client on the ward had warned me off that sort of thing, but never mind. Nevertheless I was offered that and also a chance to go either V or possibly T (names of 2 residential placements). Now although as I have mentioned before they weren't ideal places to be, at least I was given those options. Although you will irradiate later, that Dr P (name of consultant) was very caring and conscientious. He was excellent I might say and he gave my wife and myself a lot of help and encouragement with our own plans (P2).'*

The diary of the carer provided a different perspective,

> *'I received a phone call from B, tearfully telling me that she had been told that she would be released home next Friday the 10th for good, that they had said that this coming week was to be an extended stay with crisis team support and that given all went well she would be released from the hospital altogether. She told me that she had said that she was not ready to come home yet and that this would not be possible as I was going to*

> *Scotland on a three day business trip that must not be cancelled and this meant that she would be at home on her own. They replied that this would be OK as they would send someone each day to be sure she was alright. She agreed with me that this an utterly ludicrous proposal but that she had been unable to convince them otherwise.*
>
> *Whilst she was talking to me, someone from the assessment team walked down the corridor in which she was stood and asked him (N) to talk to me. I told him how ridiculous the situation was. How could they make such an assumption that she would be safe in my absence and how dare they assume without consulting me first, to be sure that I was both there and indeed in a fit state to receive and care for her on a long term or permanent basis whilst she was till in such a fragile condition. He said he would look into the matter further under the circumstances, and that he would be back to me as soon as possible. I OK'd the weekend visit and made it clear that I believed she needed to return to the ward on Sunday evening from where I would collect her again for a further weekend at home following my trip. He asked if there was anyone to care for B in my absence and I said I didn't know, that this was yet another unreasonable factor, that they were presenting us with giving us only a few hours notice, and even less of course for whoever may be able to help, after all, the hospital were creating a need to arrange for someone to cover 3 days and 2 nights! (P11)'*

When asked about choices about treatments one service user summed up, *'There are very, very few options available to us.'* One reported that infrequent contact with medical staff reduced the opportunities for expressing choices. It was the consensus that as inpatients people had little choice with regards to medication.

> *'Well when I was in hospital there was no choice at all..... But as an out-patient I've found I was given much more choice and discussion as an out-patient' (P8).*

There were descriptions about how people had been involved or not in decisions about their medication although none of these occurred during their experience of the ICP. Again it was expressed that people perceived an over reliance upon medication as opposed to other forms of therapy.

15.2.1 Decision Making Processes

When asked about how decisions were made about care people described varying levels of awareness and involvement. All the participants in the focus groups felt that decision making went on in ward rounds and no one expressed their experiences of this positively. A service user reported,

> *'....Now don't talk about ward round...... The fact that you walk into a room and there's 8 people there and it's just so disconcerting. Because all I used to do is - get the chair and put it in front of the psychiatrist and just look at him. Because, I just had to ignore everything else because it was just too overwhelming (P1).'*

Another service user agreed, *'Case conferences are an absolute nightmare. It's like being given the third degree (P2).'* A carer reported,

> *'I've been to several MDMs (Multidisciplinary Meetings). But I must admit from H's (name of wife) perspective she'd get wound up about this the day before. So 12 hours before hand she'd slowly go up the wall and most people going in there felt the same. You know - because it was so big, so intimidating. I mean I went in and there would be questions asked and no-one exactly knew what was going on (P5).'*

Participants described ward rounds as *'oppressive (P2)'* and that

> *'You're under that much pressure at that point, you know. You've got tunnel vision, you can't really see, your mouth is all dry. Yes, it's very difficult and you're expecting these people to perform in front of all these people (P5).'*

Others added,

> *'You're expected to come out with your inner most thoughts and emotions and the way you've been feeling...(P1).', '....It's totally the wrong conditions.....(P2)', 'a room full of examiners (P11)'*, and *'It is the wrong conditions. You can just about do it on a 1:1 basis, or perhaps if a SHO or the Registrar and consultant are together, I could probably tolerate two people. But anymore than that, you are not going to get the best out of me (P1).'*

Feeling strongly about it one service user said,

> *'I couldn't understand why there were so many in that ward round... ....at all. I couldn't wait to get out. I lied, I said yes I am well, just so I could get out - because it was awful (P4).'*

Another added that she asked if her mother could go in the ward round with her,

> *'They said 'no, we'll talk to you later' and I went in and felt that there was 7 or 8 people all looking at you. They've got their minds made up before you go in. They know exactly what's going to happen to you. When you think you're better and you can go home, you didn't and then when you felt you weren't well enough, they said 'well we need the bed (P10)'.*

The impressions of the carers seemed to echo this,

> *I found that, I'm not usually intimidated or anything but one ward round I walked in and there was a row of people and I was, 'I didn't know who they were'. I knew the doctor and one of the staff, but none of the others and they all just sat looking at you (P4).'*

The carer's diary described an experience of the ward round.

> *'B and I were kept waiting nearly an hour beyond my appointed time and even at that D wanted to see B on her own first. Fifteen minutes later I was allowed to join them. I was led to an office where B sat in the middle of the room on a dining chair. D (psychiatrist)*

> *sat facing her, six of his staff created a semi-circle around her, three to each side of him. I was invited to use an empty chair to his right. He looked at me for a long moment and then shrugged his shoulders. I replied to the gesture.... 'What? You want ME to start?' 'Yes', he replied. So I did. I told him how unhappy I was that arrangements had been made for B's virtual release the week before without any consultation with me, either for advice or to assess my ability to cope. I told him I thought it utterly ludicrous to judge B ready for home in her quite obvious frail and frightened condition, that though she had been in care for two months, I could see no real sign of change. I talked of my eager anticipation for psychotherapy to begin in order to help B search out just what it is that is triggering these deep depressions, and how I had seen nothing forthcoming at all. How on the last occasions of the depression in C (name of town) Mental Health Unit she had psychiatric sessions on a regular basis. I ask what the point was of her one-hour registration upon admission – asking her questions covering everything from her childhood, marriage, sex-life, previous periods of depression and self harm to how she felt about herself now, to what she saw of her future and any thoughts she may have of future self harm, if it was that none of the answers would in any way be used in relation to her care (P11).'*

The only service user who talked positively about decision making, talked about how her care co-ordinator had been involved in decision making.

> *'My experience has been actually on the face of something positive because I have an excellent care co-ordinator. He was very concerned about what would happen once I left the unit and so towards the end of my stay he became involved more and came to the ward round....(P1)'*

This seemed to be an exception.

15.3 Individualised and Interpersonal Care

This theme focuses upon whether people felt that their care was individual to their needs, and perceptions about their general experience of care. The latter is reflected in how people felt they were treated and how their needs were addressed at an interpersonal level.

15.3.1 Individualised Care

Participants in the focus groups agreed that they as individual service users needed different things in terms of care. In one group it was acknowledged that the three service users in the group had different views and were different as people. In relation to their care they proposed therefore,

> *'We all respond differently to treatment..... Because we've got an illness that's a mental health illness, you're still a person, you've still got your own personality...... You're still a human being, you know.... So we will all respond differently to the way nurses and doctors are treating us (P8).'*

The impression was that to treat everyone the same was neglecting the person. One carer suggested that her husband's care needed to be unique to him; that particular ways of helping him that worked were personal to him. She reflected on some of the pre-planned care.

> *'I wouldn't want him to be pestered to go down to the gym. To do this or to do that. All he wants is to make sure he is getting the right medication and he wants to get home. So any other further people trying to encourage him to do this and that, does not work (P8)'*.

Whilst another service user made clear *'Yeah but it works for me (P8).'*

The carer acknowledged, *'Yeah because everybody is different and I think that is one thing that you never ever are going to solve (P7).'*

The same carer described how over the years of looking after her husband and contact with mental health professionals she has seen repeated '*patterns (P7)*' in his care, with staff asking the same questions and offering the same interventions over and over.

> '*They will ask if you're hearing voices, do you see things? Do you think the world is against you? All this rubbish. They don't lift their head up, they just ask and tick the boxes basically, and I do find that if one specific person has dealt with them, they said been there got the t-shirt, you know (P7).*'

She reported her husband's care seemed always to be based on what had happened in the past. People seemed to respond to her husband's needs with a conditioned response. The doctor '*automatically says that he needs some Lorazepam for a week or two (P7)*'. Rather than working with carers and assessing his current situation, she had a sense that her husband's care was based upon his '*file*' and not the root of his problems. A service user remarked about standard assessments being repeated,

> '*They have this criteria to measure your needs. They have this assessment, they go through, a list of things. God knows how many times you must go through it. The trouble is like you say, it's not simple when you are confused. It is difficult when you are agitated. It is uncomfortable (P7).*'

Whilst participants reported their care was not individualised to them some stated that particular people were treated differently to others. One suggested that staff have their '*favourites (P10)*' and she described her response to that as '*just be quiet and keep your head down, be one of the good ones (P10).*' Another described how individual staff influences the experience of care,

> '*I think it is a little slice of the world that is in there, you know, if you see what I mean. You've still got different personalities amongst the patients and the staff..... You'll get some staff who will have a rapport with the patients..... And another patient that they*

> *won't have. It's like in teaching with teachers and students..... I don't know how you get round that, because that's to do with all our personalities isn't it? (P8)'*

It was reported that there was a significant difference between inpatient and community care. When cared for by the crisis team, people reported that their care was unique to them. But when in hospital service users reported, '*I feel that you become one of a number.... Because you're not the only focus. That's what I have found (P9).*' Another service user agreed, '*You could be one of twenty who are on that ward (P8).*'

One service user described how his care seemed to be based on broad standards as opposed to what he needed as an individual.

> '*They seem only to really as a priority, at least be interested in how many baths and showers you've had. 'Have you trimmed your whiskers, have you managed to put your clothing through the wash today?' They want you in a clean pair of socks, underwear but this is what annoys me. A clean pair of trousers every other day.* Another service user challenged this, saying '*But they are supposed to be helping you live normally outside the unit.*' He went on to describe, '*You got set times when you were supposed to put your washing through on one specific day of the week, the same day indeed as your bedding was done, preferably all together. But if you wanted to do some washing of an evening, heaven help you - that's against the rules.... (P2).*'

15.3.2 Care and Respect

Many participants described general impressions and experiences about the care they received whilst on the care pathway. Often they talked of this in terms of how they felt that they were cared for, how staff acknowledged their needs, and whether what they believed they needed was accommodated. Several service users made remarks about approaching staff to talk, or for help and this not being responded to as they would have anticipated.

> *'You can't approach them. If you knock on the door. It's 'not now. I'm having a meeting, come back later' (P2).'*
>
> *'I would go to the office and I would be told, 'we'll come and see you in 10 minutes, Oh, come back in 10 minutes' (P10).'*
>
> *'You have to go and ask them in the office to see your key workers. They don't come and find you (P6).'*

It was acknowledged though that this was not a uniform response and this varied according to different members of staff.

> *'There were two particular staff members, that if they were on duty, I would ask them if they could spare me some time because they were particularly good members of staff (P1).'*

Another service user agreed,

> *'They did see me quite regular, once a day. For about 20 minutes or half an hour, but if you don't ask them they won't bother seeing you at all, I don't think (P6).'* She also reported, *'They were trying to do things, but probably because I'd got a good key worker and they are not always the same, keyworkers (P6).'*

She stated that with a 'good keyworker',

> *'They sit down and talk to you and go through the problems.... It had been beneficial, at least he'd (referring to her husband and carer) got somebody to talk to. But I've known many a time that he has gone to the desk and the keyworker is not on and they turn round and say 'you'll have to wait to the keyworker is on duty (P6)'.*

The service user/carer reflected that at times he felt his wife and himself were not afforded the level of dignity and respect that they warranted. He felt that at times they were treated like '*children (P2)*' and that in his experience there was a '*lack of respect (P2)*'. He stated,

> *'Now the whole policy has shifted in terms of care and I know what is behind it, this assertiveness, everything is assertive, even the assertive outreach. It's goading and pushing people for their own good into getting a grip and making an effort for themselves. I know what's behind it. But I think for a lot of people you have to distinguish between those who require a push, psychologically and physically, and those who require more nurturing and care, and a more affectionate and kinder approach. Very often a smile and some kind words will go a lot further than hurry up, get up, do this and do that, time to go to the toilet (P2).'* He went on to say of staff though, '*Don't get me wrong, some (members of staff) are excellent (P2).*'

A service user and carer described one nurse *'She took a lot of time out for individuals. It was her own time to actually look after certain people (P5).'* It was suggested that this was not planned, *'It's an accident or chance. It's just fortunate to happen with right individuals (P2).'*

Again experiences had varied greatly,

> *'I have seen some that will only talk to you from the office doorway. One I can think of he just stands there with his arms folded. I would be trying to explain how to help J (name of husband), and keep him calm (P7).'*

Another service user and her husband said of her care, *'We had a lot of luck with Dr O....... We've had excellent care with Dr O (P6)'.* Another service user described wanting to write her own care plan but not being able to because she needed help. Another participant reported,

> *'if you're left to sit festering in your room then you just think then, well even the staff don't care. So it just lowers your self esteem because they can't be bothered to come and see if you are okay or anything (P4).'* Similarly she described that when things are busy on the ward, *'You're not a priority and you kind of get forgotten about. There was a bloke in when I was in who was really manic and I just stayed in my room because I*

> *didn't want to be around him. He was kind of running the ward and the staff were just kind of following him around everywhere, sort of thing (P4).'*

Some reported that if you were not able to ask for help your needs could be overlooked. Whilst others described when nurses particularly tried to motivate them into activity,

> *'I didn't find that at all helpful because I just wanted to stay in bed with a quilt on top of me, hiding.... They used to come about 8.00 in the morning all chirpy and make you go off. I didn't want to, I wanted to be left alone and go to sleep and be in the dark (P10).'*

Although a carer viewed this positively,

> *'But don't you think that is a good thing that they keep you going and make you do something because when you are on your own, you are likely to dwell on bad thoughts, and you need some prompting to get you going and coming out, because it's not fair that you should spend your time under the quilt. You are a lady and you should be out there, you know, just going up to the hospital, even if it is not pleasant it keeps you getting dressed and gets you out. That to me should motivate you a little (P7).'*

15.4 Summary of the Focus Group Findings

Service users and carers high level descriptions of their admissions were very similar and closely aligned to the care pathway content. However, then studying the detail within each stage of the care pathway, after admission there was increasing variation in the care and interventions that people experienced. Yet despite this variation people still felt their care was not particularly individualised to meet their needs and that the level of input they received was largely dependant on the individual staff available at the time.

There was not a sense that a particularly formal care pathway was being followed over and above the general stages of admission, discharge and the period in between. People reported that decisions were made at ward rounds and they were not following a pre-agreed structure. There was variability in the experiences of care – some were involved in care planning and some not, and some were aware of their onward pathway and had an active role in decisions – whilst others did not. With the exception of one carer, carers reported being excluded from care decisions. When talking about choice and decision making, this also varied and there was a tendency for service users to talk about housekeeping issues as opposed to decisions about treatment, medications, aftercare and interventions. In terms of the overall care experience, people often talked of their interpersonal care and how people related to them, this lacked descriptions of more formal interventions like problem solving, cognitive and brief therapies. Formalised therapies including occupational therapy do exist within the ICP, although they were only outlined by one service user in this sample.

16. Documentary Analysis

These findings are those gathered from an analysis of 60 ICPs and healthcare records. The purpose is to answer the third research question and establish whether the care reported in the ICP was given. The findings outline the general characteristics of the sample, data which describes the completion of the ICP and whether this may be influenced by the characteristics of the sample.

16.1 Characteristics of the Sample

As a consequence of the sampling strategy the ICPs were evenly split across the 3 Trust localities. Six wards were represented, with between 4 and 16 ICPs per ward. Service users were under the care of 21 different consultants. Three consultants had more than 6 ICPs, and 8 consultants had 2 ICPs which was the most common number of ICPs per consultant (see figure 4). The average age of service users at the time the ICP began was 45.77 years (see figure 4).

Eighty percent (80%) of service users were admitted as informal patients. This is higher than the 60% reported for 2007 by the Healthcare Commission (2008) in their national review of acute inpatient care. The gender of the sample was fairly evenly split with 34 males (56.7%), and 26 (43.3%) females. The ethnic group of service users was predominantly White British (n = 56, 93%). Forty-one service users (68.3%) did not have a Care Programme Approach (CPA) level stated on admission. Nine (15%) of those that had this stated were on standard CPA and 10 (17.7%) on enhanced. Ten patients had their Health of the National Outcome Scores (HoNOS) stated on admission, these ranged from scores of 8 to 33, with a mean of 18.5. HoNOS is the most widely used routine clinical outcome measure used by English mental health services following its recommendation by the National Service Framework for Mental Health (DH, 1999a) and the working group to the Department of Health on outcome indicators for severe mental illnesses. The assessment which is poorly completed in this case contains 12 items, measuring behaviour, impairment, symptoms and social functioning and the scales are recommended to be completed after routine clinical assessments.

The average time spent on the pathway is shown by the length of stay of which the average was 26.05 days (figure 4). The average number of interventions which were documented as completed for the 60 ICPs was 67.2% (figure 4). Kolmogorov-Smirnov tests of normality were significant for age and length of stay indicating a non-parametric distribution (see table 2). Whereas for the percentage of interventions/activities completed, the distribution of the sample was not significantly different (at the level p=<0.05) from a normal distribution.

Table 2 –Tests of Normality for Age, Length of Stay & the Percentage of Interventions/Activities

Tests of Normality	**Kolmogorov-Smirnov(a)**		
	Statistic	**df**	**Sig.**
Age at time ICP began	.173	60	.000
Length of stay	.213	60	.000
Percentage of interventions/activities	.104	60	.167

a Lilliefors Significance Correction

16.2 Completion of the ICP during different time periods

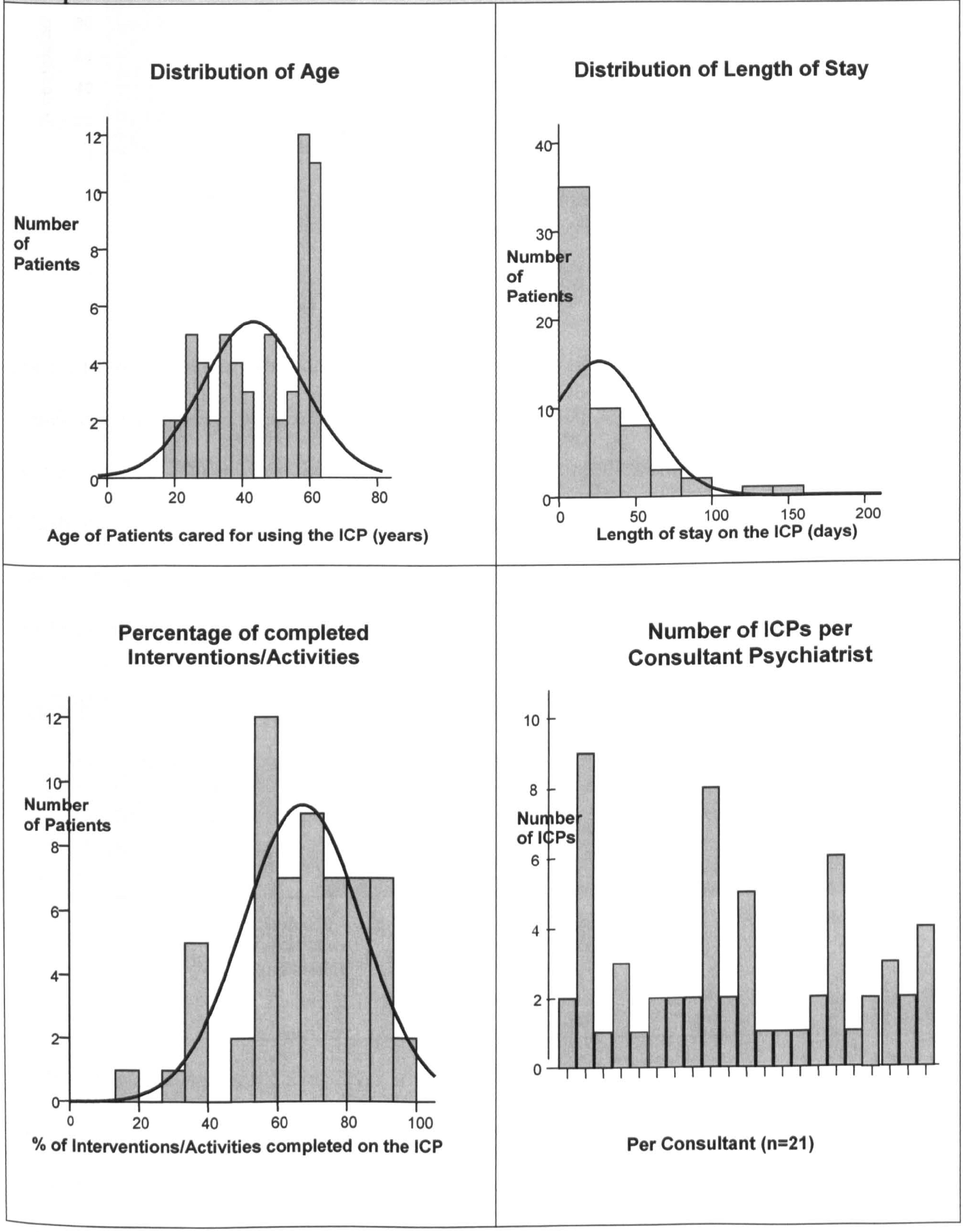
These findings relate to the 60 ICPs whether the activities on the ICP were completed. The findings in table 3 show how frequently the interventions/activities in the ICP were completed on admission. The three activities less likely to be completed were the review of a carer's assessment, the identification of cultural and spiritual needs and consideration of any advance directive. The average percentage of the activities completed on admission was 76.56%.

Table 3 – Completion of Activities on Admission

	Question	YES	
		%	n
1.	Was the main carer identified?	91.7	55
2.	A carer's assessment was considered?	43.3	26
3.	The Care Co-ordinator was known on admission.	50.0	30
4.	Cultural and spiritual needs were identified on admission.	30.0	18
5.	The physical description was completion on admission.	88.3	53
6.	Consent was discussed / recorded on admission on the ICP.	91.7	55
7.	Immediate observation level recorded on the ICP.	95.0	57
8.	Immediate reception and care signed off.	96.7	58
9.	The confidentiality statement has been completed.	80.0	48
10.	The reasons for admission have been completed.	88.3	53
11.	The purpose of admission has been stated.	76.7	46
12.	The need for an interpreter considered.	88.3	53
13.	Whether there is an advance directive was considered.	48.3	29
14.	A named nurse was allocated within 3 hours.	91.7	55
15.	The RMO has reviewed the observation level within 3 hours.	85.0	51
16.	The physical observations needed have been clarified within 3 hours.	78.3	47
17.	The physical examination is completed within 3 hours.	78.3	47

Three of the four parts of the ICP to be implemented within 24 hours of admission were completed consistently (see figure 5). An exception was the risk management plan which was completed in just over half of all the ICPs. The average percentage of the ICP interventions/activities completed within 24 hours was 84.5%.

Figure 4 – The distribution of age, length of stay, % of interventions/activities completed and number of ICPs per consultant



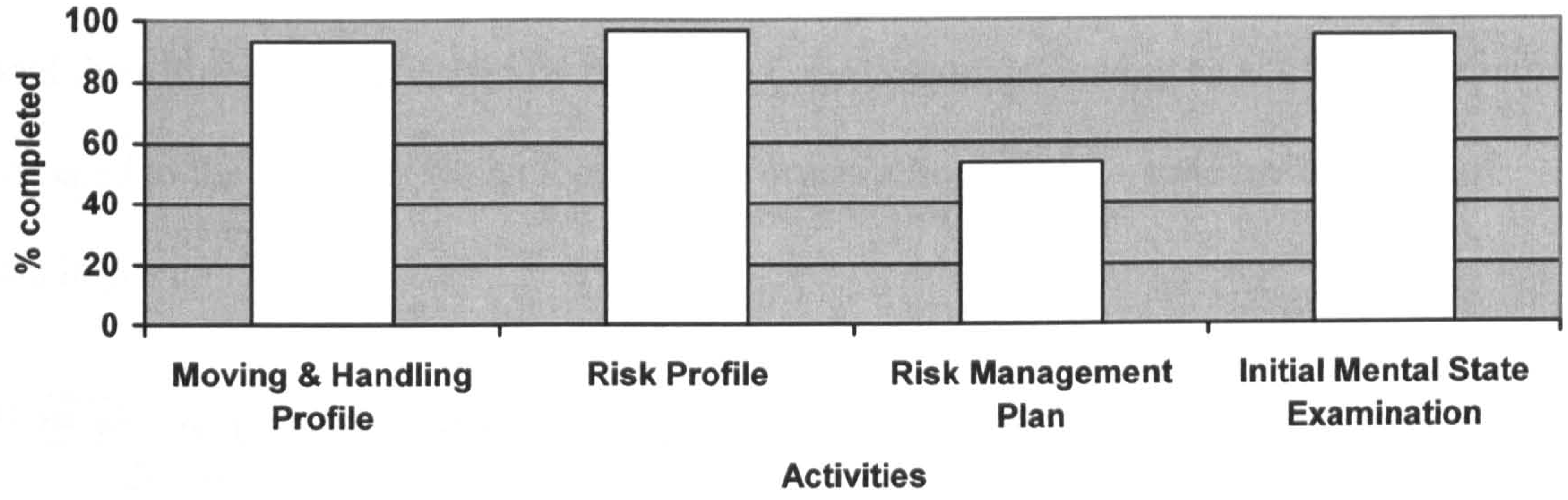
Distribution of Age

Distribution of Length of Stay

Percentage of completed Interventions/Activities

Number of ICPs per Consultant Psychiatrist

Figure 5 – Percentage of activities completed within 24 hours



The six further activities to be completed within 72 hours of admission showed a wide variation in their completion rate. With referrals to other agencies (in 38.3% of cases) being the activity least completed. The highest level of completion was for the Manchester Care Assessment Schedule (MANCAS) which is a health and social care assessment - completed in 91.7% of cases (see figure 6). The overall average percentage of interventions completed within 72 hours of admission fell to 61.4%.

Figure 6 - Activities completed within 72 hours

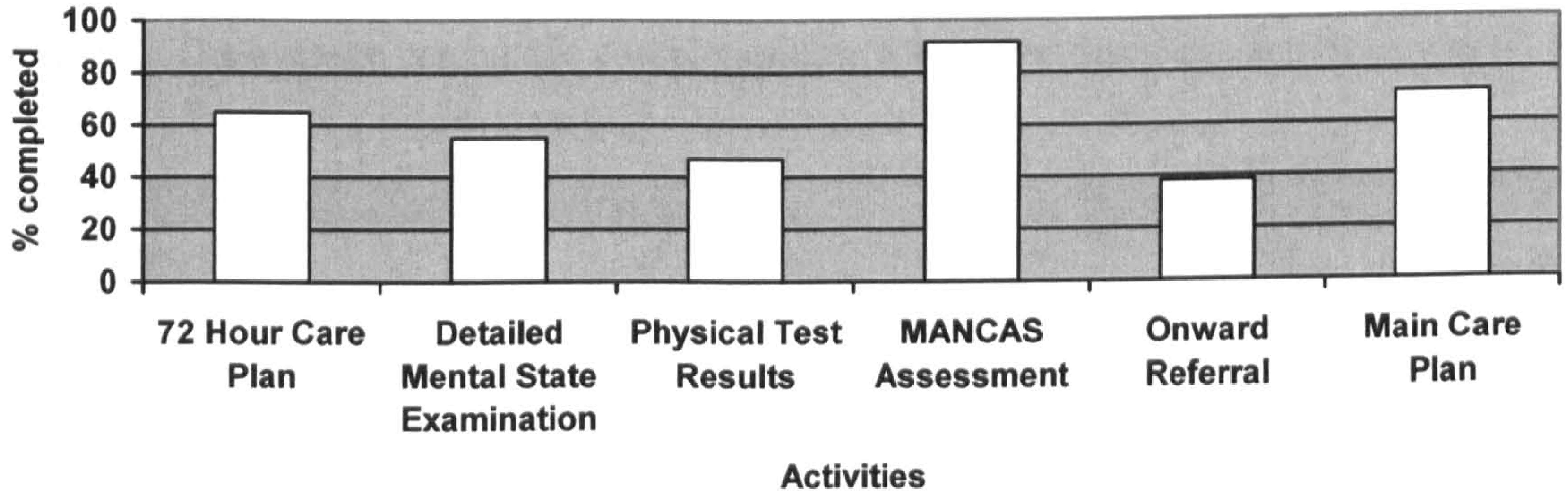


Table 4 shows the further reducing level of completion by days 5 and 10 of the ICP. The part of the pathway used to record interventions by occupational therapy, physiotherapy, social work and community teams (interdisciplinary interventions) being used in 28.3% of cases, whilst the initial multidisciplinary case review was completed in 91.7% of cases. The average percentage of activities completed in this period was close to half (50.25%). It is noticeable that there is a distinct drop in completed direct care interventions (i.e. service users being given information about their illness, being visited by their Care Coordinator and having an activity programme compared to the activities which focus on the organisation of care – case review and care planning).

Table 4 – Completion of activities by Day 5 and Day 10

	Question	YES	
		%	n
1.	Interdisciplinary interventions are recorded.	28.3	17
2.	The Care Co-ordinator has visited.	36.7	22
3.	The service user has been given information about their illness.	36.7	22
4.	An activity programme is in place.	35.0	21
5.	The main care plan has been completed.	71.7	43
6.	The initial case review has been completed.	91.7	55
7.	There is an estimated date for discharge.	51.7	31

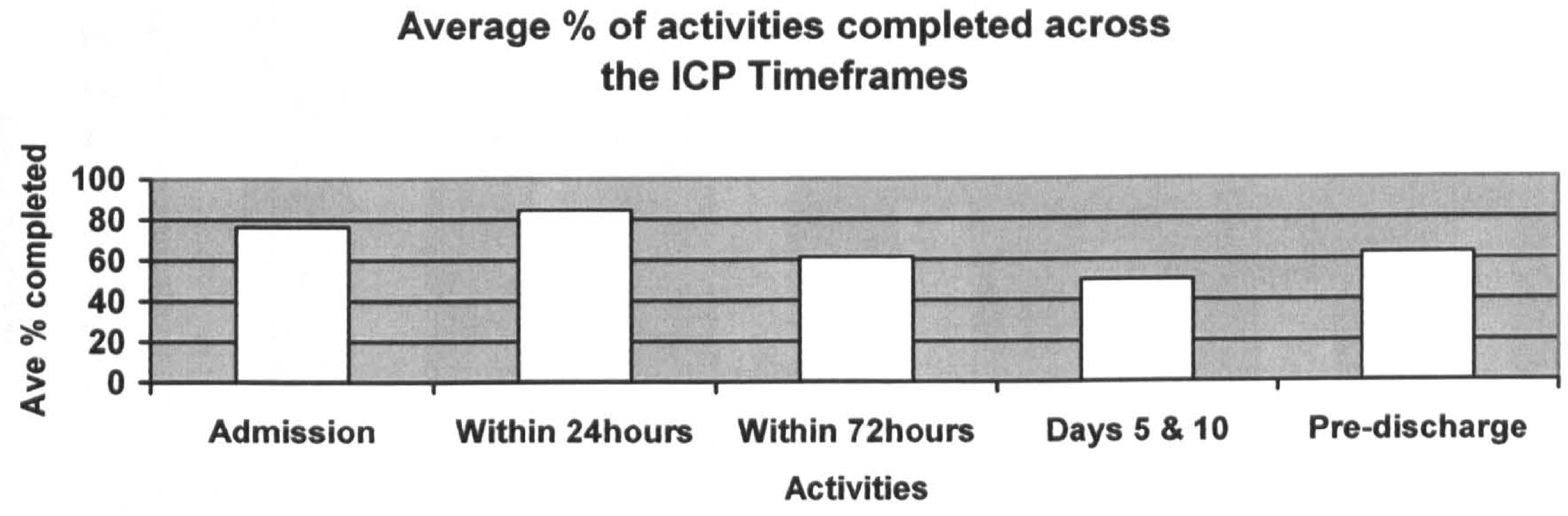
The findings related to pre-discharge activities show a split between the activities ensuring that service users and carers had copies of the discharge plans (completed in 35 and 20% of ICPs respectively) and the other activities (see table 5). The activities completed suggested a degree of adherence is paid to ensuring that there are multidisciplinary case reviews (91.7%) prior to discharge, that there is a forward plan (83.3%) and that other stakeholders are made aware (80%), but this does not follow through into the activities which directly involve service users and carers. The average percentage completion rate for the pre-discharge activities was 63.19%.

Table 5 – Completion of pre-discharge activities

	Question	YES	
		%	n
1.	There is a pre-discharge case review.	91.7	55
2.	The carer has a copy of the discharge plan.	20.0	12
3.	There is a plan of agreed interventions.	83.3	50
4.	The interventions around discharge are in the care plan.	56.7	34
5.	The service user has medication to take home.	76.7	46
6.	The service user has a copy of their aftercare plan.	41.7	25
7.	The service user has signed off a copy of their aftercare plan.	35.0	21
8.	Stakeholders have been made aware of discharge.	80.0	48
9.	The Care Co-ordinator has visited prior to discharge.	50.0	30
10.	Outpatient attendance has been considered.	73.3	44
11.	The GPs letter informing him of the service user's discharge has been completed.	86.7	52

Figure 7 shows a summary of the average percentage of interventions completed across the different timeframes of the ICP. .

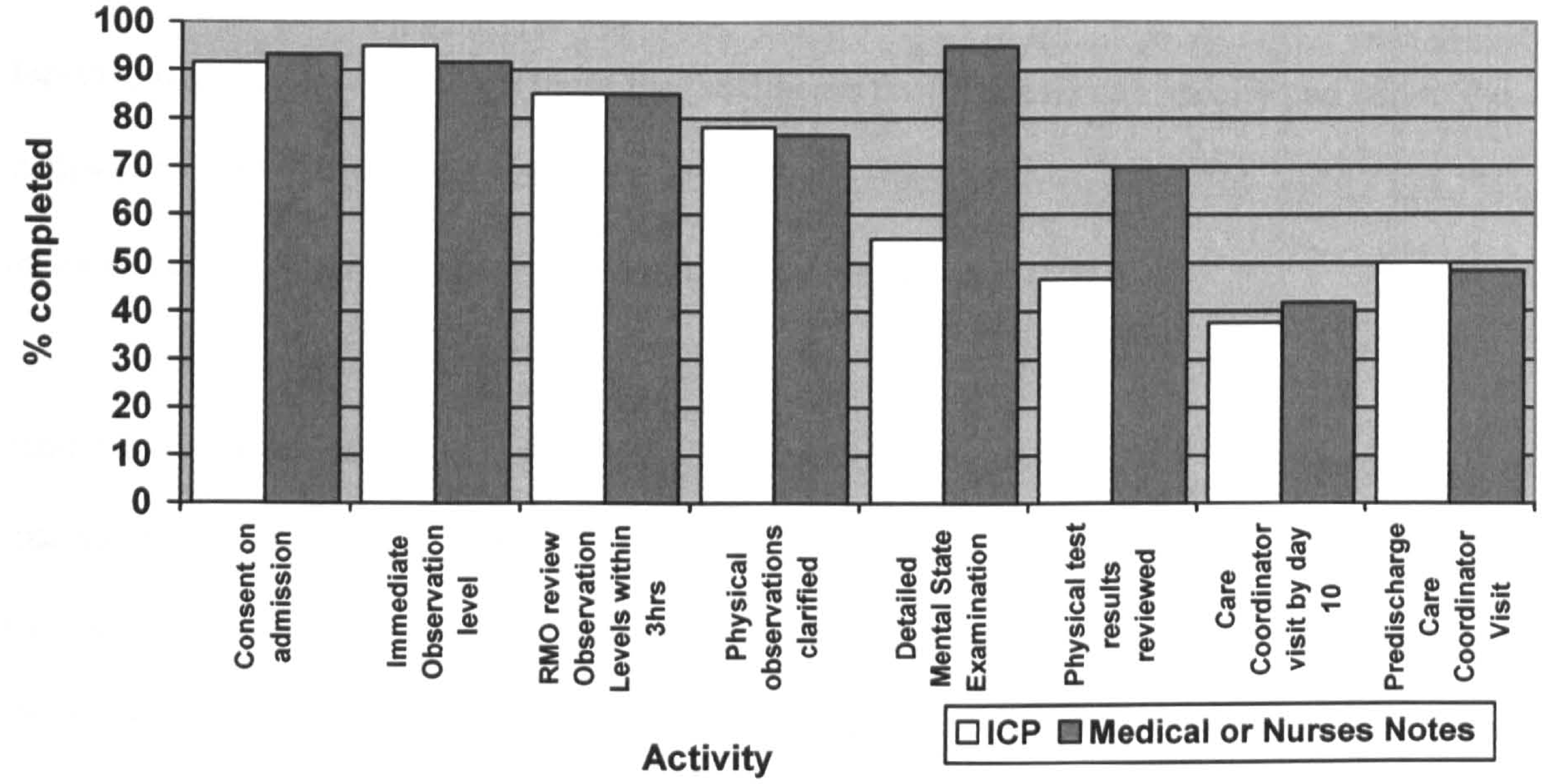
Figure 7 – Summary of completion of the activities in the ICP



16.3 Comparing the ICP activities to other information in the health care record

To establish whether the activities/interventions in the ICP had actually been completed rather than just being recorded as completed on the ICP, reference to certain activities in other parts of the healthcare record was sought. This was to understand the degree of concordance between the ICP document and other parts of the health care record, and seek further evidence about the completion of interventions. For example, as shown in figure 8 - the first activity considered represents the percentage of ICPs which documented that consent to treatment had been discussed on admission and its matched column shows the percentage of medical notes which document the assessment of capacity and discussion about consent to treatment. Overall, there was a high degree of concordance between the ICP and other parts of the healthcare record (see figure 8). There were two exceptions: the ICP recorded a much lower rate of completion than the medical notes. These were for the completion of the detailed mental state examination (55% on the ICP and 95% in the medical notes) and the review of physical tests results (46.7% on the ICP and 70% in the medical notes).

Figure 8 - % Activity completed in the ICP contrasted with information in the nursing and medical notes



16.4 Service User and Carer Involvement Activities

Considering the earlier findings related to activities which specifically focus upon service user and carer involvement these were examined as a discrete group. Table 6 shows the relatively low rate of completion with the average percentage across the whole range of activities being 45%.

Table 6 – Service User and Carer Involvement Activities

	Question	YES	
		%	n
1.	Was the main carer identified?	91.7	55
2.	A carers assessment was considered.	43.3	26
3.	There is evidence that service users or carers are involved in risk assessment.	65.0	39
4.	There is evidence that the service user is involved in developing the risk management plan.	48.3	29
5.	There is evidence that the carer is involved in the risk management plan.	41.7	25
6.	Carers are given a copy of the plan from the initial review.	28.3	17
7.	The service user has signed the care plan.	43.3	26
8.	The service user has been given information about their illness.	36.7	22
9.	Ac copy of the discharge plan has been given to the carer.	20.0	12
10.	The service user has a copy of their discharge plan.	41.7	25
11.	The service user has a signed copy of their discharge plan.	35	21

16.5 Individualised Interventions and Recording Variances

There are four main points at which individualised interventions can be recorded on the ICP; on admission, within 3 hours of admission, within 72 hours of admission and discharge. Individualised interventions are those that healthcare professionals can specify and add to the pathway to meet individual needs. At each of these points between 7 (11.7%) and 13 (21.7%) service users had individualised interventions recorded in their ICP.

Similarly, there are several opportunities to record variances from the ICP (i.e. where interventions and activities were not offered, refused or did not happen for another reason). This happened for between 5 and 40% of ICPs depending upon the stage in the ICP (see table 7). Thirty-one (57.7%) ICPs had variances reported in the cumulative record at the end of the ICP (where all the variances are collated for audit purposes).

Table 7 - Variance Reporting according to Stage of ICP

Question		**Yes**	
	Were variances recorded?	%	n
a)	on reception to hospital	20.0	12
b)	within 3 hours of admission	40.0	24
c)	within 72 hours of admission	18.3	11
d)	during the middle period of the ICP	5.0	3
e)	on discharge	11.7	7

16.6 Activities completed in relation to the timeframe set in the ICP.

Table 8 shows an increase in activities delayed (completed late) at the 3 day point of the pathway and at the point of follow-up after discharge. The activity showing the highest rate of delayed completion was the review of physical test results, the longest delay for this activity was when it was completed 10 days later than the ICP suggests. The longest delay in any activity was for an initial case review completed 51 days later than suggested by the timeframe in the ICP.

Table 8 – Completion of Activities in relation to their timeframes

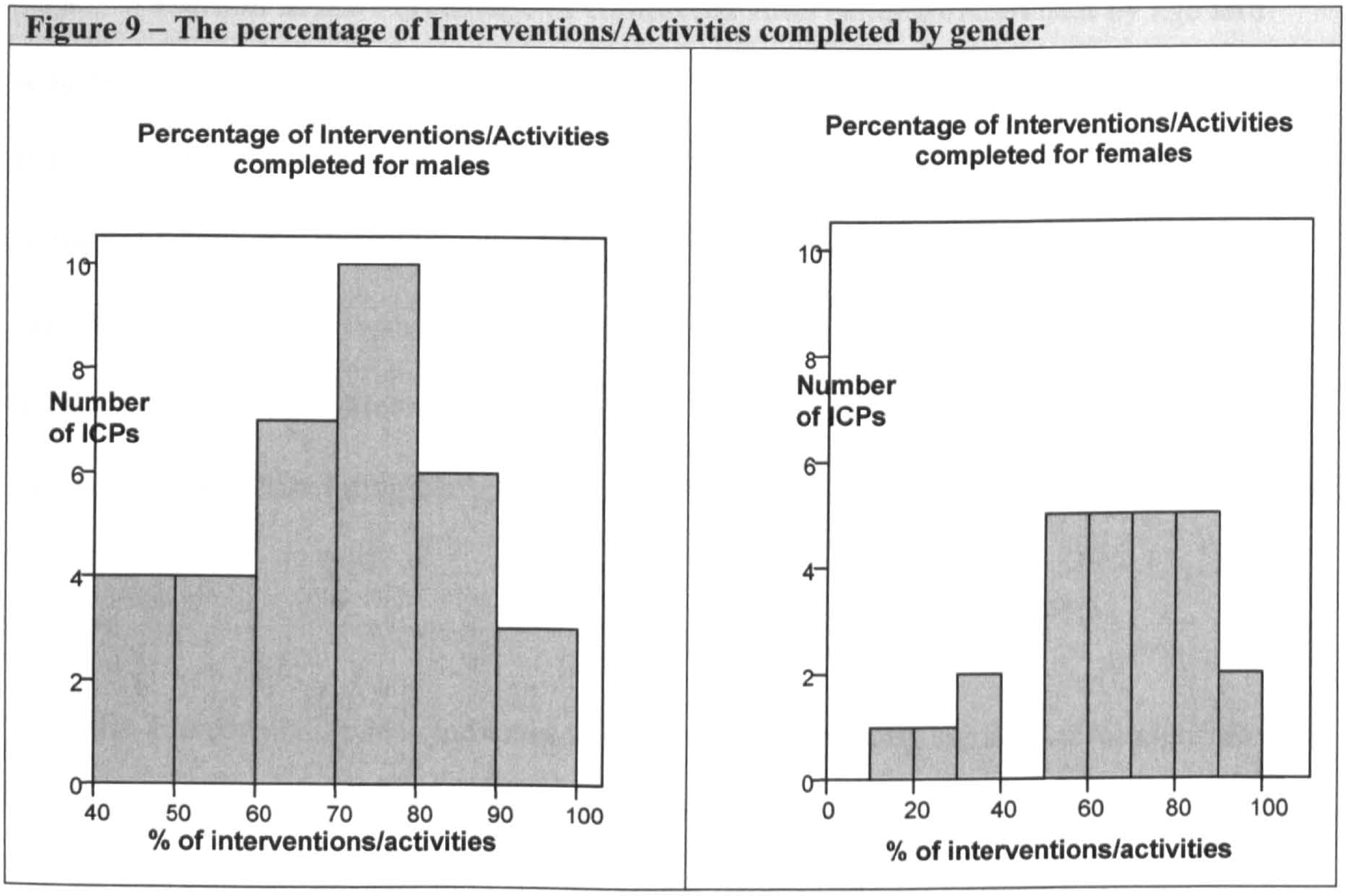
Activity		Completed on time		Completed late		Not completed		Longest Delay	Variances
		%	n	%	n	%	n	days	
1.	The moving and handling profile is completed within 24 hours of admission.	80	48	13.3	8	6.7	4	14	5 completed on the 2nd day 1 completed on the 9th day 1 completed on the 11th day 1 completed on the 15th day
2.	The risk profile is completed within 24 hours of admission.	85	51	11.7	7	3.3	2	4	5 completed on the 2nd day 2 completed on the 5th day
3.	The risk management plan is completed within 24 hours of admission.	45	27	8.3	5	46.6	28	30	2 completed on the 2nd day 1 completed on the 5th day 1 completed on the 11th day 1 completed on the 31st day
4.	The MSE was completed within 3 days of admission.	88	53	7	4	5	3	5	2 completed on the 4th day 1 completed on the 5th day 1 completed on the 6th day
5.	The results of physical tests were reviewed within 3 days of admission.	11.7	7	35	21	53.3	32	10	5 were reviewed on the 4th day 3 were reviewed on the 5th day 4 were reviewed on the 6th day 3 were reviewed on the 7th day 1 was reviewed on the 9th day 3 were reviewed on the 10th day 1 was reviewed on the 11th day 1 was reviewed on the 13th day
6.	The MANCAS is completed within 3 days of admission.	73.3	44	18.3	11	8.4	5	11	4 were completed on the 4th day 2 were completed on the 5th day 1 was completed on the 6th day 2 were completed on the 7th day 1 was completed on the 12th day 1 was completed on the 14th day
7.	The initial case review is completed within 5 days of admission	80	48	11.7	7	8.3	5	51	4 were reviewed on the 6th day 1 was completed on the 10th, 12th and 56th days
8.	The full care plan was completed by day 4.	65	38	6.7	4	28.3	17	14	1 was completed on the 5th, 10th, 16th and 20th days
9.	Mid-stay interventions were completed by day 10.	26.7	16	5	3	68.3	41	27	1 was completed on the 19th, 20th and 37th days
10.	The time between the last case review and discharge not more that 2 weeks.	88.3	53	5	3	6	4	8*	1 was completed 15, 17 and 22 days before discharge
11.	The time between discharge and follow up is less than 7 days.	53.3	32	20	12	26.7	16	29	Follow up happened on one occasion on the 8th, 12th, 16th, 18th, 34th days after discharge In 3 cases on the 10th day In 2 cases on the 14th day

*Case review 8 days before 2 weeks before discharge

16.7 Variation in the percentage of interventions/activities completed according to gender, Consultant Psychiatrist and Trust locality

Splitting the sample by gender revealed that there was little difference in the average amount of interventions/activities completed: a mean of 69.04 (standard deviation 14.95) of activities for males and 64.80 (standard deviation 19.79) for females. Observing the distributions in figure 9 shows a peak for males between 70 and 80% of interventions completed whereas, for females the distribution is much flatter in the range between 50 and 90%. To consider the relationship between gender and the percentage of interventions/activities further completed, a Mann-Whitney Test was used to test the means using gender as the grouping variable. The Mann-Whitney test indicated that the differences were not statistically significant ($p<0.05$).

Figure 9 – The percentage of Interventions/Activities completed by gender



Kruskal-Wallis tests were used to consider whether there were differences between the average percentage of interventions/activities completed in the ICPs, according to the three localities of the Trust's services and individual consultant psychiatrists (see table 9). Results suggest statistically significant differences in the percentage of interventions/activities completed depending on the Trust locality and between the four consultants who had over five ICPs (at the level $p<0.05$).

Table 9 – Kruskal Wallis Tests for correlation between Trust locality, consultant psychiatrist and the mean % of activities/interventions completed

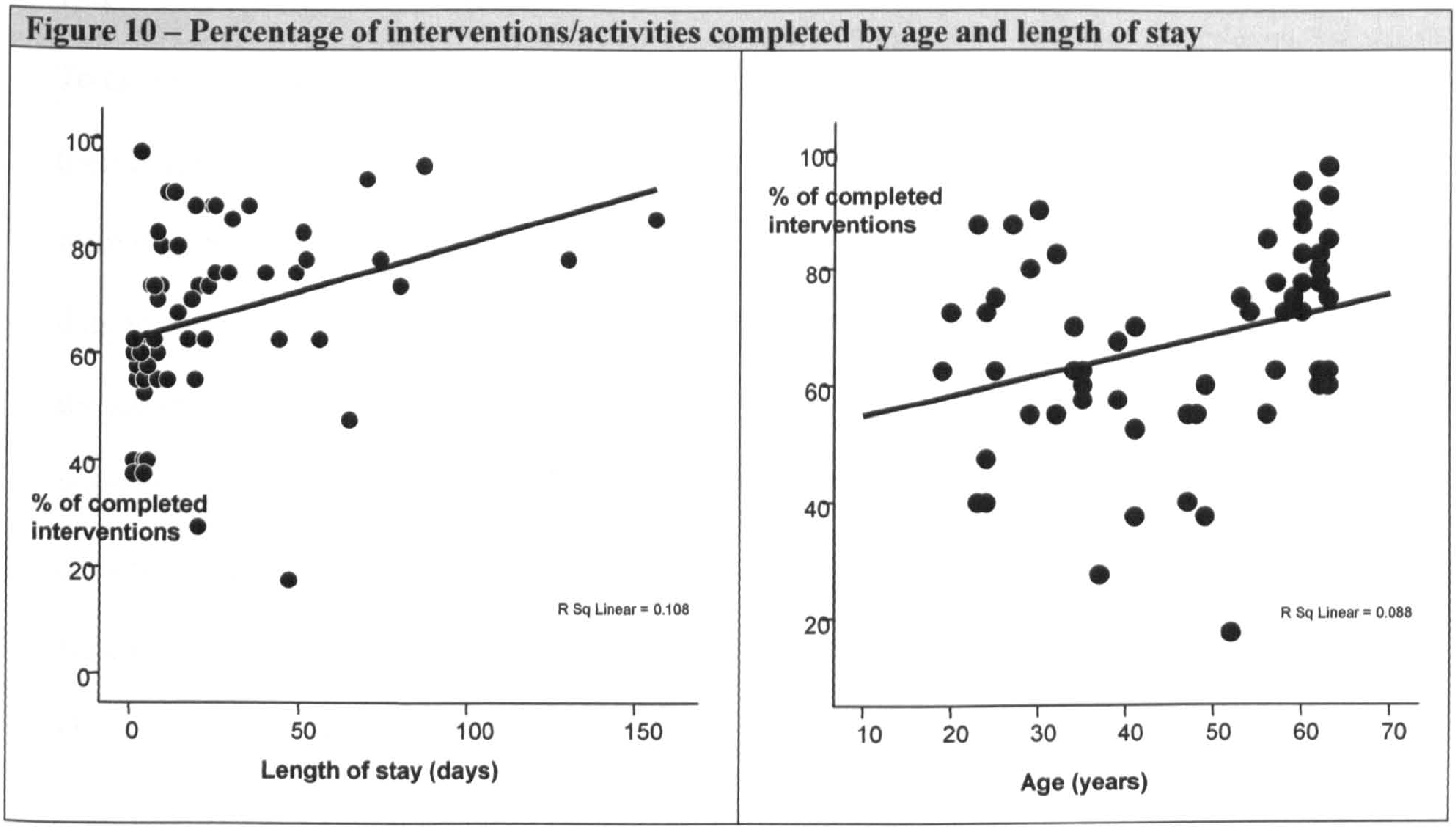
Grouping Variable	Trust Locality	Total sample of 21 Consultant Psychiatrists	Consultant Psychiatrists with more than 5 ICPs
Chi-Square Statistic	8.562	24.17	10.569
Degrees of Freedom (df)	2	20	3
Asymp. Sig.	.014	.235	0.014

16.8 Variation in the Percentage of completed Interventions/Activities by age and length of stay

Figure 10 shows the variation in the percentage of interventions/activities according to the age of the service user and their length of stay. The percentage of interventions/activities completed increases with an increase in length of stay. Also, the older the service user is, the higher the percentage of interventions/activities completed. One-tailed Kendalls Tau test suggests that the correlation between age and interventions/activities completed is significant ($p<0.01$).

Kendalls Tau correlation also indicates that there is a statistically significant relationship between the percentage of interventions completed and length of stay ($p<0.01$). The longer the service user stays or the older they are, the higher the percentage of interventions they receive. However, it cannot be assumed that age or length of stay has a direct causal effect.

Figure 10 – Percentage of interventions/activities completed by age and length of stay



17. Across-case comparison of Key Performance Indictors

These data were analysed to answer the fourth research question which considers the potential impact of the ICP upon performance indicators. The performance under consideration is length of stay, follow-up within 7 days of discharge from acute inpatient care and readmission rates. These data consider two datasets each drawn from the Trust using the ICP and a Trust which did not. One set is data collated as part of the national mental health minimum dataset which was used to consider whether the characteristics of the populations are similar (between the ICP and non ICP Trust), and whether there are any significant differences in length of stay. The second is performance dataset which is used to compare key indicators between the two organisations.

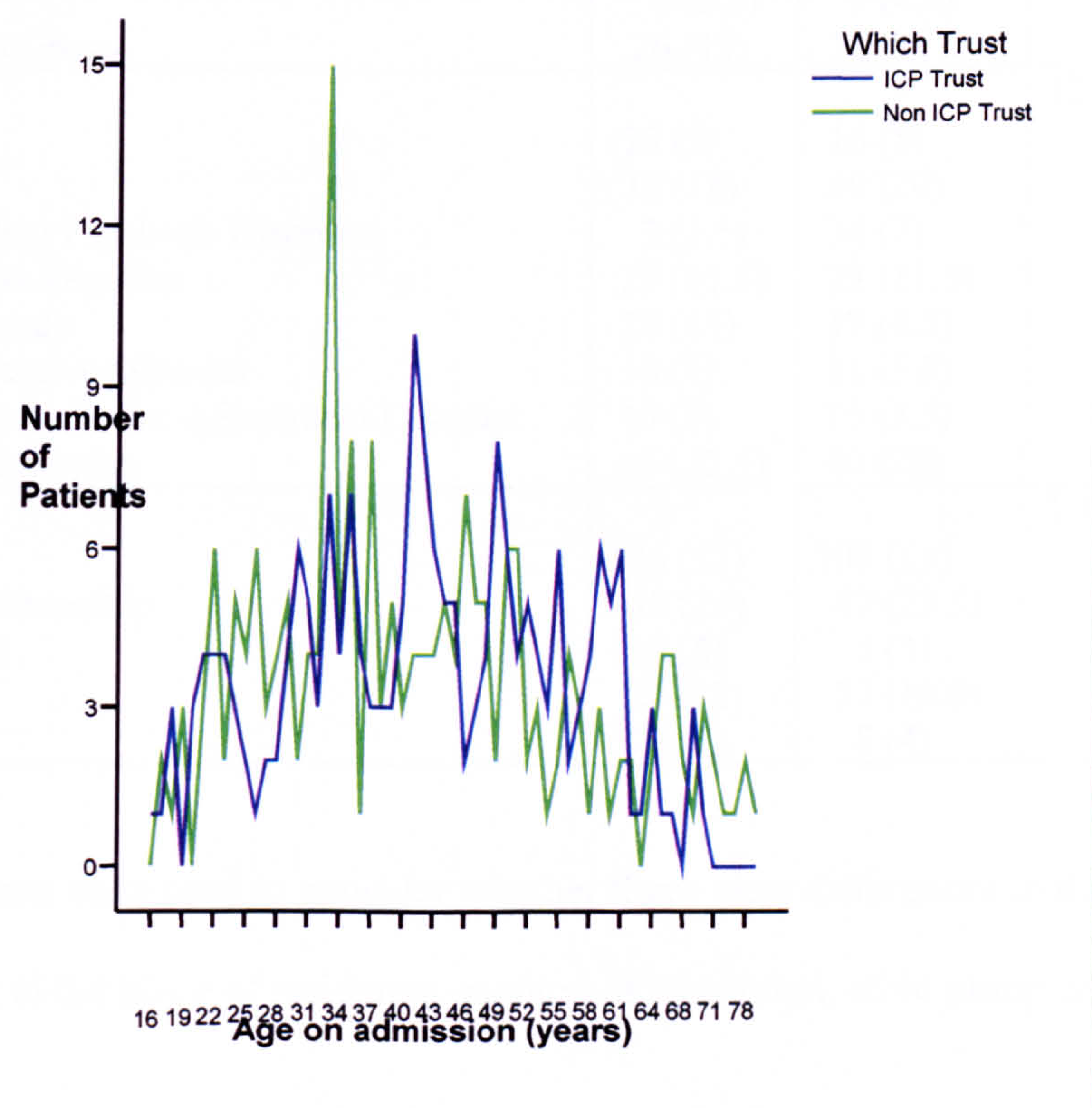
17.1 Across-case comparison of the population

To consider whether the samples from the Non ICP Trust and the ICP Trust were different, their characteristics were examined using t-tests and chi-square tests. The characteristics that were compared were the age of the service users, their marital status, religion, ethnicity, diagnosis, reason for admission and where they resided before their admission. Table 10 shows the summary statistics for the age of the sample grouped by Trust, also shown in figure 11. Independent t-tests were not significant (t=0.335, df=398, $p<0.05$). The age of the population does not differ significantly between the 2 groups. Kendals Tau test showed that there was not a statistically significant relationship between age and length of stay at the level ($p<0.01$) in either the ICP or non ICP Trust.

Table 10 – Summary Statistics for age by group

	N	Minimum	Maximum	Mean	Standard Deviation
ICP Trust	200	16	70	42.55	13.021
Non ICP Trust	200	17	80	42.08	14.656

Figure 11 – Age of Service Users grouped by Organisation



Further factors considered were the marital status, religion, and ethnicity, diagnosis of the service users, reason for admission and where service users resided. These were compared using chi-square tests and the results are shown in table 11.

Table 11 – ICP and Non ICP between group comparison

	ICP Trust	Non ICP Trust	Significance	
	N (%)	N (%)	Chi-Sq Value	p
Method of Admission			142.028	0.000
Planned or Transfer	9 (4.5)	98 (49)		
A&E	25 (12.5)	0 (0)		
GP or Domiciliary	32 (16)	2 (1)		
Outpatients	7 (3.5)	20 (10)		
Emergency	126 (63)	80 (40)		
Place of Residence			6.852	0.033
Temporary/Permanent Residence	153 (76.5)	132 (66)		
Prison or Police	12 (6)	11 (5.5)		
Hospital (any type)	35 (17.5)	57 (28.5)		
Ethnic Group			9.803	0.002
White British	188 (94)	171 (85.5)		
Other Ethnic Group	9 (4.5)	27 (13.5)		
Religion			3.023	0.388
Church of England	96 (48)	82 (41)		
Catholic	16 (8)	12 (6)		
Christian	5 (2.5)	9 (4.5)		
Other Religious Group	26 (13)	16 (8)		
Diagnostic Group			12.401	0.088
Alcohol	10 (5)	16 (8)		
Schizophrenia	36 (18)	40 (20)		
Acute & Transient Psychotic Disorders	3 (1.5)	14 (7)		
Bipolar Affective Disorder	23 (11.5)	23 (11.5)		
Depressive Episode	28 (14)	17 (8.5)		
Recurrent Depressive Disorder	10 (5)	11 (5.5)		
Reaction to Severe Stress; Adjustment Disorder	10 (5)	15 (7.5)		
Other Diagnostic Group	45 (22.5)	40 (20)		
Marital Status			1.418	0.841
Single	106 (53)	108 (54)		
Married/Civil Partnership	48 (24)	47 (23.5)		
Parted/Separated	10 (5)	6 (3)		
Divorced	24 (12)	27 (13.5)		
Unknown	10 (5)	8 (4)		

Kruskal-Wallis tests were used to consider whether there were differences in the average length of stay according to the place of residence, method of admission, ethic group and diagnostic group (see table 12). With a statistically significant relationship between diagnostic group and length of stay at the level of p=<0.01, for the ICP, Non ICP and combined groups.

Table 12 - Kruskal Wallis Tests examining differences in length of stay according to key variables				
a) In the combined dataset of the ICP and Non ICP Trust				
Grouping Variable	**Place of Residence**	**Method of Admission**	**Ethnic Group**	**Diagnostic Group**
Chi-Square Statistic	7.392	26.331	4.575	38.224
Degrees of Freedom (df)	2	4	1	8
Asymp. Sig.	0.025	0.000	0.032	0.000
b) For the ICP Trust				
Grouping Variable	**Place of Residence**	**Method of Admission**	**Ethnic Group**	**Diagnostic Group**
Chi-Square Statistic	2.925	6.033	0.000	19.612
Degrees of Freedom (df)	2	3	1	8
Asymp. Sig.	0.232	0.110	0.992	0.012
c) For the non ICP Trust				
Grouping Variable	**Place of Residence**	**Method of Admission**	**Ethnic Group**	**Diagnostic Group**
Chi-Square Statistic	9.338	0.547	4.261	27.225
Degrees of Freedom (df)	2	2	1	8
Asymp. Sig.	0.009	0.761	0.039	0.001

17.2 Across-case comparison of length of stay

Table 13 shows the summary statistics for the length of stay of the sample grouped by non ICP Trust and the ICP Trust (also shown in figure 12). An independent t-test was significant at the level of p=<0.05 (t=-1.999, df=82.883, p=0.046). The length of stay does differ significantly between the two groups.

Table 13 – Summary Statistics for length of stay by group					
	N	Minimum	Maximum	Mean	Standard Deviation
ICP Trust	185	0	648	35.91	64.119
Non ICP Trust	200	0	520	49.39	68.131

17.3 Across-case comparison of readmission rates

Table 14 shows the summary statistics for monthly readmission rates of the sample grouped by non ICP Trust and the ICP Trust (also shown in figure 13). An independent t-test, was not significant at the level of p=<0.05 (t=-1.552, df=67.459, p=0.125). Readmission rates did not differ significantly between ICP and non-ICP groups.

Table 14 – Summary Statistics for readmission rates by group

	N (number of months)	Minimum	Maximum	Mean	Standard Deviation
ICP Trust	46	0	14	3.41	3.67
Non ICP Trust	46	1.3	8.5	4.35	1.89

Figure 12 – Length of stay grouped by Organisation

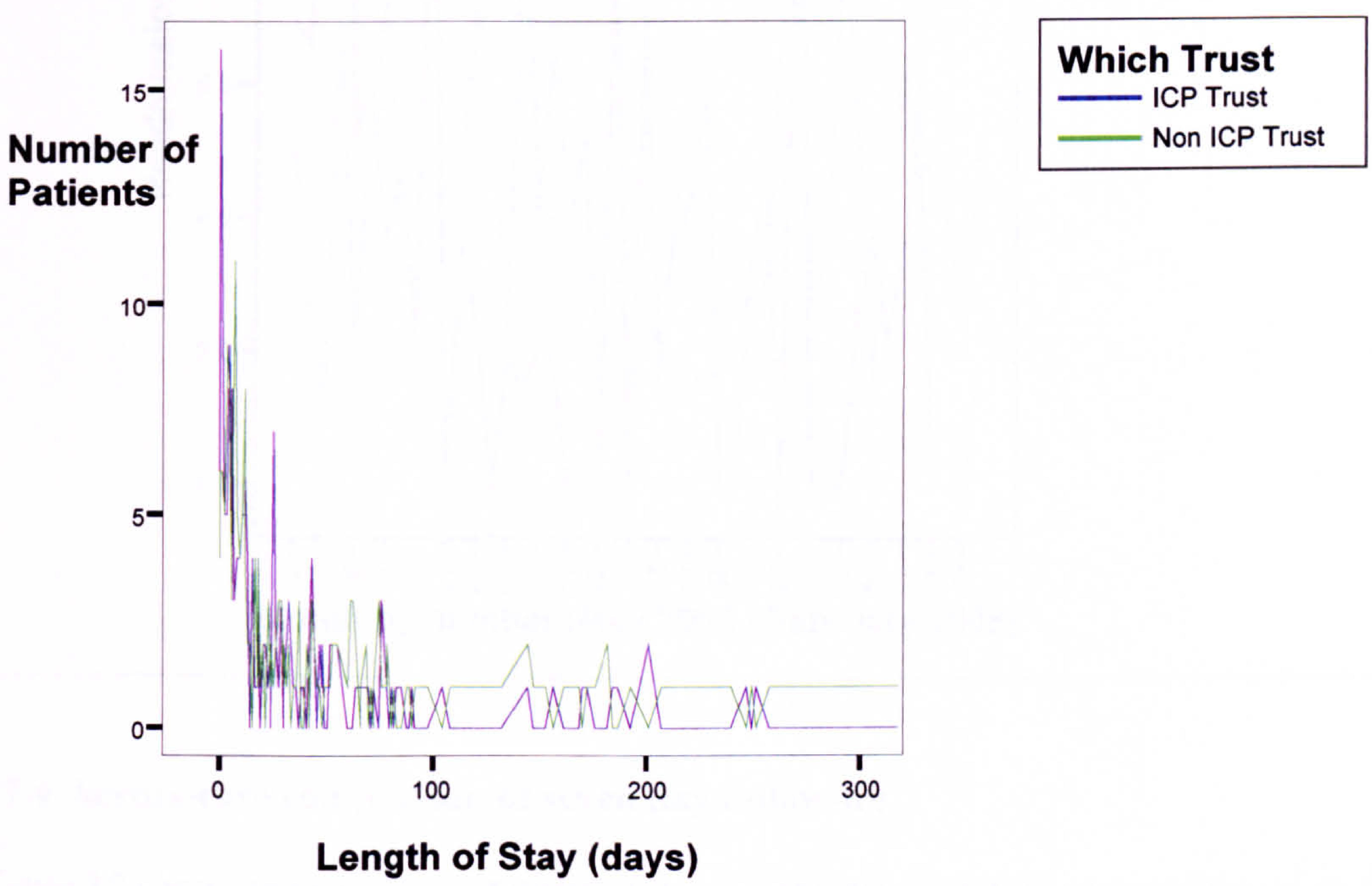
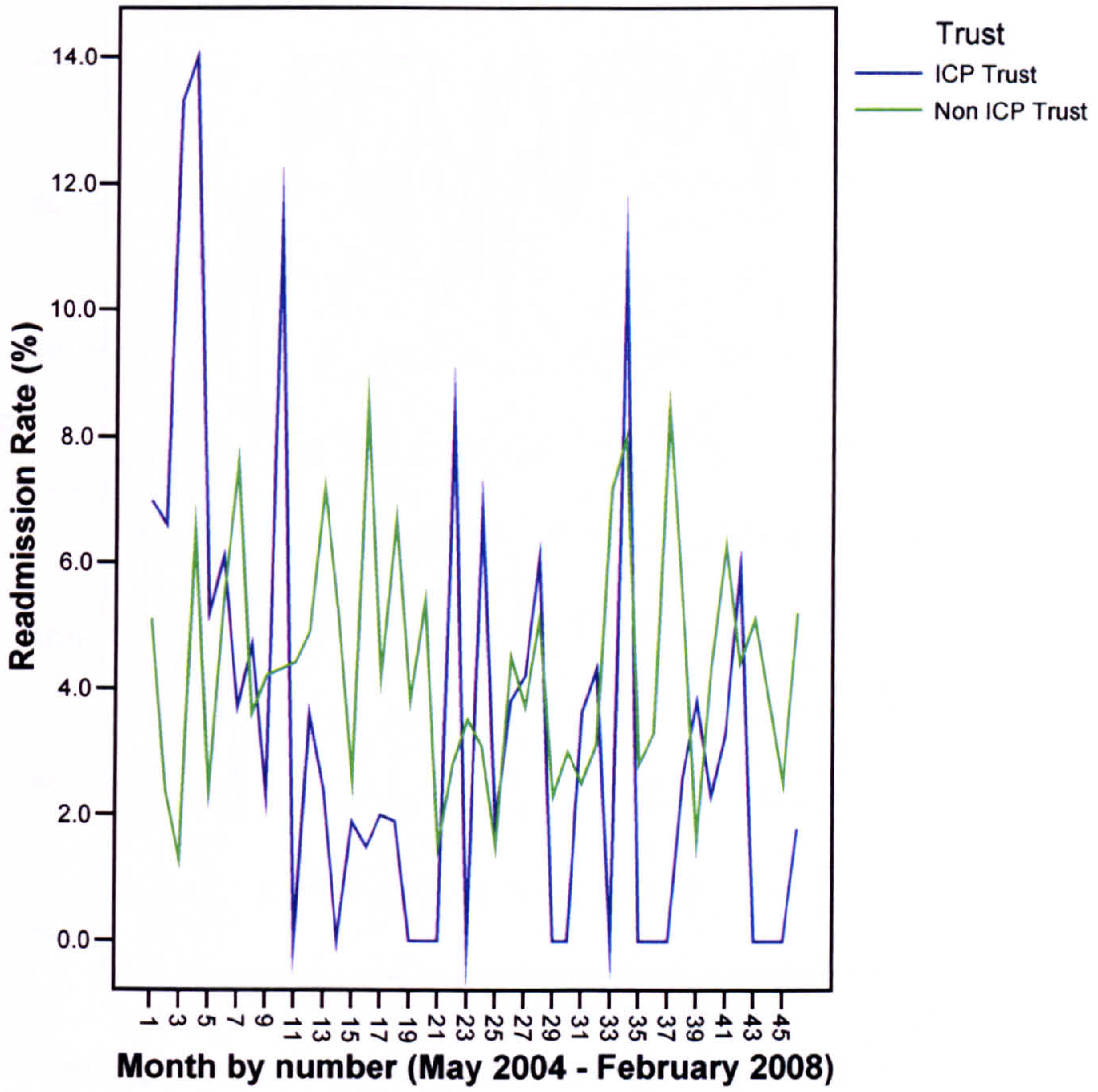


Figure 13 –Readmission rates grouped by Organisation



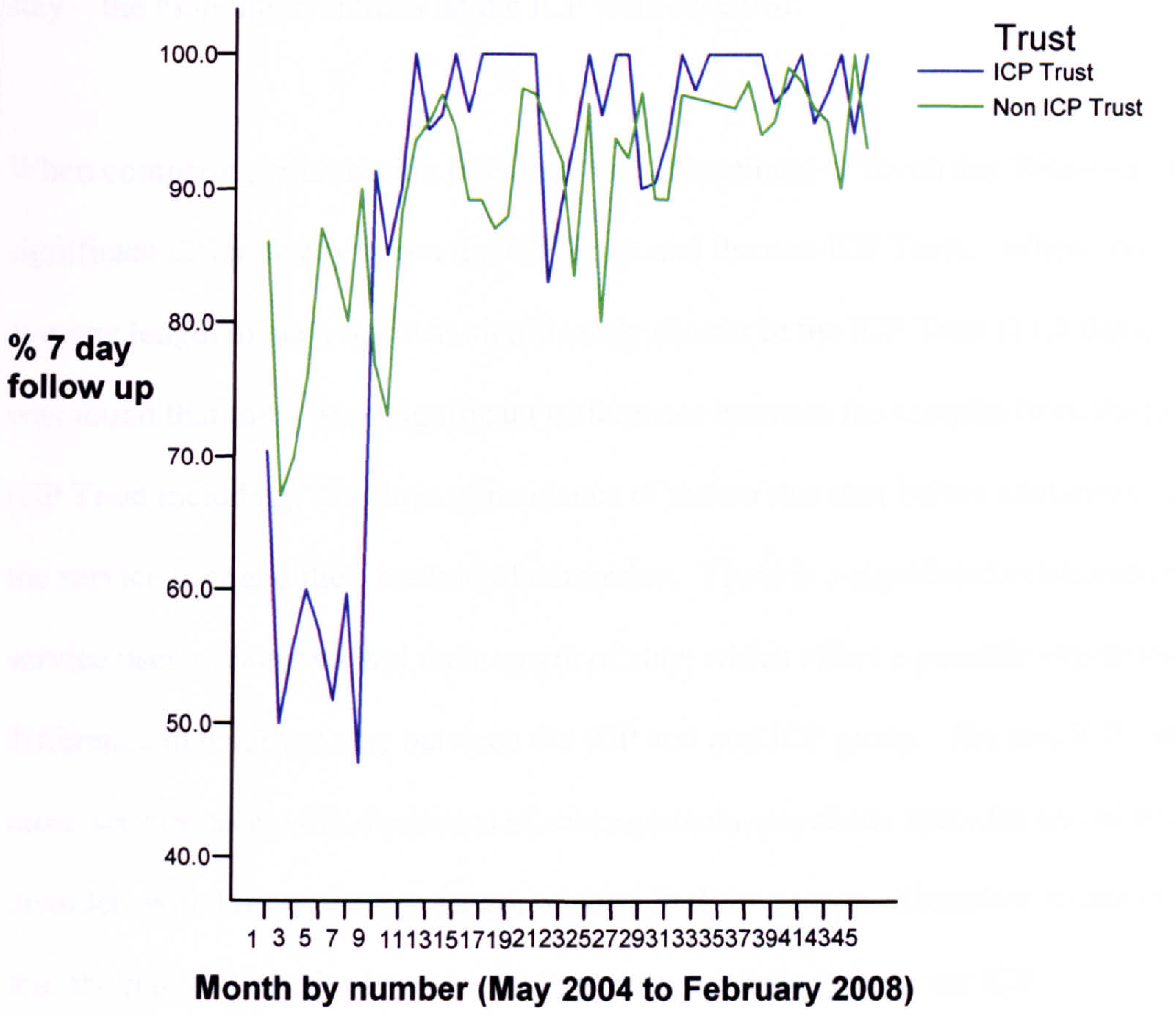
17.4 Across-case comparison of seven day follow-up

Table 15 shows the summary statistics for rates of seven day follow-up achieved in the sample grouped by non ICP Trust and the ICP Trust (also shown in figure 14). An independent t-test, was not significant at the level of $p=<0.05$ ($t=-0.146$, $df=67.271$, $p=0.885$). The achievement of the seven-day follow-up target does not differ significantly between the two groups.

Table 15 – Summary Statistics for performance of 7 day follow-up by group

	N (months)	Minimum	Maximum	Mean	Standard Deviation
ICP Trust	46	47.1	100	89.48	16.15
Non ICP Trust	43	67	100	89.87	8.10

Figure 14 –Performance of 7-day follow-up grouped by Organisation



18. Summary of Quantitative Findings

It was found from the sample of 60 ICPs that just over two-thirds (67.2%) of the interventions in the ICP were completed. The highest likelihood of interventions being completed is on admission. Those that specifically focus on service user and carer involvement were less likely to be completed than other interventions. The recording of individualised interventions and variances was much lower than the rate of interventions not completed in the ICP. The activities on day three of the ICP were provided late more than in other timeframes.

There was no significant difference in the interventions completed depending upon the gender of service users, although there were differences depending on the location in which the ICP was used and the consultant psychiatrist. The older the service user and the longer the length of stay – the more interventions on the ICP were received.

When comparing readmission rates and the achievement of seven day follow-up, there was no significant difference between the ICP Trust and the non ICP Trust. When considering average length of stay, this was significantly shorter in the ICP Trust (13.5 days). However, it was found that there were significant differences between the samples from the non ICP and ICP Trust including; the place of residence of the service user before admission, diagnosis of the service user and their method of admission. There is a significant relationship between the service user's diagnosis and their length of stay, which offers a possible explanation for the difference in length of stay between the ICP and non ICP group. The non ICP sample included more service users with diagnoses of schizophrenia, psychotic episodes and bi-polar affective disorder, with longer average length of stays in these groups. Therefore it cannot be assumed that the reduced length of stay in the ICP Trust is attributable to the ICP.

CHAPTER 5

DISCUSSION

This discussion includes reference to the specific research questions, and focuses upon key theoretical concepts. The content addresses the research aim of understanding how an ICP is used to manage mental health care. Attention is given to ensuring that the four specific research questions are considered, i.e.

1. How do healthcare professionals' use ICPs as an approach to managing mental health care?
2. What are service users' and carers' experiences of care that is managed using an ICP?
3. How does care that is described in the ICP compare with what is provided?
4. What is the impact of using an ICP upon key performance outcomes?

The structure of the discussion that arises follows three particular themes;

- The experience of the ICP from the perspectives of the different stakeholders, including service users and carers, nurses and other professional groups. Opportunities are taken to discuss the sociological influences upon these experiences and the issues of relationships and social structure.
- The care given focusing upon this ICP as a case, including the influence upon key performance indicators, fidelity to the ICP model and whether care has been standardised.

- A review of the main theoretical challenges of using this ICP. These include representing a consensus of the patient journey, addressing the issue of complexity and the implied challenges to the ICP model.

This approach uses the descriptive framework of the study as a basis to consider alternative explanations as Yin (2003) suggests, whilst acknowledging the contrasts and patterns across the multiple sources of data. Underpinning theories which contribute to the discussion are social theories about power and relationships in healthcare, and complexity theory.

Opportunities are taken to contrast the data with recent findings from a national review of the acute mental health services provided by 69 UK mental health Trusts in England (Healthcare Commission, 2008). Both the ICP and non ICP Trust took part in this review which claims to be the most comprehensive examination of this episode of care that has been undertaken. The Healthcare Commission data include findings about a number of activities that are reported in this study.

The chapter concludes with a summary of what has been gained by a holistic understanding of how an ICP is used in mental health practice, and the main theoretical propositions that have been gained a discussion of the limitations of the study, the significance of the study and recommendations for mental health practice, education, management and research.

19. Experiences of the ICP

19.1 The Perspectives of Nurses

Data from the interviews acknowledges that all the healthcare professionals interviewed were aware of the ICP. However, their involvement with it varied by professional discipline. The nurses and (to a lesser extent) the social worker described using the ICP as a schedule to follow or as a place to record care given, and with less frequency for variance reporting. These impressions are similar to those reported in Hendricks et al's (2008) study of 11 ICPs implemented in a Singapore Psychiatric Hospital. They highlighted that staff felt the ICPs were useful as a checklist, although less than half used the ICPs to support clinical decision making. In this study there are no impressions which suggest that the ICP directs the interventions of staff beyond reminding them that activities need to be completed.

Chan and Wong (1999) specifically studied nurses' use of an ICP for schizophrenia at a hospital in Hong Kong. Their findings were similar to this study reporting that the ICP helped them deliver interventions within key timeframes. This case study makes clear that the nurses interviewed were supportive of the ICP as a concept, seeing it as potentially helping to reduce variation in practice and making clear expectations about interventions. Perspectives suggest that whilst using the ICP, nurses still felt able to offer patients choice and accommodate individual needs. The favourable response of nurses to ICPs may be explained by the protection that is afforded by a task based system. Menzies (1998) describes how the functioning of nurses is influenced by several factors. These include their role as a care giver as well as the environment, relationships and available technology. Alongside these there are the nurses' needs for social and psychological satisfaction, and the relief of their anxiety. It is suggested that at the core of a nurse's anxiety is the relationship with the patient, and the closer this relationship is - the more anxiety the nurse will experience.

It is possible that the schedule of an ICP, broken down into a list of tasks, directs the activities of nurses into an overall approach. They can therefore use this rather than any depth of individual engagement with the service user and their illness, to determine what care needs to happen. This distance reduces the anxiety on the part of the nurse, and can significantly influence the experience of receiving care. Menzies (1998) suggests that such systems depersonalise the patient and eliminate the distinctiveness of both the patient and the nurse. Indeed an ICP does operate to ensure that groups of patients do receive standardised interventions, with the aim to reduce variation within care delivery. There is an inherent drive against distinctiveness and personalisation. ICPs fit with the analogy that the way that a patient is cared for is 'determined largely by his membership of the category patient and minimally by his idiosyncratic wants and needs (Menzies, 1998 p207)'. It is arguable that the reduction in individual distinctiveness associated with standardised care is then suited more to an operational policy of detachment.

This can be further considered applying the theories around emotional labour, and the skills and work in the social regulation of feelings. Strauss, Ehrlich, Bucher and Sabshin (1998) detailed the debates about the organisation of comfort, sentimental and medical work with a focus on the family, organisation and paid work. James (1998 p219) outlines that emotional labour 'is hard work, and can be sorrowful and difficult. It demands that the labourer gives personal attention which means they must give something of themselves, not just a formulaic response'. Use of standardised approaches to care do raise questions about the place of emotional labour in mental health care, and whether this fits with regulated views about what should happen within the care process. It is relevant to consider whether caring in an emotional sense including personal attention, warmth, involvement and empathic understanding have a current organisational place.

Over time emotional labour has been associated with low pay, low status and the work of women (James, 1998). An emphasis on the more technical approach as in ICPs (Peet and Wakefield, 2002) may be felt as a status improvement for nurses, whilst representing a move away from the labour of emotional care giving. Although this can be contrasted with the findings which suggest that few of the technical interventions within the ICP are being offered for example, formal psychological interventions. These are not described in either the accounts of healthcare professionals or service users – and they would be significant evidence of technical professionalisation.

19.2 Impressions of other Professions

The differences between professional groups are very distinctive in this case study. Use of the ICP as described by the medical staff, physiotherapist and Occupational Therapists (OTs) are considerably different to that described by nurses. In the main non nurses said they used the ICP for the purposes of information gathering and the data offers a number of possible explanations for this. For example, the OTs felt that the ICP did not adequately describe their interventions. There were two features of this, one of which has been explored by Duncan and Moody (2003). They suggested that OTs struggle to articulate their contribution to care pathways and that there is a general lack of evidence to support their interventions.

Similar findings were reported by Simpson, Bowers, Alexander, Ridley and Warren (2005) in their study of multidisciplinary working and occupational therapy on acute wards. Their study explored relations between occupational therapists and other members of the multidisciplinary team through structured interviews with 47 staff on 14 acute psychiatric wards. It was found that nurses and psychiatrists appreciated the role of occupational therapy but did not understand the extensive range of OT interventions that could be offered. In this study the OTs felt that their interventions were not being sufficiently recognised but that it is possible to express these. The other aspect described by the OTs is the suggestion that they operate within a general framework, but that the interventions they offer are highly individual dependant on their assessment of each patient. Consequently then it would be challenging to predetermine interventions for the mass of patients accessing acute inpatient care. This corresponds with Jones' (2001a; 2001b) action research findings about individualised care and how it is difficult to articulate complex patient journeys in the format of an ICP.

The findings in this study clearly suggest that the medical staff were not supportive of using an ICP, viewing it as bureaucratic and inflexible. One consultant was momentarily supportive but then went on to suggest many reasons why she felt ICPs could not be effective and that they and other approaches to standardising care have negative impacts upon professional decision making and individualised care. These impressions are not new and mirror those expressed by Olsen (1994) and Iglehart (1996).

In this case study it was the unanimous impression of the medical staff that mental health care needs to be individual, and not standardised in the way that the ICP suggests. They expressed strongly that if the ICP were closely adhered to then this would have potentially negative consequences. Their dismissal of the ICP is underwritten by the current social structure whereby doctors retain control over diagnosis and treatment (Morrall, 1998). A body outside of the medical professional (i.e. an ICP) suggesting how doctors operate opposes the way that medicine has maintained its own province and boundaries, with the profession dictating what doctors do. A neo-weberian perspective suggests that the ICP is a potential threat to the power that medical staff have over service users, other professionals and new recruits (Rogers and Pilgrim, 1994).

Considering this further Hearn (1987) outlined how the medical profession has a history of domination, and of defining the emotional work of other healthcare workers. Whilst there may have been some shift over time, findings in this research note that this dominance remains. The doctors interviewed barely acknowledge the ICP, and other healthcare professionals, service users and carers described that clinical decision making remains medically focused. The dominance of the medical profession as an institution of social control has been widely documented (Gillespie, 1995; Morrall, 1998; Zola, 1998; Clarke, 2001). Zola (1998) describes how medicine has been major agency of social control, where by medical professionals make absolute and final judgements that have become inextricably woven into modern society. Psychiatry in particular has seen this through the exercising of legal powers of the state allowing involuntary commitment and the removal of certain rights and privileges for people deemed as ill and requiring treatment.

The consequences of this power and position has been overwhelming monopoly and freedom to act, which is now under considerable scrutiny (Craddock, Antebi, Attenburrow, Bailey, Carson, Cowen, Craddock, Eagles, Ebmeier, Farmer, Fazel, Ferrier, Geddes, Goodwin, Harrison, Hawton, Hunter, Jacoby, Jones, Keedwell, Kerr, Mackin, McGuffin, MacIntyre, McConville, Mountain, O'Donovan, Owen, Oyebode, Philips, Price, Shah, Smith, Walters, Woodruff, Young and Zammit, 2008). In the case of the ICP there is the anticipation that medical interventions are pre-defined and sit alongside (rather than dominate) the contributions of other disciplines. The ICP suggests that the work of doctors can be defined by others (i.e. the institution), whilst conversely doctors maintain the legal supremacy, professional autonomy and generally the authority to control the work of others. This possibly places an ICP and the institution which is directing its use, in a weak position. Morrall (1998) acknowledges how the medical profession has not been easily influenced by managerialism, still maintaining autonomy over their discrete area of work.

The potential consequences of this medical autonomy and control enable doctors to disregard the interventions that the ICP suggests. There are also indications that doctors also discount the interventions that it suggests of others, using the 'ward round' for decision making and not applying the assessments of others in formulating care. Strauss et al (1998) acknowledge that within hospital settings there is a negotiated order amongst professional disciplines. Each professional group achieves a specific hierarchical position and this plays a part in the division of labour. Fiddler, Borglin, Galloway, Jackson, McGowan and Lovell (2010) highlight how service users remain dissatisfied with current once a week ward round practices and that now this is being replaced by daily reviews, in order to make care more responsive. The traditional ward round was suggested to have provided a safe structure, although Hodgson, Jamal and Gayathri (2005) acknowledged that there has been no discernable links made between ward rounds and clinical outcomes or indeed individualised care.

Also within professional groups as reported in these findings, there can be considerable variation in the philosophy and the ideology of individuals (Strauss et al, 1998). Strauss et al (1998) report that within a mental health care setting there should be a common goal for what should be achieved as a consequence of care. However, although there is often considerable ambiguity about how this is to be achieved. In this case the ICP has done little to suggest agreed outcomes, and the care process involves much more variation and negotiation than the ICP content acknowledges. The determination of outcomes seems influenced not only by professional experience and knowledge of the patient, but also by the perspective of each discipline. Consequently, whilst the overall stages of the pathway are described by everyone, there is far less consensus about the interventions that will be provided.

19.3 Consensus and Integrated Working

The findings in this study highlight that there is little evidence of integrated working within the setting studied. Particularly the nurses highlight that often there appears to be no consensus around the aims of care and interventions to be provided. Medical staff, the physiotherapist and occupational therapists complete their own formulations to decide on an individual basis the interventions to be provided. Whilst service users and carers articulate that their care appears to be based on the values, interests and skills of the individual practitioners involved.

The findings in this study highlight that it is discussion between services users and healthcare professionals, and individual assessments that determines what care will comprise. These findings are similar to those found when evaluating the application of clinical guidelines (Kramer, Danielas, Zieman, Williams and Dewan, 2000; Tiemeier, De Vries, Van het Loo, Kahan, Klazinga, Grol and Rigter, 2002: Parker, 2004). Tiemeier et al (2002) studied adherence to clinical guidelines for depression in the Netherlands. It was found in their study of 264 healthcare professionals who outlined proposed care for 22 case vignettes, that 31% of interventions were not consistent with the clinical guideline. It was found that there was considerable variation in the interventions posed according to professional group, but less variation within psychiatrists as a single professional group. Likewise Parker (2004) reported that clinical guidelines are not sufficiently precise to support clinical or evidence based practice. Whilst Kramer et al (2000) reported considerable variation in the care for over 5000 people with depression attending 6 psychiatric clinics. All these studies acknowledge variation by individual practitioners and interventions based upon individual assessment, rather than the consensus of a pre-agreed guideline.

Harrison (1998) reported that there has been opposition to guidelines because of the link to rationing, and that the public prefer to see clinical decision making by professionals rather than the state or government. Harrison (1998) also cites that the medical profession still retains the monopoly for clinical decision making. He describes that doctors clinical practice is more likely to be influenced by experience with patients, views of colleagues and by their own reasoning rather than published guidelines. Reference is made to the habit of doctors being influenced by memorable cases and the individual ethic of medicine. Many of these perspectives are similar to those shared by psychiatrists in this study.

The psychiatrists' preference to base practice upon individual assessments can be considered from a numbers of perspectives, and a clear one is that this maintains the status quo and the existing power relationships between the parties. As suggested previously, psychiatrists have longstanding power associated with their role within society (Freund and McGuire, 1991). Also given that behaviour in relationships is regulated through a number of mechanisms including social status and class, the role of the ICP could potentially have a moderating effect on these influences and the social relationship, giving all parties a clear expectation about interventions and standards for care delivery which are explicit. Rather than as the findings describe leaving this at the liberty of individual relationships.

Particularly the work of medical staff in setting norms and social control gives them an authority which takes precedent over the ICP, the views of other healthcare professionals and at times the wishes of service users and carers. In this case study it is clear that the medical staff maintain the power to define illness and consequent treatment. They have not allowed the ICP to have a function within this. In relationships the medical staff maintains its autonomy and authority by their exclusive role and control of technical knowledge. Their rationale is that they at times must use this to represent or oppose the views and wishes of service users (and others). Freund and McGuire, (1991) confirm that medical assessment determines care and directs the work of other members of the team. That still very much remains the case where this ICP exists.

In relation to this Atwal and Caldwell (2002) questioned whether integrated care pathways do in fact improve inter-professional collaboration. Their action research study in an orthopaedic setting found that whilst the ICP they implemented had a positive impact upon outcomes, it had no discernable impact upon inter-professional relationships and communication. Defining effective integrated working by good communication, teamwork and commitment to delivering integrated care – they measured a number of indicators associated with inter-professional collaboration and found little evidence of any impact. Issues around inter-professional conflicts related to patients' goals were still evident, as were failures to accept the assessments and judgements of others. Their findings like this study suggested that variations in individual clinical practice continued to cause delays in the patient journey.

As suggested previously the issues underpinning the lack of integrated working are longstanding and deep rooted. Keen (2003) reports how mental health nurses have yet to assume a strong professional identity and Coombes (2004) talks about the rise of nursing within general management and policy making. Coombes (2004) writes that the current conflict between doctors and nurses is vested in the processes of clinical decision making that are used and the hierarchies of knowledge that inform these. She proposed that with relevance to mental health nursing, psychiatry and medicine remains better supported by empirical evidence. Also that clinical decision making does have a historical hierarchy. The ICP studied in this case has not changed this dynamic.

Traynor (1999; 2007) who studied the dynamics between nurses and managers in the late 1990s described the stance of nurses as moral and self sacrificing, in the face of exploitation by their managers. Traynor (2007) relates this more recently to a conflict between the moral discourse associated with nursing and the emerging scientific trend around evidence based practice. Interestingly the nurses in this study tended to be in favour of the ICP, which may indicate a leaning toward the influence of managerialism as Traynor (2007) suggests. Whilst in the same discussion Traynor (2007) noted that within medicine there has been a rebuke against evidence based medicine and claims made about the loss of the art of medicine. This suggests that the professions of medicine and nursing may be pushing in opposite directions against both science and the ICP.

Considering the dynamics between doctors and nurses further, Simpson (2007) reported similar findings to this study in his research of team processes in psychiatric case management. The multiple case study of seven community mental health teams in the UK suggested as had North, Ritchie and Ward (1993) previously, that nurses lack the status, power and authority to influence the work of others. With the use of this ICP there was no suggestion that this perception has changed, and that claims around close integrated working are unfounded. Interestingly Simpson (2007) reported that in teams where the use of structures and processes were high this appeared to benefit teamwork and care coordination. If the ICP is considered to be enhanced practice around structure and policy, the same benefits have not been realised.

Simpson (2007) reported that staff shortages were a factor that influenced the application of policy and process. It is not clear in this study the extent to which staffing levels influenced the use of the ICP. Simpson (2007) reported that in difficult circumstances it would be the psychiatrists who would attempt to resolve problems, sometimes resorting to their position of authority or their own personal influence (Simpson, 2007). This could then manifest itself in resentment by other team members, and that same hierarchical influence was found in this study. Factors suggested to improve interdisciplinary working reported by Simpson (2007) were the sharing of skills, recognition, feeling secure, consultation and valuing of people's contributions. These appear to be cultural and interpersonal factors upon which the ICP has not had any influence. The discouraging effects of the lack of integrated working described by Simpson (2007) and in this study are clearly concerning.

19.4 Impressions of Service Users

When service users describe their experiences of the care pathway, they base the sequence of events upon the same main stages as the healthcare professionals in terms of admission, care after admission and preparation for discharge. High level descriptions of the admission process are congruent with both the activities described in the ICP and the descriptions of healthcare professionals. After the admission stage service user's descriptions then become less aligned to the activities in the ICP. Only one of the service users described having an activity programme, one to one interventions focused towards recovery, psycho-education and help with problem solving. This is supported by the information from the documentary analysis where activities after the 72 hour point of the ICP and direct care activities were less likely to be completed.

Whether admission is routinised and the care after this stage needs to be more individualised, can be debated. However, it is noticeable that the small sample of service users and their carers, generally suggested that they experienced a dearth of activities after admission, rather than a range of individualised interventions. This does detract from the impression that the ICP is not being adhered to due to the preference to deliver individualised care, as this is not what is being expressed by service users.

Assumptions have been made in the ICP literature about increased satisfaction, improved involvement and education being the lived experience of service users (Brett & Schofield, 2002; Nott, 2002). These potential benefits cannot be identified in these findings. The experiences of two service users are distinctly different to others involved in the focus groups. One was fully aware that she would be in hospital for a limited time and knew exactly what would be achieved before her discharge. Another viewed all aspects of her care very positively across the whole ICP. For all the service users and carers the most common positive experience was the promptness of the follow-up care, although data from the diary of the carer did differ significantly from this. With the exception of the service user who described her experience of the ICP very positively, there was the tendency to describe the experience of the ICP in terms of what people felt didn't happen that should have, alongside environmental factors and interpersonal relations. Although this case study used a different research method, the impressions of service users in this study did not corroborate Nott's (2002) findings of increased satisfaction associated with the use of an ICP for acute inpatient care. Overall, there was little to suggest that on the part of service users there was a standardised or satisfying experience of the ICP.

Variation in service users' experience also showed through in impressions about involvement in care planning. Some described writing their own care plan, or completing it with healthcare professionals. Other impressions were not being involved in writing the care plan or never seeing the care plan. If the care plan exists within the ICP as a way to provide individualised interventions or to support involvement it would seem that this is ineffective. This is further supported by the findings about choice and involvement in which service users described their experiences of choice in matters not related to treatment or interventions, but about environmental factors. They described that decisions about care were made almost exclusively at the ward round and were led by medical staff. This type of narrative reveals important features about how the ICP is not being used and experienced.

In the main service users and carers did not perceive their care as being individual to them. There was a feeling that attention given to them as a unique person did not feature highly, and that care did seem to be based upon broad standards or patterns. The broad standards were not perceived positively as something that may protect service users from poor practice, but as a feature which did not consider them as individual people, with distinctive needs. It is notable that in the documentary analysis less than half of the ICPs contained individualised care plans and even fewer had the specific parts of the ICP completed where it is asked that individualised interventions are considered. Peet and Wakefield (2002) acknowledged the need to consider issues like individualised care and particularly the features of the therapeutic relationship within ICPs. Although where this ICP can accommodate such individuality these opportunities were not exploited.

Whilst there is a longstanding critique of medical domination, potentially the same appraisal can be levelled at ICPs as a structure that may detract from care being service user focused.

Within mental health there is a strong focus on the knowledge of service users as consumers and how this should influence care (Floersch, 2002). In a Fordist regime ICPs can be seen as production line mentality within healthcare (Burrows and Loader, 1994). A system of managed mass production using standardised processes and products can be closely contrasted with the way that an ICP is intended to work. If ICPs are seen as large scale, inflexible and bureaucratic then meeting the needs of individual service users arguably seems to require less centralisation. Personalising care delivery is clearly important to the service users and carers in this case study, and despite the ICP health professionals have maintained the discretion and control over the their work to be able to in principle, afford a degree of individualisation.

19.5 The issue of Relationships

Using an ICP to pre-formulate the care that people will receive potentially changes the dynamic that exists between healthcare professionals and patients. Self care and patient participation have been encouraged over recent decades (Clarke, 2001) to have positive impacts upon experiences and outcomes. Whereby service users wish to have a mutually participative relationship with professionals involved in their care, using the ICP in a pre-described way may encourage a passive response from service users. As in, this is what the care pathway suggests should happen, and this is what will be offered. The ICP potentially becomes the dominant party. However, in this case the experiences of the service users and carers vary so much it can be assumed that the ICP is not having that effect. The findings give the impression of significant variations i.e. the OT describes delaying involvement due to someone being too ill, one of the medical staff describes how social factors like housing and family members influence how long someone is in hospital and their recovery, and a carer suggests that she would not wish for her husband to be pressured into occupational activity that is the same was as other people might wish. What does happen during the care process as Hollender and Szasz

(1956) explain is determined by the relationship between health professionals and patients, and varies according to the extent of illness and individual circumstances.

Gillespie (1995) describes how the interaction between professionals and patients is of the utmost importance. The quality of these interactions does feature highly in the data from the focus groups. Whether this communication was effective and if people felt that their needs were understood were significant issues. This included if people were involved in organising their care, making decisions and whether they felt informed. It was suggested that the way that care is delivered tended to stem from assessments and 'ward rounds', rather than a view that they were following a specific journey. There was no sense that the ICP had assisted in achieving a mutually participative relationship between professionals and patients. The doctor still being seen as the expert (Hollender and Szasz, 1956) and services users feeling obliged to cooperate. In the focus group data there are suggestions that service users and carers felt that they had limited control. This could be interpreted as the paternalism associated with the sick role and a traditional form of medical encounter (Gillespie, 1995). This ICP has not shown that as a process it has been able to operationalise the role of the service user in decision making, and bring about a stronger sense of consumerism.

The impressions of the service users reported indicate that their care seemed to be dependant on the individuals involved and their relationship with them. Rather than, as an ICP suggests the interventions, interpersonal care or activities being available or delivered regardless of which professional is available. So to an extent this detracted from standardisation, where more noticeably after the admission period services user experiences would be dependant upon the individual staff rather than any standard within the ICP. This is portrayed in descriptions of some professionals intervening when others would not, some of these acting in different ways and frequently waiting for decisions to be made at the ward round. Given that one of the anticipated benefits of ICPs is about reducing variation (Pearson et al, 1995; Thornton, 1997; Dykes, 1998; Hall, 2004a) this brings into question whether its aims are being realised. Much of the development of mental health ICPs has been associated with clinical governance, risk management and the implementation of evidence based practice. Considering the experiences of healthcare professionals, service users and carers it is difficult to offer evidence to verify that the ICP is being used to reduce variation, beyond functioning as a checklist.

Freidson (1970) identified that there have been longstanding discrepancies between the expectations of organisation, service users and professionals. He described how there could often be a difference between the expectations of patients and professionals with a degree of resultant conflict. Whilst the ICP asks for a standardised approach, this does detract from some of the fundamental functions of the professional-patient relationship. What the institution suggests as the care that should be given via an ICP does not take into account the expertise that parties accumulate about their own experiences of health and illness (MacIntyre and Oldham, 1984). Similarly, the ICP does not consider where there might be conflict between what the service user may feel they need, what the organisation suggests should occur in the ICP and what the professional involved feels is the correct approach. The ICP rather suggests that patients and professionals will move along as passive recipients.

It has been suggested that what goes on in lay-professional interactions reflects wider social relations and structural inequalities, especially those of gender, race and class. 'And related to this, such relationships and the values perpetuated within them, form key dimensions of social control and regulation (Nettleton, 1995 p131).' There remains the possibility that health professionals neglect to take the view of patients seriously and this remains a significant limitation of contemporary formal health care. In the accounts of professionals and service users in this case study the care process is described as evolving from the professional-service user relationship. So there remains the potential that the social influences i.e. gender, race, class, social control etc are of more primary influence than the ICP. The ICP from a lay or professional perspective potentially interferes with the status quo. Albeit, that it has been the longstanding role and obligation of doctors to determine what is right (Parsons, 1951) and it possibly satisfies both parties not to change this by fully utilising an ICP.

There also is a potential for an ICP to follow a disease model, with a precise set of decision rules for proceeding and governing the actual therapeutic intervention. Whilst the ICP can outline decision rules, it cannot define the social judgements that are made within a therapeutic contact. Freund and McGuire (1991) describe how miscommunication and depersonalisation can occur when there is a predominant focus on the illness and not the person. A focus on the technical leads to professionals losing sight of the person and an inadequate understanding of their needs. That may be the basis of some professional's reluctance to use mental health ICPs – although it cannot be substantiated if this would differ for other methods of managing care. The ICP does operate on the premise that people accessing the ICP will have similar requirements. Although the relationships that people have and their views give the care process very different meanings.

19.6 The influence of Social Structures

The social structure within which this ICP existed reflects the continuation of medical dominance (Nettleton, 1995). The psychiatrist maintains the power and authority for decision making and is more influential than the ICP. Service users and carers are more generally experiencing the psychiatrist's view of what their pathway is, as opposed to that which is in the

ICP. It is of course possible that the pathway offered by the individual psychiatrist may be superior to that outlined in the ICP, which as one service user describes in the findings may have indeed have been the case. Reviewing the literature there is no evidence to suggest that other mental health ICPs have replaced the traditional form of decision making that occurs through the therapeutic relationship and the 'ward round' process. Even studies that have evaluated the impact upon length of stay (Morgan et al, 1996; Nott, 2002; Kazui et al, 2004; Emmerson et al, 2006) do not include sufficient detail to suggest how clinical decision making is managed within the ICP. There is no evidence to suggest from the literature and the findings of this study that mental health ICPs are used for this purpose, nor have they impacted upon professional dominance.

Carers on the whole did not feel that they were positively involved in the ICP. The impressions of carers would support the documentary findings about lack of carer's assessment, involvement in risk management plans, care and discharge planning. These are also echoed in the Healthcare Commission's (2008) review of acute inpatient care, in that almost a third of care records did not record whether or not the service user had a carer, and staff generally had little interaction with carers. It would seem that the findings in this study are similar to experiences in other acute inpatient settings, and that the ICP has not had a differential impact on the experience of carers. This would suggest that the way in which the ICP is used is failing to locate the person within their social context, and is seeing the person only as they exist in the inpatient environment. Given that it is repeatedly asserted that health is inextricably associated with social factors (Nettleton, 1995), this would seem a significant weakness. Writers like Nettleton (1995) document the influence of social class, income, lifestyle, housing and health behaviour upon health inequalities. The ICP is either not sufficiently detailed or designed to recognise people's own interpretations of their illness, or their social context and embed these into the care pathway. The risk then is that the service user and carer are viewed passively as an object moving along a journey, rather than actively being regarded as individuals with the complexity of what is their life.

Illich (1976) suggests that the dominance of biomedicine has led to carers becoming deskilled and dependant upon experts. Indeed the description from the diary of the carer would suggest that whereby a carer tries to influence interventions and decision making this is not always successful. This carer appeared to be in the position of having responsibility for significant aspects of his wife's care – but had little authority or influence in decision making. There is the impression in the diary and in the verbatim data from carers that decisions do seem predetermined to an extent. There are pivotal decision points which they observe to happen but they feel that they have little involvement in. Whilst it has to be acknowledged that the qualitative data from carers came from only a small number of people – it questions how consumer orientated or paternalistic the delivery of care is.

Given the experience of service users and carers the impact that an ICP has for them as a stakeholder group is complex to explain. ICPs are to an extent prescriptive and institutionally determined which can be considered as inherently paternalistic. Whilst the content of the ICP includes the interventions that aspire to service user and carer involvement these are not frequently implemented. It is these aspects that could seek to improve professional and service user (and carer) relationships. There is a sense though that the medical views remain privileged. This does not fit with the consensus view of care managed by ICPs, in which the medical profession is one of a multidisciplinary team and the ICP is pre-fashioned to follow an already agreed journey. On the one hand this can be seen as critical of the extent of medical dominance. But conversely, if the structure of the ICP is not sufficient to ensure that service users' needs are being met, then exercising professional dominance to address this may be seen as acceptable.

A consequent question is posed about the paternalism of pre-formulated care and how this may or may not be advantageous. Indeed even placing mental health ICPs in a framework of illness engages debates about the social construction of mental illness (Ingleby, 1980). Although this ICP does not consider a specific diagnosis, many do. Individuals and groups influenced by anti-psychiatry and anti-stigma principles would see either the dominance of medicine or the institution, as incongruent with their position. Freidson (1970) questioned the autonomy and power that medicine has and its position in society. These findings do highlight that the ICP is significantly influenced by each individual's doctor's application of medical knowledge. That means that the variations in the care process are not reduced and the position of the service user and carer within the care pathway varies according to the individual practitioners involved. ICPs do rely upon a single and coherent view of the care process, whilst in reality there is often no unified view of what that could be a consensus for one individual service user.

The form and function of this ICP has not impacted upon the existing social order. If an ICP is viewed as a method of corporatising medicine then its use would see doctors lose some of their longstanding autonomy. Freund and McGuire (1991) suggest that there are moves towards counter-dependence between doctors and healthcare organisations, but that the medical profession retains a monopoly over complex skill and knowledge. It can be argued that the authority of doctors remains a powerful source of advocacy on behalf of patients. Whereby organisations may be dictating reductions in services and interventions, which may not be in the best interests of service users.

There is though an emerging acknowledgement that the distributing the responsibility for providing care in a more interdisciplinary style of working is potentially threatening the position of psychiatry in the UK (Craddock et al, 2008). Some psychiatrists have described what they see as a downgrading of medical care in favour of more non-specific psychosocial support, ultimately reducing contacts and time that doctors are involved with patients. They see this distributed arrangement as compromising evidence based practice, increasing risk and devaluing the role of psychiatrists. This serves to substantiate further the medical staff response to this ICP seeing it as a method for achieving dispersed responsibility. Even though the ICP does acknowledge medical interventions it is clearly an unwelcome accountability framework for medical assessment and interventions. Not surprisingly Craddock et al's (2008) paper attracted a plethora mixed commentary and did emphasise the insecurities that the medical professional currently faces, although these have not been evident in this case study.

20. The Process and Outcomes of the ICP

20.1 The Care Process

The findings from the documentary analysis suggest that on average just over two-thirds of the interventions in the ICP (67.2%) were implemented. These data consider whether each intervention was delivered, regardless of the responsible professional or time in the pathway. Whether it was delivered or not was established by determining whether there was documented evidence of its completion in the ICP. Corresponding with the verbatim data the interventions in the first 24 hours of the ICP were completed more than during the other time periods of the ICP. Suggesting that much of the care during this stage is to a degree standardised. It is notable that after this period and up until preparation for discharge the interventions are less consistently offered. Follow-up of physical tests results, detailed mental state examination, being visited by the care co-ordinator, interventions provided by OTs and physiotherapy, service users being given information about their illness and having an activity programme for example, are poorly completed. Following on from this the activities in the pre-discharge period that suggest service user and care involvement are less frequently implemented. For example only 35% of ICPs included evidence that the service user had a copy of their discharge plan.

It is acknowledged that as described within the methods chapter certain caveats exist about this source of documentary evidence (Finnegan, 1996). It is assumed that the interventions signed as completed in the ICP have been offered – and this for a number of reasons may not be the case. The recorder's interpretation may be the result of a taken for granted routine, or influenced by inner feelings without awareness of these. There are also indications in the findings that professionals have rarely recorded variances from the ICP. These certainly have not been recorded as sufficiently as suggested by the number of interventions completed. So conversely it would be unwise to say that the reported interventions completed is absolute.

Contrasting this with other studies that have considered whether the interventions planned in mental health ICPs are delivered is possible, particularly as Grant et al (2005) considered an audit of the ICP in this case study. At the time of that study it was found that on average 73.6% of 7 particular standards within the ICP were implemented. Although Grant et al (2005) used a much smaller sample of ICPs and fewer interventions were considered. The results from this study, albeit that the sample was drawn from a later period, are consistent with the level of implementation suggested by Grant et al (2005). Grant et al (2005) also reported that interventions later in the ICP were more likely to be delayed. In this case study the intervention most likely not to be completed within the suggested timeframe was the review of the results of physical tests to be completed in the third day of admission. This activity was a particular outlier in terms of timeliness.

It is possible to compare rates of completed activities with other Trusts in England by using the findings from the Healthcare Commission's (2008) review of acute inpatient care. The rate at which patients had their capacity assessed and consent discussed was much higher in this study (91.7%) than the average reported by the Healthcare Commission (just over 50%). In this case study the ICPs had carers details recorded in 91.7% of cases, compared to an average of 16% in the national review. The national review indicated that 59% of patients had a comprehensive assessment recorded, compared to 91.7% in this study. In this study 78.3% of patients had a physical examination in the first 3 hours of their admission, compared to 86% in the Healthcare Commission review. The rate at which people were visited by their care coordinator in this study and the national review were similar (36.7% and 33% respectively). In the overall national ratings the ICP and non ICP Trust both scored 3 (Good) for their overall assessment. For the effective care pathway criteria the ICP Trust scored slightly better (Good - 3) than the non ICP Trust (2 - Fair), whilst they both scored the same for individualised whole person centred care (3 - Good). The case study findings suggest a better rate of completion in the ICP Trust than in the national average reported by the Healthcare Commission (2008) for 3 out of 5 comparable standards.

Bultema et al (1996) considered four quality standards pre and post their implementation of an ICP for depression. One possible comparison can be made to an activity completed in this study. From a small sample of 12 patients Bultema et al (1996) reported that all the patients on the ICP had had their medical history and physical examination completed on admission. This compares to 78.3% having had a medical assessment of their physical health within 3 hours of admission for this ICP and 95% having had an initial mental state examination within 24 hours. Comparisons cannot be made with the other 3 quality standards as these interventions do not have equivalent activities within this ICP. The same can be said of the studies by Repper-DeLisi et al (2008) who considered compliance with 6 standards in an ICP for alcohol withdrawal. On average they reported that the standards were completed on 62.9% of occasions for the 40 patients considered. As a rate of completion this is comparable to the findings in this case study, although the individual interventions as they relate to alcohol withdrawal cannot be compared to specific activities in this ICP.

Hanson et al (2006) considered whether activities in an ICP for early psychosis had been implemented for a group of 33 patients. They examined four variables which focused upon whether patients and their families had contact with aftercare providers before their discharge from hospital. Fifty-nine percent (59%) of patients and 45% percent of families had had this contact. This can be contrasted with 50% of service users in this case study having been visited by their care coordinator prior to discharge, 41.7% having had a copy of their discharge plan and 20% of carers having being given a copy of that plan. Although as service users in this case study would be older that may be an influential factor in the variation in carer involvement. Hanson et al (2006) also considered whether patients received education about their illness, which happened with 100% of patients on the early psychosis care pathway. This is significantly higher than in the case of this ICP in which only 36.7% of service users received this type of intervention. Hendricks et al's (2007) study of an ICP for schizophrenia also considered the likelihood of patients on that ICP receiving psycho-education suggesting that this happened for 98% of the 307 patients who accessed that pathway, again this is much higher than in this ICP.

Mynors-Wallis et al (2004) reported on a controlled evaluation of an ICP for acute episode psychosis and the achievement of 45 care standards for 30 patients who had been cared for using the ICP. Of these standards 21 reflected assessment activities and 24 concerned particular treatment interventions. A number of these can be compared with activities in this ICP. For example, Mynors-Wallis et al (2004) suggested that 97% of patients on that ICP had a risk screen completed, and that happened for 96.7% of cases in this study. They reported that 63% of patients had a physical examination compared to 78.3% in this study. That 43% of patients had had at least 2 education sessions about their illness, and 27% had been given written information, compared to 36.7% being given information about their illness on this pathway. Mynors-Wallis et al (2004) reported that 80% of patients on the pathway had an individual care plan, compared to the 71.7% in this study. Overall they reported the findings of compliance with 20 of the 45 standards for the full sample of patients with an average completion rate of 55.35%. With the exception of the care plan compliance with the standards achieved by this ICP were significantly higher.

These findings highlight (similar to others studies) that the use of variance reporting is minimal and that this function of an ICP is little used. The perceptions of healthcare professionals suggest that they are unsure about how to record variances and that where this is completed the information is not used for onward action. Many of the early descriptions of ICPs (Riley, 1998; Dykes, 1998) emphasise the use of variance tracking as a critical function. It is described how this is used to reduce variation, highlight risk or unmet need, indicate clinical deterioration, identify any failure to meet standards and that the information is used for ongoing quality improvement. In the case study the impressions of the healthcare professionals suggest that it is poorly used. One of the respondents went so far as to suggest that she would be concerned about how this information may be interpreted; whether it would be used constructively to address weaknesses in provision or as a critical tool solely for performance management. The findings from the documentary analysis suggest that just over half of the ICPs included recorded variances. On the basis of the variance information alone it could be determined that the remaining patients received almost every intervention on the ICP. However, given that the average rate of completion of interventions found was 67.2%, clearly this is not the case. The variance information is incomplete and a good deal more variances are in fact the reality. Subsequently there is no evidence to suggest for example, that the infrequent provision of psycho-education is reported as a variance, and that any action is taken as a consequence.

An absence of variance reporting was also reported by Mynors-Wallis et al (2004) who proposed that for the 36 patients on their pathway only 65 variances were reported. Their impression was as in this case is that variance reporting and tracking functions are not properly embedded. Variance reporting does not feature prominently in evaluations to date. It has been described as a feature of ICPs which healthcare professionals have not always fully understood or engaged with (Hall, 2000). Like in this case study Hall (2000) previously described the perceptions of healthcare professionals towards variances, as being generally reluctance to record them and having anxiety about acknowledging when they are unable to deliver interventions under particular circumstances. There was the original proposition that using an ICP and recording by variance could replace long hand written narrative records. Given the extent to which variances have been recorded this streamlining of documentation and the shift to exception reporting has not been achieved in this case, and concurs with Brown et al's (1998) suggestion that healthcare professionals have not accepted ICPs as an alternative form of documentation.

Whether any other factors influence the completion of activities on the ICP was considered according to the gender, age and length of stay of the service user. Gender was not found to have any influence upon the likelihood of interventions being received. However, the older a service user or the longer the length of stay the more interventions were completed. With regard to length of stay, clearly some service users had not remained in hospital for a period long enough to complete the ICP and therefore the interventions later in the ICP were not implemented. That accounts for some of the drop off rate for the interventions later in the ICP. There is not such a ready explanation though related to age, as the findings suggest that older service users did not remain on the ICP significantly longer. Whether older service users are more engaged in the ICP (and their care) might be the case, but has not been specifically considered.

Considering whether the likelihood of receiving interventions varied between consultant psychiatrists or by Trust locality did reveal significant differences. These findings support the earlier suggestions that the ICP has not been used to the extent of reducing variations across different professionals or locations. No other research findings consider the impact of these factors upon ICP delivery. The theory about ICPs reducing variation is again contested. Although it is acknowledged that many variables may influence the likelihood of interventions being delivered like staffing levels, access to specialist therapies, the health of the service user, diagnosis and so forth. It should also be acknowledged that there is a possibility that care recorded as given on the ICP, may, for a number of reasons, not have been the care delivered. However, there is a good degree of concordance between the care documented in the ICP and supplementary evidence of these activities in the healthcare record.

20.2 Impact upon key performance indicators

The findings of the case comparison suggest that when compared to an equivalent care episode the ICP delivers a significantly shorter length of stay. It is worth considering initially how reliable this data source is. The Mental Health Minimum Dataset (MHMDS) was developed in response to the National Service Framework in 2000 and was mandated for all NHS providers of specialist adult mental health services in April 2003. In October 2007 it was approved by the NHS Information Standards Board (ISB) as an inherited standard (NHS Information Centre, 2008). The MHMDS was designed to provide local clinicians and managers with better quality information for clinical audit, service planning and management. At a national level, it is used to monitor the delivery of national service framework priorities, facilitating feedback to trusts and the setting of benchmarks. The Healthcare Commission uses elements of the MHMDS in its indicators for Mental Health Trusts as part of the Annual Healthcheck. However, in 2008 the NHS Information Centre reported that there are still concerns with the coverage, completeness and quality of the data.

In addition to data quality issues a number of factors may contribute to the difference in length of stay (and not merely the ICP). Factors considered are whether there were any significant differences between the service users in the samples used for comparison in terms of age, the method of admission, their place of residence, ethnicity, religion, diagnostic group or marital status. There were significant differences in the ethnicity of the patients between the non ICP and the ICP datasets, as well as their method of admission and place of residence. These specific factors were analysed to consider whether they may influence length of stay as a performance measure, and the findings suggest that when the data is considered as a whole i.e. including the non ICP and ICP Trust there is a significant relationship between these factors and length of stay. Although splitting the sample into ICP and non ICP conditions - it is only the place of residence that impacts upon length of stay in both groups. It is therefore acknowledged that the place of residence could explain variation in the difference in length of stay between the ICP and non ICP groups. Given that discharge arrangements were cited by healthcare professionals as the main cause of delays in the ICP, this is a probable factor influencing length of stay. Clearly there are other factors that may impact upon length of stay between the two groups like the budget of the service, access to aftercare and the availability of specialist services. However, discussion with the two organisations and data from the recent review of NHS acute inpatient care suggested no variations in service specifications that might affect performance reported here.

Overall both organisations achieved a level 3 (Good) rating in the assessment of acute inpatient care (Healthcare Commission, 2008). Both achieved the same scores for the individualised whole person care, safety and service user, and carer involvement criteria. However, the ICP Trust scored higher for the care pathway criteria (good as opposed to fair). Any difference in the national review findings that may influence performance on length of stay between the two Trusts was considered, and the following are acknowledged. Both organisations scored the same for the level of workforce on their acute inpatient wards and their work on with delayed discharges. The non ICP Trust scored higher on crisis resolution home treatment gate keeping, facilitation of links with the community and information shared with Accident and Emergency. Whilst the ICP trust scored higher for facilitated early discharge and access to dedicated Section 136 provision. In terms of service models and their influence upon length of stay, no confounding differences therefore could be determined using the Healthcare Commission's (2008) data.

The literature which discusses the impact of ICPs upon length of stay favours a shortened duration associated with their use. Five of the eight studies that consider length of stay report a reduction, two report no difference and the remaining one a longer length of stay. Nott (2002) reported that following the implementation of an ICP for acute inpatient care in the UK the average length of stay for 179 patients was 12.46 days. This is much lower than the 35.91 days reported in this case study, and also the 49.39 days reported in the non-ICP Trust. No explanation of the difference between the length of stay in this case study and the findings of Nott (2002) can be established. The ICP relates to the same kind of care episode i.e. an ICP that was generic and used for acute inpatient care. It may be significant that Nott's (2002) data predates these findings by five years and that the nature and organisation of mental health services has potentially changed over this time. Also Emmerson et al (2006) reported on an inpatient care pathway used in Australia with a much shorter average length of stay than in this case (i.e. 16 days). A study by Hendricks et al (2007) that reports on another acute inpatient care pathway did not report an average length of stay but suggested that over 30% of patients were not discharged within 21 days – so appearing more congruent with this study.

Hendricks and Mahendran (2007) reported the length of stay for patients on seven different diagnostic based inpatient care pathways used in Singapore. The longest average length of stay was for patients on the schizophrenia ICP at 20.1 days. It is notable that Hendricks and Mahendran (2007) reported a wide variation in length of stay across the different diagnostic ICPs. For example the average length of stay for patients on the ICP for major depression in 2006 was 7.7 days. Although in this study there were no significant differences in diagnosis between the non ICP and ICP datasets, diagnosis was considered as a confounding variable that impacts upon length of stay. It was found that diagnosis does have a significant relationship with length of stay in the ICP group, non ICP group and across both cumulatively. In this study like that of Hendricks and Mahendran (2007) patients with a diagnosis of schizophrenia or acute and transient psychotic disorders had much longer average lengths of stay than for patients with other diagnoses.

This finding along with those of Hendricks and Mahendran (2007) offers a potential critique of ICPs that are used for general episodes of care as opposed to specific diagnostic groups. As length of stay has been shown to vary widely in Hendricks and Mahendran's (2007) for different diagnostic ICPs and in this study, this poses the question of whether such a broad ICP can be used effectively – given its significant relationship to diagnosis and the broad range of variation in length of stay. The literature raises caution about using ICPs as an approach to reducing length of stay (Jones, 1996). Whilst clearly in recent years attention has been drawn to their potential impact upon this performance measure little has been said about what may be the most effective model of ICP. Whether this is a broad process based ICP such as the one in this case or an approach that is based upon diagnosis, which seems to have strong links with length of stay as an important parameter of ICPs.

There has been the opportunity in this study to compare readmission rates and the achievement of follow-up within seven days between the ICP and non ICP data, neither of which differed significantly between the two groups. Readmission rates for the ICP group were an average of 3.41% a month over the two year period. That is the percentage of patients readmitted within 28 days of their discharge. This rate is much lower than that reported by Hendricks et al (2007) in their study which specifically looked at patients who had been cared for using an ICP for relapsed schizophrenia. Unfortunately it is not possible to determine the readmission rate for that particular subset in this study – so direct comparisons are not possible.

Emmerson et al (2006) reported on the use of an acute ICP with a readmission rate ranging between 11% and 17% per quarter. Again comparison is difficult as it is not clear if the same criteria are being used i.e. readmission within 28 days and there is no data available about volume. The readmission rate in both the ICP and Non ICP Trusts are lower than the average of 6% reported by the Healthcare Commission (2008). The achievement of seven day follow up targets for the ICP and non ICP group were very similar, and both were slightly higher than 86% reported by the Healthcare Commission (2008). There is little substantial evidence to suggest therefore that the ICP significantly impacts upon either readmission rates or follow-up rates.

Hendricks et al (2007) noted that patients with schizophrenia who received psycho-education during the ICP they studied had a significantly increased attendance at follow-up appointment and low readmission rates. This type of improvement in outcomes cannot be claimed in this case particularly due to the low likelihood of this intervention being provided. Examining the differences between the samples it was found that there were significant differences between the places of residence for service users before their admission. In the non ICP Trust there was more service users admitted from hospital, prison or the police station. This may have impacted upon length of stay in the non ICP Trust which was 14 days longer.

The findings which contrast length of stay should be considered in the context of a comparison between two cases and placed alongside growing interest in the impact of ICPs upon this as a potential outcome. It is acknowledged that many factors may contribute to the difference in length of stay, place of residence being an example. Diagnosis is a factor that was found to influence length of stay, although there was no significant difference in the diagnosis of the service users between the ICP and non ICP Trust. Variations in length of stay according to diagnosis, places the ICP in a questionable position both as a factor explaining the difference in length of stay but also from its theoretical position as a way of managing care that is based upon a pre-agreed timeframe. There is in both the ICP and non ICP data considerable variation in length of stay according to diagnosis.

The length of stay findings should be considered within this context. Back in 1996 Jones raised concern about length of stay being viewed as an indicator of quality within mental health services (Jones, 1996). Further to this he added misgivings about links being made between ICPs in mental health and potentially reduced costs. Costs have to date rarely been reported as part of evaluation studies (Bultema, 1996; Kazui et al, 2004), although there has been an alternative stance more recently posed in that a shorter length of stay may allow a better quality of life (Hendriks et al, 2007). This could be argued either way. Jones' (1996) reticence about reduced length of stay, have not been entirely borne out in this study given no apparent detriment in follow up and readmission rates. Indeed one of the aspects that service users and carers in this research did generally speak highly of was the organisation of their aftercare.

Also, given the concerns about fidelity to the model it would be inappropriate to attribute the reduced length of stay in the cross case comparison conclusively to the existence of the ICP. In this case study nothing is known about the chronicity of illness of the service users cared for within the cross case comparison. Hendricks et al (2007) in their study of the clinical outcomes for patients on a relapsed schizophrenic ICP noted this as a factor affecting readmission rates. Peterson and Micheal (2007) considered the treatment responses of 170 patients cared for on 5 different acute inpatient care pathways, and measured their length of time on each stage of the pathway. They found an unexpected phenomenon in that those patients with more severe symptoms moved through the pathways much faster. Co-morbidity also had a similar effect.

Peterson and Micheal (2007) attributed some of these findings to the potential subjectiveness of feelings of distress, and the need and motivation for rapid relief from symptoms. The degree to which this is influential is complex and has not been possible to establish in this case study. To an extent the distress experienced and the degree to which under certain circumstances service users have sought out interventions by directly approaching staff, is acknowledged in these findings. The influence of this upon length of time spent on this pathway may be a contributing variable. Peterson and Micheal (2007) allude to the view that, care for people with particular diagnoses may be more effectively managed via a care pathway approach than others. Placed in the context of this case study, one can again acknowledge that there are considerable limitations of general process based ICPs.

20.3 Fidelity to the model of an ICP

Converging the findings to the four questions, enables an understanding about the extent to which the ICP is used, the way that it is used and whether the proposed benefits are achieved. A significant critique can be found in the extent and the way that it represents an integrated approach to care. A key feature of ICPs is how their content should accurately represent the activities of all professional groups, and that as a whole system this should reflect an integrated approach to care (Jones, 1999a). This then in turn becomes an ICP that is used by all professionals involved in a person's care. Jones (2003) outlined how professionals have been reluctant to articulate their contributions to care, for reasons related to a lack of evidence, feelings that ICPs are not congruent to individualised care and so on. This case study adds to the body of knowledge about ICPs as an approach to providing integrated mental health care. Suggesting that, even where an ICP is being used, there remains criticism of its content and a failure to represent the activities of each professional group. Moving beyond the previous general impressions about why that may be the case, there is a strong sense that the factors that continue to influence this relate to the need to determine interventions based upon individual assessments. In addition to that there remains a level of variation associated with professional dominance (previously discussed) which has a stronger power base than the ICP.

Power can also be influential outside of the dynamic involving the medical profession. Rees et al (2004) discuss the implementation of an ICP in a community mental health team. In that case the professionals involved (which did not include medical staff) viewed the theory of ICPs positively. Nevertheless when it came to implementation it was felt that there was still a lack of agreed processes between the professional groups. There were tensions around professional boundaries, views that the ICP needed to be more flexible and that there were not enough resources and support to to make it successful. Jones (2006) discussed how different professional groups need to work together to ensure successful care delivery, and the possible role of ICPs in structuring and defining how care is delivered. He suggested that care pathways have not been able to achieve this due to an 'underbelly of professional rivalry (Jones, 2006 p19)'.

Jones' (2006) proposals were based on the stage of developing an ICP and within this it was felt that the power base of some professional groups was very influential. What was perceived as the superior position of the medical staff, and their perceived scientific knowledge apparently led to other professional groups feeling inferior and defensive. Whilst this case study has considered an ICP in use, there were features of this splitting of professional groups. Jones (2006) talked about different professional groups still doing their own assessments, and that practice being defended vigorously. In this study despite the ICP having an agreed risk assessment, and health and social care assessment – the OTs, doctors and physiotherapist continued to undertake their own assessments. Then go on to describe how based upon this assessment they each decide upon what interventions they will provide. There was little evidence of discussion, agreement or verification about these between the professional groups as an integrated team, although the ward round was the most likely place where this might occur.

These individual assessments and packages give a sense that the actual pathway is not particularly integrated. Jones (2006) noted that there was 'little enthusiasm for endorsing a single assessment process as this would be seen to work against professional roles (Jones, 2006 p25)'. In this ICP where one has been endorsed it has not been used to that effect. Fundamentally there are other indications that the care pathway has not been successful in achieving an integrated approach to care. Indeed it has not been used by all professional groups, and there are impressions that there has not always been an agreed understanding of what the care pathway is for particular patients, to the extent of some professionals expressing that there is not a shared understanding about the care that some patients receive. A further indication is that decisions about care primarily focus upon discussions as the ward rounds, rather than using the structures or timescales on the ICP. Service users, carers and healthcare professionals see the ward round as the place and time in which decisions are made, with the hierarchical implications of this. Whereas the theory of ICPs suggests that using the ICP as a basis for decision making reduces reliance on such mechanisms, particularly with a view to reducing delays (Jones, 1999a).

In terms of fidelity to the features of ICPs as described in the literature (Hall & Howard, 2006) the lack of an integrated approach to care is an obvious deviation. However, there are other digressions from the theory of ICPs in the way that it is used. For example, not all disciplines use the ICP to record care. Whilst those that do, do not use it as a way of reporting by exception. Subsequently the latter part of Riley's (1998) definition which focuses upon using variance analysis as a means of monitoring variation and securing quality are not evident. This means that the primary features of ICPs in that they reduce variation, tracking planned care against actual care and aiding clinical and risk management (Riley, 1998) are not being achieved. These features are there and available for use – but are not used. The ICP is primarily used as a checklist by nurses and as a source of information by other disciplines. Using it in this way suggests that just over a two-thirds of the activities planned are delivered. Those that have been found to be less frequently implemented are those that involve direct therapeutic interactions with service users and carers.

Wakefield and Peet (2003) and Jones (2006) talked about the risk of ICP content not sufficiently considering interpersonal care or psychological interventions. In this case there is a view that these may not have been adequately incorporated and where these have been built in, they have been poorly adhered to. The pathway itself as an educative tool does not appear to be known at all to service users and carers. Raynor (2005) highlighted how care pathways can be viewed as a way of managing care which places service users in the position of being 'done to'. With the focus of many mental health ICPs being diagnosis based and having a strong sense of medicalisation. The ICP in this case study is process based rather than diagnosis based but has not been seen to promote involvement or foster therapeutic relationships. Wakefield and Peet (2003) outline the need to include these aspects in ICP content and Raynor (2005) talks about the difficulty doing this. These findings suggest that the likelihood of these interventions being provided is influenced by the individual professionals and not by their inclusion in the pathway content.

Rees et al (2004 p524) mention 'history, geography and team composition' as factors which impact upon ICP delivery. These case study findings would certainly support the suggestions about geography influencing ICP use. The extent to which interventions were offered varied depended upon location. Similarly they varied according to the consultant psychiatrist involved in their care. Service users, carers and healthcare professionals themselves talked about variations in practice between individual professionals. Although previous suggestions about mental health ICPs not being implemented as they do not sufficiently address interpersonal care (Wakefield & Peet, 2003), may be flawed if as in this case they are reflected in ICP content, but are not offered. Rees et al's (2004) suggestion about the lack of flexibility of the ICP may be misleading, as where this ICP is able to accommodate individualised interventions and variation these generally have been overlooked. Also service users and carers in this study with few exceptions, have talked about barely being able to influence their care or feeling that this was individualised to meet their needs.

20.4 Standardised Care

The extent to which this ICP has standardised care is questionable, given that the ICP is used to such a variable extent. Lack of standardisation is implicit in how the medical staff in particular felt about using the ICP. In their view the needs of individual patients vary considerably and therefore so do the interventions that they require. In the main it was felt that the ICP did not allow sufficiently for individualised care, which they felt was of primary importance. Since ICPs have been used in mental health this has been the major topic of debate. Reference has been made to the how individualised care and therapeutic relationships have been highly prized within mental health care and that ICPs have been viewed as detracting from that (Jones, 2005). Jones (2005) proposed that where there has been a suggested positive impact upon interpersonal care as a consequence of implementing an ICP this has been largely anecdotal.

Jones (2001a) did earlier describe that the espoused commitment to individualised care has been a barrier to ICP development. This study suggests beyond that, proposing that this is also a barrier to implementation of ICPs and their sustained effectiveness.

Professionals in this study suggest that basing their care upon individual assessments rather than the structure of the ICP offers an alternative individualised approach to care. It has been considered in the past that the actual interventions that people need and the course of their patient journey is too complex to represent in an ICP (Denton et al, 1999; Jones, 2001a). Given that this is a process based ICP used for patients with many diagnoses, varying degrees of need and lengths of stay – it is probable that individual needs cannot be accounted for in its format. Varying needs between diagnoses has led to a number of hospitals implementing a range of diagnosis based ICPs as an alternative (Hendricks and Mahendran, 2007). There is a possibility that this may be an approach which can more closely represent interventions for particular patient groups as opposed to a generic ICP.

In this case professionals have maintained assessment and planning activities that are separate to the ICP. It would be a ready and subsequent finding to suggest that much practice appears to sit outside of the ICP with a view to accommodating a more individual approach to care, theoretically suggesting then as a consequence that the experience of receiving care should feel individualised. However, it is noted that service users and carers in this study did not view their care as individual to them during the time they were cared for using the ICP. So conclusively care seems neither standardised or individualised, falling somewhere in between.

How care during an ICP is viewed or viewable is to an extent influenced by how much of what exists can be viewed as a logical pattern. An ICP considers a care process and looks for a general set of characteristics, forming these into a pattern which can be viewed as a rational structure. Key to this is seeing the patient journey as having a logical sequence. This very much influenced by structuralism as a method and a way of looking at the world (Craib, 1992). The ICP makes certain assumptions about what the care process will look like, what will happen, how long it will take etc. Assumptions are made that the health of service users will improve. They will be discharged and so forth. This does not really account for how there can be huge variations in response to treatment and a very individual course of illness. There is also the underlying assumption that care within the ICP is seen to be the same from any perspective, and that one person's experience is potentially the same as the next. The focus is upon a shared, logical and underlying structure that is interpreted and experienced in similar ways. Although the extent to which this is the case is questionable in terms of the philosophy of personalisation and individualised care. As Craib (1992) acknowledges choice, intentions, goals and values have a role and in themselves are not predetermined.

Jones (2005) considered how perceptions about individualised care influence healthcare professional's views about ICPs in mental health. Professionals involved in his action research talked about knowing the patient, developing the relationship and involving service users in making decisions about their care. Although there was a proposal similar to this study, that care followed a predictable sequence. Whilst conversely, Jones (2005) noted that how patient's recovery could vary considerably, detracting from predictability. Some respondents within his study argued that the overall process could be standardised but within that there needs to be individual elements. That corresponds with how different stakeholders described a similar overall framework, in which the professions viewed that they integrated individual assessments and interventions. A clinical psychologist in Jones' (2005 p400) study reflected that in his view healthcare professionals could not be directed to 'work in a pre-defined 'humanistic' manner'. In this study it is suggested that people have acknowledged how perceptions about care vary between individuals. How care givers behave and think differently. Indeed how services users and carers experience things differently. Although again that is confused and at odds with the impression that service users (with one exception) in this study do not see their care as being individual to their needs – despite the of degree of variation.

In this study it was openly acknowledged by professionals that their practice varied between them as individuals. One psychiatrist in particular talked about how he felt his education and experience influenced the type of care pathway he offered. This was strikingly similar to how psychiatrists remarked in Jones' (2005) action research, that some doctors relied much more upon medication as treatment, rather than other options. In a similar way in this study one psychiatrist talked about a varying length of stays between patients under his care, compared to his colleagues. Another talked about her experience and that the views of service users where more likely to influence her practice than pre-formulated guidelines. Jones (2005) also described the perspective of nurses who were reluctant to define their interventions during ICP development. It was acknowledged that this individual philosophy is not always translated into meeting individual patients' needs.

Some of the professional reluctance about standardising mental health care may relate philosophically to the critique of total institutions (Goffman, 1961). Features of the total institution are the setting, group daily activity, lack of individualisation and days which are scheduled, sequenced, prearranged and governed by inflexible predetermined rules. The care pathway in this case endeavours to schedule interventions so that to an extent people can expect to receive the same types of interventions at similar stages in their patient journey. This clearly is problematic as any two people's health can be significantly different on day two of their inpatient stay. The scheduled interventions for one of these people may be helpful, and in the other case they are completely inappropriate. Although where there is scope for individualising the care pathway in this case study, this feature to individualise care was not generally used.

Service users suggested that they felt that they themselves do have different needs and respond differently to treatments, and therefore care needs to be individually tailored to them. Instead they did experience the depersonalisation associated with standardisation 'being pestered to go down to the gym', and told when to go to bed and have a cup of tea. The inference being that the gym is on the programme and that you are expected to attend, whether or not it is personally helpful to meeting your needs. You will have a cup of tea and go to bed when it is expected according to the rules. Also people were subject to repetitive processes determined by the institution, 'They have these criteria to measure your needs, they have this assessment, they go though a list of things. God knows how many times you must go through it'. For most people the experience of care was viewed as a collective experience rather than being bespoke for individuals, 'when I was in hospital there was no choice at all' and 'when I went in, they followed the same procedure each time.'

Goffman (1961) reported that this bureaucratic style has significant consequences, amongst these is depersonalisation. It was suggested in the 1960s that caring for people by batch and handling of needs in bureaucratic structures was incompatible with the structure of our society. It is suggested that treating all people the same and the use of tight schedules lapsed by the mid 1990s in mental health care. It is particularly interesting that whilst the ICP was not fully implemented that there are still features of standardisation. Whilst healthcare professionals in this study did not make reference to institutionalisation specifically, they often referred to the need for individualised care, seeing this as the opposite of the ICP. There were factors that healthcare professionals cited as influencing how much choice people can exercise i.e. how ill they were and indeed what was actually available in terms of treatment. Even though healthcare professionals described individual assessments leading to individual treatment programmes – the felt experience of the majority of service users did not detail this consequence. The view that moving towards an ICP as a form of standardised care plausibly presents a retrograde step away from individualised care does assume that care is individualised when an ICP is not used. The clear implications of assuming a collective approach to mental health care do have to be acknowledged. Freund and McGuire (1991) reflect how self validation impacts upon recovery and if this is correct that the way that people feel about themselves is in part based on their interactions with others, then individualisation is clearly an important part of the patient journey.

21. Theoretical Challenges

21.1 A consensus view of the patient journey

In this study the healthcare professionals who were not nurses consistently suggested that one care pathway for acute inpatient care could not represent the level of detail of the care, that in their view individual patients should receive. This leads to two technical possibilities. The first is that this generic ICP i.e. one pathway for all patients admitted to acute inpatient may not be the most suitable model of a delivering an ICP. The literature represents a mixture of ICPs that are based upon a general care episode as in this case, or the alternative of a diagnosis based pathway. Diagnosis based pathways make up the majority of those that have been evaluated using research. Presently there is no consensus about which model of ICP may be more effective. However, there is no indication in these findings that respondents would view a diagnosis based ICP as any more appropriate or effective.

A further question is, if it is technically possible to represent the journey of services users as a linear or consensus based framework. There are statements in the data to suggest that the care given is not integrated or representing a consensus. For example, references to a lack of adherence to multidisciplinary plans, some patients not having an agreed patient journey, medical domination, different professional groups working in isolation and lack of communication. It has been suggested that the ICP itself does not accurately reflect the interventions of all professional groups. Although data from the documentary analysis does suggest that more of these interventions are completed, than are not. Also within the interview data there is the view regardless of professional group that whether each professional actively uses the ICP, the interventions in the ICP were being offered. Except where on occasions services are not available or patients are too unwell. This is a contrast to expressions about the ICP not being used or being inaccurate, and raises questions about the extent to which care is standardised regardless of how the ICP is used.

In terms of consistency, when respondents were asked to describe the current care pathway for patients they did this in a uniform manner and described the stages of the pathway i.e. admission, care after admission and preparation for discharge. As a group, their descriptions of these stages were very similar (consensus like) and contained the interventions and activities in the pathway to a great extent. The concordance of descriptions about the pathway and the interventions gives the impression that there is a common framework which healthcare professionals are following. This may be based upon their experience or knowledge, and arguably not the paper ICP. One psychiatrist articulating this described how based on his experience he uses a simple care pathway for similar patients within specific groups. Although, he suggests that those ICPs are primarily in his head and are not the one at the centre of this case study.

Some of this reflects how a care pathway attempts to overcome the conflict that can exist between individuals and groups when they are focused on the achievement of their own goals and priorities. ICPs ask for a unitary view of the process of care, and do not anticipate in their development or operation the influence of interests, conflicts and power. Burrell and Morgan (1994) acknowledge the divergence between the team striving towards a common objective, as a coalition and yet as individuals with different interests. Whereas, the ICP from a unitary perspective is only used so far as it serves to meet the needs of individuals for their own ends. Therefore it is seen as little more than a 'façade, umbrella under which a host of individual and group interests are pursued as an ends in themselves (Burrell and Morgan, 1994 p203)'.

From an organisational perspective an ICP suggests that the views and interests of all the different stakeholders can be managed without conflict, and that difference can be controlled through the use of the ICP as a form of managerial action. Because ICPs are fashioned on harmonious order, difference is only accommodated to a small degree, and variation is in that format unwelcome or troublesome. The ICP development process has not found a way of constructively managing difference, addressing conflict and expressing the view of the whole system. The question of why would it be desirable to reduce the care that people with mental health problems to the principle of an ICP is answered in the literature and primarily relates to governance and resources. Although a more fundamental discussion is about whether this reductionism is possible, and if it does indeed have beneficial outcomes.

The outcomes of using the ICP can be summarised in terms of the way that the ICP is used, the experience of care, the extent to which the interventions on the pathway are implemented and its impact upon performance. As suggested previously this ICP is used mainly by nurses as a checklist in a similar way to that described by Hendricks et al (2008). This ICP has not been used to inform daily decision making or reduce variations in care. In Hendricks et al's (2008) study there was a view that ICPs were not detrimental to good care and nor did they affect professional autonomy. Whilst in this case study individuals exercised their autonomy and did not use the ICP, for reasons similar to those suggested by Emmerson et al (2006) 'due to complexity, individuality and variability of mental disorders'. Also there are factors related to the principles and beliefs of individual healthcare professionals. Exercising their autonomy, several of the healthcare professionals interviewed have not used the ICP, and an integrated consensus about the care to be delivered, has not been achieved.

21.2 Organisational Analysis

There was speculation that post-fordist NHS reforms characterised by market forces, consumerism and demands for flexible working practices would reduce professional autonomy (Nettleton, 1995). Where something like an ICP is established as a mode of production it is possible that this could transform the relationships between the professional groups, although this has not been the case. Nurses have used the ICP, and this may be related to lower levels of professional autonomy and less secure employment status. Whereas psychiatrists exercise routes to ensure that they can control resources locally. As groups or individuals they maintain freedom from managers and organisations. As Baggott (1994) reports, the authority of the ICP like that of the manager is largely unable to assert control over resources and clinical practice, because the demand for patient services and how people are cared for are determined by clinicians.

Strauss, Ehrlich, Bucher and Sabshin (1998 p250) argue that

> 'if negotiation is called for because a generalised mandate requires implementation, it is also called for because of the multiplicity of purpose found in the hospital. It is

> contestable that each professional group has a different set of reasons for working at this hospital (to begin with, most nurses are women, most physicians are men); and of course colleagues inevitably differ among themselves on certain purposes of their working there. In addition each professional develops there his own specific and temporarily limited ends that he wishes to attain. All this diversity of labor, including not only what tasks each person is expected to accomplish but how he manoeuvres to get them accomplished. Since very little of this can possibly be prefigured by the administrative rule makers, the attainment of one's purposes requires inevitably the cooperation of fellow workers.'

Although some of the circumstances of this may have changed, an ICP can be viewed as a generalised mandate and administrative rule makers are its source. Its structured format of a schedule of care in this case study has been overridden by the power of medicine as a particular professional group, as well as the philosophies of individual professionals.

The assumption that there can be a unitary view of a patient journey largely ignores the question of power. The assumption is that the care process is a harmonious conflict free enterprise. In this all stakeholders are striving uniformly towards as common goal – when in fact as the findings in this study show there is a lack of shared consensus about what is to be offered and to what ends. The use of the ICP described in this case study suggests that organisational life reflects a more pluralistic outlook. Questions about the use and source of power are inevitable but are not addressed in the development of the ICP or its operation. The use of this mental health ICP is not neutral and it does not operate in isolation from what happens in everyday affairs. The ICP is not a framework that acknowledges the power that individuals have to control their own work situations and to achieve whatever objectives they value. The one in the study is only a loose coalition which moves through an uncertain process or bargaining, and mutual adjustment of respective claims. The findings suggest that the operation of this ICP actually sits somewhere between the pluralist and the unitary views. In that there is a unitary underpinning framework along which a mass of people are expected to progress. Then within this framework there remains a domain without the purposive rationality that an ICP suggests. Where the ICP serves to ensure that care is structured, directed and controlled – there has not been the outcome of a cooperative system, integrating both individual and organisational needs.

Burrell and Morgan (1994) reflect that it is unusual to now see theoretical propositions that reflect a unitary view of organisations. It is suggested that over the last 50 years there has been a shift towards the pluralist stance, but not to such an extreme as to leave behind unitary theory completely. Pluralism in this sense means that the interests of different parties are acknowledged and any conflicts are explicit and understood. What is difficult to grasp with mental health ICPs is how the power and interests of individual professionals appear to detract from a shared understanding of the patient journey and what is being aimed for. The ICP attempts to overlay this with a decision making process that does not recognise the plurality of these conflicts or individual interests. It underplays human relations theory which acknowledges that individual needs can be in conflict with those of the organisation. The ICP is inconsistent with clinicians who may be more cautious practitioners encouraging longer lengths of stay, or those who avoid contact with carers due to the anxiety that this causes. The ICP suggests that it is possible to satisfy the goals of all individual stakeholders within one framework. This assumes that the ICP can be a rationally ordered enterprise, and that there is an understandable unity within the whole system.

An example of the indeterminate nature of this is that there was a very good rate at which the formal risk assessments were completed in the ICP. One nurse respondent describes how he would use the assessments for the basis of developing the care plan and discuss this with others including the service users. Indeed the non nurse respondents in the interviews describe readily using the ICP as a source of information about service users. Service users themselves described not being significantly involved in their own assessments. Non nurses described that they would complete their own individual risk assessments and not feel satisfied in relying upon the evaluations made by others. Those individual clinical views then influence the interventions that were offered. Given this the reduction in variation, reduced duplication, advanced risk management or improved standards potentially brought about by using ICPs (Wilson et al, 1999; Smith et al, 2000; Hall and Howard, 2006), cannot be found in this case.

21.3 Representing complexity

A frequently raised issue in these findings and the ICP literature is the view that mental health care is too complex and interpersonal to manage in a pre-formulated way. Impressions within the findings raise serious doubts about whether an ICP can account for what are considered as the very wide range of needs of the patients accessing this ICP. This is portrayed in the discussions around each professional still doing their own assessments and then deciding upon specific and individual interventions. The view strongly forwarded is that mental health care is 'not like a hernia operation' it is arguably more individual and variable. The needs of a patient in one diagnostic group are very different from another, and people with the same diagnosis have their own unique requirements. It was noted in these findings that social circumstances have an impact and that there in an expected individual and responsive component to care. This is similar to the interpersonal issues acknowledged by Peet and Wakefield (2002).

Although they felt that whilst the interpersonal care has been lacking in mental health ICPs it was possible, if not essential to articulate and set standards around these.

Views about interventions vary between individuals and within professional groups let alone across interdisciplinary teams. One doctor in this study reported that he practiced differently to a colleague, and that this was something that an ICP could not influence. These are issues similar to those that Jones (2001a; 2001b; 2005) reported in his study of the ICP for schizophrenia. Healthcare professionals felt that that particular patient journey was variable from patient to patient, and highly influenced by the therapeutic relationship. Jones (2005) reported that in many ways the move towards standardisation was seen as conflicting with the prized tenant of individualised care. In this study it could be argued that some professionals have not implemented the ICP and have pursued what they describe as an individualised approach to care instead. Although the data allows for the counter-challenge that, service users do not in the main view that their care has been individualised. Also the documentary analysis findings reported in this study suggest that the parts of the pathway which allow the flexibility for individualised interventions are poorly used. Additionally there is a degree of adherence to the ICP as a process given the evidence that two-thirds of the interventions are consistently offered.

Wood and Green (2006) acknowledge that different professional groups operate from very different theoretical viewpoints. For example medical staff operating from a biological stance and social workers adopting a social framework. Whilst the contributions of the different professionals is what makes up the ICP, it is argued that if these inputs are pre-agreed, then the direction of travel is based on a shared understanding and the resources needed can be identified. Wood and Green (2006, p55) reported that individuals have a common understanding, and 'synergy' in working towards an end goal. Whilst in poorly directed teams individuals may be continuing along their own course rather than in a way that interrelates to the approaches of others, and that this may result in a limited approach to meeting needs. Viewing the findings of this study, uni-professional approaches are still evident. Where healthcare professionals argue that this is for reasons of protecting individualised care it could be argued as Wood and Green (2006, p55) suggest that this increases the likelihood of 'divided duties' which 'lead to divided loyalties and almost inevitably reduced effectiveness'.

It can be considered whether a mental health care pathway for more than one person can be an accurate reflection of the care required or agreed. Bryne (1998 p4) asserts that,

> 'illness of the mind in particular but by no means exclusively (the word 'stress' is the general connector of the social and the physical here) can only be understood in a non-reductionist way which rejects the theory of the levels, the proposition that the simpler can explain the complex, but not the visa versa. Contemporary theories of the genesis of schizophrenia, an illness so reactive that it has no natural history (Wing, 1978), assert a complex causation in which there are certainly genetic liabilities but in which those liabilities are only expressed under specific stress conditions. Such aetiological explanations involve complex causes and emergent properties. Moreover, for many 'health problems', notably but by no means exclusively in relation to mental health and illness, this reductionist programme had little effect.'

Bryne (1998) discusses whether mental health as a phenomenon is reducible into a described structure. He uses complexity theory to offer an understanding of how non linear relations like the different facets of mental ill-health cannot be fitted into a neat and simple linear structure. Clearly there is opposite argument that no determinism or structure at all in the care process may be a poor alternative.

Whether the use of complexity theory is relevant to this discussion is further emphasised by considering whether mental health care can be reduced to its individual component parts and if the ICP can represent the sum of its parts for more than an individual person (Kernick, 2004). It has already been suggested that within the care process individual service users and healthcare professionals behave differently over time, and this has effects upon the care given. This therefore becomes not reproducible if care is completely individualised and the needs of service users and their response to treatment varies. Therefore, similarly the outcomes vary, and indeed as this study suggests, so do the experiences of service users. The experience service users reported in this pathway rests somewhere between the deterministic order of the ICP, but not at the opposite pole of randomness.

If the care pathway is viewed as a complex system (Bryne, 1998), interaction within and around the system is highly influential. Interaction has the ability to see the ICP as a system change. For example, if someone's health deteriorates before they are discharged then their progress against the care pathway is delayed. The ICP as a system needs then to have the flexibility to change to respond to this and to represent that complexity. That is if it is accepted that health is a complex phenomenon influenced by social factors as well as individual events. The significance of this complexity needs to be better thought out in relation to the prospect of one singular ICP, which intends to specify order and outcomes for different people. Byrne (1998 p118) describes with relevance to mental health that,

> 'We can nonetheless analyse in order to see what the possible set of outcomes might be, what the possible answers are, and in situations of robust chaos, intervene in order to achieve those we want to see happen. We retain a programme of rational agency.'

In that case it is not possible to have one linear detailed ICP for more than one person which goes beyond the structural level i.e. assessment, care planning and discharge. This fits very much with Cilliers (2000, p2) definition 'complexity entails that, in a system, that there are more complexities than can be actualised'.

21.4 Using Complexity Theory to identify limitations of ICPs

Whether the apparent misfit between mental health care and care pathways can be explained by complexity theory is considered referring to the works of Bryne (1998), Cilliers (2000), Kernick (2004) and Sweeney and Griffiths (2002). Much of their work stems from Waldrop's work at the Santa Fe Institute which describes complexity as a domain that sits between linear determined order and indeterminate chaos (Waldrop, 1992). Bryne (1998) describes that complexity theory derives its theoretical underpinning in a similar way to critical realism, whereby a neither solely phenomenological or positivist approach is fully sufficient to understand a phenomenon. The relevance of complexity theory to mental heath ICPs starts with the structure of the ICP. ICPs to date have taken the format of a general linear model to represent the care that would be provided for numbers of patients and assuming a high degree of standardised delivery. This case study acknowledges that this model of ICPs by and large, does not take conscious regard of the presenting multiple variables. This could range from the values and beliefs of individual healthcare professionals, to the diagnosis or course of illness for service users.

The findings of this research highlight how the diagnosis of service users' impacts upon the ICP, and similarly the healthcare professionals' views about the effectiveness of particular interventions introduces a range of variables and complexity, which co-vary in the real world. Even more so the linearity of the ICP beyond a general high level process cannot be followed in the experience of service users in this study. Suggesting that the linearity and order i.e. the ICP are being forced on a world i.e. mental health care which is not like that. The question that follows is then, should mental healthcare be like that? Perspectives about individualised care would suggest not, whilst drives for standardisation like ICPs and guidelines propose to an extent the opposite, whilst the reality seems to be a position somewhere in between. Complete contingency represents a notion of mental health care where there is no basis for order or prediction and a complete abandonment of any way of viewing what is needed. Indeed the history and structures in which mental health care currently operate do not render that a possibility. The medicalisation discussed previously acknowledges the current influence of biomedicine and science. If the reality of mental healthcare does sit between these tenants then ICPs need to account for the ecological relationships between the stakeholders, variability of illness and individual ways of living.

If mental health care is viewed as complex system then that does raise issues about whether the care can be constrained by prior definition and whether the complexity can be described and quantified. Cilliers (2000), Burton (2002) and Kernick (2004) describe the characteristics of a complex system as one which has a large number of elements, an interactive context which changes over time, is often non-linear, is open and interacts with the environment, operates under varying conditions, has a history and in which individual elements act without recognition of the whole. The findings related to the ICP in this study would very much support that the process of care undertaken is a complex system, and consideration of how can this complexity be modelled. Why ICPs should be used is already described in the ICP literature i.e. in order to predict and to control the care process, and that in order for this to be effective the ICP as a model has to work and produce results. In this case study representation and effectiveness have shown to be significant problems.

Cilliers (2000) suggests that models of complex systems have to be as complex as the system itself. An ICP if to achieve its aims needs to describe the relations between individuals, what happens and the environment. With the ICP studied there is a focus on what happens but no emphasis on the individuals or the environment. Therefore key individuals did not interact with the ICP and issues like social factors, interpersonal care and therapeutic interventions were not effectively addressed by its use. It has failed therefore to reflect the interaction that goes on as part of the care process. It is acknowledged where there are human senses and cognitive processes involved representation is problematic. ICP development has relied upon pattern recognition to achieve some representation of this along with a rule based approach. Using a collection of views about what has worked well in a linear format, and prior knowledge to predetermine the content of the ICP means that it has not been responsive to individual needs. However, Burton (2002) and Kernick (2004) do describe this as a suitable approach to describing a complex system, bearing in mind the need to identify rules and behaviour. Although, where this seems to fall down as a model for ICP content, is around the implications of an ICP as a self organising system, and the view that a proportion of events are emergent.

22. Limitations of this study

This research set out from the premise that ICPs were being deployed within mental health services whilst little was known about their use and effectiveness. As Judge and Bauld (2001) noted healthcare providers are obliged to understand the evidence base of such changes and know as much as is possible about complex interventions and how they operate on a number of levels. This case study has been an attempt to acquire further knowledge about mental health ICPs using a case study approach which has crossed methodological boundaries. The methodology and mixed method approach has enabled a single ICP to be studied in detail from different perspectives. Taking the pragmatic view forwarded by Judge and Bauld (2001) and that all research methods have their strengths and weaknesses, the mixed methods and the triangulation of their products was seen as the best way to learn about this ICP as a complex phenomenon.

The aim to learn more about this one ICP took primacy over understanding cause and effect, and the pressure of scientific evaluation. Starting out from the premise that generalisations do not always depend upon representatives for validity, then this study can be viewed as credible (Sharp, 1998). With this direction though, the potential limitations and criticisms related to empirical generalisation are acknowledged. The most significant of which is the issue around generalisation, although Hodkinson and Hodkinson (2001) and others make solid propositions about how theory can be transposed outside of the original confines of a case study. Whilst Stake (1995) points out that case study can appear a poor basis for generalisation, although where a topic is studied in sufficient depth there tend to be generalisations within a case. For example, in this study the high level stages of a patient journey are described similarly by service users and healthcare professionals. The documentary analysis also provides further data about these – working towards a refined generalisation about how this ICP is experienced from different viewpoints.

Past research about ICPs has discussed how healthcare professionals have been reluctant to use mental health ICPs, and this case study has gone on to show how this is reflected in how an ICP has been used throughout one healthcare organisation. This uses what is suggested about ICPs in the literature as a grand generalisation which is modified by the findings of this case study. Within the methods there is full description of the case and during discussion particular care has been taken to note alternative explanations. These strategies have been used to acknowledge the variability in how mental health ICPs have been used, and to increase the readers confidence in the findings (Stake, 1995).

Basing a critique of this research upon Atkins and Sampson (2002) and Yin's (2003) view of an exemplary case study, it might be argued that this case is not significant – although the literature review would in the main dispute that. It is clear from the limitations of past research that where studies have taken place their reports have lacked details about either the context, methods or analysis. In the methodology, care has been taken to overcome these limitations. This case stands out as a situation which is distinctive and yet compliments the existing body of knowledge. Detail, depth and triangulation helped to overcome the issues of sample size, as suggested in the methodology (Begley, 1996; Shih, 1998).

At the outset it was agreed to include opportunity for case comparison and in the researcher's view it is this element that has been least effective. Without extending the study of what is potentially a rival proposition (i.e. the care delivery in the non ICP Trust) the use of the comparative data has been limited, and this is probably the most disappointing element of the study. Yin (2003) suggests that the sense of completeness is an important facet of case study research. In this case, if the non-ICP Trust is viewed as a rival proposition, then the case study may be viewed as incomplete in that respect. The data from the ICP Trust was comprehensive and whole, whereas the data from the non ICP might be viewed as insufficient or unconvincing. Introducing the comparison as part of the methodology was to enable readers to consider the findings in a wider context, and the impact of this has been limited.

Using mixed methods included data that can be influenced by the researcher during data collection i.e. that gathered through the focus groups and interviews. All the measures taken to improve the validity and reliability described in the methodology were taken. Although within the focus group findings it is notable that the participants seemed to present their experiences at either end of the satisfaction scale, either being very satisfied or dissatisfied. Without doubt the views of service users and carers contributed to the holistic view of the ICP as a case. It is acknowledged that participants each have different perceptions. Each is entirely legitimate, but ultimately the experiences of the participants reflect the views of a group of volunteers, and they add to this case study in terms of illumination, rather than suggested generalisation (Nolan & Gordon, 1993). That point is reiterated in any critique of qualitative sample size and sampling, and also has resonance for the interviews which were conducted with staff who volunteered. This was complimented by the data from the healthcare records and datasets from which the researcher was able to remain detached from.

The researcher had prior involvement with this ICP at the point when it was written seven years prior to this research being completed, and has also written since about the use of ICPs in mental health care. Yin (2003) points out the need to consider alternative perspectives and rival theories. Therefore to represent different perspectives adequately these issues were considered fully at the stage of designing this case study. Taking into account the sampling strategies, the type of data gathered and the extent to which this is influenced by the researcher. Considering the way in which the discussion offers different interpretations of the facts it is evident that not all original interpretations are correct, and there is a clear basis given when alterative propositions are introduced or rejected. For example, the suggestion that not all professionals were using the ICP because they felt that using it would mean that care would not be personalised. It could be implied therefore that that care delivered is individualised. Although this seems in opposition to service users perceptions about their experience of care, and that it did not feel personalised. Then further contrasting this with the finding that all stakeholders describing the process of the care pathway in the same main stages with common interventions. Reading across all the sources allowed alternative explanations to be considered in discussion. A key feature in the discussion is the critique of literature and the modification of existing propositions. This approach allows for the critical questioning of assumed theory and the researchers own position.

CHAPTER 6

CONCLUSIONS

Using case study methodology has enabled a holistic understanding of how an ICP is used in mental health practice. The main research question, how is an ICP used to manage mental health care has been considered from a variety of perspectives. Developing a detailed understanding through an exploratory approach has been productive in gaining insight into this complex topic. The conclusions outline the main findings of the research that can be used locally and more widely to inform the use of care pathways in mental health practice. The contribution of this research to the existing body of knowledge and onward recommendations are outlined.

The perceptions of healthcare professionals suggest that use of the ICP is not well embedded into everyday practice. It is evidently more widely used by nurses than other professional groups. This may be related to nurses finding that the task based system decreases their close contact with service users and the anxiety associated with this. As well, it offers them a technical approach that has the perception of improving their status. No professionals consistently use the ICP to the extent of guiding clinical decision making, individualising care or variance reporting. Doctors particularly decline to use the ICP, and the medical dominance and prevailing social order render this acceptable. Despite this, the ICP does exist within the healthcare record and documents that just over two-thirds of the interventions and activities in the ICP are delivered. Whilst it is not used in a premeditated way to actively reduce variation or deliver standardised integrated care. All stakeholders perceive the same general structure along the pathway, although the interventions provided and the experience of these varies considerably. Consequently in terms of fidelity to the model of what an ICP is, the use of the ICP in this case falls short in respect of risk management, reducing variation and integrated working. What happens in terms of care seems to be primarily decided by individual assessments of need, and this is influenced by existing underlying social factors and ideology. Data suggests that whilst an ICP is in place professionals still follow their own individual programme of interventions with little adherence to the ICP, or in some cases collaboration with colleagues.

The lack of agreement about what care and interventions should be provided is an aspect that has been a central discussion in the literature about the process of developing mental health ICPs. This research suggests that this pervades further on into the use of ICPs. Two facets seem central to this, the first being that ICPs and standardised care are seen as being in conflict with providing what is perceived to be, individualised care. The second is the extent to which this or any care pathway can represent the specific interventions that are required for groups of people experiencing mental health problems. Despite this ICP the interventions offered remain the consequence of the assessment of each individual healthcare professional and their judgement. Therefore the interventions that are delivered on the pathway still vary according to the professionals involved. This level of detail about the use of a mental health ICP has not been revealed previously, although there is a general congruence between these findings and the few evaluations that have been conducted.

The views of service users and carers contain their own subset of counterarguments. Healthcare professionals describe not using the ICP extensively due to its perceived negative impact upon individualised care. Not using the ICP they impressed that therefore they are able to respond to needs in a way which is more flexible and bespoke. However, in the main service users did not feel that their care was particularly individualised and described a sense of being one of many and a degree of homogeneity. Whilst the healthcare professionals perceived the care being offered as individualised, that was not the felt effect. Despite the view service users did not feel that care was personalised to meet their individual needs, their experiences of their care varied considerably amongst them as individuals. Overall the espoused benefits of ICPs like increased patient satisfaction and involvement were not experienced by the service users who took part in the focus groups. Carers did not express these types of benefits either.

Whilst the extent to which healthcare professionals used the ICP and the service users experience of the ICP varied, their descriptions of the ICP were very congruent with the main stages of the pathway. Indeed the degree to which some interventions were delivered did exceed rates from comparative national data. The provision of two-thirds of the interventions on the pathway can be seen as contradicting the impressions of healthcare professionals, explaining that they digressed from using the ICP toward a more individualised approach to care. The number of interventions in the pathway completed and the views of service users and carers both dispute that there was this individual personalisation. However, some of this ambiguity might be explained by the process rather than diagnosis base of the ICP. The ICP content does not drill down into specialist interventions for people with particular needs and these are what healthcare professionals propose that they are delivering as part of individualised care. The process based nature of the pathway is also implicated when considering the much shorter length of stay that the service users on the ICP have, when compared to a non-ICP Trust, especially as length of stay varies considerably according to the diagnosis of the service user. There was no discernable difference in other performance outcomes when comparing the ICP and non-ICP episode of care.

This level of detail about mental health care pathway use is not available in other research or literature. Conclusions overall suggest poor fidelity to the model of what a care pathway is in this case. Primarily this relates to a perceived lack of integrated care delivery and standardisation. It has been difficult to discern given the poor fidelity to the model, the impact that the ICP has had upon individualised care. Given the poor adherence, the lack of individualised care expressed by the service users interviewed cannot be directly attributed to the ICP. Indeed service users and carers suggest that individualised care, interpersonal contacts and the humanistic side of care varied according to the individual practitioners concerned. The ICP has not contributed to reducing variation in that respect. However, there is no evidence to the contrary that suggests that this ICP has inhibited individualised care or professional autonomy.

This study has raised the question of whether a mental health ICP which is based upon diagnosis would be more successful, and whether improved fidelity and outcomes would be achieved by this. Further research to discern this would add usefully to existing theory. Whilst this research has developed a credible and holistic understanding of a complex phenomenon, avenues still to explore using research include the cost benefit of mental health ICPs, impact upon clinical outcomes, observational studies of their use and perhaps most importantly whether better representations of the care process can be achieved. These aspects of further investigation would particularly improve understanding and onward development.

There is a reasonable counterargument that needs to be considered which is, do care pathways have any realistic hope of benefiting either the experience or efficacy of mental health care? This research does not substantiate that this ICP has made any discernable impact on those aspects. Therefore it can still be questioned whether the persistent move towards articulating or managing mental health care using ICPs is justified. The application of complexity theory highlights their deficiencies as a concept. For example, it identifies how the clinical interaction brings in a dynamic above and beyond the component parts mapped in an ICP, and with that more possibilities than can be actualised (Hassey, 2002). Where there is a desire to persist with the use of ICPs these need to be able to reflect the clinical encounter and information about this, and better represent the different elements of the system within an adaptive structure. Theoretically there is the proposition that some kind of phase view can be established to describe a complex system (Hassey, 2002; Boyle and Pratt, 2004). 'Like a road map of all of the possibilities for that system with its history charted as a trajectory through time (Hassey, 2002 p64)'. This warrants consideration for future ICP development, as this research clearly illustrates how there can be limitations of taking of reductionist approach to managing a complex system.

This ICP has been studied as a complex system and its limitations have been explained by the use of social and complexity theory. Considering the component parts of this ICP using the four research questions, highlighted that it could not have been fully understood without examining interaction and feedback. This is not only a lesson for the research process but for the construction of the ICP itself. The linear structure of ICPs has not been a helpful characteristic in mental health where their application needs to be more network orientated and there is a need to accommodate events which are emergent. Whilst there is a view that mental health care is just too complex to represent, there is also emerging theory about how complex systems can be viewed and measured that could inform future ICP models. The need and desire to do this would still depend upon on any prevailing appetite for prediction and determinism.

Applying complexity theory to mental health ICPs suggests that a more reflective way of viewing a mental health patient journey is as a self organising system. If the care given during the delivery of an ICP can be dynamic and 'continuously transformed through the interaction of contingent, external factors and historical, internal factors, cannot be explained by resorting to a single origin or to an immutable principle (Cilliers, 2000 p106)', that degree of self organisation allows for a flexible approach that accommodates individualised care. If in this ICP those opportunities can be shown through the addition of individualised interventions and variances – this has been unsuccessful. That may be through a rebuke of the ICP itself, as opposed to a failure to offer or deliver individualised care. Cilliers (2000, p106) suggests that self organising systems are 'anti-reductionistic' and that complex interactions cannot be represented solely in terms of their components, especially as they emerge through a variety of interactions. The present model of ICPs has taken into account the component parts (i.e. the interventions) but not the interaction, the history and the states of individuals. Therefore, it can be concluded that an analysis based on complexity theory suggests that the ICP as it stands provides an inadequate description of care.

Applying complexity theory further would suggest that an improved model of ICP or improved version of this ICP needs to consider how the ICP reacts to the environment and transforms in response to this. This reflects issues like the role of carers, the social circumstances of service users and the economic climate which all impact upon the ICP as a self-organising system. Also ensuring that the ICP rests with the service user acknowledges that power does not sit purely with a single source. Viewing the ICP as a network rather than a linear structure may be a helpful element to support this. Consideration needs to be given to the criticality of stability and prediction. Use of outcome measures in the ICP alongside a process which allow for a closer understanding of individuals may be fruitful. As all of these elements cannot be fully described by means of classical theory, predicting success is therefore problematic. The best that can be achieved might be a mapping of the system and attempted but not certain predictions. This would also suggest more decentralised control (straying from the earlier rationale for ICPs).

There is an alternative argument as Lyotard (1984) would propose that achieving the representation of the ICP is impossible as it is too complex for an overarching description. His suggestion being that the discourse involved cannot be mapped, and there are too many different patterns in the network of relationships involved. However, if as Kernick (2004) describes robustness and flexibility are seen as two sides of the same coin, in the current context of healthcare delivery, chaos and decentralisation are not seen as a veritable options. Kernick (2004) argues that some features of non-linear systems are measurable, given the understanding of the points from which they begin (for different individuals) and knowing that the interaction between individuals will moderate differences. He insists that some reoccurring patterns can be seen.

In order to achieve this, ICPs need to more closely consider initial conditions, the environment, interactions, people and outcomes in order to be more reflective. There is also a need to manage the non-linear nature of mental health care, where there is a high degree of self-organisation, dynamic adaptation and evolution. Much more realistic is the view that 'the same piece of information has different effects on different individuals, and small causes can have large effects (Cilliers, 2000 p120). ICPs to date have ignored power relations and the asymmetrical system of relationships. Acknowledging this within an ICP this would be achieved by applying soft system methodology. Powell (2004) sees this as managing a process of organised action, allowing for plurality and participation.

Moving away from the view that an ICP is linear, scientific and value free (Sweeney, 2002) may be a way of moving mental health ICPs forward. The reductionism and linearity that ICPs imply have borne out in this case study in very different experiences between individuals in all stakeholder groups, as well as indeterminable impacts upon outcomes. With the felt experience varying considerably and the assumption that inputting the same activities for all will have a particular effect is flawed. This model of ICP has not been flexible enough to accommodate managing this process of care for large numbers of people as a complex system. Current use of the ICP does not reflect the connectedness of its elements, is presented as value free and does not equip clinicians to understand the process of care beyond the intractable problems that frustrate them in everyday practice. The tension between determinism and unpredictability means that there is stress between the structure of the system and the pattern being created in the interaction within the system (Sweeney, 2002). To be responsive care pathways in mental health need to accommodate multiple perspectives, non-linearity and be dynamic and emergent. Hassey (2002) and Holt (2002) wrote commentaries suggesting that clinical practice, expertise and complexity offer possibilities for overcoming the inadequacies of traditional linear ICPs.

Given the appetite, use of the complexity framework opens up a new way of understanding for those commissioning and using ICPs in mental health care. Mental health care and the craft of this involves close engagement in a complex world and capturing that in an ICP framework could possibly give individuals and organisations confidence in the knowledge gained from practice, and a framework for critically reviewing this. Linking ICPs to complexity theory gives insight into how to accommodate and learn from the unpredictable nature of experiences and outcomes. Also in viewing how day to day practice and local health care activity can help services develop, respond and change over time. This theoretically provides a framework for critically examining our health care processes, ensuring that the system has feedback in order to evolve.

This study is an original contribution to existing knowledge about mental health care pathways. It is the only research that describes how an ICP is used in this context from different perspectives. The holism arising from case study methodology and the detailed research report provide detail far beyond previous insights. This study provides depth to emerging debates about preformulated care and individualisation which are important in the current policy context. For the future use of integrated care pathways in mental health care there is empirical support to move away from linear representations, towards an ICP model that can accommodate complexity. The conclusions of this research suggest the following recommendations for practice, policy and management, education and research.

For policy, practice and management, recommendations are that related to the development of mental health ICPs and their use.

1. Mental health care pathways need to specifically incorporate the therapeutic relationship and the management of this.
2. Similarly they need to encompass the impact of social factors and effects of treatment response.
3. The use of a linear format should be replaced with a network model of ICP.
4. Needs, outcome or diagnosis led ICPs should be considered instead of generic ICPs.
5. Monitoring variances should be integral to existing recording and activity monitoring practices.

6. Organisations need to actively manage development and implementation, given what is understood about the social order and its effects.
7. Service users and carers need to have a more active role in influencing ICP content.
8. For ICPs currently in use, organisations should determine the levels of adherence there is to the content, and the benefits of their use.
9. Future policy should make clear, its intentions about individualised care and standardisation.

The following recommendations are specific to education.

10. The issues around standardisation and individualised care should feature as a part of undergraduate and post graduate training.
11. ICPs should be taught alongside care planning, the care programme approach and case management in training for all disciplines.
12. Care pathways should continue to feature within service improvement training.

Recommendation related to further research include

13. Determining whether use of complexity theory can achieve an accurate and usable mental health ICP.
14. To verify the influence of a managed ICP upon clinical outcomes.
15. To review which models of ICPs have the most success across a range of outcomes.
16. To ascertain the impact of ICPs upon cost of services.
17. To understand what factors will influence medical professionals to use ICPs.

18. To determine whether a better alignment can be achieved between case management and care pathways.

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APPENDIX 1

MENTAL HEALTH LITERATURE SUMMARY BY DATE

Paper & Location	Type of Evidence	Research Design	Key Results / Discussion / Conclusions
Bultema et al (1996) – US	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Comparison of pre and post ICP measures for 12 patients in each group.	Description of the development and successful implementation of an ICP for older patients with depression. Development of the ICP was viewed as a positive experience for staff, helping collaboration and role clarification. The pathway was for 14 day hospitalised care, and some psychiatrists expressed concerns about length of stay becoming more important than the quality of care, and that it seemed less patient centred. Findings showed an overwhelming increase in the completion of interventions. Further comparisons of larger samples suggested that the ICP group of patients had significantly shorter length of stays, suggesting a 39% decrease and a subsequent 40% decrease in the average cost per case. Length of stay reducing by 9 days with an average savings of $5,770 per case.
Jones (1996) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	Discussion paper which debates the relationships between the use of ICPs in mental health, the under provision of hospital beds and length of stay as an indicator of quality. Jones (1996) described the increasing emphasis on reducing length of stay, the ethical concern that managed care is based solely upon cost and that health care professionals in the UK will oppose this ideology. Ultimately people may be discharged too quickly and community services are ill equipped to meet the needs of those service users.
Morgan et al (1996) – US	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case	Pre and post ICP comparison of length of stay, prescribing, discharge rates and	This study of a clinical pathway for alcohol withdrawal suggests reduced length of stay, reduced benzodiazepine prescribing and no increases in unplanned discharge or complication rates subsequent to the implementation of the ICP. The sample considered was 66 patients pre pathway, 56 after the ICP was introduced an 85 one year after implementation. Over the total period length of stay on average had reduced by 35% (2.36 days) with the largest fall achieved during the first 12 months after implementation.

	control study.	complication rates.	
Anders et al (1997) - US	Opinion and / or clinical experience of respected authorities.	Not applicable	This paper describes the development of a scientifically valid coordinated ICP for people with schizophrenia. The project describes how content validity method was used to validate the 161 items in the ICP, 151 of which were validated by local and national experts using a four point rating scale.
Jones (1997) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A discussion paper which considers whether the philosophy of managed care and care pathways would transfer from the US health system into the UK NHS. The paper gives an account of the history and components of managed care, the development of ICPs, their advantages and disadvantages. Jones (1997) concludes with the forecast that the approach to managing care imported into the UK will become associated with a professional blame culture and cost cutting; rather than the advantages of co-ordinated care, improved accountability and efficiency.
Thornton (1997) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This chapter describes the development and implementation of an ICP for Community Mental Health Services for children and adolescents. The author describes the development of the ICP with stakeholders - some of whom perceived the ICP as a threat. This was eventually resolved through process mapping and the stakeholders beginning to develop a shared vision of the service that had been established from 2 previous services combining. It is described that this ICP was successfully implemented following a pilot. It was though considered that identifying common elements of care was difficult when individuals had such diverse needs, accommodating this was the possibility of pathways within care packages used to support best practice for identifiable patient groups.
Brown et al (1998) – USA	Opinion and / or clinical experience of respected authorities.	Not applicable	A descriptive account of the implementation of a generic mental health care pathway used in inpatient psychiatry. The ICP ran across 3 phases and sought to become an interdisciplinary plan of care. Early observations were that there had been many benefits to using the ICP, although staff training needs had been underestimated.
Dykes (1998)	Opinion and / or	Not applicable	This text describes the role, process of development and implementation of ICPs. There

– US	clinical experience of respected authorities.		follows chapters that show examples of different ICPs for particular conditions and details of their content and implementation. In the text there are no systematic approaches to evaluation of the impact / outcomes of the ICPs outlined.
Jones & Kamath (1998) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Action research; participant observation and unstructured interviews.	This paper describes the issues involved in developing an ICP for inpatients with schizophrenia. The authors describe data collected through the observation of ICP development groups and interviews with staff, with the following issues identified as the main themes:- could schizophrenia be adequately portrayed in an ICP, care pathways would lead to the downfall of the interpersonal aspects of care and staff perceived ICPs would lead to the dilution and contributions of different professions.
Zacharias et al (1998) – US	Opinion and / or clinical experience of respected authorities.	Not applicable	This paper is a description of the development and implementation of an ICP for alcohol withdrawal. It was acknowledged that prior to developing the ICP there was considerable variation in practice and an MDT approach was used to develop the ICP. No difficulties were found during implementation and it was suggested that nurses in particular appreciated a consistent approach to care. Medical staff though suggested that it was a 'cookbook' approach but nevertheless used the ICP. Although not quantified there are reports of improved staff morale and improved multidisciplinary communication.
Chan & Wong (1999) – Hong Kong	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Semi structured interviews with nursing staff.	A review of the use of an ICP for inpatients with schizophrenia. Semi structured interviews with nurses were used to establish their perceptions of using the ICP. There is no information regarding sample size or reflections of other disciplines. The findings suggest that benefits of using the ICP were that care was more systematic and everyone knows their role. It was suggested that the nurses felt using the ICP had improved their autonomy, leadership and status. Difficulties were that some nurses had been resistive to introducing the ICP and that some disciplines were against the nurses' role leading the ICP.
Denton et al (1999) -	Opinion and / or clinical	Not applicable	Discussion paper in a peer reviewed journal about the complexity of mental health care and how care pathways could be utilised in this setting. Challenges to overcome were suggested

Australia	experience of respected authorities.		to be how to engage appropriate stakeholders in development, the complexity of using an ICP across a whole episode of care and determining appropriate outcomes. However, the discussion acknowledges that many healthcare organisations in Australia and New Zealand were at the time involved in ICP activity despite the possibility that they may be 'too difficult' to design for mental health care.
Jones (1999a) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Intensive interviewing strategies (sample size not stated), participant observation (duration or situation not described), and information from is facilitated work group meetings (1-2 hours per meeting – held over a period of 6 months).	This paper describes that in this case (an ICP for inpatient care of schizophrenia) ICP development was complicated and at times discussions were contentious. Barriers to developing the ICP were described as resistance from clinicians, the lack of evidence about the care and treatment of schizophrenia, interprofessional conflicts and the view that the ICP would compromise individualised care.
Jones (1999b) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This paper is a review of UK health policy and critical analysis of the literature about ICPs. It is suggested that policy is directing services towards standardised approaches to mental health care. Although the author relates that such standardisation does not align itself well to mental health problems, the ideology is likely to be opposed by mental health professionals and there is a lack of evidence to underpin the content of ICPs within mental health.

Lock (1999) – USA	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Data regarding costs, clinical outcomes and length of stay.	Lock describes a 2 years post implementation evaluation of an ICP for Anorexia Nervosa. The data suggests that payment denied by insurers has reduced and that the clinical indicator regarding the pace of weight gain had improved. In the last 2 years 100% of patients had achieved the target of increasing their weight by 1kg per week. In the first 18 months of the ICP, the length of stay reduced but then began to climb over the last 18 months; analysis suggested that this had generally been due to physical health complications, and that body weights on admission to the ICP has been significantly lower. Subsequently costs per pathway had also increased. The ICP had been used to demonstrate programme effectiveness and identify required practice changes.
Lock & Walsh (1999) – US	Opinion and / or clinical experience of respected authorities.	Not applicable	The authors describe the development and pilot of an ICP for dementia which spans hospital and out patient care. The definition of care outcomes is a strong feature throughout as well as patient satisfaction. Length of stay and charges per patient were other outcomes considered. However, the paper does not describe in detail the impact of the ICP upon outcomes – due to the small sample of patients that had used the ICP when the paper was written. Details of variances from the ICP during the pilot were given – again from a small sample of patients who had used the pathway. The authors in conclusion identify important aspects for quality improvement, challenges and system benefits for consideration in future development.
Wilson et al (1999) – Australia	Opinion and / or clinical experience of respected authorities.	Description of ICP development and data from staff focus groups post implementation.	The authors describe the ICP development process for an inpatient ICP for depression. Details of the 8 month pilot suggest that the ICP was only used for 58.6% of the patients for whom it was relevant. The ICP was not very well completed by many professional groups, and that no patients had completed the ICP by the 10 day target. In focus groups staff on the ground who had not been involved in ICP development felt that it had been imposed upon them and failed to understand what value it had.
Browning & Hollingberry (2000) – UK	Opinion and / or clinical experience of respected	Not applicable	This paper provides a description of the benefits of implementing ICPs in a UK Mental Health Trust. The account suggests that the development of several ICPs had been a manageable task conducted without difficulty. It was highlighted that similarly no difficulties were experienced during implementation and that the ICPs had contributed to

	authorities.		service development, raising awareness about evidence based practice, providing information to service users and carers and it was identified that leadership and ownership had been critical to success.
Hall (2000) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Interviews with 5 health care professionals and pre and post ICP comparison of key interventions.	A paper which outlines the development and implementation of an ICP for an inpatient organic assessment service for older people. No difficulties were reported in developing the ICP content. Pre ICP and post comparisons were made of 30 outcomes with 24 showing favourable improvements. Interviews with 12 health care professionals using the ICP suggested that the ICP had improved collaborative working, role clarification, evidence based practice and increased professionalism. Limitations identified were the reluctance to record variances, the influence of resources on delivering the pathway, anxiety when unable to deliver interventions and difficulty defining content that combined professional aspirations with realism.
Jones (2000) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Evidence from a non experimental descriptive study; Action research - including data from 29 in depth interviews, participant observation (frequent visits to the research site) and records of 15 work group	This paper describes the implementation of an ICP for inpatients with schizophrenia. It is described that during the implementation of the ICP the care setting experienced many changes, staff had left, morale was poor, the ICP was poorly implemented and there were low standards of record keeping. The findings reported poor staff engagement and commitment to the ICP, the detrimental impact of high levels of agency staff and that for the 7 patients for whom the ICP had been used much of it remained uncompleted. It was felt that a linear ICP did represent very articulately the course of the illness, individualised care or patient engagement. Consequently the pilot of the ICP was ceased.

		meetings.	
Nott (2000) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A discussion paper which describes the use of an ICP in acute inpatient care. There is a description using a case study of how the ICP works. There are impressions given about the benefits of using ICPs as an approach to managing mental health care.
Smith et al (2000) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	Description of a project about developing and implementing disorder specific pathways in acute inpatient care. Development and implementation are described positively. The authors suggest that their experience had been good and anecdotes suggest there have not been any negative impressions as a consequence of their use.
Goddard et al (2001) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Mixed methods including questionnaires and interviews with healthcare staff.	This case study set out to examine the current use of information technology in relation to decision support in mental health. A survey of the current use of Information technology suggested a large degree of duplication with existing record keeping, paltry access to information and many attitudes and barriers to moving decision support and ICPs forward.
Hall (2001) - UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Qualitative methodology with data from semi-structured interviews on 5 staff.	A paper outlining staff impressions of an ICP in older people's mental health services. A small sample provided data which suggested that staff felt that the ICP held had a positive impact upon care; improved team-working, efficiency and perceived better experience for service users and carers. It was outlined that staff were concerned about acknowledging variances, that they did not believe that the ICP had compromised individualised care and they perceived that the ICP might not influence the use of resources in the way that had been hoped.
Jones (2001a) – UK	Evidence from a non experimental	An action research	The findings suggest that care pathways may challenge the status quo that exists within mental health care. It is proposed that the process of developing the ICP in this case led to

	descriptive study, such as a comparative study, correlation study or case control study.	methodology involving ethnographic observations and 29 in depth interviews with 18 staff.	challenges about what care is given and that within the process professionals vigorously defend their professional boundaries. Therefore organisational culture and the power of professional groups impacts significantly upon ICP content.
Jones (2001b) – UK	Opinion and / or clinical experience of respected authorities.	Not Applicable	Discussion paper about the use of a care pathway for inpatient care for people with schizophrenia. The author progresses that for the ICP to be successful there is the assumption that the course of illness can be predicted, that a pathway can be used to describe the course of illness and that resources will be available to deliver the ICP. It is suggested that these issues may be overcome whilst the topic requires further research.
Keys (2001) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A paper describing the development of an ICP to ensure collaboration between community and inpatient staff in a UK mental health trust. There is discussion about the ICP as a staged process and how this serves as a framework for practitioners to follow.
McQueen & Molloy (2001) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A peer reviewed paper which considers the benefits of using ICPs in mental healthcare. The discussion stems from experience using ICPs in a high secure hospital and is shown by use of a case study describing an ICP in detail.
Baker et al (2002) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	The authors describe the development of a psychosocial interventions ICP within a low secure service. No difficulties were described in the process of development or implementation, with staff being overwhelmingly supportive. The account suggests that in their evaluation the ICP had improved care, the application of evidence based practice, service user experience and care planning.
Beardsall et al (2002) – UK	Evidence from a non experimental	Description of ICP	The authors describe the process of developing and implementing an ICP for electro-convulsive therapy. The ICP was piloted for 16 weeks, which included 15 patients using the

	descriptive study, such as a comparative study, correlation study or case control study.	development, audit, review of variances, staff survey and patient interviews during ICP pilot.	ICP. During the pilot there had been a good level of completion of the ICP document and variances recorded in 20% of the 90 planned treatments. Staff suggested via semi-structured discussions, interviews and postal questionnaires that the ICP had given structure to the process and clarified roles. Eight patients were interviewed and cared for using the ICP offered that they felt that they had received enough information about their care, their recovery was satisfactory and that staff had been helpful. They did express though that they were sometimes waiting too long for treatment causing undue anxiety – a factor addressed in a subsequent revision of the ICP.
Brett & Schofield (2002) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A discussion paper about an ICP used in order peoples inpatient services. The ICP developed is described and there is an anecdotal account of the benefits of its use. It is proposed that the ICP had improved the consistency of care and therefore the experience of service users. Staff using the ICP could be confident that the care was supported by evidence and that variances were being monitored.
Burgess (2002) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This paper gives an overview of the development of an ICP for attention-deficit hyperactivity disorder. There were no difficulties noted in the development or implementation stages. Conclusions suggest that development has improved communication, access to information, role clarity and knowledge of the management of attention-deficit hyperactivity disorder. Although these conclusions remain anecdotal.
Nott (2002) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Description of ICP development and comparison of pre ICP and pilot ICP measures.	This paper describes the development of a process based ICP for acute inpatient care. Development involved service user representation and it is described that the pathway described MDT interventions from admission to discharge with an emphasis on collaborative care planning throughout. Data from structured postal questionnaires pre and pilot pathway suggested that patients during the ICP pilot were more satisfied with information and the quality of care than before the ICP. Ninety percent said that they felt satisfied with their care (a 15% improvement). The mean length of stay during the ICP pilot was 12.46 days compared to 28.72 days pre pilot (56.6%) less. It is though noted there is little control over other potential variables that could impact upon length of stay.
Peet & Wakefield	Opinion and / or clinical	Not applicable	Discussion paper suggesting that as mental health care depends less upon technical procedures, mental health ICPs need to integrate interpersonal aspects. The authors suggests

(2002) – UK	experience of respected authorities.		that the impact of the placebo effect within mental health treatment, and its impact upon patient expectations, skills and beliefs indicates that such aspects as well as the patients role and interpersonal aspects require more elaboration in care pathway content.
Duncan & Moody (2003) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A discussion paper which stems from a review of ICPs in occupational therapy in mental health care. The authors describe that occupational therapists have contributed to multidisciplinary ICPs but there is little acknowledgement of their use in occupational therapy literature. It is proposed that occupational therapy many not strongly be embedded into ICPs because of a lack of evidence to support occupational therapy interventions and that the standardisation of care does not relate well to a patient centred approach. The authors go on to describe the integration of occupational therapy with a forensic service ICP and go on to support that the approach offer many benefits to the profession.
Hazell (2003) – Australia	Opinion and / or clinical experience of respected authorities.	Description of ICP development and evaluation of adherence for IIS presentations over a 12 month period.	The author describes the development of an ICP for young suicide attempters and ideators. There was a good degree of adherence to the ICP and it was suggested that using the ICP had led to a much higher attendance at follow up (80%) when compared to other studies. It was noted that the ICP had been highly localised and the content of it may not be generalised to other settings.
Jones (2003) - UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Interviews with 6 healthcare professionals and observation of the care pathway development process (15 working group	The aim of this research was to establish if healthcare professionals could develop an ICP for inpatients with schizophrenia. Respondents disclosed that they knew of little formal evidence to incorporate in to the ICP, although there was a general desire to improve the quality of care. There was a dominant theme suggesting that practice continues without formal knowledge about why particular interventions were offered and the impact of these; which had direct implications when trying to articulate care pathway content.

		sessions over 6 months).	
Sims et al, (2003) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This paper describes an ICP in use for a problem drinker in the community. The pathway covers assessment guidelines, clinical interventions and the process for home detoxification. It is suggested that the ICP has provided clarity about the service available, that the service is evidence based and it helped prevent inappropriate hospitalisation.
Wakefield & Peet (2003) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	Discussion paper about the critical success factors for developing mental health ICPs. The authors suggested taking a manageable approach to ICP development, developing ICPs for 'chunks' of the patient journey and engaging clinicians. Critical success factors for implementation were suggested as adequate staff training, a proactive care pathway facilitator, tracking variances and considering the relationship between ICP and the CPA (Care Programme Approach).
Chave et al (2004) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A paper describing the use of an ICP to deliver a nurse led clozapine clinic. Developing and implementing the ICP occurred without difficulty and anecdotal reports suggest an improved experience for service users and greater co-ordination and involvement by key staff.
Emery (2004) – UK	Opinion and / or clinical experience of respected authorities.	Audit of staff questionnaires, training evaluation forms, meeting and clinical review notes and records of discussions about the ICP.	Following a project of developing a care pathway for the assessment of psychosis it was suggested that staff's knowledge of psychosis, assessment and care pathways had increased (sample sizes not stated). The project identified future learning needs for staff and that various learning methods used in ICP development warranted further investigation should they be more widely used as a vehicle for staff training.
Emmerson et	Opinion and / or	Not applicable	The authors describe their development and trials of ICPs for depressions and schizophrenia

al (2004) – Australia	clinical experience of respected authorities.		in the same inpatient setting. After pilots the two ICPs were combined for all admissions (except for older adults, those with personality disorders and eating disorders). The rationale for this was that clinicians difficulty deciding which ICP to use on admission and that the eventual differences between the ICPs were very minor. Conclusions suggested that as mental health care is complex then an ICP needs to be flexible and that ICPs for mental health may be better being generic rather than diagnosis based.
Hall (2004a) – UK	Opinion and / or clinical experience of respected authorities.	Content analysis of 10 ICPs and categorisation based on a structure for analysing activity.	Content analysis suggested that much of the ICP content focused upon assessment and administration. Discussions which followed questioned how well ICP content reflects actual practice. There was a focus upon administration and assessment, and lack of direct care interventions in ICP content.
Hall (2004b) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	Chapter in a text focusing about acute inpatient mental health care describing an ICP approach to managing care, and also the limitations and benefits of the approach.
Jones (2004) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Action research methodology, with data from ICP working group meetings and 29 structured interviews.	The findings suggest that clinicians struggle with the standardisation of mental health care seeing each patient as unique and individual. It was though suggested that there could be a generic framework but that care should remain individualised. It was forwarded that if ICPs were to be used they need to be flexible to incorporate individualised care.
Kuzui et al (2004) - Japan	Evidence from a non experimental	Comparison between the	Impressions of care givers collected via questionnaires (total sample not stated) suggested that they had gained a better understanding of the patient, the expected care process and

	descriptive study, such as a comparative study, correlation study or case control study.	care of 23 patients care for using an ICP for dementia and 20 patients in a control group treated by conventional methods. Using cost, length of stay data and staff impressions.	caring for people with dementia. Although some doctors and nurses described feeling restricted by the ICP and that they were now required to do more work in a day. The length of stay for the ICP group was 6 days less that the non ICP group and the cost of the inpatient stay $669 less.
Moos (2004) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	An original paper that describes the development and implementation of an ICP for post natal depression. The paper describes the benefits of using the ICP as improved patient care, risk management, improved outcomes, patient centred care and improved collaboration – although these are based upon anecdotes.
Mynors-Wallis et al (2004) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Comparison of 45 standards for an ICP group and a non ICP group.	This is a controlled study comparing the outcomes of 26 patients cared for using an ICP and 30 patients cared for using traditional approaches (not an ICP). Interviews with 29 staff found that 90% thought the ICP was a good idea and 86% felt that it would benefit patient care. The study showed no real differences in the achievement of the process standards of the ICP, or clinical outcomes (measured via the Brief Psychiatric Rating Scale, the Clinical Global Impressions or the Camberwell Assessment of Need Scale) between the ICP and control group.
Rees et al (2004) – UK	Evidence from a non experimental descriptive study,	Interviews with 5 staff members.	Study of staff perceptions of an ICP used in a community mental health team. Staff reported positive views about the ICP but in practice were not using it. A lack of integration, inter-service conflicts, inadequate resources and absence of change management meant that the

	such as a comparative study, correlation study or case control study.	Group interviews with 6, 5 and 4 participants (staff).	ICP was not used. Conclusions suggested that the ICP alone could not overcome organisational barriers, and that strategic involvement is as critical for success as ownership on the ground.
Soltysiak & Millward (2004) – UK	Opinion and / or clinical experience of respected authorities.	Post implementation questionnaire – details unknown.	This paper is based upon information informally gathered to give feedback on the use of admission and discharge ICPs in older people's inpatient services. It is proposed that the completed ICPs were evidence of a more consistent approach to care. 47% of staff who responded to questionnaire (sample size unknown) suggested that they though that the ICP had – had a positive impact upon patient experience. However the authors did note problems with compliance in completing the ICP, and suggested that greater involvement of staff at the ICP development stage could have improved commitment as well as the content. Overall the ICP was viewed as an effective way to manage service improvement.
Grant et al (2005) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Pre and post comparison of activities / care using delineating measures – for 23 service users care via the ICP and 23 pre ICP.	Following ICP implementation there were significant improvements in the completion of interventions, and small numbers decreased or showed little difference. An average of 58.2% of interventions was completed pre ICP compared to 73.6% post ICP. There was little evidence that the ICP had though impacted on the timeliness of interventions. Data also indicated the ICP had less impact upon the completion of interventions by medical staff, compared to other staff groups.
Hall et al (2005) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	Description of ICP development and implementation in acute inpatient care, with no discernable difficulties in development, although some professional groups were reluctant to implement the ICP, and whilst all stakeholder groups were involved in development it was difficult to represent the views of all the individuals who would go on to use the ICP. The paper goes on to describe the main variances reported and the lessons learnt.
Harrison, Hillier &	Opinion and / or clinical	Not applicable	A peer reviewed paper that describes the process undertook to develop an ICP for self harm. A practice development methodology was used to develop an ICP, wishing to secure last

Redman (2005) – UK	experience of respected authorities.		practice change across the health community. It was reported to be an enabling experience to improve practice in an area of practice cited as being particularly challenging.
Jones (2005) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Action research using unstructured interviews with 11 respondents and observation of the development sessions and use of an ICP.	This paper describes perceptions about individualised care whilst studying an ICP for inpatient schizophrenia. Staff described that individualised care is about knowing the patient, developing a relationship and the values of the clinician. Conclusions suggest that mental health professionals strongly feel that individualised care is central to their value system and any form of standardisation poses a threat to this.
Rayner (2005) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This paper describes the use of an ICP in a mental health residential setting. The author agrees that service user involvement in the development of the ICP addressed the issue of the therapeutic relationship, individualised care and service user perspectives.
Fleming (2006) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	An account of using an ICP to implement the Scottish schizophrenia guidelines. There is particular attention given to outlining the process of developing the ICP and its implementation as part of an electronic health record.
Hall (2006) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A chapter that describes the relationship between ICPs, risk management and governance. The focus is upon variance analysis and continuous quality improvement.
Hall &	Opinion and / or	Not applicable	A text of 15 chapters dedicated to ICPs in mental health. Six chapters considering theories

Howard (2006a) eds – UK	clinical experience of respected authorities.		about the use of care pathways in mental health with the remainder describing the use of ICPs in different mental health settings. Some chapters describe pre and post ICP measures.
Hall & Howard (2006b) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A chapter that details the definition, provenance, theoretical framework and development of ICPs in the UK. Supported by accounts of the benefits and limitations of their use and development.
Hendriks & Mahendran (2006) – Asia	Opinion and / or clinical experience of respected authorities.	Not applicable	A paper describing the development and implementation of 9 ICPs used in a tertiary psychiatric hospital. There is an overview of the development model used, and anecdotes about implementation and outcome measures. The conclusions suggest a number of benefits – although these have not been demonstrated by any systematic investigation.
Emmerson et al (2006) - Australia	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Pre and post ICP comparison of clinical indicators (sample size not stated).	After the development of ICPs for depression and psychosis these were amalgamated into one ICP for acute inpatient care. After 12 months performance measures for the ICP of patients were compared to a pre ICP group. Although compliance to completing the ICP document was noted as variable. Pre ICP and ICP comparison was made for length of stay, unplanned re-admissions, absconding, self harm and suicide attempts – with little impact of the ICP determined. Conclusions proposed that the individuality of mental health problems suggested that ICPs for this patient group have little benefit.
Forsyth (2006) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A chapter describing the process of developing and implementing an ICP for self harm. The close attention to clinical guidelines in the process of development is discussed alongside other relevant literature. There is a clear account of implementation and its perceived impact upon engagement, boundary setting, observation and coping with the urges to self harm.
Frazer et al (2006) - UK	Evidence from a non experimental	Questionnaires of graduate	A study via questionnaires of graduate mental health workers, General Practitioners (GPs) and service users' impressions of an ICP used for depression in primary care. Feedback via

	descriptive study, such as a comparative study, correlation study or case control study.	mental health workers, GPs and service users.	questionnaires (sample size unknown) was positive. GPs thought the ICP had been a mechanism for referral but that it had not otherwise changed their practice. Graduate mental health workers felt that the ICP had clarified their practice, ensured their compliance with evidence based practice and aided collaboration. Service users' feedback suggested that they were satisfied with the service, and clinical outcome measures indicated positive changes (although there is not evidence to support the latter claim).
Gunstone & Robinson (2006) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This paper describes the development of an ICP for dementia. The authors described no real difficulties in defining the content for the ICP, although the structure of the document itself took some effort to establish. The paper does not indicate that service users were involved in ICP development, although there is a discussion about the importance of service user and carer involvement and how they (the authors) might seek to achieve this in the future.
Hall & Conelly (2006) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This chapter describes the development and use of an ICP for crisis triage and home treatment. The formulation of the ICP was followed by pilot, implementation and review. It is suggested that this ICP achieved an excellent rate of compliance through high levels of commitment and engagement with the clinical team.
Hanson et al (2006) – Canada	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Pre and post ICP comparative study. Pre ICP audit of charts and semi structured interviews with 10 clinicians.	An ICP for early psychosis was developed after it was identified that care standard failed to reach the expectations of published guidelines. The ICP was implemented across 4 communities (population of 575,000) seeing 100 clients a year. After a year the 51 ICPs that had been open for more than 3 months were included in a review of charts which measured the completion of the same interventions that were reviewed pre pathway. There was a noticeable improvement in compliance with standards, particularly in the provision of family interventions and client engagement with several measures showing statistically significant differences.
Institute for Innovation & Improvement (2006) – UK	Opinion and / or clinical experience of respected	Literature review, analysis of hospital episode data,	This document describes a prototype example of an acute inpatient ICP. It illustrates the ideal patient journey which should achieve improved outcomes and better value for money.

	authorities.	visits to 4 healthcare providers and interviews with or observation of 160 staff and patients.	
Irons (2006) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	An edited chapter which focuses upon the legal aspects of ICPs. The author reviews their relationship with clinical guidelines, the legal aspects of variance, negligence and relevant case law.
Jackson (2006) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A chapter outlining the use of an ICP for individuals presenting at accident and emergency following self harm. Yet to be fully evaluated staff suggested that they found the support that they had to implement the ICP was critical, and that outcomes for patients were beginning to be used to consider the impact of particular interventions.
Jenkins (2006) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This chapter describes the use of an ICP with a high secure forensic service. A structured evaluation process suggests that the ICP had improved the planning and organisation of care, improved communication and services as a tool for educating staff. The main problems found related to the format and layout of the document.
Jones (2006) – UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case	Participant observation during ICP development and implementation and 29 semi	Jones' findings suggested that some MDT members felt threatened during the ICP development process, whilst other professional groups saw it as an opportunity to revitalise their contribution to the process of care. But nevertheless others felt dominated by other disciplines contributions and that this had an impact upon their professional identity. Nurses and Doctors particularly experienced difficulties in articulating interventions and the outcomes of these – this corresponded with observations of more care happening in reality than was described in the ICP. Generally ICP development sessions were uncomfortable

	control study.	structured and unstructured interviews over a period of 12 months. Based on an action research approach. Field notes were also used as a data source.	with some professional feeling inferior and anxious with a feeling that power between professional groups would impact upon care pathway content. The discussion highlights that despite the fact that a multidisciplinary ICP was developed, professional groups maintained boundaries to protect their professional remits and territory, and this led to some professional groups disengaging from the ICP.
Page & Sorribas (2006) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	An edited chapter which considers the relationship between ICPs and the care programme approach (CPA). There is consideration about using a care pathway approach and a service model for the delivery of the CPA. There follows proposals about how this may be translated into an electronic format within future care records.
Pringle (2006) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A chapter which describes the development and use of an ICP for electroconvulsive therapy. There is an overview of the literature about ECT, the rationale for developing the ICP, a description of the process of development and implementation, and a summary of outcomes.
Rawdon et al (2006) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	This chapter describes the development and implementation of an ICP for adolescents with an eating disorder. The chapter describes a stepped ICP built around best practice with service user involvement to ensure that appropriate outcomes are embedded into the ICP.
Roberts (2006) – UK	Opinion and / or clinical experience of	Not applicable	The outcomes of using an ICP in older peoples' mental health services are described as improved coordination of care, role clarification and the timely delivery of interventions. The use of the ICP also triggered perceived better levels of patient involvement by the use of

	respected authorities.		patients' stories, carers' assessments and involvement in care planning.
Wood & Green (2006) - UK	Opinion and / or clinical experience of respected authorities.	Not applicable	A chapter that describes the use of ICPs as a means to integrated working. There is a discussion about using ICPs across professional boundaries, developing a common language about care, professional teamworking and risk management.
Hendricks & Mahendran (2007) – Asia	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Study of length of stay over 3 years of implementation over 9 ICPs.	This paper describes the use of 9 ICPs used within inpatient services. It is suggested that the use of ICPs had reduced length of stay and readmission rates, and increased the likelihood of interventions being delivered. There appears to be a good rate of interventions delivered (although there is no pre ICP comparison), and there is a fall in length of stay. Readmission rates are well below the target of 9% whilst again there is no pre ICP data for comparison.
Hendricks et al (2007) – South East Asia	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Audit of the demographic and social status of patients and their outcomes in relation to an ICP for relapsed schizophrenia.	A retrospective study of 37 patients who were cared for using an ICP for relapsed schizophrenia at a psychiatric hospital in South East Asia. Most of the patients on the pathway were single and still living with their parents, and had been ill for 10 years or longer. Sixty-five percent were in hospital for less than 21 days and 20% stayed longer than 29 days. Fourteen percent were readmitted within 28 days.
NHS Quality Improvement Scotland (2007) – UK	Opinion and / or clinical experience of respected	Not applicable	Authoritative guidance from an established Government sponsored health body. The document sets out what ICPs are, and anticipated generic, condition and service improvement standards.

	authorities.		
Peterson & Micheal (2007) – Australia	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Analysis of treatment response to 170 patients cared for one of 5 diagnosis based inpatient ICPs.	The findings suggest that those who were more severely ill progressed along ICPs more quickly than those who had less symptoms and distress on admission. Using regression analysis the strongest predictor of successful treatment outcome (defined as lower length of stay) was co-morbidity – an unexpected finding.
Rigby et al (2007) - UK	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Quantitative audit data and service structured interviews with service users.	It is suggested that using the ICP for occupational therapy within a crisis resolution / home treatment service that the ICP had improved access to occupational health interventions, enabling these professional to optimise their contributions. The data suggested that it had been possible to use the ICP as a framework to deliver National Standards for Occupational Therapy and improve awareness of their role and contribution.
Warr & Hoyle (2007) - UK	Opinion and / or clinical experience of respected authorities.	Fleeting reference to two focus groups with prisoners (no details available).	This paper describes the implementation of a national offender mental health pathway in a prison. There is a description of how the standards of the pathway have been implemented. Two focus groups (size unknown) with prisoners suggested that they experienced difficulties mixing with other prisoners, there is not enough meaningful activity, the first night in prison is very brief, the initial physical examination short – it was the intention that these aspects should be incorporated into future developments. Conclusions suggest that more work needs to be done around mental health promotion, access to past medical history remains a problem, multidisciplinary approaches need to be more widely embedded and there is still a need to improve discharge planning.
Wylie et al (2007) – UK	Opinion and / or clinical experience of	Not applicable	This paper describes the development and use of an ICP for perinatal psychiatry. The care pathway was developed as part of an organisational approach to managing change. It is suggested in anecdotes that the pathway improved the identification and management of

	respected authorities.		care for this patient group – mainly borne out of the development and learning process.
Department of Health (2008) – UK	Opinion and / or clinical experience of respected authorities.	Not applicable	Care pathways are cited as a way of improving practice around the Care Programme Approach. It is suggested that care pathways as part of a whole systems approach can improve the quality of care, integrated working, and the use of information as well as drive forward service improvement.
Henricks et al (2008) – South East Asia	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Questionnaires completed by 137 mental health professionals (of various staff groups). A response rate of 78.4%.	A study to establish staff perspectives about the use of 11 mental health ICPs used in a psychiatric hospital in South East Asia. More than three quarters found the ICPs useful as a checklist, whilst less (45.3%) used them as an aid to clinical decision making and 31% thought they would reduce variations in practice. Whilst only 8% felt they were detrimental to good patient care and 16% felt they infringed upon professional autonomy. Almost half of respondents indicated that the ICPs had in their view improved their care of patients.
Repper-Delisi (2008) – US	Evidence from a non experimental descriptive study, such as a comparative study, correlation study or case control study.	Comparison of 40 ICP patients to 40 non ICP patients to review the impact of the ICP on interventions and outcomes.	Study examining the outcomes of an ICP for alcohol withdrawal. It was shown from an analysis of clinical interventions that staff had implemented the ICP and that length of stay and the incidences of deterioration had improved during the use of the ICP.
Evans-Lacko, Jarrett, McCrone and Thornicroft	Opinion and / or clinical experience of respected	Not applicable	Discussion paper summarising the use of ICPs in mental health care to date. Acknowledging that the evidence base is weak and the prospective work that is being done around ICPs and payment by results.

(2008) - UK	authorities.		

APPENDIX – 2

SUMMARY OF CARE PATHWAY CONTENTS BY PAGE

Page Number	Content
1	Care Pathway Title – ICP for Acute Adult Admission and Assessment
	Description of the purpose of the care pathway.
	Personal Details of the Patient
	Location that the ICP is used in i.e. Ward, Location etc
	Objectives of the ICP; • Initiate a therapeutic relationship and provide prompt expert assessment of individual needs • Ensure effective care planning, co-ordinated care and risk management; user and carer involvement and communication • Provide effective, evidence based interventions to help recovery • Establish effective liaison and ensure that appropriate and necessary treatments and services are offered
	The evidence base of the ICP
	Instructions for completing the ICP
2	Explanation of the abbreviations in the care pathway
	High level process map of the pathway
	Notes about using the ICP as part of the healthcare record
3	A register of signatures of healthcare professional using the ICP
4	Personal and demographic details of the patient, and details of carers and others involved in care (includes Health of the Nation Outcome Scores, allergies, carers appraisal etc)
5	Details of carers
	Record of cultural and religious needs
	Physical Description (height, weight etc)
	Activities related to immediate reception and care
	Record of individualised interventions (a record of care given that is not detailed in the activities above)
	A place for variance recording in relation to the activities related to immediate reception and care
6	Confidentiality statement and agreement regarding the sharing of information
7	Details of the circumstances leading to admission
	The agreed purpose of admission
	Arrangements related to the need for an interpreter
	Details of any Advance Directive
8	A multi-agency moving and handling assessment
9	A brief risk assessment
10	A risk profile and management brief including; and assessment of risk factors and summary of risk assessment
11	A risk management plan
12	Record of observation levels
13	Activities to be completed within 3 hours of admission by the admitting nurse

Page Number	Content
13	Activities to be completed within 3 hours of admission by the responsible medical officer where urgent medical assessment is needed (or within 24 hours)
	Activities to be completed within 24 hours of admission by the nursing team
	Record of individualised interventions (a record of care given that is not detailed in the activities planned within the first 24 hours of admission)
	A place for variance recording in relation to the activities anticipated within the first 24 hours of admission
14	The 72 hour multidisciplinary care plan
	The activities to be completed by the named nurse or team within 72 hours of admission.
	The activities to be completed by the ward administrator within 72 hours of admission.
	The activities to be completed by the ward administrator within 72 hours of admission.
	Record of individualised interventions (a record of care given that is not detailed in the activities planned within 72 hours of admission)
	A place for variance recording in relation to the activities anticipated within 72 hours of admission
15-17	Health and social care assessment, covering self care and diet, psychological health, safety to self and others, accommodation, money, daily occupation, structure and interests, sigma and harassment, social contacts, close relationships, language and culture, physical health, looking after the home, employment, information about condition and treatment, alcohol and drugs, childcare, educational needs, transport, sexual expression and religious beliefs.
18	Additional referral information
19-20	Initial multidisciplinary case review to be completed within – days.
21-22	Individual care plans to be completed within - days
23-24	A record of supplementary interdisciplinary interventions
25	Progress of care and activity programme
	Named Nurse interventions to be completed by day 10
	A place for variance recording in relation to the activities to be completed by day 10
26 - 27	Pre discharge CPA Review completed within – days of discharge
28	Activity to be completed by the Nurse coordinating discharge
	Record of individualised interventions (a record of care given that is not detailed in the activities planned prior to discharge)
	A place for variance recording in relation to the activities anticipated prior to admission
29	Discharge letter to the GP
30	A register of all the variances in the pathway recorded using a code to represent the activity/intervention that arose as a variance with a variance code referencing the reason for the variance.

APPENDIX 3

INTERVIEW SCHEDULES

Interview Schedule Version 1

Aim – To answer the research question - How do healthcare professionals' use ICPs as an approach to managing mental health care?

Introduction

- The purpose and rationale for the study
- Confidentiality, ethical considerations and use of the data
- Setting the agenda, time, goal directed discussion, participation, ground rules
- Consent

Questions

1. Please describe how you use the ICP on a day to day basis?
2. What are your experiences of using an ICP as an approach to managing care (its purpose, feeling, professional issues, meaning)?
3. What would you say are the strengths and weaknesses of its use (giving examples)?
4. Please describe how the patient journey progresses through the care pathway.
5. What are the main issues that are encountered on the way (interventions, variations, choice, decision making, others)?
6. If you were asked what the main clinical or professional issues were related to using an ICP,
    - what would you say that they were,
    - how and why have they arisen
    - and what are the implications of these?
7. Is there anything that you have not said that you would wish to add to the issues already discussed?

Close

- Thanks
- Reiterate use of the data, access to findings
- Validation of the transcripts and codes

Interview Schedule Version 2 (amended after 3rd interview)

Aim – To answer the research question - How do healthcare professionals' use ICPs as an approach to managing mental health care?

Introduction

- The purpose and rationale for the study
- Confidentiality, ethical considerations and use of the data
- Setting the agenda, time, goal directed discussion, participation, ground rules
- Consent

Questions

1. Please describe how you use the ICP on a day to day basis? (or what do you know of it, or other means of managing care?)
2. What are your experiences of using the ICP as an approach to managing care (its purpose, feeling, professional issues, meaning)?
3. What would you say are the strengths and weaknesses of its use (giving examples)?
4. Please describe how the patient journey progresses through the care pathway (stages, interventions, ICP content and actual practice)
5. If you were asked what the main clinical or professional issues were related to using an ICP,
    - what would you say that they were (choice, pre-formulation, individualised care, integrated care),
    - how and why have they arisen
    - and what are the implications of these?
6. Is there anything that you have not said that you would wish to add to the issues already discussed?

Close

- Thanks
- Reiterate use of the data, access to findings
- Validation of the transcripts and codes

Interview Schedule Version 3 – Amended following the 5th Interview

Aim – To answer the research question – How do healthcare professionals' use ICPs as an approach to managing mental health care?

Introduction

- The purpose and rationale for the study
- Confidentiality, ethical considerations and use of the data
- Setting the agenda, time, goal directed discussion, participation, ground rules
- Consent

Questions

1. Can you describe to me the methods or approaches which you use to manage or structure care on a day to day basis (care plans, case management, CPA, ICP)?
2. Can you tell me are you familiar with the ICP used in acute inpatient care, if so would you please describe your use this?
3. What are your experiences of using the ICP as an approach to managing care (its purpose, feeling, professional issues, meaning)?
4. What would you say are the strengths and weaknesses of its use (giving examples)?
5. Please describe how the patient journey progresses through the care pathway (stages, interventions, ICP content and actual practice)
6. If you were asked what the main clinical or professional issues were related to using an ICP,
    - what would you say that they were (choice, pre-formulation, individualised care, integrated care),
    - how and why have they arisen
    - and what are the implications of these?
7. Is there anything that you have not said that you would wish to add to the issues already discussed?

Close

- Thanks
- Reiterate use of the data, access to findings
- Validation of the transcripts and codes

APPENDIX 4

FOCUS GROUP SCHEDULES

Focus Group Schedule Version 1

Aim – To explore what are service users' and carers' experiences of care that is managed using an ICP?

Introduction

- The purpose and rationale for the study, introductions
- Confidentiality, ethical considerations and use of the data
- Setting the agenda, time, goal directed discussion, participation, ground rules
- Consent

Questions

1. From your own perspectives can you describe the practical ways that were used to manage and organise care during the time on the pathway (care plans, ward rounds, information, pathway, named nurse)?
2. What was this experience like, how did you find it (organised, free, flexible, confusing)?
3. Can you describe how you were involved in how care progressed and it was organised (priorities, agenda, perspective, care plans, needs, decision making, information)?
4. Thinking about the pathway what would you describe as the main events as the time progressed (interventions, variations, choice, decision making, others), and what are the main issues (good or bad) that were encountered on the way?
5. Can you describe from your perspectives how during the pathway you could be or were involved in care planning, review and evaluation
    - can you give instances of where this happened
    - can you give instances of where this didn't happen
6. If you were asked about the choice you had, can you describe
    - what choice means from your perspectives
    - how you exercised choice
    - what made choice successful

    - what limited choice

7. Is there anything that you have not said that you would wish to add to the issues already discussed

Close

- Thanks
- Reiterate use of the data, access to findings
- Validation of the transcripts and codes

Focus Group Schedule Version 2
(Revisions following the Interviews to focus on choice, involvement, individualised care and communication)

Aim – To explore what are service users' and carers' experiences of care that is managed using an ICP?

Introduction

- The purpose and rationale for the study, introductions
- Confidentiality, ethical considerations and use of the data
- Setting the agenda, time, goal directed discussion, participation, ground rules
- Consent

Questions

1. From your own perspectives can you describe the practical ways that were used organise your care (do you recall anything about care plans, ward rounds, having a named nurse)?
2. What was this experience like, how did you find it (organised, free, flexible, confusing)?
3. Can you describe how you were involved in how your care progressed (priorities, agenda, perspective, care plans, needs, decision making, information)?
4. If you were asked about the choices you had, can you describe
    - what choice means from your perspectives
    - how you exercised choice
    - what made choice successful
    - what limited choice
5. Thinking about your own experiences what would you describe as the main events as the time progressed (interventions, variations, choice, decision making, others), and what are the main issues (good or bad) that were encountered on the way?
6. Would you say that your care was based upon your individual needs?
7. If you were to describe the communication about your care, with you and between those involved in your care, what would you say?
8. Is there anything that you have not said that you would wish to add to the issues already discussed

Close

- Thanks
- Reiterate use of the data, access to findings

Validation of the transcripts and codes

APPENDIX 5

DOCUMENTARY ANALYSIS DATA COLLECTION SCHEDULE

1. Case No (DA1-60)		**7. Age at time of ICP (yrs)**	
2. Ward (Coded W1-7)		**8. Gender**	
3. Unit Location (B, G, S, L)		**9. Ethnicity**	
4. Consultant (Coded C1-…)		**10. CPA Level**	
5. MHA Status		**11. Religion**	
6. Date Pathway Commenced			

	Criteria	ICP Completed? (yes/no)	Further Evidence (location)	Evidence Found? (yes/no)	Comments
12.	Personal Information recorded on Admission				
13.	CPA Status known on admission				
14.	Main Carer identified on admission				
15.	Appraisal of Carer's needs considered on admission				
16.	Care Coordinator known on admission				
17.	HoNOS Score on admission ______				
18.	Acknowledgement of cultural and spiritual needs on admission				
19.	Physical description completed				
20.	Consent for admission considered		Medical Notes		
21.	Immediate level of Observation given		Medical Notes		
22.	Immediate Reception and Care Signed off				
23.	Individualised Interventions?				
24.	Variances?				
25.	Confidentiality Statement completed				
26.	Reasons for admission completed?				
27.	The purpose of admission has been stated (as agreed)				
28.	Need for an Interpreter has been considered				
29.	There are details of an advance directive				
30.	Moving & Handling				

	Profile completed				
31.	**Date of Completion ________**				
32.	**Time between admission and completion ________**				
33.	**Risk Profile & Management Brief completed?**				
34.	**There is a summary and plan recorded on the above**				
35.	**Date of Completion ________**				
36.	**Time between admission and completion ________**				
37.	**Detailed Risk Profile & Management Brief completed?**				
38.	**Is there evidence that services users or carers were involved in the Risk Assessment?**				
39.	**The Initial Risk Management Plan has been completed?**				
40.	**There is evidence that the service user was involved in the plan**				
41.	**There is evidence that a carer was involved in the plan**				
42.	**Opportunities for risk prevention have been considered**				
43.	**The responsibilities for future actions are clearly stated**				
44.	**Date of Completion ________**				
45.	**Time between admission and completion ________**				
46.	**The record of observation level has been maintained**				
47.	**There is a stated named nurse within 3 hours of admission**				
48.	**Within 3 hours of admission the RMO has reviewed the observation level**		**Medical notes**		
49.	**The need for physical investigations has been confirmed within 3 hours of admission**		**Medical notes**		
50.	**Within 3 hours of**		**Medical notes**		

	admission a physical examination has been completed				
51.	Individualised Interventions?				
52.	Variances?				
53.	72 hour care plan completed?				
54.	There has been a full Mental State Examination, formulation and management plan recorded		Medical Notes		
55.	Time between admission and completion ________ (target within 3 days of admission)		Medical Notes		
56.	Results of physical investigations have been reviewed		Medical Notes		
57.	Time between admission and completion ________ (target within 3 days of admission)		Medical Notes		
58.	Individualised Interventions?				
59.	Variances?				
60.	The MANCAS has been completed within 3 days of admission				
61.	Date of Completion ________________				
62.	Time between admission and completion ________				
63.	There is a summary of needs at the end of the assessment?				
64.	Referrals have been made to other agencies?				
65.	The initial case review has been completed				
66.	Date of Completion ________________				
67.	Time between admission and completion ________ (target within 5 days of admission)				
68.	There is an estimated date of discharge?				
69.	A copy of the care plan has been given to the carer				
70.	There are agreed interventions		These are referenced in the		

			Care Plan		
71.	The main care plan has been completed				
72.	The main care plan is signed by the service user				
73.	Date of Completion ________				
74.	Time between admission and completion ________ (target within 4 days of admission)				
75.	Interdisciplinary Interventions have been recorded in the ICP				
76.	Progress and Activity Programme; There is evidence that the Care Coordinator has visited (if there is one)		Nursing Notes		
77.	The service user has had specific information about their illness		Care Plan/ Nursing Notes		
78.	There is an activity programme in place				
79.	Time between admission and completion ________ (target within 3-10 days of admission)				
80.	Variances?				
81.	The Pre-discharge case review has been completed				
82.	Date of Completion ________				
83.	Time between admission and completion ________ (target within 2 weeks of discharge)				
84.	There is an estimated date of discharge?				
85.	A copy of the care plan has been given to the carer				
86.	There are agreed interventions		These are referenced in the Care Plan		
87.	Discharge; The service user ahs medication to take home				
88.	The service user has a copy of their care plan for after discharge		Care Plan		
89.	Stakeholders are aware of discharge				

90.	Care Coordinator has visited prior to discharge		Nurses Notes		
91.	Outpatient arrangements are accounted for predischarge				
92.	Individualised Interventions?				
93.	Variances?				
94.	GP's letter Completed				
95.	Variance Sheet maintained?				

Date Pathway Ended	
Length of Stay (days)	

96.	Evidence of attendance at OPA after discharge		Medical Notes		Date of first OPA after discharge
97.	Evidence of Care Coordinator contact after Discharge		Medical Notes/Care Plans		Date of first Contact after discharge

APPENDIX 6

ETHICS APPROVAL

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1

1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 01159123344
Facsimile: 01159123300

27 September 2006

HEAD OF ADMIN AND
PERFORMANCE MANAGEMENT
02 OCT 2006

Mrs J Hall
Head of Performance & Administration
Nottinghamshire Healthcare NHS Trust
Rampton Hospital
Retford
Nottinghamshire
DN22 0PD

Dear Mrs Hall,

Full title of study: **A case study of how Integrated Care Pathways are used in mental health care**

REC reference number: **06/Q2501/158**

Thank you for your letter of 07 September 2006, responding to the Committee's request for information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	1	17 July 2006
Investigator CV		14 July 2006
Investigator CV	1	21 June 2006
Protocol	2	06 August 2006

Summary/Synopsis	1	16 June 2006
Letter from Sponsor		10 July 2006
Peer Review		07 July 2006
Peer Review		07 July 2006
Interview Schedules/Topic Guides	2	06 August 2006
Letter of invitation to participant - Focus group	2	06 August 2006
Letter of invitation to participant - Interview	2	06 August 2006
Participant Information Sheet: Focus Group	2	06 August 2006
Participant Information Sheet: Interview	2	06 August 2006
Participant Consent Form	2	06 August 2006
Response to Request for Further Information		07 September 2006
Data Collection Template	2	06 August 2006
Focus Group Schedule	2	06 August 2006
R & D Application form	1.0	20 August 2006
Letter from C J Slavin		30 August 2006

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q2501/158	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr C Edwards/Ms L Ellis
Chair/Co-ordinator

Email: linda.ellis@rushcliffe-pct.nhs.uk

Enclosures: *Standard approval conditions*

SF1 list of approved sites