Mapping 'Ideal' Referral Pathways

Key Considerations, Old & New Concepts

Patrice Reilly, Caroline Lawson, Juliette O'Sullivan, Lorraine McGowan, Ciara Hickey (2023)

Enhanced Community Care

Introduction

Users want continuity of care (Waddington and Egger, 2008). The complexity of the health system's design often leads to a lack of 'ownership' of the service users' problem (Goodwin, 2016). Treating one condition without recognising others leads to segmented care, poor communication within and between services, duplication and gaps in care provided. This frequently results in poor outcomes for the person, their carer and for the system as a whole (Goodwin, 2016).

Developing integrated referral and care pathways to address this has been a core aim of the integrated care programmes (e.g. ICPOP, 2016), Slaintecare (2017) and Enhanced Community Care (HSE, 2021).

This project group formed as part of the inaugural HSE & RCSI Embracing New Ways of Working course in DNCC CHO in 2023. The project group was tasked with mapping the 'ideal' referral pathway within primary care. Project group members worked across integrated care, primary care, health promotion and child and adolescent mental health in Balymun CHN and comprised of social work, nursing, management and health promotion disciplines.

Referral Pathway Definition

For the purposes of the project, a **"referral pathway"** is defined as the journey or route that a person will take from their first contact with a service, through reception, triage, admission, assessment, treatment and care to discharge. Pathways are integrated by definition with clear steps and timeframes for each stage of the process.

Aims & Methodology

The project set out to review current pathway processes, identify areas that could be improved and areas that could be scaled up, and propose new concepts from the literature and other areas of practice that might improve the current primary care referral pathway within the Balymun CHN.

Following a review of the literature, the group mapped the current referral processes. The Balymun CHN is rich in innovative solutions to address population need and improve pathways. The group was keen to build on this good practice. Considering the depth of knowledge and experience in the area, the group facilitated a focus group with stakeholder representatives from heads of discipline and managers of service. To aid next steps recommended by the focus group, a Referral Pathway Checklist was developed Reflecting further on the initial mapping, the focus group's feedback, and on the learning from the literature, the project group devised a set of recommendations to improve each stage of the current referral pathway.

Focus Group Findings
What is Core to the 'Ideal' Referral Pathway?

Key themes that emerged during the focus group, as highlighted in the word cloud, reflect the literature findings. 'Ideal' pathways are

- **person centred, planned and preventative** adopting a **social determinants approach**, harnessing supports to live well, **making every contact count** at each stage in the process.
- **responsive, integrated, joined up and well-coordinated**. The experience for the user is **holistic, seamless, smooth** care that is easy to navigate and transition through, with a **minimum number of stages, staff contacts and visits**.
- **data & evidence informed. Standardised but agile** in responding to individual and population needs.

There is **regular and timely communication** with the user & all providers. Providers know and speak to each other. Users don't have to repeat their story unnecessarily. For workers, this means

- "working with professionals from different fields and coordinating tasks and services **across traditional boundaries**" (Darker, 2014: 26). Roles and skills shift per need. It means targeted resourcing and upskilling in areas such as interdisciplinary skills and complex case management.

Core to ideal pathways is enabling organisations to find ways to co-ordinate their work more effectively…The challenge will be to support the development of networks within and between multidisciplinary teams and organisations (Ham and Curry, 2011: 2). **Collaborative working, cooperation, relationships** and good communication within and across the various parts of the system are crucial (Valentijn et al, 2013; Cameron et al, 2012; Kodner and Spreeuwenberg, 2002; Walsh 2013).

While **structures** such as integrated data and case management systems are core enablers, focus group members and the literature emphasise that **communication, relationships and a culture that permits and supports innovation, creativity and bottom up responses** is perhaps more important.

Focus Group Findings – Current Pathway SWOT

The focus group identified some key areas that could be improved in the current pathway as follows:

- Further **early intervention while on wait lists**
- **Improved team working, networking, collaboration** within the MDT and with newer teams
- **Upskilling of staff - interdisciplinary working, complex case management**
- Primary care MDT **access** to other services **at point of discharge**
- A **shared data management system** with access to data to inform services/ pathway development
- A **shared care management system** to enable timely communication and information sharing
- **One shared file and assessment** between disciplines on a team
- Team **colocation** or opportunities to collocate throughout the week

The focus group was keen to emphasise that ideal pathways are **coproduced engaging <u>all stakeholders</u>** from <u>'the bottom up'</u> in meaningful collaboration.

Next steps should be to harness user and frontline experience and bring clinician, admin and service users together to review current, and develop specific referral and care pathways, based on referral data and population needs.

Pathway Development – Tips from the Literature

In reviewing current pathways, engage all stakeholders to consider the

- No. of stages in the process
- No of professionals involved
- Time between stages (wait time)
- Task Time
- Duplication of effort
- Delays, barriers, fragmentation in pathway
- Problems identified by users
- Problems identified by staff (NCPDNW, 2006)

Developing Pathways Steps

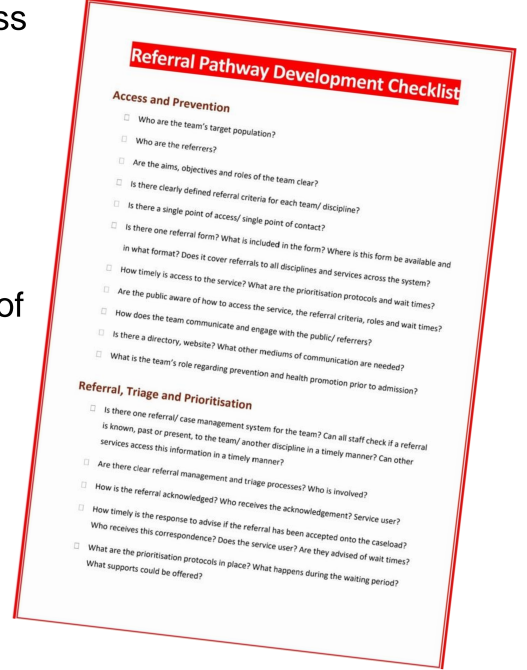
1. Identify the population
2. Meaningful Consultation with all Stakeholders
3. Assign an interdisciplinary quality improvement team
4. Research evidence base/ best practice guidelines
5. Map Current Pathways, Identify Gaps
6. Develop New Pathway Guidelines
7. Test using PDSA
8. Implement & Monitor using QI

(National Council for Mental Wellbeing, 2019)

Reviewing Current & Developing New Pathways
A Checklist

Considering next steps, and our review of the literature,

we developed a checklist for stakeholders to consider each stage of the process when developing a new or analysing a current referral pathway. The checklist provides questions prompts for consideration at each stage in the pathway.



For instance,

At point of referral management,

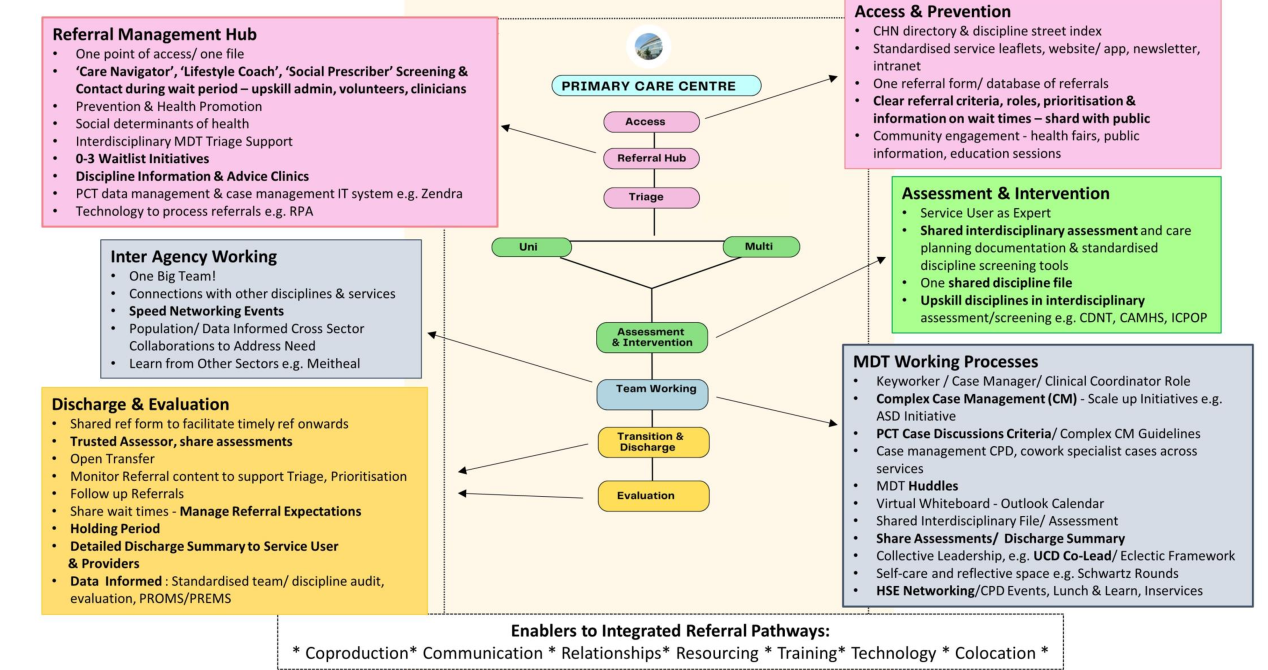
- How are referrals acknowledged?
- How timely is the acknowledgement? How timely is the response to advise of referral accept or not?
- Who receives the correspondence? Does the service user?
- What happens to referrals that are not appropriate for primary care?
- How are these re-diverted in a way that is timely and joined up?
- What happens to referrals while they are on the waitlist?

At point of assessment or discharge,

- Are assessments and discharge summaries shared?
- Who receives them? Does the service user?
- How detailed are they? Do they prevent a person having to repeat their story?
- What happens when a user is admitted to hospital for 3 days? Is there a holding period to ensure a joined up service?

The 'Ideal' Pathway – Old Concepts & New

Reflecting further on our initial mapping of current pathways, the focus group findings and the questions in our checklist, we considered areas of good practice that could be built on and processes that might improve current practice and support a more integrated and streamlined pathway. Many ideas for improvement were generated from this exercise as the image highlights.



The following provide some further detail on some of the **key recommendations** of the project group:

Building on the Old

Existing examples of good practice in primary pare, which could be scaled up include:

- **Advice and support clinics** offered across a number of disciplines assist with wait list management and discharge management, offering users support as they transition out of the service.
- **0-3 year old waiting list initiative** ensures targeted early intervention, timely access and prevention.
- **Managed Caseloads** allow CHN clinicians capacity within their workload to facilitate timely MDT working around **complex cases** as they arise.

Introducing the New

Examples of new concepts the project suggests to improve current pathways are as follows:

- The introduction of a **Referral Hub** to include upskilled admin staff to screen and process referrals as **care navigators** (Health Education England, 2016), e.g. Bedford Hospital, could signpost those on waitlist and divert them to more appropriate services across the system supporting early intervention and prevention. Other potential opportunities include upskilling of community volunteers and HSE MDT Staff to take on social prescribing roles and realigning current social prescribers, the introduction of **lifestyle coaches** and a **brokerage model of case management** to further facilitate this.
- In keeping with the value of integrated care (Minkman, 2016), and the importance of relationships, fostering a culture of **inter-professional MDT working** and **collective leadership**, utilising free toolkits & programmes such as the UCD CoLead, would support teams to develop a team identity, vision and psychological safety.
- Roles such as **keyworker, case coordinator and case manager** are essential to effective interdisciplinary working along an integrated pathway (Moore, 1990). A **Strengths Based Case Management approach** would continue the focus on building on what works and ensure that the client remains central to all interventions (Vanderplasschen, Wolf, Rapp, & Broekaert, 2007).

Results & Learning

Balymun CHN is reviewing its processes to incorporate some of the recommendations, such as including the service user on discharges summaries, sharing assessments to avoid duplication and the person having to repeat their story, and CPD in case management and team inter-professional and interdisciplinary working.

The Referral Pathway Checklist is being shared widely with further focus groups and care specific pathway working groups planned.

New concepts suggested, such as the referral hub and community navigator role, are being explored as options to improve referral and care pathways within DNCC.

This project's has been shared with the DNCC Slaintecare Integrated Referral Pathway Working Group to progress findings and recommendations further.

Learning

- Practice Collective Leadership
- Bottom Up Approach
- Meaningful Engagement & Communication
- Network & Partner
- SWOT Current Processes
- Culture eats Strategy!
- Foster Relationships
- Leverage Enablers: Technology, Whole System Skills, Experience, Support
- Barriers
- Solution Focused Approach to Barriers
- Innovate!
- Test, Refine, Measure, Sustain
- Stay Agile: Adapt to Population & Data
- Celebrate Success!

References: Available on request.

Acknowledgements: Thank you to focus group members, our sponsor and mentor.

Further Details: Patrice.Reilly@hse.ie Operational Lead, Dublin North Central CST-OP