

HEALTH AND SOCIAL CARE INNOVATION

Outcomes from the SI DRIVE policy and foresight workshop: 22nd February 2017

About the Workshop

On the 22.02.2017 the Young Foundation hosted an event, facilitated by TNO and AIT, which considered critical issues in health and social care social innovation (SI). Bringing together participants from across the globe we engaged funders, experts, and innovators. A participant list is available in Appendix 1.

The workshop considered key topics including:

- Three specific areas of health and social care SI:
 - Electronic and mobile health
 - Integrated care
 - New models of care
- The aims and goals of health and social care innovation in the EU specifically and globally.
- The factors that impact health and social care innovation
- Policy frameworks for SI in the EU and globally

In relation to each of these topics, we discussed the future direction of health and social care SI. This outcomes of this discussion will be used to provide context to our work on health and social care SI and to help us understand possible routes for policy in this field. In the following document we will outline key dimensions of the discussion.

Illustrations are provided by Raquel Duràn at More than Minutes



About SI DRIVE

SI DRIVE is an EU FP7 funded project which looks to build a greater understanding of SI. It does this through three distinct approaches:

- Integrating theories and research methodologies to advance understanding of SI
- Undertaking European and global mapping of SI, thereby addressing different social, economic, cultural, historical and religious contexts in eight major world regions. Ensuring relevance for policy makers and practitioners through in-depth analyses and case studies in seven policy fields, with cross-European and world region comparisons, foresight and policy round tables.
- The project examines examples of SI in seven key policy areas of which health and social care is one.

Health and social care systems across the world are facing increasing pressures as they attempt to balance quality of care, access to care and costs. All of this is done in the context of a world where issues such as rising life expectancy and the increasing incidence of non-communicable diseases are making this ever more difficult.

With this as the backdrop this workshop considers how policy is responding to these difficulties and what policy frameworks might help us achieve the kind of health service that we want for ourselves and for future generations.

KEY THEMES FROM THE WORKSHOP



Whilst we have provided a full account of the workshop sessions below we would also define some key themes that repeatedly emerged from the discussions at the workshop. We highlight these below:

We need to build care systems that go beyond our traditional definitions of health and put the wellbeing of people at the centre of the health system. This means embedding new cultures at all levels including: citizens, practitioners and policy makers. By building society around people, and thinking about people as both contributors to- as well as beneficiaries of- community wellbeing, we can start to create societies where the demands facing health and social care can more easily be tackled.

We need to understand how SI principles can be applied to different societies. Health contexts differ considerably from place to place and different contexts are instrumental in how different innovations develop and progress. However there are still some key findings that we believe to be common across contexts, in terms of how social innovators can work to overcome barriers to innovation. In particular the need to engage with policy makers and achieve 'buy-in' was a clear take-away.

Policy makers should look to support SI in ways which go beyond funding. Whilst lack of funding- and particularly 'follow-on' funding- is an ever present threat to SI we identified a number of policy instruments, beyond this, that could help to stimulate innovation in this field. There was an identified need to address: timelines that social innovators have to meet; the need to demonstrate high impacts quickly; the need to address regulatory restrictions; and the need to provide safe spaces for people to innovate.

There is clear scope for broader utilisation of the tools and methods of SI. Innovation frequently requires cultural change in order to scale or embed. In order to achieve this there is a key role for the methods of open innovation such as co-design, which bring together 'unusual suspects' and break down the silo's that people work within.

SESSION 1: UNDERSTANDING THE GOALS OF HEALTH AND SOCIAL CARE SI ‘PRACTICE FIELDS’

One of the ways that we look to understand SI in SI DRIVE is through the lens of ‘practice fields’. Innovation can be conceived of as an expression of specific new ‘practices’ or behaviours exhibited. These new ways of behaving can come to manifest in specific innovative health and social care projects.

Considering health and social care innovation in this way allows us to understand how specific innovative practices differ from project to project, it allows us to explore variations in the way that innovators have met their context: developing different business models or bringing together distinct groups of actors.

During the policy and foresight workshop we examined, in groups, the aims and goals of specific and innovative health and social care practice fields: Electronic/Mobile (E/M) Health; Integrated Care; New Models of Care.

E/M HEALTH

USING DIGITAL TECHNOLOGY
TO CHANGE
RELATIONSHIPS BETWEEN
DOCTORS AND
PATIENTS



Electronic and mobile (E/M) health

“the process of using mobile or electronic technology in order to increase the efficiency and/or effectiveness of health and social care by applying technological solutions to facilitate improved engagement of and/or with patients and therefore drive improved outcomes”

Goals:

Participants identified a kind of hierarchy of goals which prioritised:

1. Better provision of care
2. To be achieved through greater efficiency and quality of the system.
3. To be facilitated by integration of digital technology and data.

However there are other aims which were identified by the group. These included:

Enhancing access to health education and information was seen as an important role for E/M Health interventions. In this sense one aim of E/M Health is to improve the long term health of societies, helping to reduce demands for acute care.

Engaging stakeholders of all sorts in the processes of service development and delivery. E/M Health innovation development is frequently highly collaborative requiring many different participants in order to have the necessary competencies to innovate in this way.

Drivers of E/M Health included:

The need to provide care to patient groups prone to marginalisation. Elderly care is major arena for E/M Health. There is demand for these solutions both from the market and from policy makers. The need to reach isolated populations in developing countries also aligns with this. However it was also acknowledged that the introduction of E/M Health should not be a replacement for human and social contact as part of care and that there is a potential risk that E/M Health could increase isolation and loneliness if this is not sufficiently taken into account.

A demand for a greater degree of empowerment among patients through enhanced access. Social expectations are an important driver of healthcare innovation. This is particularly true in E/M Health because of the scope for technology to allow patients and practitioners to interact with and provide information to each other in new ways.

Barriers:

In SI drivers and barriers are frequently seen as two sides of the same coin. Constraints on innovation can also be the thing that drive forward new approaches. However some key barriers to E/M Health were identified, including:

Funding gaps. Follow-on funding is frequently unavailable and there can be problems when attempting to integrate funding streams for cross-cutting care (tertiary, primary, social care etc.) This can have an impact upon E/M Health sustainability.

Problems with data quality, security and availability. This is a concern across the entire health system, from the trust that patients put into data management systems all the way through to the way in which data quality is assured and managed at local, professional, and national level.

INTEGRATED CARE

GETTING HEALTHCARE
PRACTITIONERS
TO WORK
TOGETHER

TO PROVIDE
BETTER
CARE

ENSURING
PROCESSES
ARE STREAMLINED



CARING
ABOUT
WELLBEING
NOT JUST ABOUT
HEALTH



CULTURAL
SHIFT

TO WHERE
INTEGRATION
IS

NORMAL



BALANCE



COLLABORATION
AND
USING
CO-DESIGN
TO INCLUDE DIVERSE
EXPERIENCES

VOICES



VALUING
PEOPLES
EXPERIENCES

DRIVERS



TECHNOLOGY HELPS

IT CAN BE
DIFFICULT
WHEN INNOVATORS
HAVE TO
DEMONSTRATE
IMPACTS

IMMEDIATELY



BARRIERS

**SILO-BASED
THINKING**



**TRYING
NEW
THINGS**
TO AVOID DIFFICULTY
FOR DOCTORS WORKING
WITH ONE ANOTHER



Integrated Care

“A new approach to the way that different actors cooperate within healthcare involving integration across healthcare sectors and/ or the inclusion of new knowledge and new actors/ relationships in order to facilitate the more effective.”

Goals:

During the discussion on integrated care the key aims and goals defined were:

Finding ways to improve the balance between care quality and cost and making the best use of available resources.

Ensuring processes are streamlined so that patients don't have to knock on many doors
Technology can be a key enabler of this, with technology providing ways to manage patient data, ensure joined up services, and coordinate care.

Valuing people's experiences was also recognised as an important goal of integrated care. Not just experiences 'as patients' but more broadly as citizens. This may require cultural shifts in how health services consider their responsibilities.

Key drivers of integrated care included:

Collaboration, information sharing and in some circumstances utilisation of co-design
can people find opportunities to provide care provision which incorporates aspects such as: patient perspectives and an understanding of the ways in which other dimensions of life (e.g. socio-economic background) can impact health.

The need to increase the effectiveness of chronic care provision is a key demand driving integrated care. As such integration is important both in societies which have an ageing population and rising cases of non-communicable diseases and in those societies where communicable diseases are still prevalent.

The need to reduce costs whilst providing high quality care, and meeting public expectations was also identified as a key driver of integrated care delivery, this is particularly the case in those communities where public expectations of care are high and the demand for services is increasing.

Barriers:

Models of integrated care have often been difficult to implement, despite high levels of public demand for fully integrated services. This is due to the barriers that are operating in this field, including:

Silo-based thinking can hinder attempts at implementing more integrated approaches to providing care. The cultural barriers frequently require elements of complementary innovation as people have to find new ways of working together in order to overcome silos. Integration has to be considered at every component of the health system from the patient record systems all the way through to the funding structures available.

The need to demonstrate short term 'impacts' or 'returns on investment' is seen as a key area where contexts are not meeting with innovators. In this sense either there needs to be upskilling of innovators or a relaxing of the requirements on innovators, and possibly a combination of both. There is a clear need to rethink the indicators of success.

NEW MODELS OF CARE



IMPROVING CARE BY HELPING PEOPLE TO TAKE RESPONSIBILITY FOR THEIR

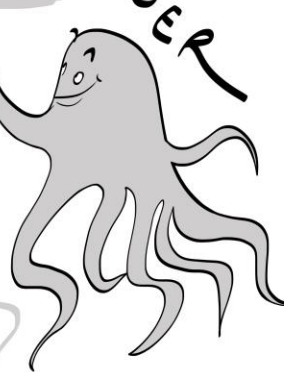


HEALTH

DRIVERS

IMPROVING ACCESS TO CARE

HEALTHIER SOCIETIES
KEEPING PEOPLE HEALTHIER



IN DEVELOPING COUNTRIES THERE IS **LACK OF ACCESS TO CARE**

AGEING SOCIETIES



CHANGING SOCIAL DEMANDS IN THE FACE OF CRISES



CHRONIC CARE NEEDS

POLICY PRIORITIES
DEFINED EITHER



GETTING NEW KINDS OF SERVICES COMMISSIONED CAN BE DIFFICULT

INNOVATORS DON'T ALWAYS KNOW

HOW TO NEGOTIATE COMMISSIONING PROCESSES



GETTING PEOPLE TO ADAPT TO NEW SYSTEMS IS DIFFICULT
IT REQUIRES CHANGES IN



INSTITUTIONS ARE WORRIED ABOUT THE RISKS OF TRYING NEW THINGS

New Models of Care

“the process of responding to new social expectations and/or social values by developing models of care that are entirely new in their context, even though they may have existed previously in other contexts.”

Goals:

New models of care is a practice field which looks specifically at the ‘practice’ of experimenting with, and validating ways of providing care. Key goals that were identified as part of the discussion on new models of care included:

Ensuring access to and quality of care. This was a primary aim of the practice field and noted to be increasingly challenging in many contexts as the expectations of the public in terms of what care ‘should’ be provided, increases.

Developing a whole life approach to care which keeps people healthier longer. In order to solve the issues of access and quality, given global constraints, new ways of approaching care are needed which conceptualise health as simply one aspect of care and recognise that we need new approaches to keep people healthier for longer.

Ensure that the world works with people to keep them healthy. We considered how ideas like smart cities as well as planning and housing regulation can help the environment to adapt to the changes that people undergo across their lifespan, and help to develop an environment of health and wellbeing.

A need to balance ‘empowerment’ with the need to ensure that people are not given responsibilities that they cannot handle. Finding this balance has many components including defining the roles of actors within the health system and dealing with changes in these roles.

Drivers and barriers to new models of care:

In this practice field social innovations are frequently satisfying new or emerging social needs and demands. However negotiation of emerging needs and demands can be complex and uneven across institutions, sectors and populations. This potentially makes this practice field highly disruptive. As such drivers and barriers tend to relate to the transitions between existing and new practices and we found that factors can frequently act as both drivers and barriers.

Social demand is a major driver of experimentation in this field. New models of care are strongly linked to social values and therefore frequently require adaptations in people’s social values and culture in order to build better health outcomes. However, just as demands can drive experimentation so too can expectations be a barrier to change. These exist at the levels of citizens, professionals and policymakers all of whom have expectations for how services should operate. Expectations can encourage people to become entrenched in their traditional ways of doing things and can make people resistant to the changes required in order to innovate effectively.

A culture of innovation can be helpful for allowing the space for people to innovate but this needs to be joined up with the wider health and social care system. This means creating cultures of change, dealing with risk aversion, breaking silo based cultures.

SESSION 2: UNDERSTANDING THE GOALS, DRIVERS AND BARRIERS OF HEALTH AND SOCIAL CARE INNOVATION

SI DRIVE takes a global perspective. With partners spanning four continents we have built up a strong empirical basis for understanding SI in the EU and beyond. We recognise that SI is frequently highly context specific and therefore as part of our second and third sessions we chose to form two groups, one considering health and social care SI inside the EU and outside of the EU. This yielded rich discussions about the extent to which context informs the development of innovation. It also helped us to understand where there might be common dimensions across regions.

Our second session looked to draw out the goals and ambitions of health and social care broadly and break this down from a regional perspective as well as those factors which hinder or drive innovation. Interestingly there were considerable overlaps between conversations around EU and Non-EU contexts.

Goals:

- A desire for increasingly integrated and patient-centred care which noted that fragmented care would benefit from an approach that prioritises continuous care.
- The need for cultural change and an approach which views patients as partners rather than ‘beneficiaries’ and focuses on wellbeing in addition to ‘health’.
- The breaking down of silos and the need to integrate care services in order to improve quality.
- There is a need to improve systems of delivery in order to achieve this. This included breaking down silos and empowering not just patients but also the organisations and practitioners who provide care.

From the perspective of the participants focusing on goals and ambitions-outside of the EU- those identified were closely aligned with:

- Tackling the considerable challenge of access to healthcare for people who are poor, marginalised isolated.
- In this vein participants noted the need, in developing countries particularly, to enhance the use of frugal innovations and inclusive innovation in order to try and drive access.

It was noted that the health aims of the ‘development’ community are aligned with a large scale UN agenda which finds expression through the Sustainable Development Goals but also goes far beyond them.

In the EU context goals articulated included a better understanding of the risks and needs to move from an illness to a wellness perspective.

Drivers and barriers

Drivers and barriers are significantly context dependent, however there are some dimensions that are common across contexts

- Innovation frequently requires policy level buy-in. This means more than just providing an enabling environment, it means the active advocacy of a person with influence over policy priorities.
- Personal silos of policy makers appears to hinder SI whilst breaking them down can enable it by forging new relationships.
- Technology is a driver of health and social care innovation, in developing contexts this may come in the form of frugal innovation or remote services to services whereas in highly developed health systems this might come in the form of ambient technologies.

Significant differences in the way health and social care manifests were revealed in the ways that different governing systems operated.

In China, for example, the government five year plan has an overwhelming influence on innovation, defining the aims of society and regulating the way policy and the rest of society are able to participate in innovative activities.

By contrast in sub-Saharan Africa it was noted that SI tends to be highly connected to the grassroots due to little government capacity. The lack of government support for SI was identified as a key barrier for SI.

In the EU context dimensions include:

- The longevity of funding: The short term nature of innovation funding was identified as a barrier to the innovations being able to demonstrate their worth in the long term.
- Longevity of outlook: It was felt that taking a longer term look at health outcomes, taking a whole life approach to health and engaging in projects with long term perspectives is necessary but that the short term priorities of new cycles and political cycles can sometimes get in the way of this.
- Tools used to understand impact: Where these are sensitive and case dependent this can be a clear driver of innovation. Where the tools are not fit for purpose this can pose a considerable barrier as innovation are called to engage with metrics or measures that may be inappropriate for their aims or practices.

SESSION 3: WHAT ARE THE ROLES AND POSSIBILITIES FOR INNOVATION POLICY?

Different global contexts are at different stages in terms of their enabling policy environment for SI. However what was clear from the input both from conversations about EU and Non-EU contexts is that no country has an optimal policy environment. There is still more that can be done.

In some contexts with less highly developed innovation pathways the next steps might be:

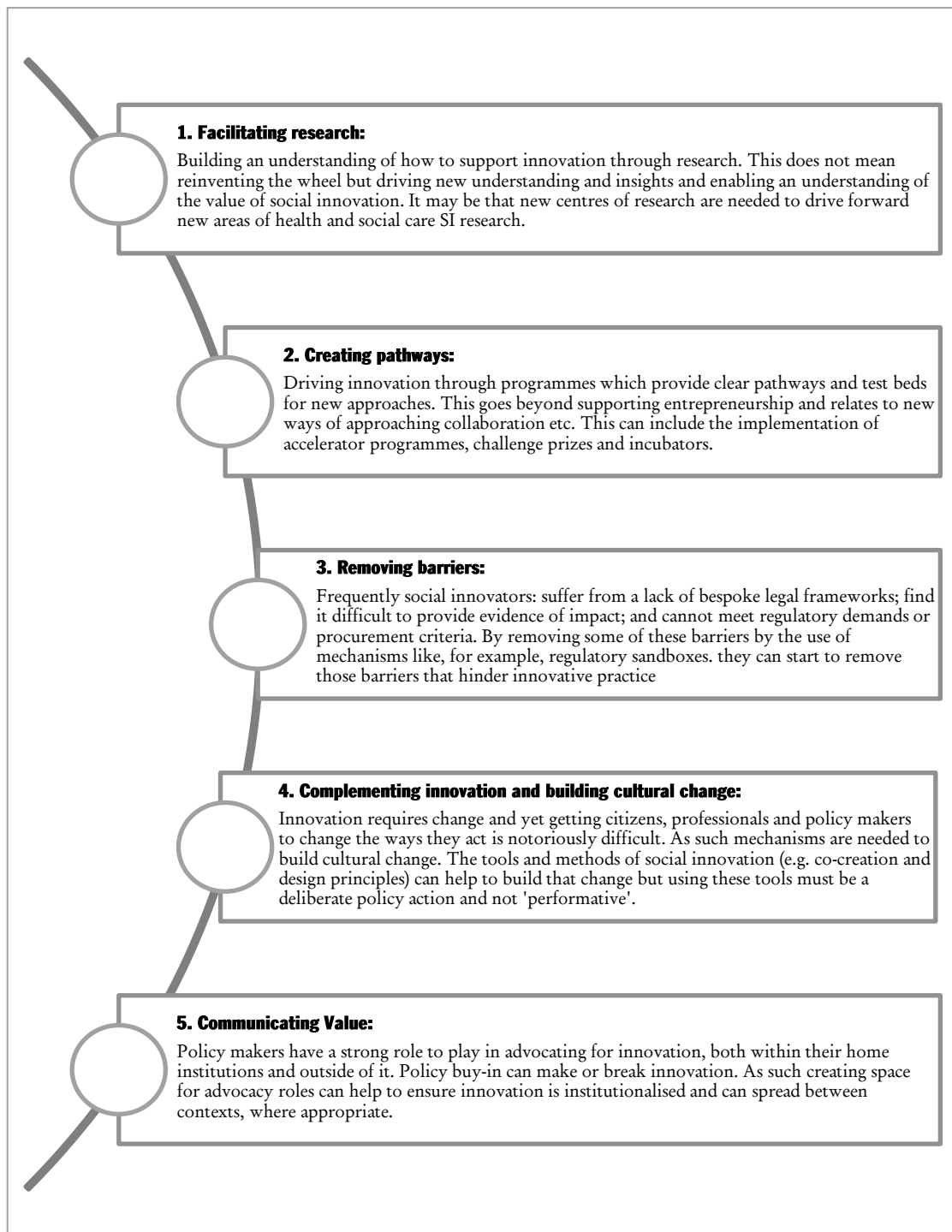
- To develop centres of research which can communicate the value of SI to policy makers, particularly building research capacities around concepts such as frugal innovation where ideas can be incubated and/or accelerated.
- Developing SI testing grounds and classic innovation programmes such as accelerators and incubators.
- Developing incentives for private sector investment in SI.

In contexts with more significantly developed pathways for innovation the role for policy included:

- A move away from a programmatic approach to SI to an approach which incorporates the tools and methods of SI into the ways that practitioners and policy makers define their approaches. This means moving beyond public consultation towards methods that embrace methods like co-creation and user-centred design.
- Developing a change in culture at all levels of the health system so that innovations have the opportunity to embed themselves. This may involve training and knowledge transfer
- Provide longer term funding so that innovations have greater opportunity to validate their approach
- Develop models of support beyond funding mechanisms. This might include policies such as regulatory sandboxes which remove regulatory barriers to innovation and provide a safe space for innovators.
- Develop policies to address the gap between evidence needs and innovator capacity. Frequently innovators are not able to provide the kinds of evidence needed in order to satisfy policy makers and this may require both change on the part of policymakers and innovators.

Despite these differences we found that policy making for innovation broke down into five categories designed to support innovation across the lifecycle: providing a research bases for SI, creating pathways that enable SI, reducing barriers to innovation, driving the cultural change necessary for radical solutions to institutionalise; and celebrating successes and communicating the value of SI.

The five roles and responsibilities of health and social care policymakers seeking to enable innovation



FUTURE STEPS FOR SI DRIVE

The SI DRIVE programme is now in its final year. The team is currently in the process of gathering insights drawn from our sector engagement activities and from the extensive empirical research that has been conducted. This will result in public facing documents which explore SI both from a regional and thematic perspective. There will also be a number of key outputs which will look specifically to help understand and drive forward progress in health and social care innovation.

The SI DRIVE project will also have a number of future events designed to provoke further discussion around these topics including an International Roundtable bringing together experts from each of the policy fields to explore cross cutting issues. In addition the final SI DRIVE conference will be held at the end of October 2017.

If you would like to know any more about these events or the work that the Young Foundation is doing as part of SI DRIVE then please contact Charlotte Heales at charlotte.heales@youngfoundation.org.

APPENDIX 1: WORKSHOP PARTICIPANTS

Name	Organisation
Amanda Hill Dixon	Young Foundation
Beatrice Halpaap	World Health Organisation (WHO)
Bev Meldrum	University of Cape Town
Charlotte Heales	Young Foundation
Doris Schartinger	Austrian Institute of Technology (AIT)
Francesca Cignola	Innovation Lab
Gareth Presch	World Health Innovation Summit
Hazel Harper	InnovateUK
Hua Li	Zhejiang University
Lindi Van Niekerk	London School of Hygiene and Tropical Medicine
Mireia Sanabria	URBACT

Mohamed Wageih	University of Heliopolis
Peter Oeij	Netherlands Organisation for Applied Scientific Research (TNO)
Sebastian Merkel	Institute for Work and Technology (IAT)
Steven Dhondt	Netherlands Organisation for Applied Scientific Research (TNO)
Tony May	Young Foundation
Wolfram Rhomberg	Austrian Institute of Technology (AIT)