Road to nowhere? A critical consideration of the use of the metaphor 'care pathway' in health service organisation and delivery

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Abstract:	Metaphors are inescapable in human discourse. Policy researchers have suggested that the use of particular metaphors by those implementing policy changes both influences perceptions of underlying reality and determines what solutions seem possible, and that exploring 'practice languages' is important in understanding policy enactment . This paper contributes to the literature exploring the generative nature of metaphors in policy implementation, demonstrating their role in not just describing the world, but also framing it, determining what is seen/unseen, and what solutions seem possible. The metaphor 'care pathway' is ubiquitous and institutionalised in healthcare. We build upon existing work critiquing its use in care delivery, and explore its use in health care commissioning, using evidence from the recent reorganisation of the English NHS. We show that the pathways metaphor is ubiquitous, but not necessarily straightforward. Conceptualising health care planning as 'designing a pathway' may make the task more difficult, suggesting a limited range of approaches and solutions. We offer an alternative metaphor: the service map. We discuss how approaches to care design might be altered by using this different metaphor, and explore what it might offer. We argue not for a barren language devoid of metaphors, but for their more conscious use. Pathways abstract.docx

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Road to nowhere? A critical consideration of the use of the metaphor 'care pathway' in health services planning, organisation and delivery

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36
37 Word count: 8023

38 Abstract

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40 particular metaphors by those implementing policy changes both influences perceptions of
41 underlying reality and determines what solutions seem possible, and that exploring 'practice
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51 service map. We discuss how approaches to care design might be altered by using this different
52 metaphor, and explore what it might offer. We argue not for a barren language devoid of
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54 Introduction

55 Humans are story-telling animals, apprehending the world and communicating about it in narrative
56 terms. Metaphors represent an important narrative form, communicating complex concepts using
57 analogy and inference. Richardson (1990) highlights the ubiquity of metaphor in social science,
58 arguing that paying attention to the metaphors-in-use is important in both carrying out research and
59 representing its findings. Institutional theorists see rhetoric and metaphor as important indicators of
60 underlying norms and assumptions (eg (Suddaby and Greenwood, 2005)), whilst linguistic

61 sociologists emphasise problematising the use of metaphorical language in understanding social life
62 (Sewell, 2010). A rich seam of social science research focuses upon the effect of common or
63 recurring metaphors in structuring and framing the social world. For example, Cornelissen et al
64 (2011) explore metaphors used by managers seeking to legitimise organisational change, arguing
65 that particular types of metaphor may be more successful in particular contexts. Perhaps more
66 dramatically, Annas (1995) locates the failure of the Clintons to reform the US health system in,
67 amongst other things, a poor choice of metaphor. This illustrates the importance of metaphors in
68 understanding policy implementation. Allan (2007) used this approach in studying natural resource
69 management schemes. She found that the metaphors used had profound implications for the
70 planning, implementation and evaluation of water management schemes, with those who used a
71 'journeying' metaphor adopting different approaches to those who spoke about 'treating illness' in a
72 watershed area. Thus, the metaphor-in-use both expresses existing norms and potentially
73 determines how policy is implemented. We respond to Dobson's (2015 p702) call for empirical
74 policy research which takes seriously what she calls 'practice languages' or 'sector speaks' – the
75 unconscious and naturalised use of language by insiders - as a means of understanding how policy is
76 enacted through day-to-day practices.
77
78 The pathways metaphor has wide currency in policy research and practice including: in housing, to
79 describe the influence of socio-economic conditions on forms of housing tenure (Payne and Payne,
80 1977); in education, to refer to vocational or academic 'tracks' that students join (Watt and
81 Paterson, 2000), often with limited prospects for switching; and criminal justice, where the
82 'pathways out of crime' metaphor has become so well established as to attract classification as
83 professional myth (Haw, 2006). In this paper we focus particularly on health services and examine
84 a metaphor ubiquitous across the world – the 'care pathway'. We explore its use in the aftermath of
85 a wide ranging policy-driven change to the NHS in England, consider how it might drive responses to
86 change and ask whether alternative metaphors might drive different reponses.

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87

88 Sometimes called a 'clinical pathway', De Bleser 2006) identified the concept's first use in the

89 United States (US) in the 1980s (Zander *et al.*, 1987). Martin et al 2017) describe pathways as a

90 manifestation of Taylor's (1990) scientific management approach, whilst others trace their origin to

91 Second World War military planning (Schrijvers *et al.*, 2012). From this perspective, pathways are a

92 means of specifying, co-ordinating and controlling care processes, to manage costs, and improve the

93 quality and safety of care (Hunter and Segrott, 2008).

94

95 However, there is a more critical literature, arguing that care pathways are not simply neutral tools

96 (Hunter and Segrott, 2008); they are socially constructed, embodying particular power relationships

97 (Barnes, 2000) whilst at the same time construing patient care as self-evidently capable of pre-

98 specification (Berg, 1997). Pinder et al (2005) argue that the pathway metaphor may be unhelpful,

99 silencing and marginalising some voices. In this paper we explore the consequences of the use of the

100 care pathways metaphor in in service planning/commissioning. Based upon a study of

101 commissioning in the English NHS we explore how the widespread use of the care pathway

102 metaphor shapes both the conceptualisation of the task of commissioning health care and how it is

103 carried out. We argue that, like all metaphors, care pathway is generative, not simply usefully

104 specifying required processes but also determining what are seen as appropriate solutions to

105 problems arising following a significant system change. We offer a new metaphor – the 'service map'

106 – and discuss the different perspectives that it may encourage, whilst also being mindful of its

107 generative potential.

108

109 Our contribution is twofold. Firstly, we offer an additional approach for those studying public service

110 policy, organisation and management. As Dobson (2015) has highlighted, the unconscious use of

111 particular language by those enacting policy provides a window into their social worlds. We take this

112 a step further, demonstrating that the metaphors-in-use in a situation of policy-driven change affect

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113 the enactment of that change. Secondly, we extend the literature on care pathways, moving beyond
114 their use in individual care settings to explore their role in service planning and commissioning.
115
116 What follows is divided into five sections. A brief overview of the relevant literature is followed by an
117 exploration of care pathways as a metaphor. We then describe our methods, before exploring the
118 generative effect of the metaphor of care pathways in our study. A final discussion contextualises
119 our findings, considering how an alternative metaphor might change the framing of the work to be
120 done and exploring the implications of this for the wider literature.
121

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122 *Care pathways: an overview*

123 Care pathways have been defined in a number of ways. De Bleser et al 2006) suggest the following
124 definition:
125

> 126 *A [care] pathway is a method for the patient-care management of a well-defined group of*
> 127 *patients during a well-defined period of time. A [care] pathway explicitly states the goals*
> 128 *and key elements of care based on EBM guidelines, best practice and patient expectations*
> 129 *by facilitating the communication, coordinating roles and sequencing the activities of the*
> 130 *multidisciplinary care team, patients and their relatives; by documenting, monitoring and*
> 131 *evaluating variances; and by providing the necessary resources and outcomes. The aim of*
> 132 *a [care] pathway is to improve the quality of care, reduce risks, increase patient*
> 133 *satisfaction and increase the efficiency in the use of resources (De Bleser et al., 2006 p553).*

134
135 This identifies a care pathway as a co-ordination technology, implying an underlying rationality in
136 which goals can be clearly specified. In the UK the early focus was upon pathways as a tool for
137 quality improvement, using a rational/technical 'evidence-based medicine' approach (Hunter and

138 Segrott, 2008). However, increasing emphasis on choice and competition (Department of Health,
139 2003) has driven a more explicit focus on care pathways as co-ordination tools (Atwal and Caldwell,
140 2002), whilst growing interest in control of professionals under the rubric of 'clinical governance'
141 supported their adoption for quality control (Ellis and Johnson, 1999). Pinder et al (2005) thus
142 document a rapid growth of interest in care pathways in the UK from 1998 onwards.
143
144 It is beyond the scope of this paper to review the care pathways literature in detail. However, it can
145 be loosely categorised into four groups. Many papers focus upon defining, implementing or
146 evaluating pathways for particular conditions. Thus, for example, Graham et al (2010) review
147 evidence about diabetes management, advocating a particular improved care pathway. This
148 literature links care pathways to clinical guidelines, defining and instantiating in a pathway the most
149 effective care for particular conditions. A second tranche of literature explores care pathway
150 implementation, focusing upon 'barriers' to their adoption (eg (Evans-Lacko *et al.*, 2010)). A third
151 large literature takes a more questioning approach. Moving beyond the assumption that care
152 pathways embody best practice and are axiomatically valuable, this approach seeks to evaluate the
153 impacts of care pathways. In this vein, Allen et al (2009) reviewed the benefits of care pathways,
154 and concluded that:
155
156 *I[ntegrated] C[are] P[athways] are most effective in contexts where patient care*
157 *trajectories are predictable. Their value in settings in which recovery pathways are more*
158 *variable is less clear. ICPs are most effective in bringing about behavioural changes where*
159 *there are identified deficiencies in services; their value in contexts where interprofessional*
160 *working is well established is less certain. (Allen et al., 2009 p61)*
161

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162 Such limited evidence of benefit has not, however, translated into caution amongst health care
163 system leaders, with care pathways assuming an ever more prominent role in service planning
164 (Davina Allen, 2010b).
165
166 These three broad strands of literature take a largely uncritical view, presenting care pathways as a
167 straightforward technology, which either does or does not improve care. A final, and rather smaller,
168 body of literature critiques this view, using concepts from Science and Technology Studies to
169 investigate the work done by care pathways as technologies, exploring embedded power and
170 agency. For example, drawing upon ethnographic research on care pathway development, Allen
171 argues:
172
173 *The technologies that emerge from this process [of pathway development] are not*
174 *neutral tools reflecting an underlying reality, but are constituents of social relations*
175 *and possess structuring effects of their own. They are active in organizing health care*
176 *work and in the creation and maintenance of hierarchies between and within*
177 *professional groups. They differentiate who can write where and how much,*
178 *determining the information that is relevant and which activities are organizationally*
179 *accountable or not. (Davina Allen, 2010a p48)*
180
181 Care pathways thus act to structure what counts as relevant, systematically including or excluding
182 viewpoints depending on approaches to development (de Luc, 2000). Allen (2010a) highlights the
183 multiple purposes of care pathways, distinguishing between a managerial viewpoint seeing care
184 pathways as tools to hold clinicians to account, and a clinical viewpoint seeing care pathways as a
185 structure supporting the exercise of valid clinical judgement. She identifies care pathways as a
186 boundary object (Allen, 2009), usefully blurring distinctions between these two approaches to
187 support action without requiring explicit reconciliation between them.

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188

189 From this perspective, care pathways may enhance rather than limit the expression of
190 professionalism. An alternative view comes from Harrison (2000), who coined the term 'scientific
191 bureaucratic medicine' to describe the algorithmic approach of care pathways and guidelines. For
192 Harrison, this approach presaged a *commodification* of medical care, necessary to support
193 competition between providers (Harrison, 2009). Care pathways thus represent a tool by which
194 neoliberal ideals of choice and competition (Green, 2006) may be enacted within public services,
195 allowing costing and enumeration of 'packages' of care which could be delivered by any competing
196 provider.

197

198 This highlights one of the relatively unconsidered aspects of care pathway use: the context within
199 which they are operationalised. Whilst contexts necessarily vary by health system, the international
200 literature identifies two broadly distinct uses for care pathways. The first lies within individual care
201 settings, where care pathways are a means of co-ordinating the care required by categories of
202 patients. Overlapping this, and arising from service models separating purchasers of care from
203 providers (Figueras *et al.*, 2005), care pathways are also used by purchasers/commissioners to
204 specify the care to be purchased, potentially supporting choice and competition. These uses are
205 subtly different, as one arises within a care setting and is usually, at least in part, locally specified,
206 whilst the other might, at the extreme, be specified externally by a purchasing authority, and used to
207 manage contracts . In practice, these two uses overlap and are elided one with the other: potential
208 care providers often help to specify care pathways to be commissioned (Checkland *et al.*, 2012).

209

210 Pinder et al (2005) extend these critiques in a study of care pathway development in a
211 commissioning organisation. Researchers asked those involved to draw their particular care
212 pathway. They found significant variation in the pathways drawn from different professional
213 perspectives, with different professionals delineating their zone of practice. They found that:

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214 'pathways were important mobilising metaphors, prescribing as well as describing' (Pinder et al.,
215 2005 p775) and argue there would be benefits to clinical teams fostering greater awareness of
216 pathways as evolving processes rather than constituting complete, finished products. In this paper
217 we take this idea further, exploring the generative nature of the pathways metaphor in relation to
218 health care planning, and critically considering the application of an alternative metaphor.

219 *Metaphors and meaning*

220 Public services, administration and research are full of metaphors. Policy researchers, for example,
221 use the metaphor of 'translation' to explain and illuminate aspects of policy transfer between
222 contexts (Johnson and Hagstrom, 2005), whilst Malpass conveys a rich picture of both the problems
223 facing housing policy and the potential knock on effects of these on other services with his use of the
224 metaphor of a 'wobbly pillar' (Malpass, 2003). In the health field we talk about 'barriers to change'
225 (Checkland *et al.*, 2007), 'frontline NHS staff' and 'battles against disease', 'Integrated Care Pioneers'
226 (https://www.england.nhs.uk/integrated-care-pioneers/), and 'care pathways'. Each metaphor
227 conveys more than the words alone. Thus, 'barriers' to change implies a clear road across which an
228 obstacle has fallen, but it also implies a solution – the lifting of the barrier, or its destruction. In
229 reality, of course, change does not happen for complex reasons embedded in social realities, and
230 'barriers' are rarely amenable to simple removal (Checkland et al., 2007). Similarly, military
231 metaphors such as 'frontline staff' or 'battles against disease' valorise health service staff and
232 responsibilise patients, whilst implying that those failing to support 'our troops' or patients failing to
233 recover are somehow culpable. In each case the reality is more complex and messy, and the
234 solutions implied may not be as straightforwardly beneficial as the metaphors suggest. Moreover,
235 embedded power relationships within particular metaphors may go unnoticed. As Foucault (1988)
236 reminds us, a 'responsibilised' patient is not simply engaged in neutral acts of self-help; they are
237 'disciplined' to act in ways which may serve other ends.
238

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239 These things matter, because as Schon (1993) clearly demonstrates, metaphors are generative.
240 That is, they frame problems such that certain solutions are visible or desirable and others are not.
241 Thus, for example, Schon (1993 p130) describes how re-imagining a paint brush as being like a pump
242 opens up a range of different technological approaches to improving performance than appear
243 when thinking of it as a device for spreading liquid. Conceptualising the things impeding change as
244 'barriers' focuses attention on approaches to removal, rather than accommodation or adaptation,
245 whilst describing those at the forefront of change as 'pioneers' prevents consideration of the fact
246 that they may be misguided. In each case, the metaphors are not necessarily immediately visible,
247 and the embedded power relationships may be obscure.
248
249 'Care pathway' is a metaphor rich with meaning. Whilst its origin is plural, it has arisen in the context
250 of a significant sociological literature likening patients' experiences of illness to a journey (for
251 example, see (Lapsley and Groves, 2004)). Care pathway is thus a concept with broad appeal, as it
252 suggests that not only will care be available for patients on their 'journey', but also implies guidance,
253 direction and clarity. The pathway metaphor allows those planning and providing care to see
254 themselves as accompanying patients on their journey, smoothing the way and helping them move
255 logically and inevitably from a to b. However, this begins to demonstrate a potential problem. A
256 pathway can suggest unidirectionality, with limited branching or switching, and implies a clear
257 understanding of the order in which things need to happen. But the real world of patient care is
258 rarely that simple, and generative metaphors not only explain the world, they shape it. Llewellyn et
259 al (2017 p422) explore the care pathways metaphor from the patient's perspective, arguing that:
260 '[pathways] shape patients' lives by particular and often hidden valuations about risk, evidence,
261 tolerability of side effects and symptoms, and fundamentally the goals of care.'
262
263 We extend Pinder et al's (2005) and Llewellyn et al's (2017) critiques, suggesting that not only is the
264 metaphor 'pathway' potentially unhelpful at the micro-level of providing and receiving care, where it

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265 may act to marginalise patient voices, engender false expectations of the degree of co-ordination
266 that is possible, conceal inter-professional rivalries and obscure the uncertainty inherent in medical
267 treatment (Pinder et al 2005; Llewellyn et al 2017), but it is also unhelpful at the meso-level of care
268 organisation, commissioning and planning. Using evidence from a study of a significant
269 reorganisation of the NHS in England, we show that the care pathway metaphor potentially
270 hampered commissioners as they adapted to policy-driven change by limiting the range of options
271 'seen' as being possible and by focusing adaptive activity on particular approaches. More broadly,
272 we show that paying attention to - and possibly altering - the metaphors-in-use within a complex
273 public sector field provides an additional avenue for understanding and supporting policy enactment
274 and change.

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275 *Methods and context*

276 The context of this study is a major reorganisation of the English NHS, resulting from the Health and
277 Social Care Act 2012 (HSCA12). It is not our intention here to describe this in detail; multiple
278 accounts of the changes which occurred have been published (for example, see (Exworthy *et al.*,
279 2016; (Timmins, 2012)). For our purposes the important fact is that the reorganisation not only
280 abolished some organisations and created others, but it also significantly redistributed
281 responsibilities between a wider cast of organisations within the system. In particular, the HSCA12
282 transferred responsibility for public health services from the NHS to Local Authorities (LAs), and
283 created a new national body responsible for providing public health advice and support, Public
284 Health England (PHE). Commissioning responsibilities, previously held by Primary Care Trusts (PCTs),
285 were redistributed between LAs, newly created Clinical Commissioning Groups (CCGs) and a new
286 national body, NHS England (NHSE). The outcome of these changes is widely agreed to be a more
287 fragmented system with, for example, a report from a House of Lords Select Committee concluding
288 that: '*The Health and Social Care Act 2012 has created a fragmented system which is frustrating
289 efforts to achieve further integration*' (House of Lords Select Committee, 2017 para 99).

290

291 We used qualitative methods to explore various groups' – including employees of CCGs, NHSE, LAs
292 and some third sector organisations – experiences of the reformed commissioning system in two
293 health economies, centred upon two large urban areas in England. Ethical approval was granted by
294 [name blinded] research ethics committee in March 2015. A total of 143 interviews with 118 unique
295 participants were conducted between July 2015 and August 2017. Interviewees included both
296 clinicians and managers from the aforementioned organisations. Interviews were carried out by
297 (##initials removed for anonymization#), and conducted either face-to-face or by telephone.
298 Respondents were asked to reflect upon their experiences of commissioning services since the
299 HSCA12; the concept of pathways was not initially a focus of the study, and not mentioned
300 specifically by the interviewer. A snowball approach was used. Initial interviewees were identified
301 primarily by searching the web sites of relevant organisations within each area. Interviewees were
302 asked to recommend colleagues who they thought, based on the issues discussed during their own
303 interview, may have insightful perspectives to offer. Twenty-five interviewees were interviewed
304 twice, in order to follow up particular issues which were the subject of ongoing change in the case
305 study areas. In each case, the research team contacted the interviewee to request a subsequent
306 interview.

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307

308 Interview transcripts were uploaded to the computerised data analysis package Nvivo 10, and read
309 repeatedly for familiarisation. Within these accounts, the concept of care pathways was so
310 naturalised amongst interviewees that they appeared unable to talk about their work – and the
311 increased complexity that they were experiencing - without using it. Moreover, in team discussions
312 about the emerging findings, it became clear that its use was associated with particular ways of
313 speaking about tasks at hand, often alongside concerns about 'fragmentation'. It was thus clear that
314 the metaphor played an important role in the discourse surrounding adaptations to the reforms. In
315 order to explore this emic phenomenon more closely, all mentions of the word 'pathway' were

316 extracted. Associated data extracts were scrutinised for evidence of generative work associated with
317 the metaphor. Team members discussed these data extracts, and analytic categories were created.
318 These are reported below, and generic job titles are employed in data extracts to preserve
319 respondent anonymity.
320

321 *Results*

322 **Care pathways in the reorganised system**

323
324 The concept of care pathways was ubiquitous, with respondents from all organisations drawing
325 heavily and repeatedly upon it. Respondents often accompanied their use of the term with evocative
326 adjectives. These are listed in Table 1.
327 [Table 1 near here]
328 These descriptors suggest a desire for clarity and simplicity, with complexity tamed, muddle
329 removed and every eventuality covered. They also imply some ideal yet to be attained, a 'proper'
330 pathway, 'the right' pathway, coherent, and possibly just out of reach. When things went wrong,
331 pathways were described as broken up, their coherence lost. We were told many stories of 'broken',
332 'fractured' or 'fragmented' pathways. For clarity and brevity, we present three of these as vignettes
333 in Boxes 1-3, highlighting the specific aspects of pre and post-Act commissioning that demonstrate a
334 pathway related issue, an articulation of this by an interviewee, and an assessment of the role that
335 the pathway metaphor plays in this articulation.
336 [Boxes 1 and 2 near here]
337
338 In Box 1, the participant appeals to the 'pathway' approach to solve the problem of integrating
339 different commissioners, but highlights challenges in developing such a solution, exacerbated by the
340 split in commissioning responsibilities between different organisations. In Box 2, the respondent
341 highlights the complexity of breast cancer services, particularly as new tests and technologies are

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342 introduced. The pathway metaphor infuses the account, with reference to ‘go[ing] for treatment’,
343 and ‘onward travel’. However, whilst the manager talks about ‘the pathway’, s/he later goes on to
344 suggest that actually the complexity of services makes it a ‘crazy’ pathway that would be very
345 difficult to commission.
346
347 Other similar examples discussed in interviews included obesity, HIV, maternity and drug and alcohol
348 services. In all examples, informants used the metaphor of ‘pathway’ to describe the issues that they
349 were experiencing following the reforms to the system, with associated adjectives such as
350 ‘blockages’ or ‘fractures’. However, closer examination of the accounts suggests that the metaphor
351 may magnify rather than solve the identified problems.
352

353 **Pathway: an unhelpful metaphor?**
354
355 As the vignette in Box 2 highlights, the pathway metaphor is inadequate when faced with complex
356 services commissioned and delivered by a variety of organisations. The point being made in the
357 example is about the complexity of commissioning since the HSCA12. However, conceptualising the
358 task as ‘commissioning a pathway’ compounds that complexity. If care is conceptualised as singular
359 and unidirectional as inscribed in the pathway metaphor, then it is indeed a complicated and difficult
360 task to make sure services are ‘joined up’. However, if the pathway metaphor is removed, we are
361 left with patients requiring a number of different types of services at different times. Sometimes
362 they will need more specialised services, sometimes routine local services. Thinking of it as a
363 pathway – linear, unidirectional, moving from a to b - makes the task one of specifying what should
364 happen in what sequence. However, patients vary and the sequence of care cannot always be pre-
365 specified. Taking away the pathway metaphor paradoxically may simplify the task, reconceptualising
366 it simply as ensuring that sufficient capacity is available in the relevant services, and that patients
367 can access them as needed. Box 3 illustrates further how letting go of the pathways metaphor might

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368 be helpful in conceptualising commissioning across multiple local areas involving multiple
369 commissioners.
370 [Box 3 near here]
371 These examples suggest that removing the idea that it is *necessary* to design a single pathway suiting
372 all localities potentially makes the problem easier to solve. Commissioners no longer need to 'design
373 a pathway' which is seamless, they just need to consider what services might be required and make
374 sure that patients from different localities can access them. 'Pathway' thus complicates the problem,
375 rather than solving it.
376

377 **Pathway: a generative metaphor**
378
379 These examples suggest that the pathway metaphor might make the job of commissioners adapting
380 to a new system more difficult, because it conditions those involved to think of their task in a
381 particular way. Perhaps more worryingly, the metaphor may also generate a medicalising approach.
382 In our interviews, patients were described as being 'on', 'put into', 'flowing through', 'led' along and
383 'moving down' pathways, implying motion, but also passivity, controlled by the parameters of the
384 pathway to which they had been assigned. Our respondents talked about 'intervening earlier in the
385 pathway' [4438 NHSE manager], and a 'long term conditions pathway from prevention to end of life
386 care' [2388 CCG manager]. This latter implies that anyone and everyone might be conceptualised as
387 'on' a pathway, including people (the targets of prevention) who currently would not regard
388 themselves as needing care. Llewellyn et al (2017 p422) highlight the potential for care pathways to
389 'shape patients' lives'; conceptualising even those not yet ill as 'on a care pathway' implies a
390 medicalised view of the world, with potential significant consequences for society more generally.
391 There is also an implication that once 'on' a pathway, it might be difficult for patients to get 'off'.
392 When talking about orthopaedic services, respondents highlighted the slide towards expensive
393 treatments once a patient started along a pathway:
394

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395 *You get to a surgeon, and a surgeon will say, oh yeah we'll do your hip. He won't say, no*
396 *we'll not do your hip. …. So we've had this thing about to try and get this concept out into,*
397 *certainly, all our members, around, we should do a lot more at this end of pathways, and*
398 *be much more supportive. [4785 CCG clinician]*
399
400 The solution to this perceived problem was to design another, separate pathway, not including
401 surgery:
402
403 *What we've managed to implement this year, which has been quite political, but we've*
404 *mandated a community MSK Service, which is therapy led with consultants involved and all*
405 *referrals now go through the MSK Service and patients are given informed choice and*
406 *proper assessments in terms of* ***whether they need to follow a therapy pathway or a***
407 ***surgical pathway*** *[4721 CCG manager]*
408
409 This may or may not be a desirable approach; the point in highlighting this is to suggest that the
410 pathway metaphor is acting generatively in determining what solutions are regarded as possible.
411 Rather than working to change surgeons' behaviour – an option clearly regarded as too difficult - or
412 to provide a variety of options in one clinic, commissioners designed a *separate, non-surgical*
413 *pathway*. In other words, the pathway metaphor was active in making particular solutions appear
414 obvious, whilst potentially obscuring alternatives.
415
416 The pathway metaphor also generated particular ways of describing problems - pathways are
417 'blocked', rather than services overwhelmed:
418
419 *Our relationships [with the local authority] are improving, but there's still a transparency*
420 *issue, because there are spending cuts, so we'll hear …for example, that they are reducing*

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421 *the number of social care placements without carefully planning it with the health service*
422 *staff, in terms of, you know, what alternatives we need to put in place or whether we could*
423 *have jointly commissioned those placements – [that]would have been cheaper than the*
424 *implications around, you know, the acute pathway being blocked [4721 CCG manager].*
425
426 Thus, the lack of availability of social care services is conceptualised in terms of the 'blockage' it
427 creates in the 'acute care pathway'. Conceptualising the problem in this way is likely to lead to a
428 particular set of solutions, focused upon the needs of frail patients leaving hospital. It also allows
429 organisations shift blame, and potentially obscures or downplays the political decisions underlying
430 funding levels.
431
432 Thus, the metaphor used defines the task, whilst at the same time projecting a particular narrative
433 which may deflect attention from more fundamental underlying problems of funding or political
434 ideology. This commissioner described a planned stakeholder event in this way:
435
436 *Today we're going to… work with this stakeholder group around their views, their opinions*
437 *et cetera, because what we're looking to do is* ***change the care pathway for intermediate***
438 ***care in older people*** *[7831 Commissioning Support Unit manager]*
439
440 The commissioning task is not to explore stakeholders' views about the range of services available,
441 rather it is to 'change the care pathway'. Starting from this metaphor confines the task within a
442 particular set of parameters, excluding some areas of policy from discussion. Interestingly, some of
443 those who had consulted patients found that the concept of care pathways had less resonance
444 amongst users:
445

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446 *Certainly the feedback we got through the consultation was that the public generally were*
447 *really open to that community based design and* ***the service wrapped around the patient,***
448 ***rather than the patient jogging between different steps on the pathway*** *[7679 CCG*
449 *manager]*
450

451 Discussion

452 In this paper we have responded to Dobson's (2015) call for empirical research which foregrounds
453 'practice languages' (p702) in understanding how policy is enacted. We have highlighted the ubiquity
454 and breadth of use of the pathways metaphor in relation to a range of public services, and unpicked
455 its use in the health field. Exploring how commissioners approached their role in the context of a
456 large scale health system change, we have shown how pervasive the metaphor of 'care pathways' is
457 amongst commissioners, and how it tends to condition particular ways of seeing their job. This is not
458 to claim that it is never useful; indeed, the very complexity of the commissioning role in the more
459 complicated system made the metaphor particularly attractive, with commissioners from all areas
460 expressing their concern over the changes as a desire for simpler or more straightforward pathways.
461 However, notwithstanding its appeal, we have shown that the pathway metaphor tends to limit the
462 appreciation of possible solutions to problems, framing the issues in particular way and highlighting
463 some approaches whilst hiding others. Thus, for example, a problem with a surgical orthopaedic
464 service was solved by creating a separate 'new pathway', rather than by working with the service
465 provider to change their behaviour. Moreover, the pathways metaphor may obscure the power
466 relationships and political ideologies which underpin particular approaches to service delivery, whilst
467 shaping the choices available to service users in particular ways.
468

469 Of course, the metaphor-in-use is not the only factor affecting the system's responses to change.
470 Indeed, the very complexity and reach of the changes which occurred means that many contextual

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471 factors will have been at work in determining system responses. Nevertheless, exploring the use of
472 the pathways metaphor by our respondents has provided an additional way of understanding the
473 impact of these policy changes, and has suggested an alternative approach by which ongoing
474 adaptation might be facilitated: might changing the metaphor change the way in which the task is
475 perceived?
476
477 Commissioners aim for 'seamless' and 'joined up' pathways, and see 'blocked' pathways as
478 problematic, but as the breast cancer example above (Box 2) suggests, the care that individual
479 patients require may not be appropriately organised in a linear fashion. They may need to see a
480 specialist for a while, return to a more general service when stabilised, seeing the specialist again if
481 something changes. This is not a unidirectional 'pathway', it is a patient moving between available
482 services as their circumstances require. We concur with Pinder et al's (2005) suggestion that the
483 pathway metaphor is liable to be invested with a problematically high degree of objectivity and
484 solidity by professionals, in such a way as to foreclose consideration of processes of creation,
485 obscure the individual life worlds of patients, and engender conflation between the pathway as a
486 construction and the processes and events it is intended to represent. Moreover, as highlighted by
487 Harrison (2009), the use of the care pathway metaphor in service commissioning in part arose out of
488 a need to 'package' services so that they could be specified and potentially put out to tender to
489 multiple providers. It thus inscribes in the service as a whole a particular approach underpinned by
490 an ideology privileging choice and competition, even though this underpinning ideology is rarely
491 visible to those using the metaphor as convenient shorthand.
492
493 In response to these concerns, we offer a different potential metaphor for service planners and
494 commissioners: a *service map*. This new metaphor resonates with the 'journey' metaphor so often
495 used by patients, but emphasises the multiplicity of ways in which citizens might engage with
496 services. A map suggests that a patient may travel in various directions, or miss out a particular

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497 destination, whilst remaining orientated and clear about options. Thinking of service planning and
498 commissioning as a task of drawing and populating a map reconceptualises the key tasks as being
499 about providing information about services, as well as ensuring that it is clear how the different
500 destinations on the map relate to and connect with one another. A service map may also facilitate
501 better integration of care for people with multiple complex long-term health conditions, as it
502 challenges the single disease-specific structure inherent to the pathway metaphor. Conceptualising
503 service commissioning as producing a service map leaves space for consideration of individual
504 patient's needs and values, as it removes the assumption built into the pathway metaphor (and
505 illustrated in our examples) that once 'on' a pathway patients will move 'seamlessly' through its
506 stages. A service map may thus support a more authentically person-centred approach, providing
507 opportunities for patients to consider, with their healthcare professionals, the available services for
508 their condition, with their personal goals, values and beliefs as a guide to help them decide what
509 they wish to do. Furthermore, conceptualising service commissioning as drawing a map may allow a
510 broader range of ideological approaches to service delivery to be enacted. Whilst a map may allow
511 choice, it does not necessarily or inevitably imply the commodification of care packages, and could
512 therefore support an approach to service design based upon planning and management of linked
513 services rather than competition. Crucially, in the more complex post-HSCA12 English NHS, the idea
514 of commissioning as 'map making' moves us away from the metaphor of the 'blocked' pathway, and
515 provides a common language for commissioners responsible for different services to talk to one
516 another. Commissioners in different organisations could agree what was missing from a map, and
517 work together to fill the gap. Moreover, the map metaphor shifts focus away from trying to pre-
518 specify the order in which things should occur towards ensuring links between services function well
519 in whichever order they are accessed. Of course, it may always be necessary for some things – tests,
520 perhaps – to happen before others such as diagnosis, but any essential sequences could form part of
521 a map's notation.

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523 Changing the metaphor also changes the nature of the task of integration between services.
524 'Integrated care' (with the associated metaphor 'integrated care pathway') has emerged as an
525 important goal for welfare provision across the world (Suter *et al.*, 2009). The care pathway
526 metaphor positions integration as an act of joining up, so that pathways can be 'seamless'. It focuses
527 attention on multidisciplinary teams (Stokes *et al.*, 2016), and on contracts linking providers
528 together (Addicott, 2014). A service map approach to commissioning could refocus attention on the
529 relations between services, the amount of information they have about one another and their ability
530 to see themselves in respect to one another, with structural or functional integration considered
531 according to how far they enable working together, rather than being seen as an end in themselves.
532
533 Maps, of course, carry their own metaphorical baggage. Price-Chalita 1994 p242) notes, "[t]he map
534 is commonly regarded as an objective record of what exists in space, and hence the map is often a
535 metaphor for transparency" or, indeed, a symbolic shorthand for a depiction of truth. Yet a map is a
536 product of interpretation, abstraction, and idealised representation. Thus, the process of map
537 production can be understood as fundamentally political: "[t]o catalogue the world is to appropriate
538 it, so that all these technical processes represent acts of control over its image which extend beyond
539 the professed uses of cartography." (Harley, 1989 p13). However, this could also be regarded as a
540 strength of this alternative metaphor. The accounts of our respondents suggest that pathways
541 appear natural and endemic, existing in the world rather than being actively created. Re-imagining
542 the role of commissioners as 'map makers' explicitly positions them as active political actors, and
543 this potentially opens them up to greater scrutiny. Of course, map making remains constrained by
544 the political and policy environment in which they are conceived, and embedded power
545 relationships will continue to determine what is possible. However, drawing the map becomes a
546 visible act of prioritisation and resource distribution, about which debates may occur and for which
547 the map-maker can be held accountable. Care pathways, by contrast, tend to render decisions about
548 resource allocation invisible, as such decisions fall outside the purview of any particular pathway,

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549 which is presented in neutral terms as the expression of the best evidence in any particular
550 condition.
551
552 The map metaphor may also emphasise process and flow rather than destinations fixed in space and
553 time. Haraway (2013) develops this idea of a map as a guide to evolving possibilities. This represents
554 a shift from maps as a means of "transparently communicating the totality of what exists" to
555 "rhetorical guides to possible worlds" (Price-Chalita, 1994 p244). In health care organisation, Pinder
556 et al's (2005) conceptualisation of care pathways aligns with this. They argue for a *processual*
557 approach, focusing upon the drawing and redrawing of pathway 'maps' from different perspectives
558 – patients, commissioners, providers - rather than the creation of a single, comprehensive, one-time
559 picture. Understanding commissioning (or planning) as *map making* is in keeping with this approach.
560
561 Health systems face huge challenges, and ensuring the provision of care which patients experience
562 as integrated in the face of shifting population needs is a complex task. The recent reorganisation of
563 the NHS in England is widely agreed to have made this task more difficult, generating a more
564 complicated system (Exworthy *et al.*, 2016). Our study of this new system has yielded an important
565 insight: whilst struggling to adapt to change, service planners reached for a familiar metaphor which
566 may, in practice, have made their task more difficult. We have considered an alternative metaphor,
567 suggesting that conceptualising the task of service planning as one of 'map making' may have
568 broader value. A conscious use of a new metaphor to describe service commissioning may prompt
569 more detailed consideration of the issues involved, make explicit power relationships and thus may
570 provide an opportunity for improved accountability. 'Map making' may link more closely with the
571 lived experiences that patients describe, with systems characterised by plurality of supply such as
572 those based around a personal insurance model with potentially the most to gain. Our study does
573 not, however, test that proposition, and research is needed to explore whether and how far it is

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574 possible to change the metaphors-in-use. As we have noted, 'care pathways' are institutionalised
575 within the health field; changing that may be difficult.
576
577 Nonetheless, we would argue that it may be worth trying. As Schon (1993) has shown, and our study
578 confirms, all metaphors are generative, bringing into view particular ways of doing things and hiding
579 others. We argue not for a barren language, scrupulously avoiding analogies and metaphors, but for
580 their conscious, thoughtful and reflective use. As suggested by Dobson (2015) we have examined
581 empirically the 'practice languages' (p702) in use amongst service commissioners. Surfacing such
582 naturalised discourses has allowed us to critically examine their impact and the assumptions and
583 ideologies embedded within them. As Schon highlights, it is not metaphors per se which are
584 problematic, rather it is their unconscious use:
585
586 *One of the most pervasive stories about social services, for example, diagnoses the*
587 *problem as "fragmentation" and prescribes "coordination" as the remedy. But services*
588 *seen as fragmented might be seen, alternatively, as autonomous. Fragmented services*
589 *become problematic when they are seen as the shattering of a prior integration. The*
590 *services are seen as something like a vase that was once whole and now is broken. Under*
591 *the spell of metaphor, it appears obvious that fragmentation is bad and coordination,*
592 *good. But this sense of obviousness depends very much on the metaphor remaining tacit.*
593 *(Schon, 1993 p138)*
594
595 With this in mind, we offer our metaphor of commissioning as 'map making', conscious of its
596 potential limitations and of its generative nature. We hope that academics and service
597 commissioners, as well as patients and carers will engage with us in debating its merits and
598 considering how it affects the solutions that might be sought to current health system problems.

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1 Table 1: Adjectives associated with care pathways

2

Desirable characteristics	Undesirable or problematic characteristics
Seamless	Fragmented
Slick	Crazy
Efficient	Blocked
Integrated	Split
Neat	
Stable	
Comprehensive	
End to end	
Evidence-based	
Proper	
Right	
Smooth	
Nice	
Regimented	
Joined up	
Coherent	
Holistic	

3 4 5 6 7 8 9 10 11 12

13 Box 1: Child and Adolescent Mental Health services

14 (CAMHS)

15

16 ***The issue:***
Ensuring complex pathways are integrated when different commissioners are involved

17 ***Pre HSCA12:***
Services designated Tier 1-4: Tier 1 includes preventative services delivered by all in contact with children; Tier 2 represents mental health workers in any setting, e.g. schools, community paediatric teams etc; Tier 3 includes specialised CAMHS, delivered by locality-based multidisciplinary teams; and Tier 4 represents highly specialised day/in-patient units, forensic services etc. All of these commissioned by PCTs (either alone, for Tier 3, or with other PCTs for more specialised services), with additional funding provided to LAs for preventative and school-based services. Some areas initiated joint commissioning arrangements for Tiers 1 and 2, bringing together LA and PCT commissioners.

18 19 20

21 ***Post-HSCA12:***
Responsibility for Tier 2-3 commissioning transferred to CCGs (working together with LAs http://www.cypiapt.org/site-files/jcpmh-camhs-guide.pdf) , with Tier 4 commissioned by NHSE for the entire population of England. Tier 1 services commissioned by LA, NHSE and CCGs

22

23 *So one of the areas and, sort of, we're not getting the kind of right response* ***we need to take the whole pathway*** *approach, so if you take [Tier 4] CAMHS [which is an NHSE responsibility] for example, there's a short fall in people capacity, as a consequence of that shortfall, we have children delayed in other facilities and NHS England have, so far, not been able to address that. So that's a really good example where* ***we need a pathway approach*** *and there's been various attempts to try and resolve it, but so far it's been a problem and the split in commissioning responsibility hasn't really helped to resolve that.*
7160, CCG manager, Area 2

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27 Box 2: Complex oncology pathways

28

The issue:
29 Integrating complex pathways

Pre HSCA12:
30 Investigations and surgical treatments commissioned by PCTs, oncology services commissioned by PCTs working
31 together across a wider footprint. Co-ordination overseen by regional Cancer Networks

Post-HSCA12:
32 Commissioning responsibilities divided between CCGs and NHSE; Cancer Networks subsumed into Strategic
Clinical Networks.

33 *If you're commissioning a breast cancer pathway the* ***number of commissioners of that pathway*** *doesn't make sense. At the beginning point a patient enters primary care and that's commissioned by what was the Local Area Team [NHSE]. The patient then goes on for investigations - that's commissioned by the CCG. The patient then if they're found as positive have to go for some form of treatment so a lumpectomy or mastectomy plus oncology. Some of that's commissioned by the CCG. So the surgery is commissioned by the CCG, the oncology's commissioned by specialist commissioning. Then the patient returns back to their [local hospital] for follow up care, that's commissioned by the CCG and then they return back to primary care for onward travel. Treating cancer is a long term condition after you've had cancer, that's back to the Local Area Team. That's really complicated, isn't it?*
Q: So there's a lot of handovers in the chain.
*A lot of handovers, a lot of changes in responsibilities, with new advances. There is a new test that can verify whether your cancer is suitable for oncology or not. That test is paid for by specialist commissioning as is the oncology but it could knock out a whole load of ladies who would never need to have oncology but to get those commissioners to commission that it's just...****it's a crazy pathway that.*** *I think it's the best example of fragmentation that makes the least sense and I forgot to mention the screening part of the pathway is commissioned by Public Health England. So the breast screening section that we get monitored and performance managed on, how many ladies turn up for screening, is all commissioned by NHS England. So there's another commissioner thrown into that as well.*
4519, CCG manager, Area 1

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Box 3: Specialised services

The issue:
Agreeing on a singular pathway when multiple commissioners, working in a range of localities and at multiple scales, are involved

Pre HSCA12:
Specialised services (https://www.england.nhs.uk/commissioning/spec-services/) are low volume, high cost services, such as renal transplantation, or services for people with rare cancers. These were previously commissioned by PCTs in groups.
Post-HSCA12:
NHS England took over commissioning responsibility but on the basis that a centralised approach would reduce geographical variability in available services (a 'post code lottery')

The bit that's now different is that the people who are the commissioners of the different elements are in different places and don't necessarily talk to one another along the way, so the CCGs have got the majority of it, [the specialised commissioning service] has got some bits at the far end and screening has got some bit that plays into the process that comes through, so that puts in place in theory three [commissioning] organisations. So in [local area] at the moment… there are [more than 10] CCGs so if you're trying to get CCGs, [specialised commissioners] and NHS England screening [commissioners] in a place to talk about the pathway ….that becomes, I think, more challenging …. and then what happens in [town 1] and the pathway they want there might be different from what they want in [town 2], and how do you get those things together?
18352, NHSE manager

Role of 'pathway' metaphor
Designing 'the' pathway is problematic because the different localities may want different approaches.
If the metaphor is removed, the point being made is simply that Town 1 might need different services to Town 2.

view