

SI-DRIVE

Social Innovation: Driving Force of Social Change

SOCIAL INNOVATION IN HEALTH AND SOCIAL CARE: CASE STUDY RESULTS

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Remark:

This case study summary is an own interpretation of the case study conductors and policy field leaders based on the information and data accessible and given by the initiatives.

A. METHODOLOGY

1 METHODOLOGY AND DESIGN

1.1 SI-DRIVE METHODOLOGY

The SI-DRIVE methodology is constructed as an iterative research process characterised by two empirical phases based on and feeding the three central research pillars of SI-DRIVE: theory, methodology and policy. Starting with a first theoretical, methodological and policy and foresight framework the empirical phase 1 lead to a global mapping of Social Innovation: comparative analysis of 1.005 cases worldwide, seven policy field reports, global regional report, external database screening, and eight first policy and foresight workshops. These results led to the improvement of the three pillars and set the ground for the second empirical phase: the in-depth case studies, which results will be presented her and in a reporting of each of the seven policy fields of SI-DRIVE. Finally, the results of both empirical phases will lead to a summarizing comparative analysis in each of the policy field and to the final theoretical framework, the final methodology and the final policy and foresight recommendations of SI-DRIVE.

Thus, the chosen triangulation and combination of quantitative and qualitative methods has also a sequential aspect: While the quantitative approach is more appropriate for the analysis of 1.005 mapped social innovation cases, the qualitative methodology is more relevant for the in-depth case studies (based on the quantitative and qualitative analysis of the first empirical phase).

Iterative Process: Two Empirical Phases Based on and Feeding Theory – Methodology – Policy Development

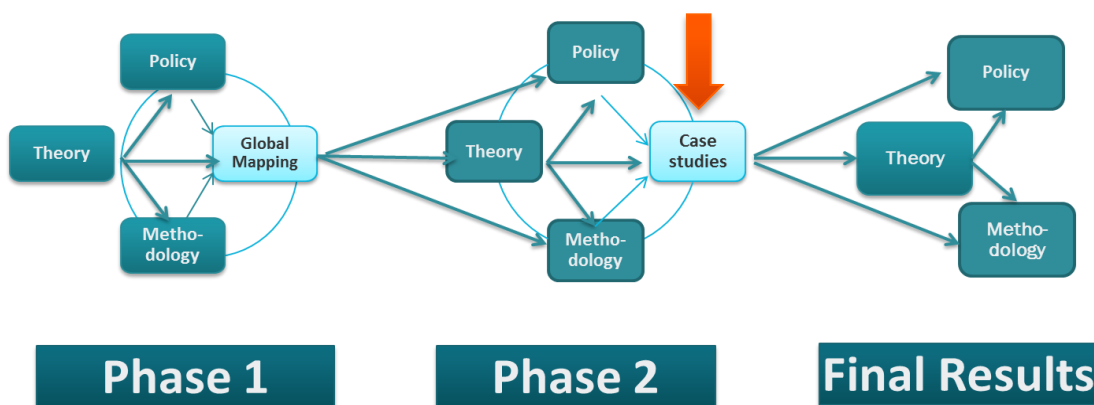


Figure 1: Continuously Updated Research Cycle

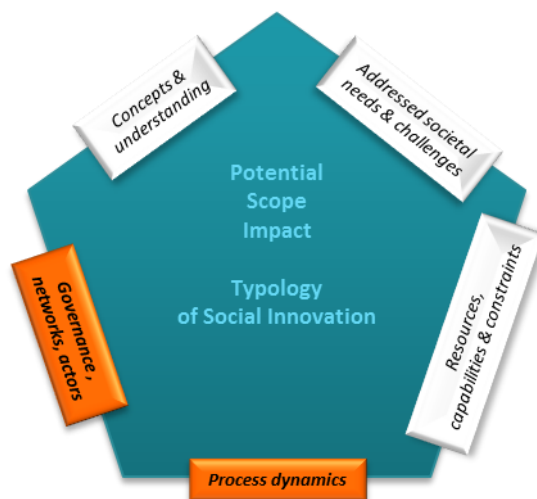
So, this report is summarizing and analyzing the case studies conducted in the policy Field Education and Lifelong Learning, delivering a further depiction for the final comparative analysis within the policy field at the end of the project.

1.1.1 Background and Central Questions of the Case Studies

The focus of this qualitative research is on the dynamic **interrelation between social innovation, the practice field and various mechanisms of social change**. Therefore the guiding meta-question for the case studies of SI DRIVE is focusing on **mechanisms of social change**:

Does Social Innovation actively use, reflect or contribute to the defined mechanisms of social change (see annex)? Can we identify other, additional mechanisms?

All these mechanisms are reflected in the five key dimension, but putting a focus on social change. Related to the five key dimensions of SI-DRIVE the main focus of the case studies is on **Governance, Networks and Actors** as well as on **Process Dynamics**, mainly asking which changes appear and are driven by what/whom (see also the research foci in the Annex). Within these focused key dimensions and mechanisms of change **factors of success (and failure)** are of high importance as well.



The **degree of social change** is also considered: **diffusion** in society, degree of **institutionalisation**, and **importance of the practice field / initiative** for everyday life and local communities.

Therefore, the main objectives of the case studies are aiming at a better understanding of

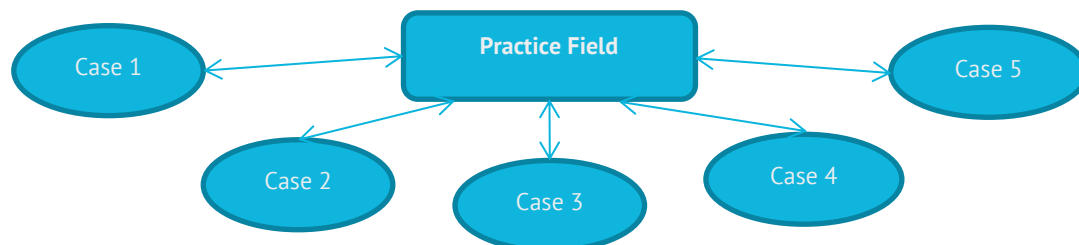
- the **processes and dynamics** of social innovation in relation to social change (institutionalisation, diffusion and imitation of social practices)
- the **functions and roles of actors and networks** for the development, diffusion, imitation and institutionalisation of social innovations
- including the identification of **critical success (and failure) factors**, leading to social change.

1.1.2 Methodological Design

The methodology is consisting of two levels for the selection and analysis of cases:

- Selection of the relevant **practice fields** (about 2 or 3 in each policy field)
Main criteria: Importance for the policy field, already leading to social change
Main interview partners: different kind of representatives of the practice field, e.g. associations, interest groups, politicians, leaders, etc. - representing the Social Innovation Ecosystem or sectors (**public, private, civil society, and science**)
additional documented material, documents analysis.
- Selection of social innovation **initiatives related to the chosen practice field** (about 4 to 5 cases)
Main criteria: Connection and contribution of the initiatives to a practice field.
Main interview partners: people who were *actively* involved in developing the social innovation initiative, project organisers/participants/actors, users and beneficiaries – representing the Social Innovation Ecosystem or sectors (**public, private, civil society, and science**)
complemented by additional document analysis.

Because there might be only limited information for the chosen **practice field**, the results of the case studies with the single initiatives will be used as a background for the practice field examination and analyses (**hybrid approach**).



All in all about ten cases were conducted within each policy field, ending up at 82 case studies. The cases were selected on the background of given framework and the partners' knowledge and experience. Beneath practical points like access to and willingness of social innovations to participate and a general regional variety the following aspects were taken into account:

- For the **selection of the practice field**: The (strategical) relevance for the policy field, the differentiation/ spread of single cases, and an advanced development phase (cases that are already in the implementation, impact phase).
- For the **selection of the related cases**: The selected cases should be already highly developed (implementation or better impact phase, embedded in networks, movements or umbrella organisations), and be representative for the practice field showing its variety in terms of social demands and regions.

Against this background the cases were **selected from the existing mapping data base**. If there was a new important case of high interest (not in the database) there was the possibility to add at least **one additional case** per policy field. Because the global mapping stressed that social innovations often comprise more than one policy field **overlapping cases** were taken into account and finally assigned by the policy field leaders.

The template developed for the case studies had a **common, but flexible structure**. This means that the main topics and the related main questions have to be reflected, additional questions helped to structure the deepening of topics appearing as relevant from the interviewees or interviewers perspective, and from the particular context of the initiatives, the actors of the social innovations or practice fields.

While the case study inquiry followed the context and perspective of a single initiative, the structure of the reporting document is starting with the practice field as the overarching context for the related case studies, bundling and summarising the results of the different related cases, illustrating the practice field, summarizing the given topics (reflected in the single case studies).

Therefore the structure of the template for the case study inquiry is the other way round as the template for the reporting:

1. The **case study inquiry (bottom-up**: initiative perspective as the starting point) started with the perspective of the initiative, leading to the overarching perspective of the related practice field in the end: focusing on the context of the concrete initiative (starting with the idea, passing the development process and ending with the impact perspective) → leading to and completed by the practice field context (integration of the initiative in the broader practice field background, conclusions, institutionalisation).
2. This **reporting document (top down**: context of the practice field as the starting point) is structured the other way round starting with the overarching practice field perspective, activating the overall on social change

oriented perspective as a context at the beginning and reflecting the social innovation initiatives from this background.

Already given and available information from the mapping and internet/documents were integrated in the interview template first, including information of the practice field. The practice field information already gathered in the case studies (earlier) were updated continuously in the case study guide.

For the field work and the analysis a common and obligatory structure across all the seven policy fields was developed (case study template, QCA questionnaire, reporting template). The following procedure is characterising the case study performance:

1. Extraction of the given information from the mapping database and integration into the reporting template, interview guide for the specific initiatives.
2. Search for additional documented materials (internet, literature, etc.) and integration of the results in the template as well.
3. Selection and inquiry of key persons for the practice field and the related cases.
4. Interviews, group discussions, site visits etc. (of **all the relevant actors** of the initiative, **including if possible the users, beneficiaries**)
5. Reporting within the given template (integrating all the information of the database, interviews and group discussion in one template).
6. Qualitative Comparative Analysis (QCA)
7. Summarising reporting document (done by the work package leaders).

Within the case study template the questions did not vary a lot between social innovation projects and social practices, but the answers relating to the questions are expected to vary to the different levels of uptake. For instance, in a more mature case/practice field there may be a wider set of competitors as a context feature (e.g. car sharing), whereas in a case that is still in its infancy (although it should be well implemented and show dimensions of success as well) competition may be very different in quality or limited in total. We speak of a social practice when there is already a set of different initiatives, when the original initiators of first social innovation projects (sometimes) are already difficult to identify, variation of the original initiatives have already been applied, maybe a bundle of initiatives exist (institutionalized in a practice field), they have different business models (if any), their services vary, accordingly users vary, incremental differentiation between various offerings.

1.2 WP9 HEALTH AND SOCIAL CARE: PRACTICE FIELD AND CASE SELECTION

The practice field dimension of the second round of mapping has been complex. The SI Drive project has taken an approach to understanding social innovation that focuses on social practices and developing 'practice fields' of social innovation. Within the Health and Social Care work package we have considered the innovations that were gathered in the first stage of the mapping process. At that point we considered the practice fields that would therefore offer us the best chance of developing varied and widespread cases. We opted to look at case studies within specific practice fields and selected case studies that we feel represent interesting examples within those practice fields.

We based our decision making on a set selection criteria.

Tier 1	1. Details of the SI & Contacts	3/3 Exclusion
	2. Not a start-up but a 'viable concern'	
	3. Practice field	
Tier 2	4. Partner confirmation or viability	Discussion
Tier 3	5. EU/Non EU (global variety)	Spread
	6. Integrated: Non Integrated	

Selection criteria within the first tier were required for each case and involved establishing whether the case could be studied. This included whether we could contact the people who set up the initiative, whether it related to a selected practice field and whether the case was a 'viable concern'- that is to say whether it was still running and had progressed past the start-up phase to the point where it was likely that it would continue into the future. To begin with we opted to try and ensure that cases met all of these criteria in order to be considered. Then (tier 2) we consulted with partners in order to understand their perspective on whether a case was viable to take forward. Finally (tier 3) we looked to ensure reasonable geographical spread and some representation of cases that were integrated or not integrated into the existing health systems.

We had originally anticipated that we would only look at case studies across two practice fields: integrated care and E/M health however we found that it was not workable to cover only these two and the process was expanded to also include 'new models of care'.

In all 15 case studies were examined across the three practice fields:

1. **Integrated Care:** We define this practice field as: *'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 provision of health and social care.'* The first round of mapping produced a set of 15 cases with a primary allocation to the integrated care practice field.
2. **New Models of Care:** We define this practice field as: *'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.'* The first round of mapping produced a set of 43 cases with a primary allocation to the New Models of Care Practice Field.
3. **Electronic or Mobile (E/M) Health:** We define this practice field as: *'the process of utilising the increased dispersal of technological capacity and capability among the global population in order to increase the efficiency and/or effectiveness of engagement of/with patients by applying technological solutions'*. The first round of mapping produced a set of 21 case studies with a primary allocation to the E/M Health practice field.

Case study selection was complex for a number of reasons:

- There were a limited number of viable case studies in the database. Because of the mapping procedures for stage 1 it was frequently quite difficult to determine whether a case was in fact possible to complete. This led to some level of iteration in the determining of cases as the work package leaders and partners negotiated to find cases that were both viable and fit with the practice fields requirements whilst still giving geographical spread. In addition some cases were thought by partners to be viable but in fact turned out after further investigation not to be possible to take forward meaning that new selections had to be made.

- Cases frequently represented multiple practice fields. Specific practices that are emerging in order to improve health and social care services and delivery are frequently not mutually exclusive and – perhaps understandably – multiple ‘good practices’ can be exhibited in more than one project. As an example both the **Smart Elderly Care (China)** and the **Care (Russia)** case studies are primarily assigned to the E/M health practice field but also can be considered examples of the integrated care practice field. Likewise, the **Family Hall (Austria)** case study has been assigned to integrated care but could be seen by some as a new model of care. In addition new models of care frequently overlap with other practice fields.
- The practice field listed in the database was not always a good fit to cases, which could more appropriately be assigned to another field. We found that many cases which had been listed in the database as one practice field, the partners felt could usefully be classed as another.

As a result of the above complexities we have taken a more iterative approach to case selection than we had first envisioned, this has meant that some cases now sit within different practice fields to the one in the database, as one can see from table 1 below.

In total changes to practice fields were as follows:

- two cases were included from outside practice fields because of their relevance to a specific included practice field
- two ‘integrated care’ cases were found to be more appropriately considered new models of care, though they may have relevance to the integrated care practice field
- one ‘new models of care’ case study was found to be more appropriately considered an ‘e-health/m-health’ case study, though it did have relevance to the new models of care case study
- three cases previously labelled as ‘new models of care’ were found to have greatest applicability to the ‘integrated care’ practice field.

Table 1: Case study selections (highlighted cases have moved practice field between stage 1 and stage 2)

Partner	Project	Practice field (stage 1)	Practice field (stage 2)	Rationale for change where appropriate
ISED-T-RAS	Social geriatric Centre: 'Protection'	Shift in care location	Integrated care	On the recommendation of partners this case was included for its relevance to integrated care.
IKED	Self-managed dialysis	Self-management	New models of care	On the recommendation of the partners this case was included for its relevance to the new models of care practice field and therefore appears in this section.
ZU	voluntary teams of elderly service	Integrated care	New models of care	On appraisal of this case it was decided by the WP leader that this case in fact belonged in new models of care
LAMA	House of Michele	Integrated care	New models of care	Whilst this case study is listed in the database as integrated care it was felt by both the partner and the WP leader that this would be more appropriately labelled as 'new models of care'
TNO	Better Together in North Amsterdam	Integrated care	Integrated care	n/a
AIT	LIFEtool	E-health/ m-health	E-health/ m-health	n/a
ISED-T-RAS	Care	E-health/ m-health	E-health/ m-health	n/a
LAMA	Vitaever®	E-health/ m-health	E-health/ m-health	n/a
YF	Doc Ready	E-health/ m-health	E-health/ m-health	n/a
ZU	Smart Elderly Care	E-health/ m-health	E-health/ m-health	n/a
UCT	mothers2mothers	New models of care	E-health/ m-health	Whilst this case is listed in the database as new models of care it was felt that this was an overlapping case and its primary practice field should be E-health/ m-health
AIT	Family Hall	New models of care	Integrated care	While this case can be seen as a new model of care, it is classified by an official body as integrated care and includes a clear relationship with bodies external to the healthcare sector, and therefore it was felt by the partner that this was a more appropriate practice field.
IKED	Physical activity on prescription	New models of care	Integrated care	Although this could be viewed as a new model of care it was agreed by the partner and WP leader that, although it was the integration of only one thing (physical activity into healthcare), it fell more appropriately into the practice field of integrated care.
UCT	Khethimpilo	New models of care	New models of care	n/a
IAT	Healthy Kinzigal	New models of care	Integrated care	New models of care offers a broad category that many innovations can fit into but as this was primarily about providing integrated care across a region, it was agreed that integrated care made a better fit.

This does demonstrate some major challenges to the practice field approach. In particular the overlaps between practice fields can throw up problems in how to assign cases, particularly where they exhibit characteristics of more than one.

A clear effort was made to try and create geographical spread among the practice fields and the final practice fields for each

Table 2: Case totals according to practice field and partner

Practice Field Partner/Country	E/M health	Integrated care	New models of care	Cases in Total
YF/ UK	1			1
AIT/Austria	1	1		2
IAT/ Germany		1		1
IKED/ Sweden		1	1	2
LAMA/ Italy	1		1	2
UCT/ South Africa	1		1	2
TNO/ Netherlands		1		1
ZU/ China	1		1	2
ISED T RAS / Russia	1		1	2
Cases In Total	6	4	5	15

B. PRACTICE FIELDS AND EXEMPLIFYING SOCIAL INNOVATION INITIATIVES

The SI Drive project defines practice fields as *'a generic type of project that expresses general characteristics common to different projects'*. To put this another way practice fields represent 'types' of practices representing specific ways of working that are commonly utilised across different projects. They can represent specific- often emergent- ways of operating.

'Practice fields' are reliant on two elements:

- Clear 'practices': It requires that it is possible to define distinct ways of working that can be considered a 'practice'. In the Integrated Care practice field, for example, this practice is the process of 'integrating' the provision or delivery of care by different health and social care actors in order to drive up the quality of care.
- Multiple incarnations: In order to represent a 'field' there need to be a number of incarnations of a specific 'practice' that are present in different contexts.

Practice fields can be a particularly useful mode of analysis because they allow us to understand not just the impacts of particular projects but the ways in which ideas or ways of working can come to have impact beyond themselves by contributing towards a larger body of 'practice' which can influence the ways in which others work.

However it is important to note that practice fields can be difficult to 'pin down' and achieving sufficient granularity is also difficult, particularly across different contexts. Within specific practice fields there can be significant variation and it is sometimes possible to identify groups, or types, within a practice field. In E/M health, for example, it is possible to discern 'types' of E/M health, such as Telemedicine or self-management apps. It should be noted that, within the confines of this study, it is not possible to demonstrate the full breadth of practice fields. For example integrated care traditionally covers indication- or population-related models of care. However none of the case studies covered are indication-related. This is because of the limited number of cases within each practice field that could be mapped. Therefore we provide instructive examples of cases within each practice field in order to give a sense of the different ways in which practices can be understood in different programmes. The case study examples cannot possibly represent every facet of each practice field. Rather they provide us with instructive examples which demonstrate to us a few key examples of how different practice fields express themselves in different contexts.

Additionally it is difficult to chart the progress of practice fields, in part because their development cannot be viewed as bounded or linear. Social practices emerge from ideas and from learning which in turn impacts behaviours. Health and social care is, in most contexts, seen as a strategic priority by policy makers. Therefore there is frequently a high level of 'internationalism' to the field. This is in part due to the high degree of evidence based policy-making that many health systems exhibit, the strong links that systems often have to the wider academic community and the high degree of professionalization, which frequently means that health systems learn from one another. However the 'routine' nature of learning and knowledge sharing within the health and social care sector and the many opportunities that exist to share knowledge can mean that it is difficult to truly understand where ideas first originated from, and how they have been transformed by different actors.

We can see from the case studies that learning and diffusion frequently happens across borders as health professionals and innovators seek to learn from and adapt the work that others are doing. In some cases diffusion is clear. In the **Self-dialysis (Sweden)** case for example there is clear diffusion across national boundaries, through well-developed networks, which has led to the trialling of similar programmes in York (England) and Waco/Texas (USA). Likewise **Doc Ready (UK)**, **LifeTOOL (Austria)**, **MomConnect (South Africa)**, **FAR (Sweden)** and others have all been involved in setting up similar initiatives in other locations, or which serve other purposes. As such, their contribution to the practice field is clear. However whilst we might be able to track the linearity of diffusion in these specific examples the actual diffusion of practices appears more complex than this and frequently is not as linear.

Indeed it is possible to conceive of two ways in which new practice fields might manifest within Health and Social Care – through direct, or indirect, diffusion – that is through the dissemination of practices through observation or learning; or through a kind of ‘convergent innovation’ in which, given similar conditions and similar capacities, two distinct groups develop a similar solution. However it can be difficult to identify exactly how and whether either of these are coming about.

Examples of direct diffusion include **Smart Elderly Care (China)**, where the initiators of this project clearly refer to learning from examples from other countries including Japan. Likewise, the **Care (Russia)** case too was initially based upon other examples of technologies that had been used elsewhere. In both of these cases foreign examples were used as a basis from which the innovation was developed in reference to specific contextual factors. Indeed whilst these two cases do not refer to one another they bear striking resemblances, perhaps in part because they both respond to similar contextual factors. Specifically they focus on finding ways to look after the elderly more effectively. This appears to be because of similar emerging social changes and shifts in social values. Both countries exist in a context where shifting demographics mean that care for elderly people is increasingly a concern¹, particularly as lifestyle changes mean that families are frequently less able to care for older people in the way that they once did.

Indirect diffusion is more difficult to determine within this study. However it seems to come about due to similar drivers. An example of this would be the **Self-dialysis (Sweden)** case. This is both an example of a new model of care and an example of ‘self-management’, another practice field that emerged as part of the stage 1 mapping. However this case was not informed by other practices as many of the others are. Rather, by engaging with higher levels of (1) agency; (2) education; and (3) desire for freedom among patients, a solution was developed that mirrors many other new models of care and self-management examples. This can be seen as an example of where clear capacities and contexts end up creating conditions for innovations that will contribute to a practice field even though it was not necessarily informed by others in the same space doing the same.

It can be difficult to understand exactly how people become influenced by social practices because they are operating within complex systems. The difficulty of engaging with this level of complexity has presented challenges to the practice field based analysis and particularly to discerning the ‘connectivity to the practice field’ for each of the case studies. This exploration has been done with a mind to the impacts of the cases and with an understanding- where it is present in the case studies- of influencing factors on the development of the practice field. However what is difficult to capture is the more diffuse influences on practice.

¹ Eberstadt, N. (2006). Growing old the hard way: China, Russia, India. *Policy Review*, (136), 15-40.

1. PRACTICE FIELD A: E/M HEALTH

1.1 OVERVIEW OF THE PRACTICE FIELD

The innovative aspects of this practice field do not lie in the development of new technology, rather, this practice field focuses on the **use** of technology in order to improve the provision of health and social care services by **facilitating better engagement of and/or with patients**. This improves health provision by addressing either or both of the issues of: (1) Access to health and social care services (2) Quality of health and social care services.

Importantly these practices have arisen out of a changing environment of both technological **capacity** and **capability**:

1. Increasing technological **capacity**.

Technological solutions to social problems are increasingly arising because of the increased ubiquity of digital and mobile devices, because of the increasingly rapid roll out of internet access- particularly in the developing world- and the increasing number of people able to develop such digital health systems.

2. Increasing technological **capability**.

The use of technology in order to improve the efficiency and effectiveness of health and social care is facilitated strongly by the greater dispersal of technological capability among the global population. People are increasingly digital literate and this means that the scope for including these solutions into professional fields such as health and social care is increased.

Defining 'E/M Health' has been difficult for two reasons:

- (1) There are many definitions of E/M Health that are currently in use.
- (2) Almost all of these definitions view E/M Health from the perspective of technological rather than social innovation.

However we look to define E/M Health specifically as a social innovation, an innovation that works not just to improve healthcare but also to change or disrupt the social relationships at the heart of health and social care provision. We view E/M Health as pertaining specifically to innovations that utilize the greater dispersal of technological capacity and capability among populations in order to improve access to or quality of health and social care provision. Importantly the innovation frequently goes beyond the technology to the processes of using technology to facilitate improved engagement of and/or with patients.

We therefore define the practice field of E/M Health as:

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

1.2 THE STATE OF THE ART OF THE PRACTICE FIELD

E/M Health is a practice field that has undergone significant growth in the last decade as the availability and use of mobile technologies has grown. E/M Health is often associated with significant impacts in the developing world where it has begun to facilitate access to healthcare for hard to reach populations. However the implications of E/M Health are broader than developing countries. Governments across the world are expressing interest in the role of technology in driving more effective and efficient healthcare delivery². A WHO survey in the field of E/M Health found that rather

² WHO Library Cataloguing-in-Publication Data. (2009) mHealth: New horizons for health through mobile technologies: second global survey on eHealth. http://www.who.int/goe/publications/goe_mhealth_web.pdf?ua=1

than strategic implementation through national health services the development of E/M Health solutions has been a somewhat chaotic process in which there has been significant experimentation and innovation³. In some cases high levels of experimentation have been critiqued as it has been found that large funding pots available for piloting have resulted in a failure of many initiatives to reach scale⁴ and, what has been termed, ‘pilotitis’⁵ ⁶. However the proliferation of projects has served a useful role for the practice field by facilitating greater understanding of the ways in which E/M Health can be used. Nevertheless there are innovations that have reached scale and had a profound impact on the people’s lives.

E/M Health is viewed by people in both the technology and health sectors as a distinct field of practice, it has a dialect of its own. As such people who ‘do E/M Health’ frequently know that is what they are doing and therefore look to other examples for inspiration. In this sense this can be viewed as a cohesive practice field which is often driven forward by new initiatives.

E/M Health exhibits significant geographical spread. In the WHO survey 83% of responding countries indicated that there was at least one E/M Health example in operation in their country. Whilst it is unclear whether all of these could be considered ‘social’ rather than just technological innovations it is frequently the case that E/M Health interventions focus on improving engagement between patients and health services. Interestingly higher income countries appear to display higher levels of variation in the kinds of E/M Health initiatives that are present.⁷

Importantly E/M Health has been enabled in some contexts due to the desire to meet Millennium and Sustainable Development Goals (MDGs and SDGs) which look to ensure universal healthcare for all people. In the case of the **MomConnect (South Africa)** case study, for example, the case was strongly driven by South Africa’s difficulty in achieving their MDG targets. In many countries E/M health enables a roll out of care to more isolated or marginalized communities by either: (1) facilitating forms of task shifting (2) by helping professionals to monitor and provide care or services over distance.

Through analysis of cases provided in both the first round and second round of mapping, as well as a broader look at the practice field, it is possible to identify specific types within the practice field of digital health, it may even be the case that these amount to ‘sub practice fields’. However with the scope of this study and the data available it has been difficult to achieve the granularity needed to analyze at the level of these sub practice fields. Importantly there may also be overlaps between some of these fields.

³ Ibid.

⁴ mHealth Alliance (2010) Leveraging mobile technologies to promote maternal & newborn health: The current landscape & opportunities for advancement in lowresource settings. (The center for innovation & technology in public health; Public Health Institute, Oakland, CA.

⁵ Kuipers, P. et al (2008). Collaborative review of pilot projects to inform policy: A methodological remedy for pilotitis? Australia and New Zealand health policy 5, 17,

⁶ van Velthoven, M. H., Brusamento, S., Majeed, A. & Car, J (2013) Scope and effectiveness of mobile phone messaging for HIV/AIDS care: a systematic review. Psychology, health & medicine 18, 182–202

⁷ Ibid.

Table 3: Three examples of E/M Health 'sub-practice fields'.

Telemedicine: Telemedicine is the process of monitoring, diagnosing or prescribing at a distance using digital technology. It is frequently used as a method of rolling out access to health and social care to those people who might otherwise struggle to access it. **Smart Elder Care (China)** and **Care (Russia)** both can be seen as examples of this in that they allow for the efficient and effective provision of home care for the elderly by providing a service by which older people can use a digital service to contact medical professionals in the event of a medical emergency or when they need medical information. This can be conceived of as improving engagement of and with patients because it sets up a simplified route of communication with healthcare professionals that permits a greater level of independence alongside the increased ability of patients to call for help when they need it.

Digital Treatment and support: Digital treatment and support is the process of using digital platforms in order to extend either treatment or support of patients. This should be considered distinct, though perhaps overlapping with, 'Facilitating Self-management' which provides support but also looks to empower the individual to take charge of their own health. Instead 'Digital Treatment and Support' can provide both treatment for health problems (an example of this may be the UK's use of computer-based Cognitive Behavioural Therapy) or on-going support for chronic conditions, an example of which would be the **LIFETool (Austria)** case study which demonstrates the use of computer based technology to support people with physical or mental disabilities, particularly ones which make speech difficult.

Facilitating self-management: A distinct area of E/M Health is 'facilitating self-management' which provides technology based methods for people to take a more active role in managing their own health. This form of E/M health can take many different forms- some of the most common are apps that monitor physical activity. The case study **Doc Ready (UK)** can be seen as an example of this kind of E/M Health in that it encourages young people with mental health problems to prepare for their doctors' visits using an app, thus taking a more active role in their interactions with health and social care professionals.

1.3 E/M HEALTH: PROCESS DYNAMICS AND SOCIAL CHANGE

Collaboration between actors and leadership

The E/M Health practice field is characterized by high levels of collaboration between partner organisations. Lemaire⁸ (2011) indicates that collaboration is an important factor in whether or not an innovation reaches scale and is therefore a key mechanism of social change, both for innovations themselves and for the practice field more generally identifying as critical: "Securing buy-in from, and creating strategic partnerships with, key stakeholders, including national Ministries of Health, private sector mobile technology partners, technical agencies, local non-governmental organisations and potential sources of financing whether private sector or donor-based." Cooperation between partners can be seen as a major success factor within the mapped cases but also across the practice field more broadly.

Indeed all of the cases in the second round of mapping demonstrated significant levels of collaboration between different kinds of actors, though the structures and processes of collaboration differ significantly between cases and context. However one of the most frequent reasons for collaboration involves the need to bring together the diverse skills or actors necessary for successful E/M Health social innovation. The key competencies for the successful implementation of an E/M Health innovation are:

1. **Capabilities in the field of technology:** E/M Health is characterized by the utilization of technology in order to alter the way that health and social care is used or delivered. As such there is a need for actors to have a clear ability to build technological solutions to problems. Many of the innovations had the involvement of actors who had specific expertise in building technological products. In some cases these actors were research institutions (for example the Austrian Institute of Technology in the **LIFETool (Austria)** case) and in

⁸ Lemaire, J. (2013). Developing mHealth Partnerships for Scale. Advanced Development for Africa, Geneva.

other cases this role is fulfilled by the private actors (such as the Yuantong Company of the **Smart Elderly Care (China)** case or Nethical of the **Vitaever (Italy)** case)

2. **Capabilities in the field of health/ Understanding of the problem to be solved:** In addition to an understanding of the technology there must be an ability to understand the health dimensions of the innovation. In particular there must be a clear understanding of health needs, and of how to go about addressing these. In some cases the understanding of the health needs are integrated by including a partner with specific technical knowledge relating to healthcare and in other circumstances this is done through other methods. For example **Doc Ready (UK)** based their solution on a clear research finding from the 'Right Here' research project, which laid out the parameters for the innovative solution.
3. **An ability to work within the specific context:** The other major competency required is an ability to negotiate existing institutional, regulatory, bureaucratic context. The ability to do this appears to have a significant impact upon the extent to which an innovation can have impact. Different innovations go about developing that expertise in different ways. In the case of **Smart Elderly Care (China)** this was done by actively involving a variety of stakeholders including care providers and municipal government in the project. In the case of **Doc Ready (UK)** on the other hand the lack of integration into health services and advice has meant that the projects reach has remained somewhat limited.

Different innovations develop these competencies in different ways, however it is frequently the case that these are met through the convening of distinct organisations who each contribute their own expertise. In the case of **LIFEtool (Austria)** this was the collaboration of the Austrian Institute of Technology with Diakoniewerk, a protestant NGO with specific expertise in education.

Partners play a number of different roles in facilitating social change. A key role for partners can be providing legitimacy. In an age where people are concerned about their personal information having the involvement of government or other trusted actors can help to make people feel more comfortable engaging with a product. This was particularly the case with **Vitaever (Italy)** who teamed up with Amazon who had a key role in ensuring the security of the data. Interviews suggested that having a name like Amazon ensuring the security of data had a significant impact on the trust people have in the product.

By comparison leadership was less of a driving factor in social change. Some of the mapped cases certainly appeared to be based around the actions of a 'charismatic leader'. **Smart Elderly Care (China)** for example was a project largely driven by one man who was motivated to provide assistance- particularly emergency assistance- to elderly people after his teacher died of a sudden heart attack. However such personal motivations or clear leadership was not present across the practice field. The case of **Doc Ready (UK)**, in particular, was notable for not really having a 'leader' as such but rather people all worked together in a more collaborative fashion in order to develop the solution.

Business Models

E/M Health demonstrates considerable variation in business model with both for-profit and not-for profit models represented, this diversity can be considered to exist on a spectrum with for-profit models, such as **Smart Elderly Care (China)**, through social enterprise models to entirely not-for-profit endeavours such as **MomConnect (South Africa)**.

Analysing the role of competition requires that we separate out public from private services which utilise different business models and therefore frequently behave in significantly different ways. The business model operated by innovations frequently has a bearing on the extent to which innovations seek to protect intellectual property. E/M Health sees many innovation which have gone to lengths in order to patent or otherwise protect their innovation. This is interesting from a social innovation perspective because it relates to the debate about whether or not a truly socially innovative project would protect intellect property, given that competition can help to build better products.

Certainly **MomConnect (South Africa)** was built on the principle of openness enabled by the Health Information Exchange platform of South Africa.

Learning

A key dimension to achieving social change, which has emerged from the case studies has been the need to ensure that the product can be effectively utilized by the end-users. In some cases an approach has been taken to try and ensure that the product is as simple to use as possible. **Smart Elderly Care (China)** and **Care (Russia)** are two good examples of where the product has been designed with ultimate simplicity for end users. In these cases the end users are elderly people, often with complex needs or chronic conditions, who need a quick and easy way to coordinate or access care and get in touch with health and social care providers. However not every project is amenable to such high levels of simplicity. Other times learning is required, in some cases by the innovators and in some cases by the end users. In the cases examined here we can see that different kinds of E/M Health innovations often require different kinds of learning.

Where the product must be easy to use the learning often needs to occur on the side of the innovator. It is notable that three of the innovation cases make use of 'user centered design' and co-production, in order to create a product that works for the end user. If we look for example at **Doc Ready (UK)** we can see an example of where the E/M health product, an app designed to help young people with mental health problems to prepare for meetings with general practitioners (GPs), was entirely overhauled as a result of user-led design. The developers held workshops with groups of target users in order to understand how they would want to use the product. Interestingly this led to a totally stripped down version of the app with far fewer questions.

By contrast where there are products that need to be more complicated it can be more effective to train the people using the product. **LIFETool (Austria)**, which is an Alternative and Augmented Communication (AAC) tool facilitates use of the product by working with end-users in order to get them used to using the product whilst also adapting it for the needs of the client.

In the case of **Vitaever (Italy)** both approaches are utilized. Co-design sessions resulted in a complete overhaul of the product in order to better meet the needs of the service providers who use it however Vitaever also provides training workshops for those who engage with the product in order to build their capacity to use the product in the way that works best for them.

Through learning in these ways these innovations found that they were more able to meet the needs of end-users effectively and therefore uptake, impact and social change increased as a result. Learning then can be considered a key mechanism of social change.

Institutionalization

One key driver of social change in this practice field appears to be the degree of institutionalization of the intervention. None of these solutions can be considered to be a 'public social innovation' as such but many of them operate in association with the national health system, often by having services commissioned. Institutionalization appears to be a key driver of social change. It can often mean both sustainability and growth as well as leading to a greater degree of incorporation into the fabric of a society.

Institutionalization can come in a number of different forms but at its heart is about conferring legitimacy on an intervention often through government or policy actions. These can take a number of forms: including: incorporating the innovation into the health system; providing public funds; showcasing or promoting; and developing enabling legislation or regulation.

The incorporation of the innovation into the health system is a key way in which innovations can bring about social change. In particular when governments commission E/M Health services this offers a key opportunity not only to

impact upon the lives of more people but also to be able to demonstrate the impact of the intervention. A number of the cases here have been institutionalized in this sense, including **Vitaever (Italy)** and **Care (Russia)**. This has been identified as key to the ability of these innovations to make social change. If we look for comparison at **Doc Ready (UK)** we can see an example of an innovation that has not achieved this kind of institutionalization. The innovators identify this as a key limiter of impact because endorsement by institutional actors is seen as an important way of meeting new customers and ensuring their confidence.

The provision of public funds to an innovation is a strong signifier of the value of an innovation and also confers legitimacy in this way. Institutionalization can cause social change through the direct impacts of the programmes but it can also come about because of the social shifts that occur as a result of the legitimacy conferred upon the intervention by the engagement of formal health services. In addition when a project or programme is given this greater level of legitimacy this can make it more likely that actors in other countries will become aware of and therefore seek to imitate as such projects such as **Smart Elderly Care (China)** which has been showcased by the government, and which is commissioned to provide services by policy makers, is more likely to influence the extent to which an innovation, or indeed the practice field more broadly, can create social change.

Diffusion, replication and imitation

Scaling is one of the most powerful drivers of social change both for the innovation and the practice field. The more people that a socially innovative solution reaches the more likely that the innovation is to be recognized as a force for positive social change and therefore the more potential it has to enact social change. Diffusion comes in many different forms in the E/M Health practice field including growth, replication and imitation.

Gaining recognition for the product appears to be one of the key drivers of whether a product scales. Importantly the recognition of the product among policy makers appears to be very important. Importantly, because few of the projects have been developed directly by a health service it is necessary that they gain the recognition of the 'commissioner' (whether the patient, an organization, a municipality or government) to decide that it is worth investment. Growth then occurs when this value is communicated further and further.

In a number of case studies diffusion has occurred on this basis. For example, Praekelt, the organization behind **Mom Connect (South Africa)**, upon demonstrating the success of the model in South Africa have been requested to develop similar interventions in Rwanda and Uganda. This was driven by policy makers and funders, who upon seeing the value, decided to invest in developing the solution for their specific contexts. Likewise in the **Care (Russia)** case diffusion has been significant. The innovation went from being localized to St. Petersburg to rolling out to many of the districts of Russia in part because policy makers saw the product as valuable.

However, in the case of **Doc Ready (UK)** the product was developed entirely outside of the health service. Instead of being 'commissioned' by, for example, a government or organisation, the decision on whether to use the product is left with the patient or the individual. Also whilst individual GPs might promote the product on an individual basis there were also not systems in place that might 'recommend' the product to the patients. As a result of this the recognition of the value of the innovation has been more difficult to spread- though it still has achieved impact.

When municipalities and governments understand the value they can mandate the use of an innovation for a large number of patients. However where products are targeted at individuals there is a requirement that every patient who uses it to understand the product and sees the value. This can be helped where it engenders a social movement or receives publicity but otherwise the diffusion of understanding is more difficult to drive. With **Doc Ready** it was the feeling of the innovators that growth of the innovation would have been easier if there had been endorsement by the health service in some way. Instead **Doc Ready** was replicated in the form of CAMHS Ready, another app made by the same actors which operated along the same lines but was commissioned by the health service for use with Child and Adolescent Mental Health Services (CAMHS) instead of with General Practitioners (GPs).

In a number of the example cases it was found that a major benefit to the electronic or mobile nature of the intervention was the economies of scale that can be achieved. This was particularly the case with **Vitaever (Italy)** who found that they were able to keep the number of employees low even with quite significant growth in the number of users and the numbers of patients being reached. However not all organizations have a model that can grow in this way. The **LIFetool (Austria)** case for example requires a model that involves greater interaction between the organization and the client and as a result of this they have created a kind of 'social franchising' model where the model is adopted in a number of different offices in different locations.

1.4 SOCIAL INNOVATION INITIATIVES RELATED TO THE PRACTICE FIELD

1.4.1 Doc Ready (YF)

Description, development of the Social Innovation Initiative

Doc Ready is a digital tool (an HTML 5 App) that helps young people to prepare and make the most use out of mental health related GP visits by helping them create a checklist of factors that they want to raise with their General Practitioner (GP). It helps to empower young people in their relationships with their General Practitioner by: letting them know what to expect during a GP consultation, plan what to say and record appointment outcomes.

The case is particularly interesting for the way it has developed the app, using co-production methods that include young people in development. It is also particularly interesting that the innovation locates its action on the service user rather than the doctor, in order to disrupt the traditional roles and power dynamics of patient-doctor interaction.

Doc Ready was influenced by a piece of research called 'Right Here' that took place in Brighton and Hove. The research identified that the thresholds for Child and Adolescent Mental Health Services (CAMHS) were too high, which meant that most young people were only able to access help in times of acute crisis⁹. This left young people with lower-level emotional problems without help or support

The project was developed in response to a call for apps to support Mental Health which was put out by a number of organisations including Paul Hamlyn who later went on to fund Doc Ready. The app was developed and designed by a number of partners and in collaboration with young people using co-design methods. It was launched in 2013 and since that time it has been used by 35,000 patients and has an approval rating of more than 80%.

Actors, partnerships, alliances, networks

This innovation came out of a strongly collaborative approach.. The people involved in this project note that the **partnerships were based upon people rather than 'departments'**. Good relationships between partners meant that the different tasks of the app development were shared among developers whilst without people "walling themselves in to their own separate domains"¹⁰

The Paul Hamlyn Foundation insisted upon alignment with Right Here Brighton and Hove because this programme had already established connections with the Young People who could feed in to app development and with the NHS services- particularly GPs. One of the major funders described the existing connections with primary care services and the fact that there was a 'readymade' group of young people available to contribute their views made the project easier to get off the ground.

⁹ <http://www.mentalhealth.org.uk/projects/right-here/brighton-and-hove>

¹⁰ Brown, M. (2014) 'How Great Teams Make Great Apps and Mental Health Services' 10 March 2014. Innovation Labs [online] Available at: <<http://www.innovationlabs.org.uk/2014/03/10/behind-every-great-app-great-team/>>

The funding came from a partnership between the Paul Hamlyn Foundation and Comic Relief. The two organisations formed the Innovation Labs in order to fund digital innovations to help improve young people's mental health. They then brought Nominet Trust into the partnership. The Paul Hamlyn Foundation utilized their existing networks to find actors who might want to pitch for the innovative solution. This included Social Spider who had worked on the 'Right here' project and Neon Tribe, who Social Spider recommended. Later Future Gov and Enabled by Design came on board. However the importance of relationships between the partners was an important element of the innovation as was involvement with the initial research that developed the programme.

There was also a strong dimension of collaboration between the makers of the app and the Young People who took part in the 'Right Here' research that initiated the project. These young people had an important role in creating an app that was usable, adapting the complex app that the creators initially envisioned down into a stripped down version of what the developers initially envisioned.

Innovative solution

The innovative aspect of this project lies in the way in which technology is used in order to disrupt the relationships between young people and their GPs in order to help young people get help when they experience mental health issues. Empowering young people in their relationships with GPs and developing their capacity to get the most out of their GP appointments by using the app in order to direct their thoughts and feelings into articulations that the GP can readily understand.

The developers understood that, in order to maximize the efficiency of care, GPs have entrenched processes for how they assess patients. GPs frequently utilize 'diagnostic trees' from which they will ask a series of questions in order to establish problems. With straightforward physical issues this is an effective way of understanding the needs of patients. However with mental health problems patients often don't know how to articulate their issues and therefore often don't trigger the 'diagnostic tree'.

Because of the entrenched processes that GPs must work to in order to make the best use of their time and offer the most efficient service, the developers of Doc Ready took the decision that it would be more effective to change the behaviours of young people than the behaviours of GPs.

In addition it was felt that there are intrinsic benefits to the way in which the app empowers young people to take a more active role in their relationships with their GP. It gives them a platform in which to feel confident discussing their problems and offers them ways in which to have more productive discussions.

Gaining momentum

The progress of Doc Ready has been steady however they have had difficulty getting the intervention recognised by within the wider health system.

Doc Ready knew at the start that there was a clear problem to be addressed because it was drawn out of research. As such they were looking to solve a specific issue rather than take an expansive look at offering solutions to the broad health service. They knew that to solve the problem all that was needed was a simple tool that is little more complex than writing down what you want to say to your GP, with the added component of the prompts which facilitates a level of interaction with something that appears to be guiding you, even if it's not. However the depth of their ambition did mean that because they had planned for a light touch tool, they went into it with the mind-set that: "we're not trying to change the world, we just want to have simple tools that some people might find useful". As the project progressed, they started to see how the projects could develop and become more complicated and have more of an impact - they could start to see how the NHS might benefit from them. However, the Innovation Labs project did not have the budget to help the innovations exploit this. Despite the usability of the design there was a lack of understanding within the partnership about how Doc Ready could be integrated into the wider health system..

Although they may have been able to see the potential, they weren't in the position to be able to have conversations with commissioners about the potential use of such products because "they would just have no way of even thinking about that at the time".

However the product that they have developed does clearly work well in this context and the simplicity meant that they could effectively use "agile design principles".

Doc Ready's development involved stakeholders right from the start, development workshops were a particularly useful tool for development. They created the potential to respond quickly to problems, ideas and feedback as it surfaced. 'This accelerated problem solving'¹¹ with the developers and coders working directly with those feeding in their ideas. Because ideas move quickly in workshops, having people on the spot to be able to highlight the financial, technological, political or knowledge-based constraints of an idea or suggestion, meant that everyone involved in the development of Doc Ready were able to 'stay focused and move quickly towards improving the product together'. This mitigated the possibility of feedback being wrongly communicated and helped to speed up, and thus reduce the cost of, the development process because the team were able to work together on solutions to challenges as they arose.

One of the funders, from the Paul Hamlyn Foundation, argues that the introduction of the Health and Social Care Act 2012 created a lot of change. This meant that relationships with stakeholders that had been developed over time were lost as certain people moved or had responsibilities changed. It had the effect of undoing all the relationships they had established within the three years of the project. Therefore a lot of time had to be spent developing new relationships and it wasn't until the final year of their grant that they felt that this had been done.

The re-structure and re-organisation of the health system also meant that there was not the in-kind or match funding locally that they'd hoped for in 2008-2009, because the structures were just beginning to bed in. In addition, because of austerity, the money wasn't there. However, despite austerity and the new health and social care structures there was real progress. Right Here Brighton and Hove had made the contacts it needed to within the local CCGs, which are comprised largely of GPs, they had a new way of accessing GPs who were given more power in the new regime. Therefore Doc Ready could benefit from the fact that the young people were speaking to the commissioners and influencing how things were commissioned locally.

Complementary innovation

This is an innovation that requires behavioural change on the part of the young people. It requires that they not only see the value of it but trust that it will be useful enough that they will incorporate it into their practices when they go to visit their GP. It was assumed when the project was developed that there was a latent demand for this product. This was based on research into the needs of young people and public consultation. Indeed this has manifested into actual demand as demonstrated from the use of the app by 35,000 young people.

The innovation was in some part enabled by the increased diffusion of technological capabilities among young people. That is to say that because many young people have a high level of familiarity with using both apps and technology this played a role in the success of this innovation.

Impact, diffusion and imitation

There are mixed opinions as to the success of the projects, depending upon how one defines success. The original funders in the Paul Hamlyn Foundation, felt that their original hope was for Doc Ready to "become a sort of **national service**, that it would be widely used by GPs across the land and by young people visiting their GP". This would mean that the organisations would have to market it very effectively. Whilst for it to be used, „pervasively“ was their long term objective, it was stated that short term objectives were for Doc Ready to: (1) address the communication issues

¹¹ *ibid*

between doctors and patients, (2) give young people the tangible tools, to try to have better conversations with their GPs about their mental health.

It has not become embedded in the health service. However it has been used by 35,000 young people since its launch. It has received endorsements from prominent advocates on mental health. What is more In an independent evaluation by MindTech, which surveyed 56 Doc Ready users¹², 80% said it had partly (9%) or completely (71%) met their needs. 56% would use it again for getting ready for an appointment and 53% would use it again to prepare a checklist. The users scored the app at an average of 8.09/10.

As well as this there has been a form of 'replication' that has taken place. North Staffordshire Combined Healthcare Trust, an NHS Trust, developed a similar product with the team behind DocReady called: CAMHS Ready. This was to be used with young people visiting Child and Adolescent Mental Health Services (CAMHS)¹³.

The entire team behind Doc Ready worked closely with young people who have used North Staffordshire CAMHS and staff to create CAMHS Ready. *"North Staffordshire CAMHS were already pointing people towards Doc Ready but struggling to provide accessible and timely information and advice about what visiting CAMHS would be like. They then funded part of the CAMHS Ready's development."*¹⁴

Rather than simply transposing Doc Ready's content and checklist into a new app the CAMHS Ready team began with some user research. The team maintained the 'same co-design ethos as the original Doc Ready'¹⁵ by combining insights from these questions with co-design sessions with North Staffordshire CAMHS youth council to work up content for the advice section and workshops to help identify how to iterate Doc Ready's checklist content."

There are still hopes that Doc Ready will be incorporated in some way into the larger health system. The funders at the Paul Hamlyn Foundation state that diffusion is difficult for any innovation in healthcare. "Getting anything innovative integrated into the health care system these days is kind of an uphill struggle, isn't it? It has to do with the healthcare system which is hugely under-resourced and very fractured and fractionalised and a big mess."

Currently the business model for Doc Ready is to use grant or public funding to develop an app that needs no further work. This looks less viable if there is going to be greater use of the app, improvements or ongoing work around publicity etc.

Role of policy

Project initiators agreed that a favorable policy context, is important. The context of austerity in the UK has driven a chronic under-resourcing for young people's mental health and they argue that this has diminished the impact of the Doc Ready app.

The evaluators at MindTech stated that it can be difficult to get any interest in implementing digital innovation within the NHS: *"The NHS is very, very slow in terms of digital uptake in that kind of sphere"*. Importantly the bureaucratic and factionalized nature of the NHS was credited as a major obstacle for the product, in this case because of the way in which it came to get in the way of the relationships that were critical to the development of the project. This was not aided by the changes to the Health and Social Care Act described above.

However the Doc Ready team are hopeful that there could still be ways for Doc Ready to enjoy a greater level of integration into the Health Service. NHS England and the Department of Health have been doing a lot of work on

¹² Simons, L. (2015) 'The Evaluation Verdict: Doc Ready'. Innovation Labs. April 24 2015. Available at: <
<http://www.innovationlabs.org.uk/2015/04/24/labs-evaluation-verdict-doc-ready/#more-2315>>

¹³ <http://www.camhsready.org/#/about>

¹⁴ <http://www.myapt.org.uk/year-4/camhs-ready-app/>

¹⁵ Brown, M. (2015) "The first rule of CAMHS club is that no one knows anything about CAMHS club": Helping young people to prepare for their time in Child and Adolescent Mental Health Services.' The New Mental Health [online] August 12, 2015.

evaluating mental health apps and are reported to be intending to develop an online 'app library'. However such projects have stalled in the past. Actors involved in Doc Ready feel that it would be well placed to feature on such a database GP surgeries will be able to visit their database and see the benefits that such a product may deliver and know that it's essentially been given an NHS stamp of approval.

The re-structure and re-organisation of the health system also meant that there was not the in-kind or match funding locally that they'd hoped for in 2008-2009, because the structures were just beginning to bed in. In addition, because of austerity, the money wasn't there. However despite this there were some positives to the changes that occurred. GPs had been given more power- as commissioners- under the new system. Local Care Commissioning Groups (CCGs) offered routes to access these GPs who had more power to influence whether or not Doc Ready was recommended to patients as a useful tool.

Importantly policy in this context does not seem to have actively considered the way in which these changes would impact upon innovation. The innovators had to find ways within a new system to manoeuvre in order to get their innovation noticed. There was little within the policy sphere that was explicitly enabling of innovation.

Connectivity to the practice field

This case sits within the E/M health practice field in that it is an innovation that makes use of technological capacities and capabilities in order to facilitate to improve engagement of and/or with patients. This can be seen as a relatively typical example of an E/ME/M health innovation as it is working upon the space in which doctors and patients interact, using technology to make patient-doctor interactions more productive. The case has helped to contribute to the understanding of and perceived legitimacy of the practice of using technology in order to improve health and wellbeing and, in particular, to improve engagement of and/or with patients.

This case can be seen as typical of the practice field in the way that it has utilised partners in order to build this solution. E/M Health solutions frequently have a clear collaborative dimension and this has demonstrated this in the way in which it has brought together a number of different partners. The way in which they have collaborated is, however, quite an extreme example of this. Where other E/M Health cases seemingly have one initiator or leader the way in which this programme developed- with the funding first and the idea second- has led to an initiative with no clear 'charismatic leader'.

Doc Ready demonstrates a not-for-profit business model which is in line with the initiatives social aims but which has meant that after the initial pilot funding there has been little scope for development of the product or for working to get recognition either among potential service-users or among the wider health system. The difficulty in getting funding beyond pilot stage appears to be a particular problem in E/M Health where so-called 'pilotitis' is seen as a problem. E/M Health is an interesting practice field for its mix of business models which operate on a spectrum from for-profit through to non-profit.

This case can be seen as an example of the 'sub-practice field' of 'facilitating self-management' because, like many other apps aimed at the patient, it is designed to elicit behavioural change on the part of the patient and increase the extent to which they can take responsibility for their own health. This form of E/M Health can be seen as more difficult to diffuse in part because the target of the initiative is the patient rather than the system.

This is an innovation that was clearly influenced by the broader field of E/M health. The funding mechanisms that drove the innovation took note of the innovations emerging and felt that they might be able to use that as a model for addressing the specific issues arising from the 'Right Here' research project.

In addition Doc Ready can be said to have influenced the practice field. The app has gained national recognition and has resulted in replication in the form of the CAMHS Ready project.

1.4.2 Vitaever (LAMA)

Description, development of the Social Innovation Initiative

Vitaever is software developed in order to facilitate more efficient and effective provision of homecare as well as greater levels of communication between healthcare providers and families. It does this through the development of more efficient and effective plans for delivering homecare.

The project was started to address the needs of an aging population, as well as dealing with the demands of national governs and healthcare providers to control the increasing cost for chronic diseases.

Integrated homecare assistance (ADI) and Service Home Care (SAD) which are increasingly the focus of healthcare innovation, and which are increasingly becoming the focus of healthcare providers in Italy. SAD activities have doubled in Italy from 2004 to 2012, and Emilia Romagna Region shows a peak of 12 elders assisted on 100 residents (ISTAT 2014).

Vitaever answers to the needs for a smarter and cheaper management and control tool. It does this through software that offers, for operators and professionals: personalized agendas for every operator; a system of geo-localization of patients with calculation of the best route to reach them (based on Google API); the complete and updated management of patients' data, with signature of the last responsible professional who visited the patient; a record of the last visits; the possibility of defining assistance plans based on the list of available medical services; an internal messaging system; and the possibility of organising shared agendas. It offers simplified billing systems, the ability to keep track of equipment, drugs and meals delivered and importantly offers families and patients the opportunity to easily access data about the care being provided.

The development of the initiative was motivated by an understanding that there was a need for such a product. The founders of Nethical financed the research and development of the product, with around 80.000 euros of investment.

Actors, partnerships, alliances, networks

Whilst Vitaever was developed and steered by Nethical it has benefitted significantly from partnerships, and collaboration with other actors. Like many social innovations, the initiative has been improved by the incorporation of end users into the development of the product through co-design methods. This has had a significant impact upon the shape that the product has taken. The technical background of Nethical and the solid medical expertise of the ANT Foundation have been mixed to develop Vitaever, as a cutting edge mobile smart technology to track, manage and optimize staff, assets and goods of a distributed healthcare service as well as of a traditional one-site hospital.

The main partner for Nethical in this initiative has been the ANT Foundation: an Italian leading no profit organization which successfully developed the largest EU home based cancer hospital with over 4,000 Patients assisted every day at home. Working with ANT, it was possible to develop Vitaever to solve, with cloud technology, several problems in the home care sector. The collaboration with ANT permitted the testing of Vitaever in 9 Italian Regions, 13.000 cases every year, 300 operators. The collaboration started in Emilia Romagna Region, and then developed on the other 9 regions in 6-7 months.

The choice of partners has been moved by: the coherence in the field of application of the solution (home-based care, e-health; the ethicality of the partner; the need to be recognized by the scientific community, who moved the collaboration with the University; the need for ongoing research and development the initial idea.

These partners that they have engaged with include: **The University of Bologna**, who focused on research and development, most specifically on the encryption of data on the cloud; **Amazon**, who also had a role in ensuring the security of the data. Interviews suggested that having a name like Amazon ensuring the security of data had a

significant impact on the trust people have in the product; **Welfare Company**, which is a company that works on social welfare, and sell services to companies for corporate welfare. They are a commercial channel for Nethical, and one of their partners in the commercialization of Vitaever as a service; **The One Family Group**, who are a welfare company from Bologna who have been a commercial channel for Nethical, and one of their partners in the commercialization of Vitaever as a service.

Innovative solution

Vitaever was the first SaaS (Software as a Service) introduced in Italy for Home-based care, which has several, and recent, attempts of imitation. The solution has brought together several partners in order to address the need to provide more efficient and joined up home care to people with chronic conditions.

There are a number of other socially innovative dimensions to this service including the fact that the way in which patients and families are able to access and use information helps to disrupt the traditional relationships between patients and doctors and therefore also represents another level of social innovation. The technological solution has enabled innovations in the way that homecare is delivered in Italy by reducing costs and improving efficiency making better care for older people more viable. It also helped to enable greater engagement of health and care professionals, families and patients in the care of individuals.

Gaining momentum

One of the main drivers of Vitaever has been the need of the local and national health system to develop more effective and efficient home care services for chronic patients. As the value of these forms of care have been increasingly recognised so the demand for such services has been rising.

Vitaever has gone through significant adaptation as a result of vetting the product with end-users. There were a number of problems that have come about because of the lack of understanding of the product and because of the lack of capacity to use the product among end users. However, Nethical has managed to overcome these issues by using a collaborative design method to reassess the kind of processes being used. In addition, they have begun to provide training on how to use the software. Importantly, this collaborative design led to significant modification of the way that the software was organised and how it went about solving the problems of clients.

Another relevant learning point, and adaptation, regarded the pricing system: Nethical adopted a “pay as you go” approach, linking the cost to the actual utilisation of the product, in terms of assisted patients, accesses and operators using the software. At the same time, Nethical stopped charging its clients for archived data. They were in part able to do this because they found that the data were useful to Nethical, and not only to its clients, for data analysis purposes. Before this solution, the price was only linked to the number of patients, with an on-line calculator, which was quite complex to be used. The simplified system adopted now has been perceived positively by Nethical’s clients, who pay for the product segment they are effectively using, and the functions they really need to activate.

Complementary innovation

When the product was first introduced many people did not understand the value or know-how to use the product most effectively for their own needs. As a result, Vitaever offered training on how to use this product in order to remove some of the capacity issues within the market. Training of clients using Vitaever is fundamental for them to really benefit from the innovation, and use properly the software in all its functions.

At an organizational level, the introduction of Vitaever might be accompanied by a company re-organization in terms of management functions, and by an empowerment of administrative staff. This is necessary because Vitaever frees working time of administrative staff, who should be allocated to improve in terms of efficiency, and also to avoid the rejection of the innovation.

Mutual learning plays a key role in the design phase of the software, as well as on the initial pilot phase, when it is tested in the companies who adopt it. In this sense, clients are considered as partners, in a co-creation process in which collaboration and learning plays a central role.

Impact, diffusion and imitation

Vitaever has had a profound impact on the healthcare landscape in Italy, particularly as relates to homecare. Currently Vitaever assists an average of 21,160 patients per day. There has been a significant amount of imitation by competitors. As a result of attempts at imitation, Vitaever became a registered trademark in 2010.

The project itself has found it easy to scale and has become more efficient as it has grown because of the economies of scale allowed by growth. Nethical increased its number of clients from 8 to 70, having the same human resources internally. At the same time, a reduction in costs of managing the home-based care activities has been experienced by beneficiaries. In this way, Vitaever can be said to have instituted a social change because it has opened up new possibilities for the better care of older people and people with chronic conditions in Italy.

Role of policy

Health home care services (ADI), in Italy and in Europe, has been institutionalized in the last 20 years, and is constantly growing, because of the ageing of European population. ADI sees the integration of multiple kinds of professionals (doctors, nurses, psychiatrists, physiotherapists, pharmacists, social assistants, caregivers) who share objectives, responsibilities, and collaborate to assure continuity in the assistance process. Several factors influence the kind of assistance needed, and thus increase the need for coordination between operators, and for tailoring assistance around patient's needs.

Health assistance has reached very high costs: the 70% of government's investments in the health sectors are dedicated to chronic diseases, and involve patients over 65 years old. The choice of homecare assistance can support public health systems in terms of sustainability. Nonetheless, the development of new intervention paradigms is needed, to ensure the quality of traditional hospital cures.

Connectivity to the practice field

The case has contributed partially to the development of the practice field, being one of the first e-health solutions developed for home-based care services. It has been an example for the development of similar services.

This case can be seen as an interesting incarnation of E/M health because the focus is on increasing healthcare system capacity by creating more efficient ways of working. It has been influenced by certain social values that have emerged in Italy, particularly an emergent demand for home care for elders and chronic patients. The desire to build better quality of care, particularly with a focus on ensuring efficiency, is seemingly central to the E/M health practice field. There is a general belief that the Italian health system is not equally efficient in all regions and this is driving a desire for better management of healthcare delivery. The desire to build better access to health solutions can also be identified as a key driver of the E/M health practice field because of the capacity for 'remoteness' of solutions. E/M Health is frequently associated with facilitating forms of care that otherwise would be difficult to sustainably implement.

The case operates under the business model of a limited liability company (LLC) and therefore, like many private E/M Health interventions works in a context where competition is a factor. This has led to the organisation seeking intellectual property rights. Seeking these rights does not appear to be unusual in the E/M Health field where high levels of competition in the private sector can hinder the interoperability of systems.

The competition that this intervention has experienced can be seen as an example of this interventions connectivity to the practice field. Having proved this model of care the intervention has seen imitators come into the field, thus

demonstrating that this project has had a 'cascading' influence within the practice field- driving the development of other similar projects.

1.4.3 Smart Elderly Care (ZU)

Description, development of the Social Innovation Initiative

This innovative solution takes the form of a platform created by the Yuantong Company, that provides a range of different kinds of health and social care to older people. The customers (the elderly) phone a center where their calls are answered by staff who use an online platform to put out a call for assistance. Care provider partners then compete with each other to answer calls quickly and efficiently. The company manages a number of partners that it contracts to deliver the services to older people. Its key roles are to manage the centralized service, commission the delivery of care quickly and efficiently, to receive feedback and evaluate partner performance. Where performance is judged to have been poor the partner will have their contract cancelled. This division allows services to be delivered fast and to high service standards.

Older people call hotlines in order to access care including emergency services and other every day services including: housekeeping, nursing, online diagnosis, to make appointments with doctors online, and also, request food delivery, cleaning, repairing, and house security. As such this case can also be seen to overlap with the integrated care practice field.

The initiative was developed by Zhu Yao Sheng who had a deeply personal reason for developing the innovation in the way that he did. His teacher died from a sudden heart attack when emergency services was not able to get emergency help in time to save him. As a result Mr. Zhu decided to put in place a system whereby older people would have more direct access to both emergency services and advice and assistance. This case, therefore, can be seen as a good example of where an individual's motivation to innovate was driven by personal experience. The leadership of Mr. Zhu can be seen as an important driver of this innovation.

This case study can be seen as interesting because it is a for-profit model that is driven by the firm desire to do a social good. This makes it interesting from a social innovation perspective because it looks to balance both the demands of profitability and the demands of society.

Actors, partnerships, alliances, networks

As with many E/M health solutions it was necessary for the project to include diverse partners. The Yuantong model is interesting and innovative in part because of the way that it works across many different actors including government, the community and service providers, in order to build better quality care and services for older people. The intervention is run by the Yuantong Company (primarily a technology company) however the first partnership developed was with the organisations that went on to become their parent company- the Zhejiang telecommunications company Ltd. The position of this organisation enabled Yuantong to operate by obtaining the licence to operate in the field of telecommunications.

The government interacts with Yuantong by purchasing services from them on behalf of customers. Care is then supplied to the service-user at a low cost, and in some cases for free. The system also engages the local community by setting up local information centres which refer members of the public. The community also leverages its own resources to assist in the system. This can take the form of organising volunteers to participate in providing home-care. Around 700 community centres in Hangzhou can, therefore, monitor the wellbeing of their local population and help them to engage with the services. Finally the intervention is run in partnership with health and social care delivery organisations. At present the programme has 36,412 partners who provide care. However these relationships

are highly formalised. They are built upon a contractual arrangement whereby the Yuantong Company monitors partner performance and decides whether to maintain partnership. The initial selection of partners was made with information from local networks who understand the needs of the elderly people in their areas. Organisations then applied to become partners.

The Yuantong Company innovation can be seen as being part of a larger social movement within China which focuses on the provision of smart care for the elderly. China has seen significant progress in the development of care for the elderly in the context of an ageing population. Due to factors like 'The One Child Policy' and movement of people, many older people do not have children who can easily look after them in their old age. As such smart solutions to elderly care, particularly facilitated by technology have become increasingly popular. The growing social concern for this issue can be conceived of as a social movement

Innovative solution

The innovative solution here lies in the provision of a variety of different kinds of care support, from emergency services along to cleaning and housekeeping, using mobile technologies to manage and provide the care. This was the first nation-wide programme to provide smart-elderly care. It can therefore be said to have made improvements both to access to and quality of care innovating to improve the efficiency of the relationships between patients and service providers. In addition the way in which the solution has used a combination of actors to deliver this solution, and particularly the involvement of the government, can be seen as an innovative approach to service delivery in this context.

The initiative was first developed in response to increasing numbers of 'lonely older people'- partly as a result of the 'one child policy'. This significant social change has meant that a large number of people have been left with no one to look after them in their old age. What is more in the wake of improvements in access to care in China there is an increasing drive among policy makers to improve the quality of the care that's available.

These factors have resulted in changing social attitudes and the development of a social movement that focuses on the provision of high quality homecare but looks to find ways to provide this that are both efficient and effective. The belief among government and community actors that there is a need to provide these forms of services has been very important in helping to build partnerships across these diverse actors and can be considered an innovative partnership between diverse groups in order to improve the quality of care.

Gaining momentum

The idea itself was first safeguarded by the provision of intellectual property rights early on in the project development. The granting of patents had an important role in ensuring the long term viability of this project. This is an intervention that has been driven by high levels of competition. The home care sector has a number of both public and private providers and this competition has driven levels of innovation. However this has also created problems. It has been necessary to contest a number of copyright infringement cases which has been a costly encumbrance.

Once the idea was developed it was driven forward by a number of factors including public and political support. After the pilot of the project in 2005 the project got support from leaders of the municipal government as well as also from various civil society organisations including the federation of the disabled, elderly associations and the veteran association.

In addition there has been significant positive media coverage which has also helped to build momentum for the project, for example, in 2006 the Chinese central television station Zhejiang TV and newspapers highlighted the project. This has built the positive image of the programme and in 2009 it was awarded a status of 'national high-tech enterprise'.

Complementary innovation

The technological aspects of this solution have been key to its success and innovations have continued throughout the life of the project. For example two years into operations the Yuantong Company designed a new cloud based management platform- this was the first cloud based management platform in China. In addition as the project progressed the need to understand the quality of the care being provided under the system meant that additional skills needed to be developed in customers service and satisfaction. These technological and managerial innovations have played a very key role in enabling this innovation to take place. However the core of the innovation has been seeing how the combination of these can be aligned with a growing demand in China to address the challenges in caring for elderly people.

Impact, diffusion and imitation

The diffusion of this programme has been wide, in part because this was first nationwide program to promote smart elderly care (started, 11 years ago). The diffusion of this model can be imitated by other regions. This program created a new and innovated way for elderly care which made the elderly care services, more effective, high quality and convenient. The project has achieved significant impacts in terms of the scale that it has reached. Currently the initiative provides services for over 850,000 people. The Yuantong Company has looked to diffuse this project widely and has done this across geographical region (pushing out from Zhejiang Province into 26 provinces) and across different groups in society.

The innovation measures its impacts in three distinct ways: the profitability of the business model; the number of users and partners; the satisfaction of the customers. By these measures the innovation continues to be successful. In addition the project has become a key example of social innovation across China and is included as a case study in the teaching programs in the Party University of the Central Communist Party as an example of social innovation. The extensive coverage of the innovation by the media has been a key driver of diffusion, increasing demand from service users and helping to develop markets.

There have been attempts to imitate the project by others but the protections offered by the patents obtained has meant that this has resulted in lawsuits.

Role of policy

This project has largely benefitted from the role of policy which has been use directly to support this innovation, in part because it aligns closely with government priorities. The project aligns clearly with the desire of policy makers to develop high quality care for elderly people. There appears to be a perception among policy makers that smart elderly care is the solution to the challenge of aging society. Policy makers have endorsed this idea as a good example of this future by highlighting it as a case study and offering contracts to the Yuantong Comapny to deliver services. They have demonstrated this ,buy in' in a number of ways including through: purchasing of services, and favourable fiscal and taxation policies.

For example in 2009 the parent company of the Yuantong Company was awarded the status of high-technology company by the state bureau of industry and commerce in part because of the positive role that the initiative had played. In practice this meant that the company was made the subject of favourable government policies including tax reduction, low-interest loan from banks, and to precure lands for use at the low costs.

Policy has played an important role in offering protections in the form of patents. The innovators have identified this as an important dimension of the innovation. In addition the granting of licencing was a major enabler of this innovation.

Connectivity to the practice field

This is a very clear example of E/M health because it is an example of where technology has been used to facilitate changes in the way that older people are able to engage with the health service. This is a solution that has rolled out health and social care access but that has also improved the quality of care that people can expect.

Within the field of E/M health this innovation clearly fits into a model of providing 'smart home care'. This is a clear field of development in China but also beyond. There is an increasing global recognition that home care can be the best and most efficient solution for many people facing chronic conditions, however the provision of this care can be complex. Technological solutions offer a very clear way of dealing with some of these managerial issues by allowing for remote coordination of services- potentially en-masse.

Like many of the for-profit models in E/M Health this case operates in a context of significant competition and this company has sought to protect its intellectual property. This competition has accelerated the development of both this initiative and the practice field at large as competitors try to innovate in product development and improve social outcomes, this has led to clear 'innovation cascades' as one innovative product comes to breed further products, which come to constitute the practice field and develop out a 'sub-practice field'.

Like with many E/M Health examples there was significant collaboration needed in order to develop this solution. In this case however there was also a 'charismatic leader' who felt a clear personal motivation to help develop this solution. This initiator can be seen as a 'technical innovator' who worked from outside of the system- not a professional in the field of health and not a policy or institutional actor. As such in order to develop the solution they required significant 'buy-in' from institutional actors in order to gain the legitimacy and the licences to be able to operate in this field.

Like the 'Care example' below this can be seen as a clear example of overlapping practice fields. The example can be seen as a form of integrated care in that it provides a form of integrated service delivery to older people who can use a single platform in order to order a variety of different health and social care services.

1.4.4 Care (ISED-T-RAS)

Description, development of the Social Innovation Initiative

The 'Care System' was developed as the first 24 hour multifunctional social support service in Russia. The services are provided by means of mobile communication through a mobile phone or a remote control device with buttons, which allows direct connection with the operators. In case of need, the client can press the button and inform about the type of assistance required. The service works on a 24-hour basis. By just pressing one button the user contacts the call-centre dispatcher who will quickly resolve the callers query by either getting the necessary service provision or by providing information or consultation. Care System is currently operational in 10 Russian regions, 72 settlements and the number of users is over 16,000.

Ageing populations represent a significant challenge for Russian health services. The share of elderly people currently amounts to 25% of the population, and, according to expert forecasts, this share will go up to 30% and higher in the near future. Whilst there are many people who need social assistance, the government does not have special institutions capable of providing such services on a 24-hour basis. This was the challenge that the project was set up to address. The project was very much driven by the project founder, Konstantin Livshits who is Director General of "Lege" LLC which has provided informational services in healthcare and social sphere since 1999. He originated the concept and drove it forward by providing clear and present leadership. The motivation behind the project was the concept of 'looking after your loved ones' and a recognition that elderly people need support.

The major driver was an ambition to improve the services available to older people. Whilst the project was driven by a call by an international public organization the Care System was also developed with reference to a number of examples from other countries. In order to develop the project in Russia there was consultation with experts from Sweden and Finland who had developed similar programmes.

Actors, partnerships, alliances, networks

The primary initiator of this innovation is “Lege” LLC which was founded in 1999. The company has established itself as a leader in the field of informational services for medical sciences and healthcare. “Lege” LLC includes several companies engaged in health products manufacturing and promotion and “Care System” is one of these companies.

The formation and development of “Care System” as a social support service for elderly and disabled people is primarily due to the activity of the original team members. Apart from the project’s initiator, the team included deputy director for development, IT-specialist and head of the contact-center – 4 people in total. After executing the request to establish “Alarm Button” service for the international public organization, the team decided to further develop the initiative. The basis of such decision lay in selfless care for people’s welfare, i.e. altruism. “If it hadn’t been for altruism, we would simply establish the project without its further development. Of course, when we started implementing our ideas, we realized the demand for such services, the problems elderly people had, we understood that that we can help them, and we knew *how* to do it” (interview, Irina Lobyntseva , 2016).

Governmental bodies

At the initial stages of the project’s development (2003–2007), when it operated only in a few districts of Saint Petersburg, financial support from the state was essential. In 2008–2009, the importance of the social innovation was marked by the Committee of Labor and Social Protection and the Government of Saint Petersburg. Due to their support the project was implemented throughout the city, and in 2010, “Care System” acquired legislative status as one of the measures of social support under the law of Saint Petersburg “On additional social support measures of individual population groups for covering the costs related to the provision of specialized emergency services of “Alarm Button”. Moreover, the project was included in the Social code of Saint Petersburg. Later, the initiative to expand social innovations to other Russian regions was backed by the local authorities (in the Leningrad and Pskov oblasts, the Republic of Karelia, etc.) and the Ministry of Labor and Social Protection of the Russian Federation. (interview, Irina Lobyntseva, 2016; Care System, 2016). The project is currently based on the principles of public-private partnership.

Media

Working with the media is an important aspect of “Care System”. The manager and the staff are actively involved in various TV shows, give interviews to newspapers, etc. (e.g. social project “Care System”, 2016; “Care System” – psychology for elderly people, 2014; What will change the new law on social services, TV 100 Channel, 2014).

However, the effectiveness of advertising for the project’s promotion, particularly in publications, proved to be rather low. “Advertising simply was not working. The service is not very clear to our customers, despite the fact that we have worked in this field for a long time. Any service is difficult to sell. It is not a product, it is intangible, impossible to feel or try” (interview, Irina Lobyntseva, 2016).

Non-profit associations

“Care System” is included in a non-profit partnership “World of the Older Generation”. Within the framework of this organization’s activities best practices are considered and disseminated in the practice field; offers are created to amend the legislative frameworks regulating the field; sites for training qualified staff specializing in elderly people social support are created; uniform service standards are developed; market research is carried out, etc.

Innovative solution

The project offers an original technological solution to the problem of social assistance for elderly and disabled people. It is being implemented with the use of technology that is absolutely new for Russia, which includes the project's own medical information center, IT-infrastructure; a tested system of cooperation with partner organizations; a working scheme of effective cooperation with the main Russian mobile service providers.

The company provides each client with a mobile device by means of which he can quickly contact the call-center with qualified doctors-operators available on a 24-hour basis. The call-center is equipped with certified equipment. Seventy-five digital communication lines from two separate providers are connected, this ensures full redundancy so that no one will go without care in case of an emergency. If necessary, the operator may call an ambulance, the police or other emergency services giving notice to relatives and controlling the call; provide psychological support; arrange home care through social service representatives; make an appointment; call the private hire taxi ("social" taxi); hand a request over to the specialists of communal services; provide with all necessary information including that on benefits, medical and social institutions. Data on each user are put in advance into a special database.

In this sense it is possible to see this innovative solution as a 'one-stop-shop' system of social support for elderly and disabled people. The system user can at any time call the contact-center and receive necessary assistance: from consultation and psychological support to medical attention, the solution of legal, household and other problems. "Alarm Button" technology allows the user to receive necessary services at any time and in any place. The project is also aimed at creating a positive image of an elderly person as an integral member of society; increasing the level of integration of elderly and disabled people into society.

Gaining momentum

When the project was first piloted it was initially only an alarm button that provided emergency care to one district of St. Petersburg. However with support from the Government of St. Petersburg this pilot was expanded to cover more areas. In 2010 the project acquired a legislative status as one of the measures of social support under the law and in 2011 'Care System' LLC was registered and a 24 hour service was started. The ongoing endorsements of public bodies and policy-makers has been a key driving force of this project.

In 2012 the Agency for Strategic Initiatives and the Ministry of Labor and Social Protection of the Russian Federation recommended the implementation of the project throughout Russia. This led to the launch of two regional projects in Gatchina (the Leningrad Oblast) and Petrozavodsk (the Republic of Karelia). This has been followed up by the expansion of this project so that by 2016 the project covered more than 16000 users from 10 Russian regions (72 settlements).

The implementation strategy has been based on the mechanism of public-private partnership. The implementation stages have been:

- region's assessment of demand;
- the decision to implement the project;
- preparation of regulatory documents;
- the launch of the pilot project (for the development of interaction systems);
- and the launch of "Care System" in the region (with possible further expansion of the coverage area).

Cooperation with a diverse range of partners presented an opportunity to use the service opportunity to provide a wide range of services for the users of "Care System" – from addressing various medical issues and supplying accurate and timely information on medications and healthcare facilities to assistance in solving social and household problems. The project is currently functioning as a "one-stop shop". As a result a 'social movement' focused upon the

needs of older people and a desire to provide high quality services, has been a driving force in the development of the solution.

The development of diverse partners is felt, by the initiators, to be a key dimension in the success of the project and one of the major reasons that the project has not faced any significant barriers. Even in the wake of economic difficulties in Russia the innovation has continued to be rolled out, with the value clearly understood by all partners.

Complementary innovation

The project carries out functions that the State cannot perform. In Russia, health care, social protection, housing and communal services, etc. largely do not interact. "Care System" makes it possible for such interaction to exist on a systematic basis. However in order to allow for this kind of programme to function major changes in the existing regulatory framework have been necessary. These have taken the form of:

- the inclusion of the "socio-medical Alarm Button" in the register of mandatory social services;
- the development and adoption of the law on the "socio-medical Alarm Button" in each region of the Russian Federation;
- the formalization of criteria, conditions and regulations of "socio-medical Alarm Button" functioning in the regulatory framework.

The project was driven by a rising demand and increasing understanding among policy makers, citizens, business and civil society about the needs of older people and the requirement to provide greater access to and quality of services.

Impact, diffusion and imitation

The impacts of this project have been both social and economic. Economically the provision of the innovation has reduced spending on in-patient/hospital care by 7 times. In addition there has been a 9% reduction in the number of non-core ambulance calls and a 12% reduction in the number of unmotivated calls for medical/social workers or district doctors.

From a social perspective the provision has led to higher quality services for older people, real time data on the needs of users, reductions in social tensions within society, and increased innovation accessibility for the users about social, medical and other services. Due to the success of the project there are currently plans to try and roll it out across the whole territory of Russia. However in order to do this the support of the regional authorities is required, including financing from the budget.

"Care System" is currently a unique project, one of its kind. There are no competitors in this sphere and organizations that are similar are mostly focused on either security, selling socio-medical technologies (like health trackers, bracelets or, for example, the 'magic watch'). Therefore imitation has not been a particular concern for this project.

Role of policy

Political support played a very significant role in the development of the project of social innovation. After successful testing of "Care System" the initiative was supported by the Governor of Saint Petersburg who signed a decree and then the law "on additional social support measures of individual population groups for covering the costs related to the provision of specialized emergency services of "Alarm Button".

The municipal program is currently developed in the framework of the "Social Code of Saint Petersburg" (Chapter 31. Additional social support measures of individual population groups for covering the costs related to the provision of specialized emergency services of "Alarm Button").

“Care System” as an effective mechanism to achieve the goals in the Federal Law № 442 “On the framework for social service for the citizens of the Russian Federation” was approved by the Supervisory Council of the Agency for Strategic Initiatives under the chairmanship of the President of the Russian Federation and recommended for the implementation in all Russian regions. The project gained support of regional authorities participating in “Care System”.

Connectivity to the practice field

This is a clear case where there are overlaps between practice fields. This case very clearly sits within the E/M health practice field because it uses technological capacities in order to provide greater access to and quality of care. Thus it uses technology to alter perceptions of what people can expect from care services. In addition it works at the level of patient/ practitioner relationship by ensuring greater access to practitioners in a way that is sustainable.

However this can also very clearly be seen as an overlapping with both the ‘new models of care’ and ‘integrated care’ practice fields because this is a way of providing care that had not previously been trialled in Russia and therefore is an entirely new solution, not only to providing care but in the kinds of care that should be provided. Like the **Smart Elderly Care** case above it provides a single platform through which people can access a number of different health and social care services.

Whilst the case was developed by one individual with specific technical expertise the project had very clear ‘buy-in’ from institutional actors very early on. The project had access to state funding relatively early and this appears to have had an impact upon the level of competition that this project has faced. The Care System is currently a unique project because no other product has been able to develop such an integrated solution. The other organisations present in the market appear to be focused specifically on other aspects such as ambient technology.

The programme has contributed to the development of the practice field in the sense that it represents a clear positive example of how such a system can be achieved. In addition there have been attempts to adapt the project for new audiences which demonstrates the extent to which a ‘cascade effect’ can be seen from this innovation. A particular innovation was developed in one context and for one audience and it was observed to be a success and adapted in order to provide a solution for another audience. In one clear case there was adaptation of this model in order to provide a support service for deaf people, which required further innovation and development and which ultimately proved successful.

1.4.5 LifeTool (AIT)

Description, development of the Social Innovation Initiative

LIFETool gGmbH is a non-profit limited company based in Linz, Upper Austria, that was founded to support people with physical handicaps, learning disabilities or multiple impairments through computer technology and software, and to give people without phonetic language a voice. This is done through mechanisms such as scanning, where the computer reads the movement or blink of the eye and translates this information into another form of spoken, written or icon-based communication. LIFETool is specialized in the research and development of Alternative Augmentative Communication (AAC) and also provides advisory services and support for such products.

LIFETool is owned by Diakonie, an NGO and charity, and the Austrian Institute of Technology (AIT), Austria’s largest non-university research institute. In the first years, both organisations founded a working partnership which was fueled by investments from the province of Upper Austria in the form of a start-up financing for five years, EUR 220.000.- per year. The foundation of LIFETool solutions as a limited company followed in 2008.

LIFETool has developed 22 different software programs which are used for education in schools and particularly developed for children and persons with disabilities. LIFETool has seven advisory service points (five in Austria, one in Czech Republic, one in Serbia) with 25 employees. These LifeTool offices operate on an almost 'social franchise' basis. Each service point has a different thematic focus, for example the one in Graz, Styria, is located in a retirement home and focuses on life in old age, the one in Axams, Tyrol, is located in an integrated centre for children and focuses on child support. The service centre in Linz, Upper Austria works as a central office.

Actors, partnerships, alliances, networks

As with many E/M health cases LifeTool has incorporated a number of different actors into the development of the project. The collaboration of different partners has been a key success factor of the LIFETool project.

The product was developed by the NGO/charity Diakonie -which has a particular focus on vulnerable people- in partnership with AIT which provided technical competence for hard- and software. These two worked together to develop 'LIFETool', which is its own entity. The Diakonie Austria and the Austrian Institute of Technology AIT are the owners of LIFETool each with a share of 50 % and equal say.

The combination of team members with different backgrounds and approaches has been used in order to develop more efficient, comprehensive and sustainable AAC products. In some cases collaboration was challenging, as stated by one of the key partners at AIT: "At the beginning the coordination has not always been easy and I needed to moderate a bit. The experts from AIT and Diakonie had different ideas and priorities about how things should be handled, but by the time this worked better and better."

The LIFETool team are well connected to networks, including research and development networks and user networks, maintaining links to selfhelp groups of for example: autistic children, people suffering from strokes, etc, user groups, parents and teachers. In some ways LIFETool can be conceived of as operating as a kind of "R&D hub" in Upper Austria, working closely with universities, colleges, businesses and health-care facilities in the field of Assistive Technology.

LIFETool receives financial support from governmental authorities and different non-profit organizations, such as the state of Upper Austria, Verbund-Empowerment Fund of the Diakonie, Brot für die Welt, Erste Stiftung and Licht ins Dunkel.

Innovative solution

This project has taken a number of innovative elements in order to develop a socially innovative solution to the problems faced by people who have trouble communicating. In particular it is socially innovative in the ways that it combines a number of different kinds of innovative approaches in order to offer new services to people who need. It combines:

- **Technological innovation:** LIFETool has pushed forward Alternative Augmentative Communication hardware and software. This includes developing software in the areas of: early intervention and games; acquisition of culture skills; language promotion, learning about real-life educational content; improvement of concentration; improvement of working memory performance; and Support in learning disorders
- **Process innovation:** LIFETool utilises user-led design in order to ensure that they are providing services that work for their target audience. This takes the forms of workshops and consultation, both during the design phase and in evaluation.
- **Service innovation:** LIFETool has innovated in the way that they deliver their service, providing consultations and training to service users about how they can best use the products. In addition they provide workshops for teachers and caregivers, as well as offering options for the short term rental of equipment.

Gaining momentum

There have been a number of key dimensions of this work that have been instrumental in its growing and developing.

The project began as a working partnership, set up as a for profit-limited company: LIFEtool Solutions GmbH is a full subsidiary of LIFEtool non-profit GmbH and is among other things responsible for the distribution of products that assist people with disabilities to come as close as possible to the opportunities of humans without impairment on the basis of the solutions found. The project received basic financing from both Diakoniewerk and AIT, but remains organisationally independent from both owners. It has also received basic financing from the province of upper Austria. LIFEtool combines commercial and non-commercial goals. Basic financing has been essential for the last 17 years because it allows experimenting, gives room to try out and drop.

In general, public funding is seen as absolutely crucial to be successful with a project such as LIFEtool: "LIFEtool develops niche products and it is just not possible to cover extensive research and development activities just through the sale. The funding has been important and necessary in order to develop such high-quality products." However the project has also suffered as a result of funding cuts. This has presented a major barrier to this project. There were severe financial cuts of basic financing in 2013, after which LIFEtool had to conduct saving measures. Saving was done in different areas, for example the working time of some employees has been reduced and a lunch subsidy has been removed.

There has been an interdisciplinarity inherent to the organization from the beginning which has come about because of the two initiators. Over time, this was cultivated which has meant that different partners/ team members were well placed to offer the different perspectives necessary for the project to work. This is a project that needed significant levels of technological expertise in order to weather changes in the market place. The development of the iPad, for example, has significantly changed the landscape in which this product is operating. The development of the iPad influenced not only the strategy of LIFEtool, but changed the whole market of ACC technologies. The whole industry had previously been focused upon the production of communication devices for people with disabilities, however demand almost disappeared entirely and there was a need to refocus on software that could be used on a number of different platforms. This drove the cross-platform approach that the innovation developed. In 2015 LIFEtool received the audience award of the SozialMarie prize for social innovations. The award was given for a concept of a complete iPad-based service bundle: The hardware, already installed software tailored to the specific needs of users with physical disabilities who suffered for example from a stroke, plus specific advisory service. Responding to the role of iPads in the sector has been a challenge but one that LIFEtool has coped with.

Competition has also played a significant role in the development of this initiative. LIFEtool has a number of both national and international commercial competitors. This can be a source of frustration for LIFEtool, they have for example found that their own promotional literature reproduced in part on the websites of competitors. However, interestingly, competition is also seen as an important driver of improvement as they seek to refine their competitive edge. They are increasingly finding themselves in competition with large scale companies such as Microsoft and Google who are increasingly focused upon offering assistive technologies. Equally, the small size of the company can also make it more difficult to attract staff and therefore competition for human resources is also a key worry for the organisation.

Complementary innovation

There is clear demand for assistive technology. In Austria there are around 63000 people without phonetic language. Demand for particular technological solutions is diffuse because a lot of development and adaptation has to be done to be of use to the individual. LIFEtool works in order to absorb technological trends and needs of people with disabilities, whereas LIFEtool products are designed in a way that they can be used intuitively. Regular meetings are held by the team in order to use knowledge gained through engagement with users in order to adapt products and

meet with user demands and requirements. LIFEtool products are designed in a way that people can use them as intuitively as possible and adapted to the individual's physical and mental capabilities.

However, in some cases a certain amount of learning is intended on part of the user in order to use the products. In these cases it can be necessary for someone (e.g. young children) to learn a system of icons. This can be a challenge and frequently requires engagement of both the user, their families and other stakeholders. Integration of the end-users and their knowledge has been essential to the success of this project understanding.

Impact, diffusion and imitation

LIFEtool has clear evidence of impacts and diffusion. Currently the intervention has 2 patented medical products which have 26,000 users worldwide and has provided 22,860 hours of counselling. Products and solutions are currently supplied in 40 different countries and in 16 different languages and has 100 international LIFEtool distribution partners worldwide. Despite significant impacts the company employs only 25 people in the LIFEtool network. In addition to this breadth of impact there is also a depth of impact on people's lives that has been documented.

Role of policy

Public funding from the state of Upper Austria has allowed LIFEtool to stay financially flexible. The original intention was to found the company in Vienna. However, no contact person or supporter for this special combination of research, development and service could be found in Vienna. It was a member of the regional government and responsible for economy in the province of Upper Austria.

Connectivity to the practice field

LIFEtool is part of the practice field of E/M health. In addition it can be seen as sitting within the sub-practice field of 'assistive technologies' of technologies that help people with everyday tasks including – in this case – communicating. Again like many E/M Health solutions this innovation is characterized as arising out of collaborative efforts which allow for the development of the diverse competencies necessary for an E/M Health innovation to be successful.

The project has diffused through the development of a kind of 'social franchising model' in which a number of hubs have been set up in different countries in order to provide the services. In addition LIFEtool sits alongside other organisations in attempting to develop these kinds of AAC technologies however is interesting because of the level of success that it has achieved. It has been imitated by other organisations and therefore can be seen as contributing to the practice field. Imitators are seen as competitors. What gets imitated is the concrete LIFEtool "binary model": A non-profit association for social, technical and financial counselling and care, and a commercial supplier for the distribution of technological product solutions. Interestingly despite a non-for-profit business model this innovation has looked to protect its intellectual property. LIFEtool is a figurative trademark protected by trademark law in Austria. The IntegraMouse, LIFEtool's most prominent product, is also protected as figurative trademark on the European level (year of application 2002), while the patent has expired after ten years.

1.4.6 MomConnect (UCT)

Description, development of the Social Innovation Initiative

The Praekelt Foundation along with more than 20 partners and run by the National Department of Health (NDoH) in South Africa, designed a free mobile service for pregnant women and new mothers. Called 'MomConnect' the National

Department of Health Pregnancy Registry connects more than 1 million women to vital services and stage appropriate information. Since it launched in 2014 it has sent out more than 58 million messages and 95% of health clinics across the country are participating.

The approach involved educating women on their own health, as well as that of their infant, and giving them the opportunity to feedback on the quality of healthcare they received in local clinics. Improving the quality of the healthcare services they received. The primary challenges the NDoH faced were around how to access these women - not all women report their pregnancy to their local healthcare center and more specifically, how they could reach women at the early stage of their pregnancies, rather than waiting until later. The solution to this challenge was to set up a comprehensive digital programme that could access women wherever they are.

Actors, partnerships, alliances, networks

The driver of this project was the National Department of Health (NDoH), under the leadership of the Minister for Health Minister Motsoaledi. Over 30 partners worked on this project including the Praekelt Foundation who designed and built the application. Two other technology partners - Jembi and HISP, worked with them to implement the technological side of the programme. Other partners include funders, training partners, mobile network operators, two universities undertaking monitoring and evaluation, content providers and strategists. Relationships and trust formed a key component of choosing partners.

This is a complex partnership with partners from Government, the private sector, academia, funders, non-profit organisations and social enterprise. None of the partners are groups of beneficiaries - they either deliver services to or design services for beneficiaries or their representative organisations; or they represent them at a government level.

Because this project was initiated by the Minister of Health in South Africa, who has remained involved along with his team, this project seems to have navigated its way through. This highlights the extent to which Government buy-in to social innovation can be important in helping programmes to be successful. Innovating within Government systems in South Africa can be a real challenge. Government institutions tend to be highly bureaucratic, records have remained paper-based, demand is high and the institutions tend to be under-resourced.

Innovative solution

The MomConnect programme ticks all the boxes for types of social innovation - between technological innovation of the software, service innovation of providing stage-based messaging for users and feedback loops, to innovation within the systems of the health clinics, and organisational innovation within Government. The technology that enabled the MomConnect project was not in itself innovative because it had previously been developed by the Praekelt Foundation for another project. What was innovative was MomConnect's use of the newly developed Health Information Exchange (HIE) and a number of other dimensions were innovative including the development of the SMS Helpdesk. Importantly the technology enabled a programme that was socially innovative in the way that it met the needs of service users and in the way that it organised delivery of those services.

The technology enables the services provided to pregnant women and new mothers across South Africa to be improved through the stage-based messaging and SMS help desk directly through their mobile devices. It allows the women to rate the service at the clinics they attend - without having to fill out lengthy forms - knowing that their responses will get to the people who can address issues and make changes without fear of their input being filtered or tampered with. It empowers the women by providing more information than they may previously have had access to and puts them in a position of being able to make informed decisions and access advice when they need it, directly from their device.

This then creates innovation within the systems in the health clinics; as nurses and health clinic staff are trained and supported in using the MomConnect platform. For the first time in South Africa information on pregnant women across

the country is held digitally - the first step to digital record keeping across the board. It provides access to a digital database of pregnant women across the country, and makes sure that positive feedback gets back to the staff of the clinics. This has led to organisational innovation within the clinics and at different levels of Government, as they get used to the idea of a mobile platform being able to serve 95% of the health clinics across the country and of a digital database to hold all of the information. It is also enabling continuing innovation as actors look for new possible ways in which the model can be adapted to other existing needs.

Gaining momentum

Although it was the non-achievement of the Millennium Goals around maternal and infant mortality that were the initial motivators for the programme, Praekelt are clear that without the leadership from Minister Motsoaledi that the MomConnect programme would not have succeeded. His willingness to try innovative ideas to address old challenges, and to hear directly from the users what is not working in the clinics was a brave choice to make.

From the launch onwards, the commitment of the Minister and the ministry was vital to the buy-in from the health sector, and really contributed to the figures seen in 2016 of 95% of clinics across the country using the platform. This, along with the training that was rolled out across the country for clinic staff, ensured that the staff knew about the MomConnect platform and how to use it.

During the evolution of the platform, the feedback loops that had been built in to the system were invaluable not only for its continued development, but also so the NDoH could address issues at a clinic level. One example of this was when messages started coming through that clinics in one district had run out of iron supplements. The department undertook an enquiry into the whole province and discovered widespread stockouts.

The key factors for the future development of MomConnect will be ensuring that it changes and adapts to technological, mobile advances and customer preferences, to ensure it remains future-proof for as long as possible.

MomConnect has also faced a number of barriers. The initial timeline for the project of 3 months, was a real challenge. By the launch that timeline had increased to 6 months. Looking back Praekelt feel they would have planned a 6 month project very differently than a 3 month one, and time was wasted re-building some elements that would not have happened with a more generous timeline. Once the initial rush was over, trying to balance the speed the developers would like to work, with that of Government and academic institutions has been a real challenge.

Another sticking point is the issue of inventory. This is the major cost for the project and funders and Government do not like having to pay for it. There are ways out of this - such as using the WhatsApp platform. However, the developers are at the hands of the WhatsApp team as they have yet to release their API.

Praekelt, having worked on similar technology projects before were expecting the platform to change over time. They would like to work faster and make more changes, and the pace of the development of the platform has caused frustration at points. However they see NurseConnect and the other iterations that have happened since as important developments that are having an impact. One of the features that did surprise Praekelt with its popularity, was that of the service ratings. With 27% of users responding to requests for feedback, this was much higher than expected. It has created the opportunity for Praekelt to gain more information from these women, through additional requests for feedback.

The strategy of the HIE is a non-competitive one. MomConnect and other tools are designed to fit this approach. Because of the HIE's plug-and-play nature, the NDoH is not tied to one provider. If at some point it is decided that MomConnect is no longer the best solution it can be replaced with an alternative. The Open Source nature of the HIE allows other developers to work on apps. This competition is seen more as a driver for improvement and creating opportunities for partnerships rather than as something of concern in itself. Praekelt see their strong relationship with

the NDoH and their proven track record, as future-proofing as much as possible, their role as a trusted provider to the ministry.

Complementary innovation

At the user level, women were asked to register for a free service and then start using their mobile devices to interact with the MomConnect platform to receive information, ask questions and give service ratings. The way they use their phone - USSD and SMSs - are used in MomConnect so there is not the learning curve that there would be with a new technology.

The staff at the health clinics are required to register pregnant women on their first visit to the ante-natal service. This requires capturing information on paper and then putting the information onto the online MomConnect system. Staff at each clinic have been trained to do this, and they are then expected to pass this information on to new staff to ensure all staff know the same information. More support was needed for the nurses and other clinic staff than was expected. This is what led to the development of NurseConnect. Monitoring had shown that some clinics had low numbers of registrations, and nurses' feedback around issues in the system was sometimes more about a lack of standardisation in training for them, than the system itself.

Impact, diffusion and imitation

Over 95% of clinics and health facilities in the country are participating in the programme, allowing over 1 million pregnant women and new mothers to become MomConnect subscribers. MomConnect has sent over 58 million messages since launching in 2014. Aside from the sheer scale of the programme, one of the most notable achievements is the high level of engagement elicited from subscribers. Over 27% of subscribers have completed service ratings and more than 330,000 messages have been received and processed by the MomConnect help-desk (Praekelt, 2016).

After the first year:

- Just over 98% of users felt that the messages have helped them.
- Almost 71% of users indicated that they would welcome more messages.
- Almost 84 % of users reported sharing the messages with a partner, friends or both.
- The majority of users (80%) reported that the messages helped them to remember more of their clinic visits
- The majority of users (81%) reported that the messages helped them to better understand their baby's growth.
- The majority of users (77 %) reported that the messages helped them to feel better prepared for childbirth and delivery.
- Although 88% of non-converted users had in fact visited the clinic at least once, almost 30% of users reported that staff had not offered to register them for the full set of clinic messages.

A recent demographic study has shown that MomConnect is reaching its intended target audience of low-income women who are most vulnerable to health risks and may not have access to information. From a sample of over 10,000 SMS users, 44% are from households earning less than US\$125/month (Haas, 2016).

Praekelt are currently working on HelloMama, a maternal health care platform in Nigeria based on MomConnect but including Interactive Voice Response (IVR) so that illiterate people may also use it. They are also working on FamilyConnect in Uganda, a similar programme that is household based and sends messages to heads of households. The introduction of NurseConnect, a new Facebook bot and the SMS help desk is being developed further with organisations in Rwanda. For all three of these countries there has needed to be significant change and development to ensure it is right for these new markets.

Role of policy

The structure and culture of policy does not encourage the creation, diffusion or adoption of social innovations. The policy environment is very risk-adverse and the Minister was deliberately turning his back on this culture by suggesting an innovative solution was required to address the issue of maternal and infant mortality. Hopefully, the success of this project will begin the turning of the tide towards innovative solutions to social issues from a policy perspective.

Connectivity to the practice field

This E/M Health solution sits very clearly within this practice field. Like many successful E/M Health examples there was buy-in from policy makers who, understanding the value of the initiative, opted to support the project and thus provided it with the ability to circumvent the highly bureaucratic context of the South African health system. This has helped to make this project one of the first E/M health projects to be run by Government and rolled out nationally through public clinics on a national scale.

MomConnect has served as a proof of concept from which the South African National Department of Health (NDoH) can further develop initiatives that link together laboratories, nurses, doctors, and patients. The open nature of the HIE allows for significant development of initiatives. However a concern was expressed by the project initiators that well-meaning but ill-informed groups, or groups seeing this as an opportunity to make money will begin building apps that do not have enough of an impact. They see a real need for the NDoH to ensure it has staff with expertise in their team, who can advise on the real opportunities that could be really impactful, and pick out which ones will not.

1.5 PRACTICE FIELD CONCLUSIONS

The E/M Health practice field is characterized by the use of technology in order to facilitate changes in the relationships between healthcare providers and service-users. It does this by enabling new (often more efficient or effective) ways of working, and/or by improving capacities either among providers or service-users.

The practice field is a key area of growth in the health and social care field and also demonstrates significant potential across global contexts. As technology is becoming progressively more sophisticated so these technologies are finding their ways into the ways that we deliver health and social care or act to improve health and wellbeing.

The field has a very high level of adaptability and therefore is seen across different healthcare systems, with varying levels of capacity. This adaptability has also resulted in a high number of different expressions of E/M Health which can to some extent be classed into 'sub-practice fields'.

However there are some key challenges being faced by people operating in this space. Like many rapidly evolving fields policy has a hard time keeping up. In many regions there remain concerns about the use and misuse of personal and sensitive data and in many contexts policy around this is insufficient.

In addition, for those initiatives that do not have a for-profit business model there are some issues around financing. Whilst there is clearly funding available for start-ups and pilots there have been problems in this field when it comes to creating sustainability, particularly where E/M Health initiatives are not integrated into the wider health system. It may be that greater work has to be done in order to find functioning business or funding models that allow the entrenchment of these programmes, in order to reap the most benefit from them.

2 PRACTICE FIELD B: INTEGRATED CARE

2.1 OVERVIEW OF THE PRACTICE FIELD

Integrated care organises the way that different actors cooperate within healthcare in a new way. What makes integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological and social needs of the patient. In general integrated care aims for long-term positive patient outcomes through better coordination and a reduction in fragmentation. Quality of care and reducing the cost of health care long-term are two key drivers behind the move towards integrated care as well as a shift towards greater patient self-care/ self-management and a focus on prevention and early intervention.

Integrated care can be pursued with two dominant approaches, which could be considered subfields;

- *Indication-related models* are tailored to the care of patients with a particular disease, for example disease management programmes. Although none of the integrated care case studies actually came under this model, **self-dialysis (Sweden)**, which is covered under new models of care could to some extent be considered an integrated care approach to kidney failure by focusing on patient and medical professional cooperation and allowing greater patient control over their own health condition. Other examples of innovation in this sub-field include Oxleas Advanced Dementia Service (Greenwich, London) and Sunderland dermatology and minor surgery service (UK).
- *Population-related models* involve health care for groups of patients, either depending on their location (e.g. regional-based integrated care such as in the cases of **Healthy Kinzigtal (Germany)**, **Physical Activity on Prescription (Sweden)** and **Better Together (Netherlands)**, or according to certain characteristics such as young people with complex needs in the case of **The Family Hall (Austria)**.

Integrated care is an interplay of different forms of innovation – service, organizational, technological and system – and it can be argued that the interaction of all of these types of innovations is essential for something to truly be considered integrated care. However, given the varying levels of integration across the case studies, and the different approaches that have been taken to integrated care, we have chosen a loose definition of integrated care as:

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 provision of health and social care.

2.2 STATE OF THE ART AND CONTEXT ANALYSIS OF THE PRACTICE FIELD

Integrated care has been a goal in health care for quite some time and many good examples of integrated care exist. However, innovations in this field are still largely developing due to the complexity of creating models of integrated care and of managing complex partnerships and cooperation between bodies. The field of integrated care has added complexity because it requires system innovation within health care, for example in the way that funding is allocated. It also requires change in the way that healthcare is viewed more generally.

Integrated Care is influenced by various societal, political, medical and economic interests all of which should be considered when designing new concepts and models of service delivery. Though strategies to achieve better

integration may differ, the driving forces for the reform process are similar in many countries¹⁶. All of the social innovation projects have developed in response to, or as complementary to, healthcare challenges which call for changing roles for professionals, clients, organisations of health and social care, and insurers. Particularly significant has been:

- **A shift in focus from treatment to health and wellbeing more generally:** Across Europe and globally, governments have made commitments to making evidence-based integrated health and social care the norm¹⁷; For example **Better Together (Netherlands)** has been viewed as part in a shift in the understanding of healthcare from a focus on “sickness and healthcare” towards “health, behavior and participation” which asked for new ways of working. This shift is partly driven by a desire to reflect social values¹⁸ and often puts strong emphasis on patient responsibility for their own health and a focus on preventative actions.
- **Concerns about division and fragmentation of healthcare:** In many countries there is increasing concern about service fragmentation for patients, and in particular a lack of coordination between primary, secondary and tertiary care. Integrated care marks progress away from this fragmentation and heading towards population health¹⁹.
- **Demographic change:** In the WHO European Region, the population aged 65 and over is projected to rise from 129 million in 2010 to 224 million by 2050; with the number of people 85 years and older expected to rise from 14 million to 40 million. Similar trends are expected elsewhere in the world. Since the number of people of working age is in decline, this means a significant increase in the old-age dependency ratio²⁰. Sustaining this ageing population requires an increasing focus on prolonging and achieving equity in good health and wellbeing throughout the life course.
- **Healthcare costs:** The proportion of income spent on health in virtually all developed countries has progressively increased²¹. The high cost of providing healthcare, and a desire to maintain the quality of healthcare was a significant factor in the development of all of the integrated care social innovations in the second round of mapping.

The political environment forms the framework for the health system and hence integrated care. Thus, it is of utmost importance to consider health targets, targeted programmes, national interests and the image of a disease or groups concerned for the analysis²². The growth of the practice field has been partly attributed to regional responsibility for health care – the shift in responsibility for health care to regional government has opened up space for innovative approaches to health care. Integrated care is considered a more manageable goal at a regional level and the innovation projects have found that close relationships with local- and regional- government are essential in developing effective integrated care innovations. It has also been found that the openness of local governments to innovative solutions varies across different locales. One example however, did go against this. In the case of **Better Together (Netherlands)** the decentralisation of social policy actually threatened the innovation as it provided competition for their approach to integrated care, eventually leading to the renegotiation of relationships and rethinking of the approach as an alternative to integrated care provided by the municipality.

In addition, social values provide a significant context for the development of the practice field and meaningful development of the social innovations within this field. For example **Physical activity on prescription (Sweden)** was

¹⁶ Gröne, O., & Garcia-Barbero, M. (2001). Integrated care: A position paper of the WHO European office for integrated health care services. *International Journal of Integrated Care*, 1, e21

¹⁷ Royal College of nursing (2014) *Integrated Health and Social Care in England: the 14 Pioneer Programmes*. RCN Policy and International Department.

¹⁸ UCL (2012) *The Future of Healthcare in Europe*. London: UCL.

¹⁹ Alderwick, H., Ham, C. & Buck, D. (2015) *Population health systems: going beyond integrated care*. London: The Kings Fund.

²⁰ UCL (2012) *The Future of Healthcare in Europe*. London: UCL.

²¹ *Ibid*.

²² Eger, K., Gleichweit, S., Rieder, A., & Stein, K. V. (2009). Prioritising integrated care initiatives on a national level. Experiences from Austria. *International Journal of Integrated Care*, 9, e91.

initially established in the early 1990's but gathered momentum in 2001 following a national conference which called for a national movement 'Put Sweden in motion' which engaged civil society, schools, and companies as well as the health care sector. At a wider level there is a shift in the way that the medical profession is viewed and the relationship between patient and healthcare provider, where the public is demanding greater say in their healthcare provision and has less belief in the total authority of healthcare professionals. This is slightly separate from the institutional shift towards patient responsibility and may stem from different motivational positions. For example the institutional focus is the reduction of cost of healthcare whereas patients are driven more by the ability to have agency in their treatment.

The innovations which are included in the practice field of integrated care may happen within, or externally to, the dominant healthcare 'system' in countries, but usually require significant 'institutionalisation' in the form of collaboration and cooperation with governments, insurers and health practitioners.

Although integrated care is a key focus of reform in healthcare services, across Europe and internationally, efforts to integrate care services have rarely extended into a concern for the broader health of local populations and the impact of the wider determinants of health²³: **Healthy Kinzigtal (Germany)** and **Better Together (Sweden)** are two examples of this focus on population health and demonstrate that integration at this scale is a complex process that requires optimum political, professional/ institutional and social cooperation and collaboration. This is a goal that may be difficult to achieve in places with a less optimal context.

The **functions and roles of actors and networks** are very significant in the development of integrated models of care. In all cases, the initiator had strong institutional backing and support, and the development of good working relationships with political bodies responsible for health care within the areas that the innovations were operating have been shown to be essential. In two of the cases there was also the drive and charisma of one individual – in the case of **Physical activity on prescription (Sweden)** this was Hans Lingfors who was employed by the District to a post supporting preventative care; likewise, in the case of **Helathy Kinzigtal (Germany)** Dr. Hildebrandt was a key figure promoting the idea of change in the German healthcare system but was already embedded in the system as the owner of the healthcare management company in Hamburg. Where change came from outside, such as in the case of **Family Hall (Austria)** the good reputation of the organization behind the innovation (SOS Children's Village) was essential in being able to promote change.

However, integrated care is not just about the initiator but also requires good functioning relationships between actors at all levels including those involved with planning, financing and providing services, as well as users. A shared vision between these actors is the sustaining force behind innovation in integrated care. New actors are in fact a cornerstone of integrated care. In the cases showcased here these 'new' actors include providers of physical activity, businesses, charities and insurers.

2.2.1 The relationship between the social innovation programmes and the practice field.

The four different case studies displayed different levels of integration:

Healthy Kinzigtal (Germany) and **Better Together (Netherlands)** both took a regional approach to integrated health care in its totality – focusing on population health rather than the integration of treatment services. In these cases the integration tended to be very complex involving altered roles for different health professionals and a large degree of cooperation across sectors. These innovations can actually be viewed more as a series of innovations at different levels, including system innovation, institutional innovation, process innovations and operational innovation. These are integrated much more extensively but, because of this, display less diffusion and replication than the other models

²³ Alderwick, H., Ham, C. & Buck, D. (2015) Population health systems: going beyond integrated care. London: The Kings Fund.

This may be because of the disruption that is required for this type of innovation to be successful. However, Healthy Kinzigtal is beginning the process of diffusion and replication so these programmes do offer potential for the growth of the practice field.

In the case of **Family Hall (Austria)**, the aim was the same in addressing the needs of a population holistically – in this case young people with complex needs – but this could be viewed as less of a radical integration. The innovation was more about bringing a bundle of services together under one roof. In this case cooperation was required but there was not the same level of collaboration in terms of negotiating roles, and the focus was on treatment rather than population health. Health professionals' roles remained distinct, but they were located together, allowing easier cooperation across services. Additionally new roles were created focused on the users, who provided the integration. In addition the innovation can be thought of as integrated because of the inclusion of the SOS Children's village as an additional partner in the provision of health and social care, and driving the development of the Family Hall.

Finally, **Physical activity on prescription (FAR) (Sweden)** can also be considered a case study of integrated care but focuses on the integration of a discrete activity (in this case physical activity) into the health care system. This is a more limited integration but still involves the negotiation of complex relationships and requires system change which we see as a core element of integrated care.

2.3 INTEGRATED CARE: PROCESS DYNAMICS AND SOCIAL CHANGE

There are a number of mechanisms of social change which are influencing the development of integrated models of care. The full definitions of these mechanisms can be found in the annex.

Learning

Learning is reflected in the growing knowledge and capabilities that both providers and users of healthcare services have regarding the need for a more holistic approach to healthcare, the possibilities which integrated rather than fragmented care hold for the reduction of healthcare costs, and a focus on long-term health rather than high-cost treatment. It is also reflected in the increasing knowledge that is held in society around the responsibility that they hold for taking care of their own health, including holistic practices and, for example, the significance of healthy diet and physical exercise. This learning is reflected in the media, in scientific journals and is beginning to be reflected in policy which promotes integrated care as a more promising model.

In addition, the capacities and capabilities of both providers and users of healthcare are significant for the development of the practice field. For healthcare providers, this learning requires working out ways of forming and maintaining relationships; including new ways of working across different fields, and working with new partners such as with providers of physical activities or the social care sector. For users, new capacities and capabilities are required in terms of the ways they approach their own healthcare; for example taking preventative measures to maintain a healthy lifestyle. It is also likely to involve a new way of working between users and providers, with providers required to listen and respond to the needs of users and include them to a greater extent, while users are also responsible for acting on the recommendations given by providers.

Variation

As mentioned, there has been a shift in the collective values and beliefs concerning the role of society in the own health care and around holistic approaches to health. There is a widespread belief that the definitions of 'health' and 'healthcare' need reformulation, although this is recognised to be an ambitious and complex goal²⁴. This has been reflected in local and national policy contexts where efforts are being made towards integrated care at different

²⁴ Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., ... & Schnabel, P. (2011). How should we define health?. *Bmj*, 343.

scales. The more innovative models of integrated care have been able to thrive in regional/ local environments where there is space for innovation in the plans for healthcare reform.

In addition, conferences and conventions such as 'Put Sweden in Motion', and scientific publications such as toolkits for models of integrated care (**Physical activity on prescription, Sweden**) accelerated and gained support for integrated care innovations. The challenges faced by these innovations highlight the degree to which current models of healthcare can cover this need.

Selection

Of the cases showcased in the second round of mapping it can be seen that less complex integration is more likely to be subject to processes of **adoption, diffusion and imitation**. The case of **Physical activity on prescription (Sweden)**, for example, is about integrating a new method (prescription of physical activity) into existing systems (primary healthcare services). In this case, although the idea is innovative, requiring complex negotiations of relationships (for example with providers of physical activity), and new ways of working it is limited in terms of the number of services that were integrated. As a reflection of the success of this method it has diffused across Sweden and is being imitated in other countries. The **Family Hall (Austria)** is also replicable and SOS are planning to use this structure in other urban contexts. More complex integration such as the population health approaches of **Healthy Kinzigtal (Germany)** and **Better Together (Netherlands)** are less likely to be subject to these processes because of the complexity of relationships involved. Funding systems and healthcare structures are key in allowing innovation to take place and these need to be re-thought in order to encourage this more radical innovation. At a minimum, developing a population health systems perspective requires "greater pooling of data and budgets; population segmentation; place-based leadership drawing on skills from different agencies and sectors based on a shared vision and strategy; shared goals based on analysis of local needs and evidence-based interventions; effective community engagement; and incentives to encourage joint working"²⁵.

Tension

Integrated models of care can largely be seen as a response to the **tension** that has been building in healthcare globally as outlined in the context above – demographic change, the need for a reduction in the cost of healthcare and a desire to reduce fragmentation and change the focus of healthcare – are all challenges which have driven institutional change towards integrated care. There is also a tension that although governments want to change healthcare systems, funding models still do not fit to integrated care, usually focusing on particular diseases. Powerful partners such as Pharmaceutical companies, may also try and prevent a shift towards more preventative models of care by maintaining focus on drug-based treatment programmes. Integrated care is unlikely to be successful on a large scale unless impact (in terms of cost reduction) is demonstrated, but this type of impact takes a great deal of time to prove making it difficult for new innovations to influence the practice field without strong professional and institutional support.

Cooperation

Cooperation is a key mechanism of social change in the practice field of integrated care. This cooperation is required at a number of different levels:

Between healthcare providers: Integrated care is based upon the integration between various providers of healthcare. In successful cases the initiators have been part of an already developed network, for example a physician's network, or there has been a strong leader providing motivation for health care providers to integrate. There are still challenges in cooperation at this level as there is a lack of motivation for them to work together due to different goals.

²⁵ Alderwick, H., Ham, C. & Buck, D. (2015) Population health systems: going beyond integrated care. London: The Kings Fund.

Between various stakeholders in the provision of healthcare: Likewise, cooperation is required with other stakeholders that do not necessarily provide care but are involved in various other capacities. These may be existing stakeholders such as insurers and government. These institutional relationships are one of the main barriers diffusion as, even if the desire is there, funding models may not be set up to be able to fund these systems of care. Cooperation is also required with new stakeholders such as providers of physical activity, or third sector organisations etc., requiring new knowledge and motivation on the part of healthcare providers to work in a different way.

Between users and providers of healthcare: Integrated care also requires a renegotiation in the relationship between healthcare providers and users of healthcare services which require new forms of cooperation. As mentioned, integrated care goes hand-in-hand with a movement towards people taking more responsibility for their health but this can only be done if the healthcare professional equips them with the knowledge and trust to be able to do this. The success of these innovations is largely dependent on getting this relationship right. When this relationship is not present the programme may fail. For example in the case of **Physical activity on prescription (Sweden)**, findings show that in the most vulnerable groups, 40% of people do no physical activity at all. In this case there is not the cooperation between user and provider, hindering successful innovation with this group.

Diffusion of (technological) innovations

Technological innovation has a large part in the development of the practice field. Current technological systems for reporting and prescribing healthcare are not sufficient for integrated models of care. Therefore the development of new technologies for managing users' needs has been essential in the growth, diffusion and replication of innovations within the practice field of integrated care. The technological innovation can be seen as supporting the development of new relationships and cooperation which are essential in the practice field of integrated care.

Evidencing impact

Slightly separate to learning, but an important mechanism of social change in integrated care is the significance of being able to **evidence impact**. This links to the importance of **competition** in both market driven, and government-led systems of healthcare, and is significant at both the offset, for example being able to demonstrate that health and physical activity are linked is in the offer of **Physical activity on prescription (Sweden)**, and for growth and diffusion, for example, before **Better together (Netherlands)** will be replicated it needs to be able to demonstrate cost-effectiveness. It is significant that the only successful examples of population-based integrated care have developed in insurance-based healthcare systems where there is increased **competition** between different insurance companies to prove their effectiveness, both in terms of cost and in terms of the health of those they insure.

2.4 SOCIAL INNOVATION INITIATIVES RELATED TO THE PRACTICE FIELD

2.4.1 Better Together in North Amsterdam (TNO)

Description, development of the Social Innovation Initiative

Better Together in North Amsterdam (BSiN) is a program focused on the development and implementation of integrated health and social care delivery in the district of Amsterdam-North. BSiN is a multi-level approach (client, professional, organization, financial). Its aim is to improve self-sufficiency and health and social participation of residents with multiple and complex problems.

BSiN emerged from the Krijtmolenalliantie (KMA), an alliance of 10 providers of welfare, social security, primary and secondary healthcare, nursing care, institutional care, and home care, in collaboration with the Achmea insurance company and the City of Amsterdam. It emerged because of an identified mismatch between the supply of care- and welfare services and the needs of people in Amsterdam north. The observed mismatch, high health- and social-care

costs and new insights in integrated care and welfare services were the main reasons for the emergence of the KMA and BSiN.

The new approach represents a paradigm shift from “sickness and healthcare” towards a focus on “health, behavior and participation”. This approach is integral because problems are approached holistically and integrated because relevant providers of health and social care services coordinate activities among themselves. This comprehensive and integrated approach represents a fundamental change in methods, the execution of professional duties, cooperation, ambitions and goals. In addition, simplification is a central principle in this healthcare innovation. This simplification relates to reducing the administrative burden, optimizing financial flows and enhancing autonomy at professional level.

The development of the integrated approach contained the following goals: The optimization of care and welfare infrastructure; the embedding of proven-effective innovative and integrated methods; and realizing a sustainable cooperation between health- and social-care providers.

For the first phases of the project the providers made provisional agreements on financing of the integrated agreements. Achmea Health (insurer) and the municipalities compensated the extra costs of innovation and implementation. The intention is that in the course of time the providers bear a growing part of the costs of integrated care. The ambition is to finally realize an agreed system of cost sharing and benefits. TNO supports this transition by developing new business case models on shared savings.

Actors, partnerships, alliances, networks

The KMA was the main responsible body in the development of BSiN. The additional partners were involved for their specific resources. For example the main reason Achmea was involved was because of their desire to contribute to the triple aim (improving the patient experience of care, improving the health cost of populations, and reducing the per capita costs of health care), TNO was approached for their organizational power and innovative solutions while the city of Amsterdam was involved based on their political influence.

The formation of this program organization was distinguished in five components:

Extensive government consultation (EGC): In the EGC directors of various providers, relevant municipal services, TNO and Achmea are represented. Meetings are scheduled twice a year. The members of the EGC are responsible for contractual and administrative arrangements and are in close contact to the city district, municipalities and the ministries.

Management consulting Krijtmolenalliantie (MCKMA): The MCKMA forms the board of this initiative and is formally commissioned to employ activities funded by Achmea or the providers themselves. The MCKMA is also responsible for the crew and effectuation of the program management and attend to monthly meetings.

Program management: Daily management of BSiN, coordination of activities and risk management are responsibilities of the program management. The program management is accountable to the MCKMA. The MCKMA determines the composition of the program management.

Quartermasters group: The quartermasters group (QG) is a mandated task group of expert professionals and case managers who are well aware of the daily practice in the districts. Their main task is to develop the innovation from the perspective of fellow professionals in co-creation with experts from TNO. The QG plays an important role in the dissemination of the innovative approach at the workplace and acts as the first point of contact for co-workers.

Consultative group of residents: Five active residents act as a consultative group on behalf of clients in the districts and acquired an important role in organizing support among the residents. Moreover, the consultative group provides advice on activities, processes and methods related to the BSiN approach.

Innovative solution

The implementation of integrated care is actually not just one innovation but a chain of innovations, both substantive (the acting of professionals, job profiles), process/procedural (which agreements and procedures exist) and institutional (administrative, agreements and contracts).

Unlike the classic care delivery models an integrated approach is based on a holistic perspective. This requires health and social workers, from multiple professional backgrounds and different organizations, to work together..

Through its multidisciplinary triage BSiN is aimed at referring clients to the most appropriate form of support. This is essential when aiming to improve health, restore credibility and reducing the per capita costs.

The innovative solution is based on the following principles:

- 1-1-1: transparency of care provision based on 1 client, 1 plan, 1 case manager.
- 0-1-2: self-management, supported by informal and/or formal welfare provision if necessary, forms the basis. Professional primary and/or secondary care should only be used for specific and more specialized needs and demands and in support of self-management.
- 2-1-0: professionals will make every effort to (partly) substitute from secondary to primary healthcare and to self-management and social support. This will involve boosting the capabilities of individuals and augmenting their social networks.

Gaining momentum

The innovation has been developed with reference to a predetermined roadmap, which was worked out extensively in the project plan. Because the pilot was supported by a process evaluation the development of the program was adjusted several times.

Nevertheless, developing, executing and embedding this innovative program is a gradual process. Because internalizing the process is an important condition for the success of BSiN, case managers were involved in developing and implementing this new way of work. The adoption and internalization of BSiN is promoted by: (1) training, (2) peer review meetings, and (3) the operationalization of the process into a placemat. During the development of BSiN case managers required the exchange of knowledge and experience because they were not familiar with an integrated and holistic way of work.

In the beginning, case managers struggled to operationalize, adopt and internalize the new way of working for two reasons. First, they struggled with the role of co-creator. The case managers were not used to co-creating daily routines and work procedures through learning by doing. Second, the new way of working itself was difficult. The case managers, traditionally specialist on one domain, struggled with becoming a generalist. They needed general knowledge of all relevant life domains and a holistic and multi-dimensional view on their clients' needs and preferences. At a later stage, case managers indicated that they had become more aware of the interrelatedness of the clients' problems and were able to act accordingly.

A second challenge is the vertical integration of BSiN. Most managers from the parent organizations knew very little about BSiN and the intended goals. The managers' main goal was good operational management in their own organization and the best possible support for their target population. BSiN was not on top of mind as a way to contribute to these goals, but was seen as a separate initiative.

Another barrier was that continuity of BSiN was not guaranteed. Each year project partners determined whether the program could be continued, this was mainly driven by the financial resources. This way of funding made it difficult to realize long-term agreements that fit a multi-year implementation program. One of the challenges in the project is to

develop population-based funding. Although major steps have been taken in this direction, this is an ongoing topic of discussion among the project partners. For the development of population-based funding, a 'construction team' was established to close a contract between the two procurers (city of Amsterdam and health care insurer Achmea). A uniform price for case management was set in 2014. Furthermore a uniform protocol for case selection and case management was developed.

Complementary innovation

To benefit from this initiative, action is needed at four levels:

- *Client level:* This requires the ability to identify problems to a certain extent. In addition, users should be receptive to the new way of care delivery. One of the main principles of the integrated care approach is self-management. This requires a high degree of proactivity, positive psychology (thinking in possibilities instead of restrictions) and the ability to arrange social or professional support if needed. This is important for both clients and professionals and means a significant change in professional practice
- *Administrative level:* This requires organizations who look beyond their own borders and who collaborate with competing parties with similar interests.
- *Professional level:* Health and social care suppliers should master the fundamentals of the holistic and integrated approach.
- *Financial level:* This requires integrated funding across the domains.

In addition to the actions above, political structures must change in order to stimulate functioning in interdisciplinary teams. E.g. financial systems should enable professionals to innovate and cooperate with competing parties. On a local level the infrastructure should allow professionals to join – or collaborate with – an alliance like the KMA.

Technological innovation played a major role in this project: For instance an important precondition within the development of BSiN is an ICT infrastructure for reporting, process monitoring, and feedback aimed at the support of client counselling and the identification of target-specific collective interventions. With this aim in mind the project partners installed an ICT team which was commissioned to develop an infrastructure for registering clients. The ICT team introduced a web-based portal which provided a login module including an underlying registration database for professionals. This web-based portal could be used separately from existing registration systems already used by the organizations.

Impact, diffusion and imitation

In order to establish the effects of BSiN on participation, health and self-sufficiency among the target population TNO started an observational effect evaluation. All clients with complex and/or multiple problems living in the northern district of Amsterdam received a digital questionnaire. The answers of clients who received usual care (control group) were compared with the answers of clients who received integrated care (intervention group).

The action program shows promising first results. Self-sufficiency of the target population increased, especially in the field of mental health and income (debt restructuring). This results in a better health for the population. The business case shows that the action program leads to lower costs. Project partners are further discussing the criteria for efficient implementation, based on the outcomes of the process evaluation by continuous quality improvement loops.

Although no diffusion strategy was applied to the innovation; based on earlier experiences diffusion seems to be an option for the future as the initiative is still learning how things work out. The project partners expect to gain attention when the approach is proven effective and population based funding is realized.

An essential principle that would need to be taken in to account for any possible diffusion or imitation of this approach is the collaboration between different health- and social care providers. These collaborations are bound to local areas and require (new) alliances in order to implement an integrated approach. As mentioned before the transferability depends on local infrastructures, cooperation and population characteristics.

Role of policy

The KMA's aim is to develop an integrated approach which is innovative at first but should become an important element of regular care in the near future. By actively involving the District in the development of BSiN and asking them for explicit policy support the KMA aims to be on the social agenda.

Policy makers therefore play a key role when it comes to the assurance of the sustainability of the approach at local and national level, for example reducing the regulatory burden and reforming financial systems in order to provide possibilities for cooperation and social innovation is a task at national level.

There are some specific areas where policy support is essential for ensuring sustainability:

Wider adoption of the model: It is up to the policy makers to introduce BSiN on municipal level. Within BSiN this resulted in the adoption of some elements at municipal level. Although this generated attention, up to now this did not lead to the implementation of the BSiN approach in other city districts. Before policy makers will put this on the public agenda, the approach needs to be proven cost effective.

Budgets and funding: Likewise, at local level municipalities are responsible for purchasing and providing care, in other words they manage the budgets. Purchasing of integrated care is not an option yet, the lack of proven effectiveness might be the decisive reason. Realizing integrated funding might be the best possible solution since it offers the opportunity to allocate budgets to the own interpretation.

Legal and financing systems: Current legal- and financing systems frustrate the possibility to innovate. As long as the productive culture (all hours must be billable) exists professionals' opportunities to join alliances, cooperate and actively innovate are restricted. In order to create these opportunities institutional and operational policy is required. While tasks and responsibilities have changed the allocation of financial resources remained the same. In addition, regulatory policy is required. Tight control of the Dutch Healthcare Authority creates a very time consuming administrative burden which leads to little space for social innovation.

Policy decisions have also threatened the innovation, in particular, the decentralization of social policy which was brought in in December 2011 has played an important role, threatening the continuation of BSiN. Based on new responsibilities the municipality presented a reform agenda for the social domain with the aim to mitigate the impact of the decentralization. The starting point was an integrated approach for vulnerable households with multiple problems. The city of Amsterdam was convinced that complex social problems could only be countered through intensive cooperation between the domains care, welfare, employment and income, youth, adults, poverty and security. The new approach had a strong focus on the self-sufficiency of civilians and was very similar to BSiN.

The fast implementation of the municipal approach brought the KMA in a precarious situation. Some providers of the KMA had to cooperate with the municipal initiative because of their financial dependency on local grants or subsidies. On the contrary, some less dependent private providers of primary and secondary care turned down the excessive involvement of the municipality and were in favour of the continuation of BSiN. Although the municipal approach threatened BSiN it led to an acceleration of the development and implementation of the program.

Connectivity to the practice field

The BSiN Is clearly related to the practice field of integrated care, producing a model of integrated care across a whole district. It highlights the complexity of introducing integrated care as an innovation at this scale and the need for complementary policy reform and social movement towards greater user involvement for health care.

For now, this initiative is a pilot test. However, when the (cost) effectiveness has been established and funding is arranged BSiN is expected to be a leading exemplar of a successful integrated care program. In a society which is confronted with an ageing population caused by a decrease in birth rates and increasing longevity healthcare expenditure will continue to rise. In response to this development, this initiative provides the opportunity to reduce healthcare costs and maintain or improve the quality of healthcare.

Regarding the development of the practice field, this initiative provided opportunities to experiment. Not only in the development of the approach but also in exploring new partnerships and financing forms. The advantage of a comprehensive definition as social innovation is that many experiments fall within this term and initiators are not obliged to justify their activities. In short, social innovation provides the time and space to develop the practice field in the direction of a leading exemplar.

BSiN was developed in harmony with some exiting social movements (1) adoption of the new definition of health, (2) the focus on self-management and (3) the societal need for autonomy and freedom. Although the end user seems ready to adapt, some intractable challenges on administrative, executive and financial level still exist.

2.4.2 Family Hall – FamilienRAThaus (AIT)

Description, development of the Social Innovation Initiative

The Family Hall (FamilienRAThaus) aims at establishing a centre for families in crisis to meet and get social, medical and psychological advice. It is an integral part of the SOS Children's Village which has implemented the Family Hall. The original idea of the SOS Children's Villages, starting in Imst, Tyrol and spreading worldwide, was to use a plot with several houses where eight or nine children and one "family village mother" live together. The Family Hall in the district of Florisdorf is the result of considerations for how to translate the model into an urban context. It can be considered as:

1. The headquarters of the SOS Children's village Vienna; and
2. A set of services which, although intended to help the needs of the SOS Children's Village, have been opened up to the public from the very beginning.

The special local needs are reflected in a bundle of services that are combined and offered in the Family Hall: a parent-child centre in cooperation with MAG ELF (Magistrat 11 = magistrate 11) of the Vienna city administration, a children and youth outpatient clinic in cooperation with the Vienna Health Insurance Fund, which is a combination of medical specialist, psychology/therapy and pedagogy, and a Café ("Café Floritz") on the ground floor providing a first point of access for everyone coming to the Family Hall.

The Family Hall is expanding on different levels. Complementary to the outpatient clinic a day clinic was opened up. Also, a small school class including specifically trained teachers for up to eight children and an online- and telephone advisory service has been started ("Rat auf Draht").

Actors, partnerships, alliances, networks

At the beginning, the first networks that had to develop were within the organization of the SOS Children's Village Austria. The initiator of the SOS Children's Village Vienna was the head of the pedagogy unit of SOS Children's Village Austria. He took up the original idea of the founder Herman Gmeiner and expressed the need for an SOS Children's Village in Vienna. "A whole village. And he repeated this at every board meeting from 1998 to 2001, and it took until then [2001] to officially pass the resolution in the decision-making bodies in favour of an SOS Children's Village in the Austrian capital.

One of the key persons in the setting-up phase and today's director of the Family Hall had been director of youth care at SOS Children's Village Burgenland for 12 years when he was invited to apply for the task of developing a concept for an SOS Children's Village in Vienna. In the planning phase from autumn 2002 he had a steering group and a concept group for support. The steering group consisted of high-level SOS Children's Village officials, especially the National Director for Austria at the time and the head of the pedagogy department.

Furthermore, the cooperation with the Vienna city administration seems a key mechanism for the success of the SOS Children's Village Vienna, for example a good relationship with the city councillor has been important in the course of development and also close cooperation with the MAG ELF of the Vienna city administration who is responsible for the support of families and the protection of children and adolescents.

Cooperation with affiliates of the Vienna municipality have been helpful as well. This extends for example to Wien Energie, a company responsible for ensuring supply of electricity, natural gas and heating in Vienna (Wien Energie, 2016). They cooperate in showing special patience with adolescents cared for by the SOS Children's Village, who are not able to pay their bills immediately.

The Vienna Social Insurance agreed to finance a children's and youth psychiatry outpatient clinic on the premises of the Family Hall. Building project organisers also form another important group of partners in the development of the SOS Children's Village Vienna. And private supporters and "angels" played an important role, especially at the beginning of the Family Hall in Vienna. These women, and mostly they were women, with their extensive personal networks helped a lot in collecting money through concerts and other charity events, but also in spreading the values of our organization. They showed a high level of identification with the organization's goals and promoted them at any public occasion.

Finally, the Family Hall has a press office maintaining cooperation to journalists from big Austrian media such as ORF, Kurier or KronenZeitung. Media are important partners in raising awareness for the organization's goals, support fundraising campaigns and report about charity events. Cooperation is long-established, so that these media are seen as "partner media" by the Family Hall.

Innovative solution

In establishing a Family Hall in Vienna the core idea of an SOS Children's Village is adapted to the needs of families in an urban setting. In this regard the Family Hall with its basic concept of integration into an existing neighbourhood and infrastructure differs significantly from the other 13 SOS Children's Villages in Austria.

Normally the architecture of an SOS children's village really resembles a village, with houses and gardens and a family atmosphere. More generally, the architecture of an SOS Children's Village has to resemble its local environment. The topographical form of a village is fine for SOS Children's Villages in peripheral regions, however they do not fit for urban settings. To adapt the concept for an urban setting means to integrate the basic ideas into urban forms of living. In Vienna, the SOS Children's Village rents apartments for a SOS Children's Village parent and eight children at the most. The idea is to live in a similar way as the majority of people and families in Vienna.

A centre in Floridsdorf was established with a supply of different services, i.e. a combination of pedagogues, specialists, therapists and psychologists with close interaction in spatial proximity so that the families and children do not get lost between psychologists, therapists and specialists.

The outpatient clinic for child and youth psychiatry of SOS Children's Villages is a health care facility in child and youth psychiatry. The main asset here is the social psychiatric work approach: A team of three specialists for child and youth psychiatry, two clinical psychologists, three psychotherapists, two ergotherapists, one physiotherapist, one speech therapist, one social worker and one experimenter, works on an interdisciplinary basis and involves the entire psychosocial environment of the child.

The MAG ELF also implemented a parent-child-centre on the premises of the Family Hall. At the time of implementation the parent-child centre had a preventive work assignment. The focus has shifted and is now mainly focused on vulnerable families.

A café on the ground floor (Café Floritz) serves a point of entry and encounter and is established in order to keep the threshold to enter the Family Hall deliberately low. It is a place where everyone can come and get familiar with the different types of services the Family Hall provides.

Gaining momentum

The SOS Village itself has a **growth oriented strategy**. When new community buildings are planned, the building project organisers inquire if there is any interest on part of the SOS Children's Village Vienna, possible expansions are considered carefully. However, growth needs to be considered carefully because the social need is overwhelming and it could cause capacity issues. Growth is supported by a solid financing structure in that the Vienna municipality concedes suitable daily rates. They do not cover the full cost, there is still a share of donations in it, but this share is significantly lower compared to other regional branches of the SOS Children's Village.

Momentum is also gained through **research and insights**. These may be from the innovation (or innovations within the innovation) itself, for example the online and telephone advisory service "Rat auf Draht" also helps to gain new knowledge. Topics that are currently important for children and adolescents can be identified anonymously without violating privacy rights. This information is then implemented into the planning of new projects and plays a role in the organization's agenda setting. Scientific findings also drive the development of the initiative. For example, the organization is currently about to create new permanent job positions in order to implement a better support of parents which in turn increases the wellbeing of the children.

Fundraising is significant to the growth and momentum of the innovation. A lot of new and short-term marketing measures and charity events were necessary to acquire the necessary funding and the organisation invented new forms of sponsoring and innovative mentoring programs and cooperated with the influential public charity "Licht ins Dunkel" (= "light into the dark") by the Austrian Broadcasting Corporation (ORF). SOS Children's Village Austria coordinates communication and fundraising centrally, but the Family Hall also runs its own press office to coordinate direct requests.

The **reputation** of SOS was significant in building relationships and therefore gaining momentum. Building project organisers showed some scepticism at the beginning about potentially unstable children and adolescents and their possible behavioural disorders which then might lead to problems with neighbours in large community buildings. In the end, the brand and positive image of SOS Children's Village in general helped to build up a good and fruitful relationship. Today, the opposite is true. Some of the building project organisers have turned to mentioning the cooperation with the SOS Children's Village in their brochures already in the planning phase of large community buildings. This officially documents the information of tenants in large public estates and has the legal consequence that no one can argue that he/she had not been informed.

Complementary innovation

People using the services in the Family Hall do not need to learn anything specific. The entry threshold to get in contact with the Family Hall is deliberately low. The service is highly professional, but the access is as easy as possible. [...] This has also been the motivation for opening a Café (“Café Floritz”) on the ground floor of the Family Hall: People can just come into the house, visit the Café and get informed about the different services in the Family Hall.

Given that approaching the Family Hall has to be made extremely easy and low-barrier, employees of the Family Hall have to be vastly informed and highly professional. This is extremely challenging considering the width of the field, reaching from psychology, pedagogy to medicine and medication and jurisdiction and legal practices. This has been done in various ways:

- In-house trainings; The Family Hall offers different in-house trainings, for example for pedagogues to get new and more specific insights into the working fields of the medical specialists or into children and youth psychology and therapy. New employees need to get comprehensive support at the beginning, and even long-term employees need support in order to be up to date in all these matters, which often change and demand new and different answers.
- Face-to-face exchange; New employees of the Family Hall get comprehensive information folders. They are assigned to a “mentor” they can ask questions and exchange experiences with. Besides formal educational in-house trainings new knowledge is also transported in informal ways, for example through face-to-face conversations at meetings, lunch or coffee breaks. Exchange with colleagues’ works better the closer they are located to each other.

Impact, diffusion and imitation

In general, measuring the development of young people is inherently difficult. What has generally been measured in this situation is input variables, less impact. An attempt has been made to develop qualitative cases that follow children over the years, conducted by SOS Children’s Village Austria to see how the children developed over the years. “They are indicators that help to estimate if the children developed in a good way, but capturing the quality of the service is difficult and can hardly be measured in numbers. Often it is about what you perceive or feel as an adult when you visit a living community. Is it a distant and impersonal feeling or rather warm and friendly? How do the children react? Are they relaxed and easy or aggressive? How is the relationship to the pedagogue? These are all subjective but very important indicators, indicators of the pedagogues daily work” (Interview R, p10)

There are formal instruments for internal and external quality controls. The pedagogy department runs a special unit for quality management conducting an audit every two years. Through these internal audits various parts of the services in the Family Hall are monitored, complemented by statements from employees, children and youths. Besides there is a yearly “interim reflection” including the formulation of specific goals. Several standards are formulated regarding documentation, roster, regular supervision, teambuilding etc. On an external level the Family Hall is monitored by the Children and Youth Welfare Vienna on a yearly basis, by the OPCAT-Commission, the labour inspectorate and the AUVA Vienna. (Interview R, p10)

The Family Hall as a concept has been only recently adapted to other Children’s Villages within Austria, like for example in Stübing (Styria) and Alt-Münster (Upper Austria). What has spread worldwide, however, is the integrative concept of the SOS Children’s Villages Vienna.

Role of policy

The SOS village was developed in Vienna alongside a specific policy shift. As a result of the children’s home reform “Heim 2000” in Vienna, which had started in the year 1995, the demand for new forms of child and youth care was growing. In the course of the reform of children’s homes in the year 2000 the Vienna municipality had changed

conditions and regulations for taking care of children. Before 2000 this was a largely public task, where the Vienna municipality itself had been investor and carrier of facilities of child and youth care. From 2000, the Vienna municipality remained investor, but issues call for tenders where independent carriers can compete.

The reform the children's homes aimed at taking care for children in a more flexible, shorter-term and more differentiated way. It aimed at providing effective measures opposite to treating every child the same way, but deciding accurately according to what the individual child needs. The longer-term aim is reintegration of the child in its family of origin. Children's homes changed in structure. From 2000, large homes have been disintegrated to smaller unities with a maximum of eight children, dispersed over the whole city and integrated into the neighbourhood.

Connectivity to the practice field

The Family Hall is part of an attempt to combine child and adolescent psychiatry with integrated care – making it a pioneering innovation. The Family Hall has additional pioneering features in that it does not only combine preventive and curative healthcare, but also health and social care in one place. It is formally identified as being part of integrated and youth care in Vienna by the Competence Centre for Integrated Care (CCIC). In Austria, this is part of a developing practice field and is part of an attempt to overcome silos in funding and treatment practices that are dominant in the Austrian healthcare system. The Family Hall was not established under this paradigm shift but is now seen as part of this more institutionalized movement towards integrated care.²⁶

2.4.3 Healthy Kinzigtal (IAT)

Description, development of the Social Innovation Initiative

The basic idea of *Gesundes Kinzigtal* (Healthy Kinzigtal) is to offer an integrated care model for a whole region/population, organising care across all health service sectors and indications. The innovation aims at improving three key issues of any health care system: health, health care and lower per capita costs.

Gesundes Kinzigtal's integrated care is one of the few population-based integrated care approaches in Germany, organising care across all health service sectors and indications. An important aspect is that physicians and other health professionals are trained in supporting patient self-management and shared decision-making. The patient and the physician develop a treatment plan and define treatment goals, which are regularly revised.

Each of the health programs that are/were developed within Healthy Kinzigtal addresses certain needs/challenges: For instance, one of the programs focuses on the lack of physicians in rural regions and targets this challenge by educating and preparing general practitioners.

Healthcare within the region/for the insured persons of the two insurance companies who are part of Healthy Kinzigtal visit one of currently 65 physicians or psychologists to discuss their needs and aims considering their state of health. If they belong to a certain risk population, this initial talk is supplemented by another check-up. The whole model is based on the "Integrated Chronic Care Model" which, in turn, is an extension of the "Chronic Care-Model". The core idea of this concept is to achieve not only a better health condition of the insured persons, but also aim at organizational development of the medical practices, the competences of medical personnel and an overall societal improvement.

Several aspects led to the development of the initiative. A major contributing factor was the personal experience by Dr. Hildebrandt (Owner of the health care management company) that much more could be achieved within the

²⁶ Kern, Daniela. 2015. "Integrierte psychosoziale Versorgung von Kindern und Jugendlichen. Im Auftrag der Bundesgesundheitsagentur."

German healthcare system than it actually is. This included in particular the coordination of how healthcare is delivered, organized and coordinated. A central insight was the fact that working together should involve all actors within the system – including the patients/those who are insured by the sickness funds. Moreover, the initiators believed that the quality of care could be intensified greatly.

Actors, partnerships, alliances, networks

The initiative is a joint venture between a network of physicians and a health care management company, OptiMedis AG. Two insurance companies work in partnership with the model; the finance model is outcome-oriented. If the care cost margins of the population go down (compared to the start of the scheme), the profit is shared between the management company and the sickness funds. If costs rise, the management company bears the loss.

A local network of healthcare providers was involved from the very beginning, but was struggling to realize a sustainable initiative and lacked of a business model. An important aspect was the fact that none of the initial partners had any pressure to realize such an initiative. A point that mattered though was the fact that the physician's network was pushed by the insurance companies to save money. Critical was the involvement of insurance companies which financed the project in the beginning.

Given the aim that care across all health service sectors and indications should be delivered, the initiative requires partners from across all disciplines. More than 150 partners are involved (more than 50% of all health care providers in the Kinzigtal region participate in the GK programme): doctors and psychotherapists, clinics, physiotherapists, home care services, nursing homes, pharmacies, social psychiatric institutions, sports clubs and gyms as well as self-support groups.

It is felt that cooperation of all actors within the healthcare system is necessary, but cannot be realized everywhere since it largely depends on the willingness of the local/regional actors. While it is not perceived as difficult to find physicians, the most difficult aspect is to have insurance companies as partners who are willing to contribute.

Innovative solution

The initiative is oriented on public health and its long-term horizon. Instead of producing care services, as usual in health care systems, the GK programme focusses on producing better health. Moreover, within this model, several innovative programs have been either tested or implemented. The business model of the joint venture is also rather unique. The core innovation is the fact that the company only receives money if there is an actual increase in health of the population. One could also mention the case management approach to address marginalized groups (migrants, victims of domestic violence, addicts etc.) which does not only focus on healthcare but also support in daily tasks.

Healthy Kinzigtal organizes the way different actors cooperate within healthcare in a new way. Due to its approach in offering a population based integrated care model and not only one or more diseased-based models, it can be said that it is also a system innovation. Technology plays not a dominant role but with the electronic patient record, even this type of innovation is addressed. The interplay of the different kinds of innovation can be described as a necessity. Otherwise, the goals that were set could not be achieved. However, many approaches are tested within pilot projects to see how they work out and which effects they have. So if there is any trouble, they will not be implemented.

Gaining momentum

The most difficult phase of the innovation was the initial negotiation with the health insurers which took almost a year and a half. During this phase, the project was close to being not realized multiple times. A main driver was the fact that the idea worked out, which means that it could be shown that it was actually possible to save money respectively reduce the money that was spend on healthcare. The internal and external evaluation were essential for being able to demonstrate this.

The idea could not have worked out without the relevant stakeholders: Insurers, physicians, etc. The evolution however, was controlled by the joint venture. This was necessary because it needed to be shown that the approach pays off and one of the main reasons for this is the fact that a central actor coordinates the activities of all other actors.

Complementary innovation

A crucial aspect of complementary innovation is patient empowerment. If persons become more responsible for their own health, this leads to cost savings and hence more profit for the model. The patient-centred approach of Healthy Kinzigtal has several elements that need to be considered:

- Treatment plans with each individual member/patient,
- Shared goal setting agreements between physicians and members/patients,
- Enhancing patient self-management and shared decision-making,
- Adoption of the Chronic Care Model, patient coaching and follow-up care provided by the physician of trust,
- Involvement of patients in the development of the programme (Patients advisory board),
- A patient's Ombudsman to ensure that members' interests are carefully considered,
- Patient satisfaction survey every two years.

(Stuckmann, Boerma and Ginneken 2015: 5).

On the other hand, physicians also need to make changes in the way that they practice. Shared decision making is only possible if both sides fulfil their responsibility. And, as pointed out earlier, in particular the stasis within the German healthcare systems needs to be overcome: All different groups of actors need to concentrate on a common goal and not follow their own interests.

Some technical innovations have been initiated within the last years. This includes the implementation of the electronic networking system which supplies physician's offices and other providers, with services providing comprehensive electronic patient records. Other Web-based tools offered for the members are online prescription and online appointments. Another example are AAL-solutions (e.g. a device that monitors the opening of doors) that help (older) persons to stay independent.

Impact, diffusion and imitation

The impact of Healthy Kinzigtal is constantly evaluated by several independent organisations. The evaluations demonstrate that the mix of curative and preventive interventions resulted in better health outcomes among GK members. In addition an increase in life expectancy of 1.5 years compared to a propensity matched pair control group of not participating inhabitants in the region of Kinzigtal, has been achieved. Considering the financial impact, it could be shown that positive contribution of 146 euros per AOK-insured persons, or 4.6 million euros was achieved for all 31,000 AOK-insured persons in the region in regard to risk adjusted normal costs of care in Germany in 2012.

Upscaling/diffusion are very desirable because it has been shown that this approach actually worked and benefits, patients as well as the insurers. There have been several attempts. A similar programme is planned to be implemented in Billstedt-Horn, a part of the city of Hamburg having a population with a low social status. Further programme expansions are negotiated in the Saarland, Baden-Württemberg and Berlin; the implementation was planned in 2016. Moreover, there are discussions going on abroad, including Australia and China but also other European countries such as the Netherlands or Belgium.

The perspective of extra funding from potential savings served as a powerful incentive for stakeholders to participate, which has contributed to the success of the programme. A national rollout of the GK model would require a new funding method. However, the shared savings model can play a role in transitioning towards a more integrated

delivery system and contribute to a cultural change. The programme's transferability has not been evaluated yet, but a pre-existing physician network would be helpful for the implementation within another region.

The different programs as well as the whole approach are not protected and can theoretically be copied. A difficulty, however, is the fact that the original window of opportunity is now closed and realizing a comparable approach requires not only the willingness of all relevant stakeholder, but also capital.

Role of policy

Within Healthy Kinzigtal, the involvement of policy actors was rather low. Local political actors were informed at an early stage of the initiative, but they did not intervene, neither in a positive nor negative way.

However, The context was more or less defined through the policy context, namely the Statutory Health Insurance Modernization Act ("GKV-Modernisierungsgesetz", GMG). The GMG was so important because it allowed health insurance companies to spend 1% of their total expenditure on integrated care programmes. This money was provided only for new integrated care contracts. Without this funding, it would also have been difficult to set up the model

To promote other models it would be useful to provide the right incentives, in particular for the sickness funds. Right now, the insurance companies do not focus on increasing the quality of care and the state of health of their insurant but instead mainly on marketing to acquire new and healthy "customers". Furthermore, the continuing competition between sickness funds in Germany (currently there are 118 with a falling trend) that was politically initiated, will help to set up comparable models because it is easier to negotiate with a large company than with several smaller ones.

Connectivity to the practice field

The practice field shows that integrated care models on their own have potential, but if those are integrated and coordinated themselves, they can unfold even more potential. E.g. a project that targets a certain disease helps the patients. However, even more impact can be achieved, if not only a single disease is in the focus, but the whole supply chain.

The highlighted project is the most prominent examples in Germany and often cited as the best practice. Similar projects that were launched or which will be started in the future somehow have to be measured in comparison to Healthy Kinzigtal.

One of the key shifts in terms of collective ideas in society that are needed for this practice field is that of patient empowerment. This is essential for an integrated care model both from the perspective of physicians and patients. As part of this shift policymakers could try to change the regulations and help to set incentives for the insurance companies which focus too less on mid-term and long-term outcomes of their programmes. Dr. Hildebrandt has made the suggestion that insurance companies should also be compared according to their health outcomes so that the patients/insured persons can consider this aspect when they choose their provider (besides financial aspects and the service catalogue).

2.4.4 Physical activity on prescription (FAR) (IKED)

Description, development of the Social Innovation Initiative

FAR is a holistic approach that views physical activity as an integral part of health care and a factor that is acknowledged by all parties to support health. Both patients and health care personnel are made aware of and encouraged to consider physical activity as a complement and/or priority measure in the context of health care. The physical activity can be prescribed by legitimated health care personal, in close contact and discussion with each patient, and with consideration taken to the patient's medical diagnosis, personal interest and life situation.

The innovation can be seen as part of a response to the need for prevention in health care rather than a reliance of medicine and responds to social demand for patients with health disorders to meet with improved guidance and access to physical activity as a means to improve their wellbeing. It is also part of an effort to reduce the cost of medical care.

The origins go back to the advertising of a post to support preventive care in Habo municipality 1985. Hans Lingfors, who was a doctor as well as a previous professional athlete, was appointed. He set out to find a way of having physical activities properly applied as a means to prevent disease as well as help cure health problems. He established a local advisory board with medical doctors, nurses, therapists, school personnel, people from sports unions and politicians. He also invited personnel from supermarkets. Hans Lingfors invited middle-aged men for testing and establishing health profiles, following up on their status and issuing advice regarding food and physical activities.

In the 1990s, he proposed to arrange physical activities on prescription. He prescribed the proper activities after discussing and anchoring the programme with every single patient. The physical activities were combined with appropriate medication and other measures tailored to the needs of the individual patients. Over the course of the decade, his ideas were gradually adopted at the national level and assimilated with the mainstream institutional framework. Prescription forms changed to be more flexible and usable within the different journal systems applied in the Swedish health care system.

In 2001, a national convention called for a national movement, which was labelled "Sätt Sverige i rörelse" ("Put Sweden in motion"). The health care sector, schools, civil society, companies, etc., were all called upon to engage. Hans Lingfors made good use of this development, spreading the word about this convention. A national board of researchers was created and commissioned to gather all scientific evidence regarding the usefulness of physical activities in combination with different kinds of diseases and medical problems and treatment, and draw conclusions in their application for preventive purposes. The results were published as a thick book named FYSS.

Physical activities on prescription is now organized in every region in Sweden with special resources and personnel besides the responsibility that the medical doctors have for the prescriptions. A national authority was tasked in 2014 to review its application.

Actors, partnerships, alliances, networks

When Hans Lingfors started he started from scratch. Thanks to geographical proximity and dedicated staff, people and organizations around him the idea of FAR started successfully.

More and more health centres adopted the idea. Sport unions also discerned opportunities to assist and subsequently broadening their basis and relevance. So -called FAR-leaders and FAR-coaches were educated.

At the same time, politicians took local decisions to support FAR. The regional political level became a key proponent, with the ability for each region to tailor their distribution and organization of tasks and routines.

The national authority called Folkhälsomyndigheten was awarded an overriding responsibility and a national board with researchers was created and a commission set up to gather all scientific evidence to support the programme.

The partners were selected based on their interest, power and influence, specific background, and geographical proximity (local or distant). In Sweden, the physical activity movement was and is successful also because of the great cooperation between all the partners described.

Innovative solution

It is recognized that physical activity on prescription can be either a complement to - or a substitute for - medicine. The patient and health care personnel are both made aware of and encouraged to discuss physical activity as a

complement and/or priority measure in the context of health care. A framework is provided for the health personal to engage the patient in active considerations which physical activities are adequate, such as walking, swimming, gyming, yoga or others. The activities might be performed individually or in a group. The physical activity is part of the medical treatment and is controlled by health personal regularly.

Health personnel get to view physical activity as legitimate treatment which can be prescribed by legitimated health care personal with consideration taken to patients' medical diagnosis, personal interest and life situation.

Gaining momentum

Hans Lingfors' original strategy was networking and involving as many actors as possible and, most importantly, the patient him-/herself in the programme and thereby gain more interest, understanding and knowledge. This was based on his knowledge and conviction that physical activity is healthy. Hans Lingfors was very influential to the success of the innovation and his appointment to the role was key in shaping the focus on physical activity as opposed to another preventative strategy.

The driver was to obtain better results from the overall treatment of patients. The patient is the target and his/her involvement and participation is one important factor to a successful development and treatment result.

Another driver was the fact that the result was expected to be improved if different actors around the patient cooperate and build the best capacities for an optimal medical result, there was also an expectation of cutting the cost of health care.

One barrier to overcome was and is, of course that there are persons that are not interested in physical activity. If they are not convinced themselves there will be no physical activity produced by that person. Another barrier in the beginning was to find a solution for, appropriate, individually tailored physical activity.

Alongside this, technological innovation was required to adjust information about physical activity in the prescription form and get it to be linked to journal systems.

The growth of the innovation was deliberate and controlled. A global movement spurring physical activity played a major unplanned role, but was met with a range of initiatives to harmonize outcomes locally.

The initiators are very satisfied with the growth of their idea over time and now this system has been adopted all over the country.

Complementary innovation

In general one of the most important complementary innovations for the success of this programme is a general awareness among the targeted group as well as within the healthcare system, schools, and policy makers. The end users satisfaction, therefore has played a vital role in the success of the project.

Essential helping tools-conventions were "Get Sweden moving" and FYSS. These serious and scientifically driven movement and book helped a lot for both producers and users. The sceptical producers were convinced by the quality assured instruments that physical activity has an important role in preventive and curing purpose and the users could more deeply understand that the agreement with health care about physical activity based on the patient's responsibility is of utmost importance.

Likewise, technological innovation in the form of websites, prescriptions adjusted to journal systems, evaluation programs and digital apps impacted the innovation positively and became a part in the marketing and diffusion of FAR. The Information and evaluations between health care, physical activity leaders and the patients worked smoother, faster and easier after a learning period.

For FAR to fulfil its full potential, complementary innovations are greatly important in two aspects. One has to do with new ways to raise motivation and inspiration, as related to monitoring, reward systems or other ways of increasing the prescription adherence. This is happening in some regions and locations, but not in others, with great impact on observed results.

Second, add-on innovative services could be offered by the providers of physical activities, which so far has happened only occasionally. One of the weaknesses of FAR is that many patients have difficulty finding suitable and engaging types of physical activity and there is much room for widening the scope of innovations in this field. Healthcare centres which have engaged in close collaboration with the local providers of physical activities have been more successful in offering tailored and patient-adopted activities.

Impact, diffusion and imitation

Different studies have been released during the approximately 30 years since FAR has been active. One study by Åsa Romé, Lund evaluated expenses and consequences of FAR and identified the group of people who gain the most of the treatment. She divided them in two groups. One had physical activity twice a week and was offered motivating coaching and education about physical activities and one group which received written information and was offered physical activities once a week. The conclusion is that the FAR-programme is cost-effective and increased the physical activity level for both groups after one year and their life quality as well. Both groups showed the same result. The amount of increased activities reduced the societal expenses by 22% due to diminished costs for health care and production reduction.

However, the study also revealed that Physical activity on prescription is only effective for certain population groups. She found that 40% of the most fragile group are totally inactive physically in spite of the FAR intervention. This demonstrates that the socio-economically weaker groups do not benefit in the same way from the positive health effects of physical activities as much as in the stronger social groups. Those who were not able to fulfil the programme need more help and support from health care personnel and other actors.

The cost effectiveness of FAR was confirmed in a dissertation by Kerstin Eriksson from Umeå University, Sweden (2010) when compared to standard care. The results emphasize the advantage of an intervention that combines supervised exercise with regular follow-ups for the possibility to reach long term effects. The study highlights the feasibility of lifestyle interventions in the primary care setting and the importance of health care professionals supporting change in life style.

Hans Lingfors started attempts at diffusion more than 30 years ago and in the beginning the diffusion strategy consisted of lectures, seminars, articles, conferences - both locally, regionally and nationally. In the region where FAR started the diffusion worked very well because of the proximity of the founder and great enthusiasm from his competent team and board.

Physical activity in general has had a raised profile by the increased and expanded amount of sport events in TV. That is one factor that makes it a bit easier for the producers to stimulate patients to take up one special activity coached by special FAR-coaches and FAR-leaders.

FAR is trademark and has got copyright. It has been imitated within Sweden and also transferred internationally from Sweden to USA, New Zealand, UK, Norway and Denmark. In some countries the FAR-programme is carried through related to special national factors and circumstances.

Role of policy

The shift in policy towards patient-centeredness in general and shifting care out of hospitals by strengthening the development of primary and preventive care has been very significant in the development of FAR. In the early 1980s a new national law was adopted - "Hälso- och sjukvårdslag". This law broadened the responsibility for the health care

sector by stating that the health care system should take lifestyle issues into account, especially prevention to avoid health problems and also throughout stages of treatment.

More specifically, the concept of 'chains of care' relies on preparedness to address patient needs and make active use of evidence-based care pathways. The opening of policy for the provision of care by a variety of providers, through a multi-disciplinary team approach, helped cross traditional boundaries between providers.

The availability of funding based on principles that are similar across the country, although different county councils across Sweden are able to experiment with new methods and thus to implement methods in different ways which are in sync with their local geographies. This left space for the innovator/innovators to develop and test his/her/their ideas. To empower and build capacity and fulfil a successful marketing and diffusion the structure and culture of policy are of utmost importance.

After approximately 10 years Hans Lingfors and the project was enhanced when the new Health law was published and after some years more the national convention "Get Sweden moving" was proclaimed. The greatest impact was the scientific publication FYSS. These policy actors and instruments were key elements in the success of the innovation.

Connectivity to the practice field

FAR has played an important role in Sweden and also some other countries, notably by opening up health care to an effective interface with important other institutions and activities, such as sports. Patients are becoming increasingly engaged in demanding integrated care solutions. Their demand is paralleled by increased access to information and build-up of self-confidence among users to request better service. For FAR, latent patient demand has likewise been essential. However, in this case the initiative has been developed by actors in the health care sector, who have crossed the boundaries to other sectors and to patients. The model has further gained support from sports actors and also in some cases employers.

Multi-disciplinary teams have played a major role in enabling research and new learning of relevance to FAR and the practice field broadly. This includes the interaction between health professionals and local society in various shapes. Growing evidence on the benefits of constructive patient engagement further opened for professionalism in how to tailor solutions to their needs and increase their motivation.

In the case of integrated care, it is important to have initiators and champions with a strong platform within the sector itself, combined with openness to cross-border linkages and collaboration (as well as strong interface with and engagement by patients). That foothold is partly connected with such networks. Various associations (e.g. sports clubs, leisure time activities), where citizens including those with health issues and patients meet and diffuse knowledge and experiences, serve as important platforms.

The social innovations are reflective of such a movement when it comes to growing patient-focus and a holistic approach to health and well-being. Social innovation contributed with specific cases of positive experience, making it more and more obvious that patient-centred solutions indeed are embedded in a social movement and can be helpful to having the health care sector respond better to patient needs and become efficient.

However, traditional care continues to receive overwhelmingly larger resources, partly due to the association with pharma industry, which influences research and education of the new generations of health workers as well. Even in successful cases, such as FAR, the imbalance in cost coverage between traditional treatment and physical exercise has served to dampen the uptake.

Integrated care has many fruitful side-effects like empowerment and adjusted social practises as patients can decide themselves on a number of subjects. Institutional structures are weakly equipped to handle and link adjustment within

diverse such processes. Complementary social innovation is important for enabling responsive social change in various respects.

2.5 PRACTICE FIELD CONCLUSIONS

Integrated care can be seen as a reconfiguration of the relationships within healthcare in order to facilitate better, and more effective, healthcare provision. Although this does mean innovation within individual practices, innovation within relationships is largely what characterizes the practice field. These may be relationships between different providers, relationships with those outside of the traditional healthcare system, or the relationships between users and providers of healthcare.

Conflicts within the existing healthcare service across countries, and social values which promote different models of health are both major drivers in the development of the practice field, which have been reflected in policy decisions, in turn driving the growth of the field and defining it as a distinct practice field. Although charismatic leadership is significant, it is not as significant as the institutionalization of innovations which is required for growth and subsequent diffusion, imitation and replication. This is because integrated care requires the cooperation of many partners which cannot be achieved without a degree of institutional support and backing.

The four case studies demonstrate the wide scope of the practice field and the differing degrees of integration that may exist within different contexts. However, they can be seen to be categorized by innovation in relationships, mentioned above, and also an emphasis on people's responsibility for their own health.

The mechanisms of social change that are particularly significant are cooperation, as can be seen from the emphasis on relationships, but also competition, with population-based integrated care innovations only developing in insurance-based contexts with greater competition. Learning is therefore also a significant mechanism of social change as users, providers and external partners all have to have the capacity to reconfigure their ways of working and thinking about healthcare in order to take an integrated approach. Providers in particular may have to take a more generalist approach than they are used to.

One of the main barriers to the development of the practice field is that current systems still favor traditional healthcare models. Integrated care requires different models of funding and support which are difficult to access in current healthcare systems. In addition powerful companies such as pharmaceuticals may have strong opposition to more preventative and less drug-based measures.

3 PRACTICE FIELD C: NEW MODELS OF CARE

3.1 OVERVIEW OF THE PRACTICE FIELD

We define this practice field as: *'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.'* The first round of mapping produced a set of 43 cases with a primary allocation to the New Models of Care Practice Field.

This practice field is a complex one to consider because the practices that bring together cases lie in the process of innovating rather than in the use of a specific model of working. This means that there are high levels of variation in the kinds of innovations that fit within this field. Understandably this is a field which overlaps significantly with other practice fields because so many of these 'new models' are utilising other practices.

The practice field is interesting to some degree because it allows us to explore the ways in which people come to put practices into action in new contexts. This practice field, then, is frequently concerned with the validation of models of providing care to people. However examining this practice field also has significant draw backs, particularly that it is less likely to be recognized as a 'practice' by practitioners in the same way that, for example, 'integrated care' or 'E/M health' are.

This has had an impact on the analytical direction of many of the case studies, which have not offered a great deal of detail on the processes of setting up a 'new model' but rather have focused on the specific 'theme' of the innovation. This has placed a greater weight on the higher level analysis done at the practice field level and this has been a significant challenge. From this perspective this practice field is perhaps less instructive than the others as to the way in which practice fields are constituted.

Never-the-less there are still opportunities to recognize what is necessary in the process of developing a model of care that is entirely new in its context.

3.2 STATE OF THE ART AND CONTEXT ANALYSIS OF THE PRACTICE FIELD

The process of validating models of care is increasingly seen as a priority in a context where health sectors are changing so significantly – in terms of demands dictated by issues like demographic changes and changes in social values and expectations.

There is a focus on introducing new models and new ways of doing things into new contexts. In the UK the phrase 'new models of care' has to some extent taken hold and there are pathways being established within the health sector to enable model testing and validation. The 'New Models of Care' programme has been established in order that organisations or groups can pilot, test and validate new ways of working.

However a clear stream for developing 'new models of care' is not present in every context and even where it is present it is possible that the work would not be easily described with reference to the label. If we look at **Keth'Impilo (South Africa)** for example, we can see a kind of innovative parallel infrastructure set up outside of the health system in order to test and validate new models of care.

Context is incredibly important in this practice field, not least because context determines whether or not something can indeed be described as a 'new model of care'. For example in the case of **Protection (Russia)** or **House of Michele (Italy)** both were examples of trialing models of care that, whilst new in their context, exist in other locations. It is the process of implementing them in these specific contexts that makes this a 'new model of care'.

Unlike in the E/M health field where you can identify specific 'sub-practice fields' which tend to be distinct 'practices within practices' these do tend to be channeled into thematic 'columns' which mirror the original intervention. Due to the close interrelatedness between new models of care and new social needs or demands these columns frequently align with specific social issues being faced. Examples of these 'columns' that can be identified include: Developing new models of residential care (e.g. **House of Michele (Italy)** and **Protection (Russia)**); Developing new models to provide care to older people (e.g. **Voluntary Care for the Elderly (China)** and **Protection (Russia)**); Developing models to deal with strains on a health system (e.g. **Keth'Impilo (South Africa)**)

However it is sometimes possible to identify clear 'sub-practice fields' within this field where people specifically identify with a particular practice or way of doing something. If we look to the **Self-dialysis (Sweden)** case, for example, we can see an example of 'self-management' as a kind of practice within the new models of care field. This case has acted as a model to others

3.3 NEW MODELS OF CARE: PROCESS DYNAMICS AND SOCIAL CHANGE

Despite the fact that this practice field does not have the same degree of 'granularity' that the previous two have it is still the case that many of the dynamics at work in this practice field and the mechanisms of social change are common across the practice field. As such below we consider key dimensions that we have identified as typical of cases within the new models of care practice field and which demonstrate the specific ways in which social change is achieved within this practice field.

Collaboration between actors and leadership

Many of the cases in the new models of care seems to be a practice field are led by 'charismatic leaders'. Cases including **House of Michele (Italy)**, **Self-dialysis (Sweden)**, **Protection (Russia)** and **Keth'Impilo (South Africa)** all define the leadership of key individuals or organisations as being an important driving force in establishing and validating new models. Within the Italian example, particularly, charismatic and trusted leadership was seen as being key to the success of innovations within this practice field because solid and long lasting trust networks are frequently required in order that other actors (e.g. patients and commissioners) feel comfortable enough to engage with the experimentation.

Interestingly this practice field saw far less collaboration with policy makers in the early stage of innovation development than the two other practice fields. Many of these interventions were set up in reaction to a latent or expressed demand from patients or society that was not being filled by state actors.

As such initiators often had to begin the process of innovating alone. This is particularly the case in the **Keth'Impilo (South Africa)** example where the initiative was set up in response to clear demand (the need for new and better models of tackling the HIV/Aids crisis) that was going unmet by government actors who were too constrained by the bureaucracy of the National Department of Health to be able to pilot or test new models themselves.

However in this case as with many others when the model begins to demonstrate its effectiveness collaboration is frequently a success factor in the scaling of impact. **Keth'Impilo (South Africa)** certainly follows this model where a relationship has gradually been built with the department of health such that this initiative serves as an ongoing test bed for initiatives. It was also the case in the examples of **Self-dialysis (Sweden)**, and **Protection (Russia)**, all of which found some level of buy-in after the initiator stage from policy makers either at regional or national level.

Meeting social demands

New models of care are frequently develop in response to social demands. In some cases the demand for these new models is directly expressed by a service-user, for example the case of **Self-dialysis (Sweden)** where the idea for the model came directly from a patient's expressed wish for greater control over care. They can also be directly expressed

by society more broadly. If we look at the case of **Protection (Russia)**, for example, we can see that the drive by the government to begin to look for new models of social care for the elderly was driven in part by a media reaction to a reported social care crisis and a low public opinion of private services.

Demand can also, however, be latent. This is true in the example of **Voluntary Care for the Elderly (China)** the social demand for the initiative has arisen from changes in society that have created a need for this kind of service in order to ensure that elderly people are properly looked after in a context where there are fewer children able or willing to do this for them.

Tensions between old and new

As explored above 'new models of care' are frequently driven by social changes and new demands and they often need to adapt their models in order to suit the new context.

Because this requires new ways of thinking and often exhibits tensions with the established ways of doing things there sometimes can be problems in maintaining or scaling interventions. We can see very different expressions of this in the examples of **Self-dialysis (Sweden)** and **House of Michele (Italy)**. In the Italian case this tension lay in the funding decisions that policy makers made. Whilst the model was validated and whilst policy makers seemed enthusiastic this was not backed up in the way that funding was distributed, instead the decision was taken to fund the existing care models. This demonstrates the difficulty of behavioural change at decision maker level and the way in which new models of care frequently require more than just model validation in order to bring about social change.

In the case of **Self-dialysis (Sweden)** the tensions are less passively exhibited. Whilst the programme has validated the model and has even diffused to be piloted in other countries there has, even in this mature phase, been opposition from healthcare providers. In 2016 it was reported in the media that, in response to the decision by one Swedish regional authority to mainstream the self-dialysis model, many staff members had resigned. Seemingly some care providers including doctors and nurses find the idea behind self-dialysis concerning in that it transfers such a high level of responsibility to the patient. In some cases people appear to believe that it may not be in the best interests of patients and that the motivating factor behind it is not empowerment but is instead cost saving. This demonstrates the extent to which new models of care can frequently challenge the existing norms that are present in health systems and the significant and active opposition that can be faced as a result.

Impact and diffusion

In the new models of care practice field impact and diffusion are not as clear as in other practice fields. That is because the 'practice' in this field is essentially a form of experimentation rather than a particular approach to delivering care. This is important because it reflects how these things are diffused. Whilst many of the project participants and initiators are aware that they are doing something new and may indeed identify with the 'new models of care' label, it can be easier for them to conceptualize impacts and diffusions in terms of models rather than in terms of the practices specific to experimentation.

However, there has been significant diffusion within countries, for example **Protection (Russia)** has continued to develop care homes in different areas based on the original model. Likewise **Self-dialysis (Sweden)** has spread as a practice across Sweden and is a model that is being applied elsewhere. Diffusion, therefore is clear in both directions: innovators look to models elsewhere whilst simultaneously others look to them to inform practices.

However it is important to note that diffusion often occurs by adapting specific models. What is unclear is the extent to which the 'practice' of developing a new model of care- including the practice of prototyping and validating- is being spread. This was frequently not addressed in interview.

3.4 SOCIAL INNOVATION INITIATIVES RELATED TO THE PRACTICE FIELD

3.4.1 Social Geriatric Center “Protection” (ISEDT-RAS)

Description, development of the Social Innovation Initiative

This project established a form of residential care for elderly people within the Russian Federation which provides both health and social care services. This is set up by a social enterprise rather than by the government and looks to improve quality of care for older people. It was inspired by a clear social demand from society for better quality care for older people and was set up in reaction to a social care crisis. This is a new model of care in that it was the first such residential facility within the Russia. As such whilst this model is not new globally it is new within its context.

The journey towards what is now SGC Protection began in 2008, with an idea from the founder Aleksei Anatol'evich Mavrin. Inspired by his participation in volunteer services for elderly people around the celebration of the Victory Day, he created and took over the company “Always Near” which was engaged in the provision of services to senior citizens, using his personal funds as start-up capital. In 2009, the first boarding house for elderly people was opened (The first care home for elderly people in Russia). In April 2011, “Always Near” was transformed into the Social Geriatric Centre “Protection”.

SGC “Protection” was created as an independent social enterprise. The main motive for the project’s establishment was the desire to solve the acute problem of medical and social care for elderly people which exists in Russia.

In subsequent years, the project has grown steadily: its territorial coverage was expanded and new care homes were opened. The project’s expansion was supported by a grant from the “Our Future Fund”. In 2013, Aleksei Mavrin became the winner of the contest “Social Entrepreneur”, receiving an interest-free 5-year loan. This money was used for opening a new boarding house “Gorodskoy” the first boarding house in Saint Petersburg in March 2014, the first boarding house in the city. Before that, all care homes were located in the Leningrad Oblast.

In 2015, Aleksei became the winner of the contest for the second time. This made it possible to open a care home in Moscow in 2016. “Protection” currently has 8 care homes: 3 are located within the city of Saint Petersburg, 4 – within the limits of the Leningrad Oblast, and 1 in Moscow.

In 2015, on the basis of boarding house “Admiralteisky”, the Northwestern training centre “Protection” was established for new staff the staff already on board. The Centre provides further staff training and development. So far, more than 50 employees have already been trained.

In 2016, the project’s team was actively engaged in the development of the franchise. It is expected that it will make it possible to open care homes in other regions of the Russian Federation.

Actors, partnerships, alliances, networks

The project has been driven by one individual, Aleksey Anatol'evich Mavrin, who is the founder and project supervisor responsible for managing the affairs of the organization. Initially the project was created as an independent social-enterprise. Mavrin, opened Russia’s first residential care home for elderly people at his own expense. The main motive for the project’s establishment was the desire to solve the acute problem of medical and social care for elderly people, which exist in Russia. Importantly there was little collaboration at this stage of initiation. SGC “Protection” became member of international and Russian associations of social service providers, and acquired partners among private companies. In 2011, the project gained support federal, regional and municipal authorities.

After the project began to demonstrate positive results the public showed trust in the company’s services, as a result systematic contacts were established with government authorities.

Since development the project has built relationships with a number of other actors within the social care field. This includes a broad range of services, professional bodies and research institutions who have been used to improve capacities within the residential homes but also build a network with whom to collaborate to improve care to older people. This has been made possible by the initial successes of the project and through clear outreach by the initiators. These partnerships have served the purpose of more fully integrating the Protection model into social service infrastructure and improving the quality of the services provided.

Innovative solution

The solution is innovative because it is the first residential facility of its kind in Russia, it was developed with the aim that, upon demonstrating success, it would be integrated into the wider health services. In this sense this represents a successful service innovation, providing a new, more effective, form of care to people. However there are system innovations that are also embedded in this innovation. For example the new care model required that there also be a new innovative approach to training staff. The residential facility required specialist staff and therefore a new training system was developed within one of the residential facilities. This also required cooperation and with a number of scientific organisations including: the Association of Gerontology of the Russian Academy of Sciences; the St. Petersburg Institute of Bioregulation; and Gerontology of North-Western Branch of the Russian Academy of the Medical Sciences.

Gaining momentum

The timeline of the solution can be conceived of as:

2008	Opening of the company "Always Near"
2009	Opening of the first care home
2011	„Always Near“ is transformed into Social Geriatric Center (hereinafter SGC) "Protection".
2012	Opening of care home "Yuzhny"
	There were 5 care homes located in the Leningrad Oblast: "Istochnik", "Evropeiski-1", "Evropeiski-2", "Domashni" and "Yuzhni"
2013	Grant from the Fund "Our Future"
	Opening of care home "Gorodskoi" in Saint Petersburg
2014	Participation of the project's founder in amending Federal Law 442 on the provision of social services to Russian citizens
2015	Grant from the Fund "Our Future"
	Establishment of the Northwestern training center „Protection“ on the basis of care home „Admiralteiski“ for new staff and the staff already on board.
2016	Opening of a care home in Moscow
	Development of a franchise

Innovation strategy: The organization was originally highly dependent on the resources of the founder. Using these they focused on retaining market leadership by delivering the high quality services. Customers' confidence in the company was valued as of high importance. Therefore, SGC "Protection" considered the overcoming of negative stereotypes about old age existing in Russia as its main task. There are two ways which can be marked out in the decision of this task: cooperation with the media and direct maintaining of high quality services.

Role of competition: When SGC "Protection" started its activities, market services for the elderly in the North-West Federal District were still underdeveloped. Later there emerged businesses offering their services for elderly care. But their quality was significantly inferior to those offered by SGC "Protection". The project has maintained a competitive

advantage over competitors through the licensing agreements that they hold to provide medical services in addition to the social ones. Among the competitors there are very few companies that could offer a similar range of services.

Drivers: At first, there was no assistance neither from the state nor from loan institutions – everything was based on enthusiasm. The founder's personal involvement, his enthusiasm, idea and the ability to captivate with this idea. Among the keys to success the project manager's enthusiasm can be distinguished, his initiative and ability to communicate with the partners and the authorities. Secondly, this is the financial support from the Fund "Our Future" due to which it became possible to expand the project's geographical coverage. Thirdly, it is careful personnel selection eliminating the risk of poor-quality care to the clients. Fourthly, it is a system of personnel continuous training based on the transfer of experience from the beginners to the more experienced staff and the collaboration with research organizations.

Barriers: A barrier to the project development consisted in the lack of customers' understanding of what product they are offered (mental barriers). Many thought that boarding houses were conventional nursing homes widespread in Russia (similar to state-owned ones). But in fact, care homes of SGC "Protection" can be called hospitals for people with dementia – they provide assistance to people who have lost independent living skills. Clients are provided not only medical, but also household assistance (hygiene, walking, everyday life, leisure). It means it is an absolutely new type of accommodation for the elderly in our country. The project also faced the problem of providing quality care. Quality care can be organized only in a specially designed building that meets all sanitary and building standards.

Complementary innovation

This is an innovation that requires little in the way of complementary innovation. However training centres have been developed as part of the project in order to upskill staff who have little experience of providing this form of care.

Impact, diffusion and imitation

By the present moment more than 1,000 people used the services delivered by the assisted living residence of SGC "Protection". Business Profitability of the project is 25%. Project's self-sufficiency took 2 years. Presence region includes North-Western Federal District (St. Petersburg and the nearest suburbs), Moscow. According to the number of beds the company occupies 30% of the Leningrad region's market and is the largest in Russia (according to the data of 2013).

The organization has earned public recognition, it was awarded for winning at national and international competitions and the involvement of the founder in the draft of the new Federal Law № 442-FZ "On the basis of social services to citizens in the Russian Federation" is a clear impact of this project.

This project has seen significant diffusion across the Russian Federation. The project was designed with diffusion as a primary aim. The main difficulty while expanding the project's territorial scope is to manage the new regional branches. Therefore, when the project management set a goal to expand the representation in the regions, in the creation of the franchise has been chosen as an instrument. However there were significant risks relating to quality control and reputation by adopting this model. This led to a rigorous process of quality control.

Role of policy

The market of social services in which the organization began operating was underdeveloped in terms of joining of non-state actors. There are a lot of reasons for that. On the one hand, the legislation has for a long time limited market entry for non-state actors. Such companies could only rely on their own strength and on a good relationship with the clients. The state could support a private organization only if it won a contest. But not all regions announced contests and not all non-state organizations were able to participate in them – many of them simply lacked sufficient material base. The new law on social services must change this situation for the better. SGC "Protection" is one of the

few organizations which managed to enter the market even under the old law. At first, everything was based only on the enthusiasm of the team members who invested their own efforts and resources and provided high-quality services. The new law is based on the principle “a person chooses whether to pay or not” – people can choose a state or non-state organization most appropriate to them. If a person is recognized to be needy, his program is financed from the budget of the subject of the Russian Federation, whether the service provider is a state or a non-state organization. And that is when it all depends on the organization, the range and quality of its services. It depends on the social care service organization, the range and the quality of its services.

The Government demonstrated an interest in listening to the expertise developed by this innovation. In 2014, Aleksey Mavrin was part of the working group on the drafting of a new Federal law on social service for the population. The law is based on the principle of social service provision: “a person chooses whether to pay or not”. This approach implies that a person is given a choice whether to receive services in a public institution or in a private company. If a citizen has the right to use free social services, part of a private company’s social service cost is paid from public funds.

In 2015 a new Social Security Act was put in force and social care services offered by non-state social enterprises are partly financed from the state budget. As of January 2014, according to the regulatory filings of the Ministry of Labour of the Russian Federation, the number of non-state organizations involved in providing or organizing social care services was estimated at 78. It amounts to 1.1 % of the total number of social service establishments.

This innovation, then went from a process of operating in quite a negative policy environment to helping to forge a better one by providing validation for a model of care that is more effective and better quality.

Connectivity to the practice field

This innovation very clearly fits into the new models of care practice field. Whilst the model of care implemented in this example is not new globally it is clearly new in its context and arises very specifically from an expressed societal demand- in this case a crisis of social care that was covered extensively in the media. This was the first such residential facility within the Russia. Importantly the case is both a continuation of the new model of care practice field and also has contributed to the trialing of similar projects in the rest of Russia. As such it can be seen as having contributed to the ‘new models of care’ practice field within the specific ‘column’ of ‘developing models of residential care’.

3.4.2 Keth’Impilo (UCT)

Description, development of the Social Innovation Initiative

Keth’Impilo is an unusual innovation in that it is an organisation that was set up in order to tackle the HIV/Aids crisis by operating in parallel to the wider health system in order to develop and trial new ways of providing healthcare. In this sense is it both a systemic innovation which seeks to find new pathways to improve care and validate models. It also is an innovating organisation which attempts to put in place new programmes which will help to tackle HIV/Aids. It specifically specialises in solution development and implementation for health and community systems and services strengthening in marginalized communities.

Despite South Africa managing to secure more than a 50% reduction in the prices for ARV’s there is still a significant funding gap as external funders have reduced their funding over the years as their priorities and strategies have changed.

Health services in South Africa are often under-resourced, so Keth’Impilo seeks to support the South African public health system by trialling programmes that otherwise would not be given an opportunity to succeed. In this way the organisation circumvents the considerable bureaucracy of the South African health system and can more quickly

demonstrate the worth of initiatives. In addition they seek to improve systems, processes and services is welcomed, at least on a national level. Over the past decade KI has developed a range of training programmes, as part of this work.

Actors, partnerships, alliances, networks

Keth'Impilo was developed by Dr. Grimwood, who felt a personal mission to help tackle HIV/Aids after seeing so many people die of the disease. In this sense he can be viewed as a practitioner innovator. He already has good relationships within the sector, and with the financial backing of the investment firm he had been working for, Keth'Impilo was developed. The investment firm provided the financial resources that Dr. Grimwood needed to establish Keth'Impilo. They also gave him the opportunity and freedom within his role in the business to identify the gap that KI was established to fulfil.

The purpose of KI was to work alongside the NDoH and other departments within the South African Government to use innovation to increase their capacity and the quality of services. As such, the South African Government was always going to be a key partner of KI.

The choice of which department, and at which level - national, provincial, local or community - depends on the design of the project, and where the project is to be rolled out.

Other partners, such as funders or corporates, are chosen based on their interest in implementing projects Keth'Impilo are designing, or in other cases it may be the funder or corporate who approach the organisation with an idea for a project they would like to work on. It has been found that these relationships are of considerable importance to the success of the separate programmes of work and therefore are very important to the wider success of Keth'Impilo.

Innovative solution

Keth'Impilo can be seen as a organisational innovation in a sense because it was essentially conceived of as a complement to the existing health services. Looking to pilot projects, learn from them and feed that learning to the National Department of Health for them to incorporate into the wider health system.

Monitoring and evaluation processes are built into all of KI's projects and the programmes are constantly adapted and changed in line with what they are learning from the data they collect. A level up, at the project design level, new projects are designed to fill gaps that have been identified by staff and patients, and from the data collected.

In addition the projects developed by Keth'Impilo are innovative. Keth'Impilo's Strengthening Programme brings innovative processes to back-end services such as HR or administration. The Learnerships programmes bring an innovative solution to issues of capacity in local clinics. And the MARPs project innovates by bringing services to the potential patients, rather than expecting them to come into the clinics, as well strengthening referral systems through process innovation.

Gaining momentum

KI had a relatively secure start in terms of their funding. Their strategy had been well planned and Dr Grimwood's experience, as well as that of the team he has gathered around him, has been fundamental in ensuring their success. The significant leadership of Dr.Grimwood can also be seen as having been very important to the success of the organisation.

Dr Grimwood attributes the initial growth of KI and its programmes to the convergence and evolution of ideas from staff. Keth'Impilo staff have stated that their greatest challenge in implementing the programme has been handling the legal framework with which the programme must comply. Provincial Departments of Health initially resisted the programme, but gradually became accustomed and now value what graduates provide. The organisation has found

that there is usually a cycle of acceptance with all their innovations as in each case they need to enter into an established institution with new ideas to implement.

Comprehensive monitoring and evaluating of the project is seen as a key success factors in Keth'Impilo's work. Without it they would not be able to give a comprehensive picture of the impact that each project is having. As their projects get more complex so does their monitoring.

Complementary innovation

There has frequently been a need for public health staff who are impacted in some way in the project to buy into it. Projects such as the Health Strengthening Project, looking at back-end processes, will require buy-in from staff in the different departments - enough to engage with the changes and what is required of them. Therefore the complementary innovation that is required can be considered to be the understanding among institutional actors of the value of the piloting. For some of the projects public health sector staff may have to develop new skills, such as using a computer, or other technical skills. For others involved in different projects, a change of mindset is required - such as a willingness to adhere to drug schedules to maintain their health or to attend clinics regularly.

Impact, diffusion and imitation

At the project level there has been a deliberate effort to stimulate diffusion of knowledge, particularly in two areas. One is in the academic medical field through publishing their results in academic, peer-reviewed journals. The other is through personal relationships in the various departments of the Department of Health, both nationally, provincially and locally. The ultimate aim for each project is that, if it proves successful, the National Department of Health adopt it as their own policy. While the project is being implemented it aides KI's cause to use their relationships and networks to promote what they are working on.

However Keth'Impilo does not need to diffuse as an organisation because their focus is on building knowledge and transferring it, with the hope that programmes will be taken up by the National Department of Health.

Role of policy

The difficult policy environment for health and social care innovation has been one of the key drivers of this innovation. The high level of bureaucracy created the social need- and therefore demand- for a system to be created which could effectively experiment from outside of the health system. The process of validation is one that has not been enabled by the department of health but which is clearly seen as valuable by them. This is demonstrated by the positive relationship that Keth'Impilo enjoys with the department.

Interestingly the model that has been developed has come about specifically because of the lack of effective innovation policy in this context and can be seen as a kind of 'work around' system. In this sense this innovation exists because innovation at large is so hindered.

Connectivity to the practice field

This case does not fit easily into the new models of care practice field in part because it is a model for trialling new models of care and therefore can as easily be viewed as an innovation intermediary rather than an innovation itself. Indeed the programmes that Keth'Impilo develops could just as easily fit into this practice field.

However Keth'Impilo can also be seen as a new model in and of itself. It is an innovation that has developed a new way of promoting capacity within the health system by producing a new kind of actor. It works on the relationships between the patients and the NDOH by providing a new route for health providers to meet their end-user. This in turn has an impact of promoting the more efficient and effective delivery of services.

The case is very clearly contributing to the practice field in its role as an intermediary. In this way they are consistently developing and trialling new models of care and developing an understanding of what is needed in order to do this effectively, for example, their understanding of impact measurement and its importance has been a significant development in this field. Through publishing in peer-reviewed journals they have been able to spread their knowledge and experience more widely.

3.4.3 House of Michele (LAMA)

Description, development of the Social Innovation Initiative

Casa di Michele (CdM) is a project implemented by the Cooperative Koinè. It is a residential facility for 12 elderly persons, integrating the residential and home-based health care services offered by the health district. The key goal of this experimental project is to validate the effectiveness of a new type of residential service, which offers temporary hospitality (between seven and ninety days) for “frail elders” with moderate care needs.

Besides temporary hospitality, the attention to the social and relational dimension provided in CdM represents the core innovation of the project. The design of the facility recreates a familiar and comfortable environment in which elders reduce their social isolation while receiving the care they need.

CdM also aims to foster and integrate local public health towards more patient services and home-care. The service provided by CdM is fully integrated with the local system of health and social services, which can offer as a public service 5 of the 12 available beds in the facility.

The project has three specific goals:

- To strengthen home care services for elders through the implementation of an integrated offer of temporary residential services, which aims to help families during acute phases of need or for reducing the stress of caregivers with temporary relief period;
- To reduce the waiting time list to access to the more traditional nursing home equipped for intensive health care assistance (RSA);
- To realize and validate an innovative care service for older people, which combines appropriate responses for elders’ social and health care needs, with a rational use of public and private resources.

The small dimension of the facility, the high level of connection with the neighbourhood, the familiar environment inside the facility and the connection with the public local domiciliary service are all elements in realising these goals.

The project developed in a context of a high dependency ratio of older people in the District (39:2) and of limited public resources due to budget constraints. It is part of a broader strategy that Koinè has developed to deal with the impact of these challenges.

The project started in 2009 and is still underway. In 2012, the project scaled up and from being a local experience and was formally awarded the status of “regional experimentation” (by Regional Decree n.237/12). This led to the formal recognition of a new typology of services that did not exist before in the regional legal framework. The regional experimentations status will end in March 2017.

Actors, partnerships, alliances, networks

The project was originally set up by a network of three key actors: **Koinè**, a social cooperative which aims to improve the wellbeing of people, families, and communities by providing health and social care services, and realizing educational and empowerment projects; **Usl 8 Arezzo**, the local public health authority responsible for providing public health services to the citizens living in the area of the Province of Arezzo; and **Conferenza Zonale dei Sindaci**

(CZS), the local conference of the mayors of Arezzo district, involved in the programming and implementation of local health and social care services.

Koinè was the main responsible and leading partner of this project. It carried out all the stages of the project, from early ideation to the current management of the service. CdM is one of 70 projects/services delivered by Koinè in the district. The Usl 8 cooperates with Koinè, providing technical support for the implementation and dissemination. One year after the official opening of the facility, Usl 8 formally included Casa di Michele in their offer of care services (Accreditamento). Koinè and Usl 8 have a formal arrangement for using 8 places, out of the 12 available in the facility, as public service. Finally, the project was included in the public offer of health and social services since the very beginning, thanks to the arrangement with the CZS. The Conference also supported Koinè with technical support in the ideation, implementation and dissemination phases.

Additional partners include:

- *Fondazione Ente Cassa di Risparmio di Firenze*: a banking foundation which supported the project, providing a grant of 200K. This money was used to purchase and realize the facility where CdM is located.
- *ARCI (Italian Recreational and Cultural Association)*: provides two full time volunteers for 60 hours per week of recreational activities. These two people are part of the Italian Voluntary Service.
- *Centro Basaglia*: a centre for health promotion, participates in the ongoing evaluation of CDM and in the dissemination of the project.
- *Tuscany Region*: who were involved in order to get the status of “regional experimentation”, and to be fully part of the regional offer of health and social services.

Trust networks have been pivotal in the development of the initiative. Thanks to thirteen years of daily work in the community, Koinè has earned the trust of institutional partners, health and social care authorities, actors of civil society and third sector. This high reputation allows Koinè to develop innovative services, such as Casa di Michele, being trustworthy with public authorities and final users. This trust network also helps Koinè in getting the support of others local organizations in implementing and improving innovative services.

Innovative solution

Casa di Michele (CdM) is an innovative service which integrates the offer of health and social care in the area of Arezzo. CdM is innovative in terms of both, type of service provided (temporary residential service), and approach of care (the integration of health and social care). CdM provides temporary residential care in a small facility taking in account the relational and social aspects of their patients. The facility is designed to be, as much as possible, a “normal” family house. Indeed, medical and therapy equipment are incorporated inside commercial furniture (to reproduce a domestic environment) while, in the living room, the personnel foster social interactions among residents to reduce social exclusion and cognitive decay.

In terms of systemic innovation, Casa di Michele is designed to be a filter between home care services and residential care services. This represents a systemic innovation because it introduces a new level of care in the public offer of care services which supports care givers and home care services reducing institutionalization and improving the quality of care.

Gaining momentum

The ideation of Casa di Michele (CdM) came about after the approval of the Regional Fund for non-autonomy and Long Term Care of Tuscany Region (L.R. 66/2008). This regional law formally fosters the adoption of integrated home care services, providing the legal framework for innovative projects such as CdM. However, the key facets of CdM, such as small size of facilities and high attention to relational and social dimension, origins from the values and the practices that Koinè has developed over time. In this perspective, the evolution of CdM is the result of evaluation and adjustment process.

The managerial and organizational skills, which have been developed by Koinè in its long-lasting experience, represent crucial factors for the success, the development and the sustainability of CdM. For example, since the beginning, CdM has produced financial losses, which have been gradually reduced through adjustment processes; these losses continue, but are accepted by Koiné, being consistent with the “political” and managerial choice to set the price of the service under the marginal cost. This decision was made in order to make CdM accessible for private market users and to foster this innovative service, while proving its effectiveness in providing high standard care support.

The financial losses of CdM are covered by the surplus generated by the other project/services provided by Koinè. Therefore, a solid managerial and organizational structure is needed to ensure the sustainability of this project in absence of public resources, which are the main barrier to its growth.

Over time CdM has progressively increased the number of services provided to elders hosted in the facility. Besides social and relational activities, CdM now includes a small gym for rehabilitation therapies and a room in which a hairdresser provide her services in order to improve the well-being of elders living in the facility). Moreover, CdM has recently added two more rooms (three more beds) that are used to provide a more traditional residential services with intense health care assistance (RSA).

It remains unclear how will evolve the project after the end of the regional experimentation in 2017.

Complementary innovation

In order to foster this innovative service, one of the main complementary innovations required would be around the appropriate allocation of public resources. These resources might be found with a redistribution of budget resources among regional care services. Indeed, a reduction of resources allocated to traditional residential facilities can be useful in order to concretely re-orient the paradigm of care services towards integrated and home care services. Additional resource for integrated and home care services can also be used to cover part of the price that families have to pay to access to these services.

Moreover, the development of better integrated and home care services from regional and local health authorities can improve the effectiveness of Casa di Michele in connecting and filtering users access to traditional residential care services and home care services.

No specific complementary innovations are required on the part of users. However, a shift in families' attitude towards health insurances might improve users' access to innovative care services. Likewise, the staff of Casa di Michele did not need any specific technical skills in addition to the normal skills used in providing care services for elders. However, the staff they are required to have relational and communication capacity in order to establish an active dialogue with users based on respect and cooperation.

Absorptive capacity has been a crucial aspect for the success of the initiative. Casa di Michele integrates the knowledge of former projects and services provided by Koinè in its long-lasting experience. Moreover, CdM is subject to adjustment processes that result from evaluation and monitoring activities that were organized by the cooperative. Thanks to these adjustment processes it has been possible to reduce the financial losses of the project and to develop additional services provided in the facility of Casa di Michele.

Impact, diffusion and imitation

According to the vision of Koinè, the success of innovative services depends on how many goals and objectives are reached during the project. The final goal of CdM is to validate the effectiveness of a new model of care. In this respect, Koinè considers CdM a full success. Indeed, CdM has proven to be extremely centred on the needs of both elders and caregivers. Moreover, the project demonstrates to be even more effective than traditional services to tackle

specific need, such as the treatment and rehabilitation of elders who have just been discharged from hospitals after femur or hip fractures.

With this project, Koinè is sure to have demonstrated that humanising health and social care services is possible. Moreover, this humanisation of care services has been proved to be feasible in absence of public funding under specific circumstances.

The diffusion and replicability of this project is highly desirable, both in terms of effectiveness of care and users' satisfaction. The high value of this project was proved when Casa di Michele became a Regional Experimentation of new model of care. Nonetheless, some aspects, such as the lack of public resources and the cost structure of the project, lower the chances of diffusion of this social innovation.

Another barrier to the diffusion of the project might be represented by the business model and the price strategy of Casa di Michele. Overcoming these barriers without public resources requires that organizations that are replicating the project can rely on a developed private market of care services or on a solid structure of complementary services that are provided into the public services and that cover the financial losses of the innovative project.

Role of policy

Dealing with health and social services, it is almost inevitable that policy actors play a role in the creation, diffusion and adoption of new innovative services. Indeed, regional policy makers can enact strategic documents and, to some extent, modify the legal framework of health and social services. Therefore, policy actors can determine many crucial aspects of all health and social services such as: quality standards, priority and strategic services, new areas of care to be developed, and budget allocation among care services.

Despite the positive legal framework that promotes the adoption of integrated and home care services, over the duration of CdM, policy makers have not succeeded in allocating appropriate resources to foster a full implementation of these services. This fact is due to the prominent role of traditional residential services which require big investments and can rely on well-structured companies with high "lobbying power".

Moreover, Tuscany Region does not have a well-developed evaluating system to evaluate all these new innovative services. Without an evaluating system, regional policy makers are not able to determine whether an experimentation was successful or not. As a result, many successful experimentations were not implemented and replicated at regional level. This situation is due to lack of both financial resource and appropriate skills.

In terms of policy framework, the approval of Regional Fund for non-autonomy and Long Term Care of Tuscany Region (L.R. 66/2008) has triggered the ideation and subsequent realization of the project Casa di Michele.

Moreover, the project was included among the regional experimentations for innovative services (with the Regional Decree n.237/12) as regulated in the Regional Law 41/2005, titled "Integrated system of actions and services for social rights protection", and the resolution of Regional Council n.113/2007 (point 3.3.1).

However, despite a favourable normative framework for integrated and home care services, regional policy makers keep allocating the main part of regional health and social care budget to traditional residential services. As a result, the public offer of integrated and domiciliary care services suffers of lack of resources.

Connectivity to the practice field

The House of Michele is a clear example of a new model of care and it bears many of the hallmarks of it. It was developed specifically in order to validate a model of integrated residential care in order to try and change the way that services are delivered. Their experimental status has been solidified by their formal award of the 'regional

experimentation' position which offered it a specific legal status that was enabling. In this way, like many 'new models' examples, diffusion and social change is its aim.

Also like other 'new models of care' it developed as a response to latent social demands: a high level of older people in need of care combined with budget constraints.

Whilst changes to policy frameworks may have enabled it's the progress House of Michele has been hindered by a lack of government funding. House of Michele has had little direct diffusion within Italy or elsewhere and therefore it is difficult to understand how much they have helped to constitute the practice field. Whilst the innovation is looking to change this it is interesting to note in this example the way in which putting in place nurturing policy frameworks is not always all that is necessary. Active government 'buy-in' is often required in order to institutionalise a new model of care.

3.4.4 Voluntary Care for Elderly People (ZU)

Description, development of the Social Innovation Initiative

Voluntary Care for Elderly People developed in direct response to the changing situation for older people in China, including a rapidly ageing population and societal changes meaning that children can often no longer take full responsibility for parents or older family members.

The initiative aimed to develop an informal system of care through organising voluntary activities, including routine, chats, haircuts, general maintenance and entertainment. During festivals and national days of celebration the volunteers also organise cultural performances and events.

The initiative was initiated in 1996 and up to now has attracted over 100,000 volunteers or more than 500,000 hours of service delivery. The team has more than 100 volunteers with a long-term association with the organisation.

Timeline of the innovation

1995	The volunteer organisation 'Hangzhou Association of Volunteers' and the 'Hangzhou Association of Young Volunteers' were established.
1996	A group of volunteers specifically for elderly care service was established inside this association.
1999	The group was renamed as the Specific Team of Young Volunteers for Respecting the Elderly and started their activities under the aim 'entering the welfare institutes'.
2003	The organisation produced a regulation of voluntary services in Hangzhou.
2004	The General Association of Volunteers for Respecting Elderly in Hangzhou was set up.

Actors, partnerships, alliances, networks

The specific initiative emerged out of a wide informal organisation focusing on voluntary work with elderly people founded by Mr Chen Ping. For the last 11 years Ms. Tang Hong has been in charge of the programme motivated by a strong compassion for the elderly. The initiative is sustained by the large team of members and volunteers, with members meeting once a month for information exchange, and to discuss organisational and management issues.

The voluntary team work in a number of elderly homes for delivering their services with the involvement of various communities and welfare organisations for elderly care. These associated organisations provided the space and facilities for conducting activities, providing training to volunteers, and communicating the idea of voluntary work to

broader segments of society. Building relationships with partners, therefore, is a core element in the functioning of the initiative.

Innovative solution

The programme has developed within a cultural tradition which encourages volunteering and care for the elderly. The programme focuses on a) strengthening volunteer services; and b) Maintaining and strengthening relationships with partners. It aims to be innovative in two ways:

- Broadening the array of services offered to elderly people including provision of food, visiting, maintenance and organization of cultural activities.
- Dividing the voluntary team according to skills and capacity to make the delivery of voluntary services more specific.

In addition the organisation has collaborated with other groups to offer activities outside of their remit, such as poor relief, responding to specific needs.

Gaining momentum

The innovation actively sought institutionalisation from the beginning, evolving from a voluntary group to a branch of the voluntary association, under the supervision of the semi-official agent of the Youth League in Hangzhou. This was the central strategy for organisational development and the recognition of the project by the government made it easier to access government resources.

In addition, the relationship with the partner organisations is central to both impact and growth, ensuring the availability of staff and resources for the development of the project. Finally, the relationship with the media is also important, driving support for the project.

Complementary innovation

The innovation is mainly focused on the changing care needs of elderly people. Complementary innovation is required in adjusting this strategy to reorient elderly care to a more holistic perspective.

Impact, diffusion and imitation

The programme has seen success through the receipt of awards, including 'the advanced collectives of the service sector in Zhejiang Province' (2004) and 'the advanced collectives of the service sector in China (2005). Also gaining popular support through news reports. However, over time the operation of the project has seen a decline, for example in the number of volunteers.

The expected aims have largely been achieved, however there is limited diffusion due to the large demands which are placed upon volunteers, and the challenges of organising voluntary sectors.

Role of policy

The programme has received support from policy, particularly at a regional level. The role of policy has primarily been to support the organisation on normative requirements such as quality assessment and financial support.

In 2003, the Hangzhou city volunteers service issued guidance for the standardisation of service corps volunteer association activities. This had a positive significance for the management and to incentivise volunteers. It also provided guidance for the security aspects of the programme.

Connectivity to the practice field

As is often the case in this practice field this new model of care is a way of addressing a clear social demand. In this case the need to care for elderly people, which is currently a key policy challenge in China.

This case looks to validate a new model of care which sees services provided to elderly people by utilising the actions of volunteers. The model itself is clearly informed by a number of practices including volunteer care provision but it is difficult to understand exactly how they have been influenced by other programmes. The project has clearly found diffusion difficult, in part because of the difficulty retaining volunteers. This has clearly posed problems both for diffusion and scaling.

As with many new models of care where there is a lack of ability to scale the extent to which the project has contributed to the constituting of the practice field is difficult to determine.

3.4.5 Self-Dialysis (IKED)

Description, development of the Social Innovation Initiative

Self-dialysis is an innovation that aims for patient self-management of their own treatment with only minimal support from health personnel in the form of introduction and general support. The solution further integrates training, organisational and management changes with the shift towards patient engagement, empowerment and responsibility.

The innovation sought to address the following needs:

- Unmet demand by patients to receive better care and demand for a more active role in their own healthcare;
- Need to empower patients and reduce healthcare costs;
- Desire to achieve a more patient-centric care and to tailor services to patient's needs

The project was initiated in 2005 on the request of a patient. After being made aware of the possibility of self-treatment, patient-demand for the service grew. In addition, other benefits became apparent such as better use of time, higher activity level, cost savings and growth in patient's self-confidence. The idea became institutionalised within the hospital with the support of outside bodies and, in 2011, a dedicated centre for Self-dialysis treatment was opened at the main hospital in Ryhov, which now employs 20 employees, most of them nurses.

The programme is presently in a stage of mature application and continues to diffuse to new hospitals as well as evolve as a new form of health care application. However, some newspaper reports suggest that the activity may be transferred back to the main hospital.

Actors, partnerships, alliances, networks

The project was initiated by a patient in the county of Jönköping in South Sweden, who asked the health personnel if he could try to conduct the treatment procedure himself rather than nurses or doctors who normally carry out dialysis treatment. The nurse responded positively to the request and also took the idea to other colleagues, including management, who supported the idea.

Qulturum, a body for the development of medical care and quality assurance in the county of Jönköping, became aware of the initiative through connections with the nurses at the hospital and, on making assurances around safety, began a development strategy for the programme, including training nurses and developing procedures for self-dialysis. Through their engagement, it has been introduced to wider networks of health personnel and other hospitals,

in Sweden as well as abroad, and served as a tool to illustrate the need for new training and approaches at all levels of the care system.

The regional health authority, Region Jönköping, took responsibility for institutionalizing the initiative, within the remit of Ryhov Regional Hospital but framed as a separate centre.

Innovative solution

The principle of the innovative solution is that patients are empowered to take care of their treatment themselves, making use of state-of-the-art equipment for dialysis at the hospital with minimum intervention from medical personnel, although they are available if needed. By having access to the department at the hospital, patients may go for the treatment 24 hours/day. They can therefore plan the treatments based on their own work schedule, family activities and own activities. They often assist each other and empower each other in a friendly, family-oriented way.

Self-dialysis shifted from an isolated act of patient engagement to a model for integrated care, entailing reorganisation, retraining, organisational change and impetus for moving personnel and management broadly towards greater receptiveness to patient empowerment. The case claims openness in attitude, trust between professionals and patients, close cooperation on all levels, consecutive evaluations and adaption to test in a climate where you are permitted to fail.

The project relies on high trust on all levels. New way of organizing, reliance on the ability of the patient and limited professional service as well as the provision of technological equipment used by multiple patients themselves. The approach in its entirety amounts to a system of its own, which is run in an inclusive way where the treatment procedure works differently compared to conventional care.

Gaining momentum

The original initiative was unplanned and spontaneous. The idea was put in action in the space of just a few months, with progress mainly the result of an open attitude on the part of the individuals that were involved. With the involvement of Qulturum, the evolution became controlled, evaluated and marked by systematic improvement. Patients played a role in shaping the way forward at all stages of the operation, while managers and those involved in higher level decisions became engaged, informed and affected as well.

The development of the initiative has, to a large extent, been driven by patient demand, alongside a change in the routines of health personnel. Self-dialysis is less time-demanding on doctors and nurses, freeing them up to concentrate their time elsewhere.

The further development and diffusion became possible with the involvement of Qulturum who provided institutional support and were able to build awareness and support the model at senior management level. They could also provide quality assurance which aided growth across the region and elsewhere.

This social innovation serves as an influential precedent paving the way for a new model of care in dialysis treatment, as well as with holding implications for the management of care systems. It stands as a powerful show case for diverse medical disciplines, how to integrate patients more effectively in preventive programmes and treatment and also to attain buy-in among multiple stakeholders with such an approach.

Complementary innovation

Complementary innovation is essential to the success of the programme, both within the healthcare system and for patients themselves.

In healthcare institutions, willingness to listen and cooperate with patients as well as to accept organisational change and engage in patient-centric training is required.

Likewise, patients have to be able to learn more actively about their illness, problems to observe, procedures for treatment, how to live with the sickness and the best and most efficient way to improve their health and prepare for a kidney transplant in due time.

The technology did not have to particularly be adapted to allow for patient-led care but rather learning how to use the existing technology correctly was an essential element of the programme.

Impact, diffusion and imitation

Although success was not defined in the beginning of the initiative, patient feedback has shown that the solution has served to improve patients' life situation, enhance their awareness and motivation and allow for more tailored and thus better treatment. Results also demonstrate that patients are helped returning to a normal health status, enabling them to carry out their daily routines with greater ease.

The personnel who have supported the patients worked with the ambition that 75% of all patients who need dialysis shall be able to make the transition to self-dialysis. Over these approximately 10 years this ambition has been realised.

Diffusion of the innovation is seen as highly desirable and feasible given the impact of the innovation. Part of the institutional response, therefore has been to promote diffusion. In this, Qulturum have been influential, conveying trust in the model and supporting mutual learning and competence development.

Attention has been paid to the model at conferences arranged at hospitals and patients and personnel have been giving lectures at hospitals around Sweden as well as abroad. One patient has taken on a paid role at the hospital supporting new patients as they undertake self-dialysis as well as being responsible for patient-centred questions in the wider region.

Following the consolidation of the practice in Jönköping, the method was taken up by other hospitals in other parts of Sweden, as well as abroad (For example Waco/ Texas (USA) and York (UK)). Diffusion and imitation was aided by the systematic evaluation and consistently positive results. It was also facilitated by the relative user-friendliness of the technology and equipment.

Role of policy

The initiative developed within an overarching policy environment which encouraged increased patient engagement and empowerment, and shifting care out of hospitals, towards primary and preventative care. This policy included the concept of 'chains of care' which relies on preparedness to address patient needs and make active use of evidence-based care pathways. The opening of policy for the provision of care by a variety of providers, through a multi-disciplinary team approach, helped cross traditional boundaries between providers.

The availability of funding based on principles that are similar across the country, although different county councils across Sweden means that councils are able to experiment with new methods and thus to implement methods in different ways which are in sync with their local geographies. A key element of the reform programme in Jönköping was the recognition of cultural change as a major driver to move from a provider-centred to a patient-centred approach. A multi-disciplinary team composed of physicians, nurses, social workers and other local providers and professionals was set up to support innovation and the diffusion and uptake of new practices.

There is also the influence of a national discussion and movement pushing for health care specialists to be more responsive to patient needs. This movement is broadly viewed as related to the improved availability of information

for patients that has followed with the information society (diffusion of digital technologies). Progress is uneven in this regard though, as manifested by examples of frictions between doctors and patients in some areas, and the difficulties to digitalise patient journals. The professional structuring and promotion of self-dialysis has been a factor in combating resistance to patient-centric care at various levels.

Connectivity to the practice field

This case is very clearly a new model of care and one that has come about as a reaction to a specific social demand among patients for a greater level of autonomy and more control over their access to healthcare. Like all cases within the new models of care field the project was interested not only in developing a local solution but in validating a model that could be rolled out more widely. It has involved adaptation and learning in order to ensure that the project is able to work effectively within the existing context.

Like many examples from this practice field it was founded on the basis of changing social demands but it also hit upon resistance because it presented a challenge to established ways of doing things, it remains to be seen the extent to which this project is going to be able to refashion norms and values.

Never-the-less the project can be seen to have influenced others in attempting to establish new models of self-management. Pilots have been set up in the UK and in the USA which attempt to establish a model of self-management which might work within those specific contexts. This demonstrates that not only is this a clear example of the new models of care practice field but it also contributes to that practice field by encouraging others to experiment and validate new models of care.

3.5 PRACTICE FIELD CONCLUSIONS

New models of care is a challenging practice field with which to engage. It is a practice field that can be quite clearly defined and one which many innovators will identify being part of. Yet there are complications to this, not least in how the practice field is constituted. Whilst many people will consider themselves as 'developing new models of care' the practices that they imitate tend to be thematic. As such the practice field does not build a body of knowledge around innovating new models in the way that, for example, there is a body of knowledge around how to implement integrated care.

However a body of knowledge does develop around specific themes. Many of the cases either looked to other contexts for inspiration or have been an inspirational example to others. The lessons learned do tend to be specific to the particular model being developed but nevertheless there are clear dimensions by which the cases in this field have contributed to the constituting of themes within the practice field.

It may be possible to argue that as a unit for analysis this practice field may not be the most useful because of both the lack of granularity that can be achieved and the extent to which people tend to identify more with the themes of their innovation than with the specific practices involved in developing and trialing a new model of care in a specific context.

4 SUMMARY AND CONCLUSIONS FOR THE POLICY FIELD

4.1 INNOVATION IN HEALTH AND SOCIAL CARE

Health and social care is a policy field that is ripe for social innovation because of the significant problems being faced by health systems the world over and because of the significant differences between different health and social care contexts.

Health systems the world over are facing a number of serious constraints. World population has been ageing rapidly over the last 40 years and this rise is expected to continue. As positive improvements occur in life expectancy the burden of disease is going up. This is particularly true of non-communicable diseases. This shift in demographics also means that budgets available to tackle these issues are becoming tighter. As a result of this it will be necessary to keep people healthier for longer and ensure that we find more effective and efficient ways of caring for older people.

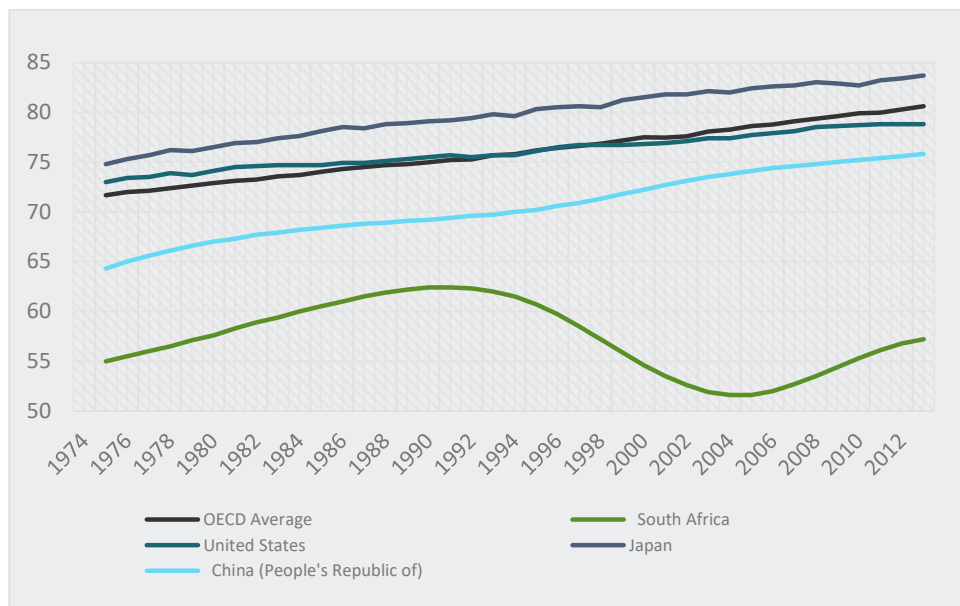


Figure 2: Life expectancy since 1974 (Source: OECD)

Non-communicable diseases (NCDs) are the leading cause of death globally. Almost 75 per cent of these deaths occur in low- and middle income countries²⁷ and older people are disproportionately affected²⁸. They include cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases and many lifestyle related diseases such as type-2 diabetes. These disease can often manifest as chronic and the number affected is on the rise. Over the next 20 years, NCDs are projected to cumulatively cost more than US\$30 trillion²⁹

Along with the rise in non-communicable diseases we are seeing a rise in the number of people who face mental health problems. Mental health problems have a dramatic impact upon both productivity and quality of life and the

²⁷ WHO, Non-Communicable Diseases Factsheet, March 2013, www.who.int/mediacentre/factsheets/fs355/en (23 August 2016)

²⁸ WHO, 10 facts on ageing and the life course, www.who.int/features/factfiles/ageing/en (23 August 2016)

²⁹ World Economic Forum and the Harvard School of Public Health (2011). The Global Economic Burden of Non-communicable Diseases.

World Economic Forum projects that in the next 20 years the cumulative cost of mental health problems globally will be US\$16.1 trillion³⁰

In addition, these challenges are set against a context of rising patient expectations. In some contexts, particularly in Europe, citizens have become accustomed to high levels of personalisation, efficiency and responsiveness in the services that they enjoy. However the integration of such changes into healthcare systems can be slow and laborious given the, often bureaucratic, systems in place. This is a particular problem in well-developed health systems which have developed clear structures in order to ensure efficiency, effectiveness and safety. However these structures must be negotiated in the process of innovation and this can present challenges.

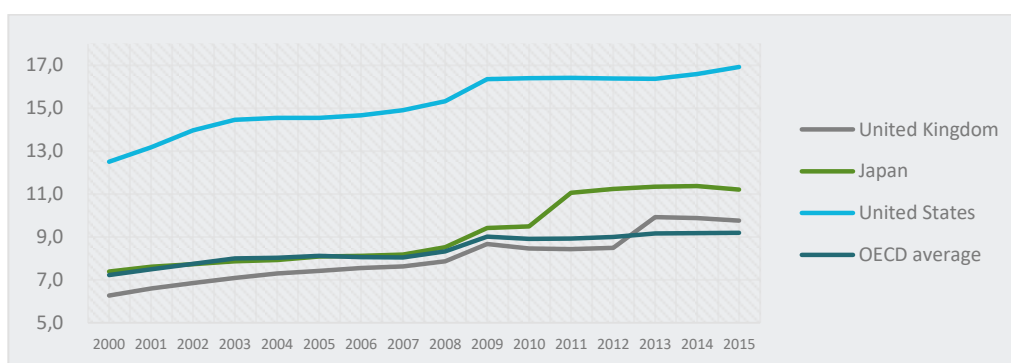


Figure 3: Health expenditure as a % of GDP (Source: OECD)

As a result of all the factors above, healthcare expenditure is, in many countries, rising as a proportion of GDP (see Figure 3). It is for this reason that it is necessary to innovate. The rising costs of healthcare combined with greater expectations for good care and a global desire (as a result of initiatives like the sustainable development goals (SDGs)), for access has meant that new ways of thinking, new practices and approaches are necessary. Indeed we have found that it is possible to define a general aim for health and social care innovation. We define this as: *the more effective or efficient provision of health and social care services, whilst balancing issues of outcomes, access and cost.*

And indeed, represented by the case studies, we are seeing new innovations developing, often out of new practices that are arising in the field. These ‘practice’ fields can be seen to be shifting the way that people are looking to do healthcare and engendering social change.

4.2 PRACTICE FIELDS IN HEALTH AND SOCIAL CARE

Whilst each context is different, many of the problems described above are global. Certain practices have emerged that seek to address some of the major issues that face health and social care systems in ways that are efficient and sustainable. Above we have found that there are clear common practices present across different countries and regions. However what is not so clear is how these practice fields are developing.

Learning from the examples of others appears to be a clear determinant in the development of a practice field. As such replication, imitation and diffusion are important dimensions of the development of a practice field. Certainly it seems that in some circumstances diffusion of practices is occurring because people find or are made aware of good practices happening elsewhere. The process of imitation however can be a force for the development of practice fields as people look at what is done elsewhere and adapt for the context in which they are implementing it. If we look at the new models of care practice field for example we can see that the transfer of models from one context into another in which they are ‘new’ has required processes of adaptation and, importantly, of validation.

³⁰ Ibid.

The validation of models- and the showcasing of them once they are validated- is a key component to the development of practice fields in health and social care where the risks can be high when models work poorly, The risk-averse nature of many health and social care systems does mean that proven examples of where models work well is an important driver of both innovation and social change.

The exact nature of interactions between innovations within practices appears on a spectrum from hearing of an example and choosing to emulate it, through directly consulting with others on how they implemented practices, to simply inferring alternative applications of specific practices and choosing to develop an innovative solution off of the back of it.

The development of practice fields is an area which requires further investigation. The data that we have above has not been sufficient for achieving granularity in our understanding of the different ways in which practice fields constitute or diffuse.

4.3 THE IMPORTANCE OF CONTEXT TO HEALTH AND SOCIAL CARE INNOVATION

In this sense context appears to be highly important to the way in which both practice fields and innovations manifest. A number of social factors appear to be important including particularly:

- **Available funding:** Whilst many health services are looking to reduce per capita healthcare expenditures this is not true across the board. Healthcare innovation is frequently an attempt to find ways to address competing demands for higher quality of care, increased access to care and budgetary constraints. Lack of funding available can be both a key driver and a key barrier of healthcare innovation. Importantly where this funding comes from, how funding is distributed and how much is available has a fundamental impact upon the shape that an innovation takes and therefore the way in which a specific 'practice' is expressed in context.
- **Available capacity:** In addition to funding there is also a significant dimension to which available capacities has an impact upon the trajectory of health and social care innovation, this includes the number of health practitioners, the state of infrastructure, and other aspects of the capacity to provide services. Practices like, for example, telemedicine take their shape according to the availability of practitioners and the need for them to provide efficient care, even over distances.
- **Type of healthcare system and level of bureaucracy:** The type of health system that is present in a country (for example Beveridge model, Bismarck or out-of-pocket) has a significant impact upon the way that innovations look and whether particular models of healthcare are viable. One of the most prominent historical examples of task shifting, for example, was the use of 'barefoot doctors' in China. Under this system government trained farmers in order to be able to provide basic medical and paramedic assistance to people who otherwise would not have access to a doctor. However as the healthcare system in China evolved away from a collectivist model towards a more free-market approach³¹ to healthcare provision this became an inviable model because of the costs associated. Different healthcare systems also demonstrate varying levels of bureaucracy and this can have a significant impact on the ability to innovate. In the two South African case studies, for example, it was possible to see that – in order to innovate within the highly bureaucratic South African system it was necessary to find ways to work outside of the national system. **Keth'Impilo (South Africa)**, for example, operates a system whereby – in order to help tackle the HIV/AIDs epidemic- they trial new innovative models of care alongside, not within the health service, in the hopes that where these successfully demonstrate impact they might more easily be incorporated into the wider health service. This

³¹ Blumenthal, D., & Hsiao, W. (2015). Lessons from the East—China's rapidly evolving health care system. *New England Journal of Medicine*, 372(14), 1281-1285.

can be seen as an innovative model within the health service and one that is quite considerably influenced by the context of bureaucracy.

- **Public expectations and the level of healthcare already available:** Public perceptions of the role of healthcare in a context can have a significant impact upon what innovation develops out of a particular practice. Populations often have expectations for what kind of healthcare provision they are entitled to, this is frequently heavily related to the kind of healthcare provision that is already available. In contexts where there is a high level of universal healthcare, public perceptions of entitlement can be high and this can shape how particular innovations function. If we look at the 'new models of care' practice field we often see models that are new in their context but are not new in other contexts. For example, in the **Social Protection (Russia)** case we can see a model of residential care for the elderly which is very new in its context and which has developed out of changing public expectations for the care that should be provided – and for what families should provide. However such care is common place in the UK where the focus has shifted on to what models can be adopted in order to keep people in their own homes into old age.
- **Social values:** Following on from public expectations of healthcare is the influence of social values on particular practices. Different societies have different social norms which influence questions like: 'who is responsible for healthcare?'; 'who deserves care?'; and 'how should we deliver care?' These social values strongly influence the ways that different practices are expressed in different contexts. Social movements are examples of changing social values which differ between contexts and frequently influence or even drive innovation. In Sweden for example we can see a growing social movement around self-management and encouraging people to take a more active role in their health and social wellbeing. If we look at the **Self-Dialysis (Sweden)** and **Physical Activity on Prescription (Sweden)** cases we can see evidence of the way in which this social movement has integrated into healthcare provision and influenced the expression of practices in this context.
- **Policy priorities:** Policy priorities are frequently determined by a matrix of the above factors. They often emerge from, determine, or align with social values but also are commonly influenced by political ideology, healthcare capacities and funds. Policy environments will come to influence the expression of practices in different contexts in two different ways: (1) because those innovations which do not align with political priorities will find it more difficult to progress as they will be the subject of a kind of passive disabling; (2) because those innovations which do align with political priorities may be actively enabled through, for example, public funds or positive support. If we look at the case of **Smart Elderly Care (China)** for example we can see that the alignment of this case with a policy priority to find efficient ways of providing care to elderly populations this case was facilitated by providing amenable regulatory frameworks and funding. Likewise, most of the integrated care innovations have come about in a context of policy priorities that emphasise a move towards reducing fragmentation, improving health outcomes and reducing costs. In this way even when there are funds available it is not the case that all innovation is created equal. Some may be more likely to face barriers if they do not align themselves with the key policy priorities of the context.
- **Buy-in:** Importantly there is an central role for individuals in determining context and therefore the shape of innovation. This is particularly true of people such as business leaders and policy makers. Importantly, when policy makers demonstrate 'buy-in' this can help to overcome even harsh policy environments. The importance of this 'buy-in' from individuals was demonstrated across the cases however was particularly evident in the **MomConnect (South Africa)** case study. Like the **Keth'Impilo (South Africa)** case, for the project to be successful it was necessary to circumvent the highly bureaucratic South African policy environment. In this case the enthusiasm for the project demonstrated by the Minister for Health helped to overcome this barrier. By comparison, without such high level buy-in at the national level **Doc Ready (UK)** has found greater difficulty integrating itself into the wider health system.

- **Competition:** Competition plays a significant role as part of the context in which social innovation emerges. For example, one of the primary drivers of the practice field of integrated care is the need to reduce costs. It would seem significant therefore that population-based models of integrated care have only developed in Bismarck-like models of healthcare – that is, using an insurance system. In these systems we can see increased competition, although it is unclear if this is a core reason for the development of the innovations.

Institutionalisation can come to create adaptations and therefore social change. By commissioning, endorsing or legitimising socially innovative programmes institutionalisation can have impact on social values and expectations of the health service. By demonstrating that something is worthwhile and offering it as a service to people it becomes normalised, it adapts society by changing people's understandings of what they are entitled to.

The context faced by different innovations shapes what is possible and drives the way that different practice fields are expressed in different contexts. One can, therefore, see the success of an innovation as resulting out of a combination of two factors: the extent to which the context enables the innovation and the extent to which the innovation adapts or works within the context. Adaptation to context can come in many forms.

5 ANNEX

5.1 MECHANISMS OF SOCIAL CHANGE (BASED ON WILTERDINK 2014)

1. **Learning:** Evolutionary theories (Dosi, 1982; Nelson & Winter, 1982) in social sciences stress the cumulative nature of human knowledge. Actors realize mistakes, apply new ideas and engage in processes of learning, which results in tacit and codified new knowledge (Cowan, David, & Foray, 2000).
2. **Variation:** Variation can range from 1) new (collective) ideas to 2) single innovation projects which introduce novelty and hence variation. Ad 1) Collective ideas are the cause and consequence of social change. The spread of beliefs, values, value systems, of fashions, of **religions**, of cultural symbols, of rules of behavior. Ad 2) Single innovation projects are on the one hand incremental innovation projects that innovate along a given trajectory; on the other hand, radical innovations that deviate from the trajectory and may lay the ground for a new trajectory.
3. **Selection:** This incorporates processes of adoption, diffusion and imitation, but also processes of **decline** and death of initiatives.
4. **Conflict:** Group conflict has often been viewed as a basic mechanism for social change, these **include** revolutions, but also minor conflicts. Social change in this view, is the result of the struggle between a predominant class and a dominated class which strives for (radical) change. (conflict model of society by Ralf Dahrendorf)
5. **Competition:** seen as a powerful mechanism of change as competition makes it more likely to **introduce** innovations in order to have competitive advantages.
6. **Cooperation:** Although competition as a driver dominates theories that put individualism, individual utility at the fore, where social change is the results of individuals pursuing their self-**interest**, other strands of literature have shown that cooperation (e.g. literature on innovation systems, game theory) or altruism (e.g. Ernst Fehr) also lay the basis for human action.
7. **Tension and adaptation:** In structural functionalism social change is seen as an adaption to some tension in the social system. E.g. a gap between fast-changing technology and necessary **associated** institutional change of some type (see W. Fielding Ogburn)
8. **Diffusion of (technological) innovations:** Some social changes results from innovations adopted in society, may be technological invention, scientific knowledge, but also new beliefs, ideas, values, religions, in short ideas. High uncertainty, most innovations disappear, those that survive follow an S-curve of adoption (cf. Geroski, 2000).
9. **Planning and institutionalisation of change:** Social change may result from goal-directed large scale planning, by governments, bureaucracies, and other large scale organisations. The wider the **scope**, the more the competencies needed, the more difficult to reach goals and the more likely that unforeseen events interfere. Planning implies institutionalisation of change, but institutionalisation does not imply planning (Wilterdink, 2014). Included here are changes in the organisation of the state, interstate relations, laws and directives, programmes etc.

5.2 RESEARCH FOCI OF SI-DRIVE DERIVED OUT OF THE KEY DIMENSIONS

The critical literature review opened the view on a theoretically sound concept of social innovation grounded in theories of social change, innovation studies and social innovation research. Based on the results of the critical literature review eight, first research propositions were elaborated and became the basis for the empirical work of the global mapping.

Research Focus 1: Concepts and Understanding

Social innovations in the perspective of SI-DRIVE encompass new practices – concepts, policy instruments, new forms of cooperation and organisation – methods, processes and regulations that are developed and/or adopted by citizens, customers, politicians etc. in order to meet social demands and to resolve societal challenges in a better way than existing practices. The emergence of such new social practices, including patterns of imitation and adaptation, will be subject to research of SI-Drive.

In this perspective, research will be focused on analysing the process of invention, implementation (introduction to a context of use), diffusion and institutionalisation of new social practices in different areas of social action. A great deal of attention should be devoted to better understanding the relationship to technological innovation as well as innovation oriented at creation of economic rather than social value.

Research Focus 2: Ambivalence

Referring to both the normative and analytical concepts of social innovation (cf. CLR of SI-Drive) highlights the importance of identifying to whom a social innovation is ‚desirable‘ – whose objectives and whose demands are being met and whose objectives and demands are being overlooked?

This difficulty is reflected in heterogeneous and conflicting interests in different societal sectors, e.g. in civil society (Scoppetta, Butzin, & Rehfeld). We also have to consider „*unforeseeable social side effects*“ (Howaldt & Schwarz) of social innovations. Their impact may differ according to different actors or groups of actors and there may be winners and losers of social innovation, e.g. according to „*different perspectives of development*“ (e.g. Western against native). Establishing a new social practice can mean – using a Schumpeterian term – ‘creative destruction’ of another previously dominating social practice. In this regard the empirical research will put more emphasis on analysing the ambivalence of the outcomes of social innovation (i.e. social side effects, unforeseeable consequences, different perspectives), also in relation to actors’ intentions.

Research Focus 3: Process Dynamics

Considering the experiences in the field of technological innovation a pending task would be thinking towards a concept of Social Innovation Assessment, as one aspect of policy recommendations to be developed.

The successful implementation and/or active dissemination of a new social fact *usually* follows targeted intervention but can occur also through unplanned diffusion (Greenhalgh et al., 2004) – how much this is the case will be subject to research.

From this perspective one of the main objectives of the empirical work of the SI-DRIVE project should be analysing the process dynamics of social innovation (idea – implementation – social practice – institutionalisation).

Research Focus 4: Relation to Social Change

While social and economic problems identified in public discourse are increasingly prompting a call for extensive social innovation, the relationship between social innovation and social change remains a largely under-explored area in the social sciences as well as government innovation policies. To better understand the relationship between social innovation and social change we have to analyse the mechanisms of social innovation processes (e.g. imitation and social learning).

Special attention will be devoted to social innovation as a mechanism of change residing at the micro and meso level. In the context of the broad debate surrounding sustainable development and necessary social transformation processes (Geels & Schot, 2007) the question of the relationship between social innovations and social change arises

again. To better understand this relationship we have to analyse the social embeddedness of any innovation in a dense network of innovation streams.

Taking into account the micro-foundation of social change we have to analyse how processes of social change can be initiated which go beyond the illusion of centralist management concepts to link social innovations from the mainstream of society with the intended social transformation processes.

Research Focus 5: Governance

To understand the modes of governance of social innovation, one focus should be on networks, including social networks, and their actor constellations, modes of cooperation and communication channels.

The literature review has provided starting points of how diverse modes of governance might be according to the mode of innovating. For example, governance structures might differ according to the intention or purpose of actors (i.e. the formation of a strategic alliance to communicate interests, to have access to various resources in the process of innovating/ community of practice, etc.). As with innovation management within firms, the role of employees and the governance of employee involvement in innovation processes at the work place is a central question. Concepts such as frugal and reverse innovation originating from the global south describe alternative innovation logics (downscaling and innovations diffusing from the global south to the global north) with supposedly different governance structures that need to be understood to grasp the variety of types of social innovation and vice versa. As a conclusion relating to the diverse forms of governance we suggest studying the specific governance in different types of social innovation processes and assess the particularities as compared to other innovation processes. To develop an integrated understanding of the role of various actors in social innovation, a broader concept is needed that appreciates social entrepreneurship but also takes account of other actor types.

Research Focus 6: Actors

The different roles and functions of actors will be studied by SI-DRIVE. Especially in comparison to social entrepreneurs, there is an under-representation of the various other actor types and their specific impulses and impacts as generators of social innovation. As a conclusion, different types of actors and their roles in the generation and spread of social innovations will be discussed.

Furthermore, a research focus on diverse actor types relates – again – to the issue of adequateness and transferability of existing concepts. While actor constellations in innovative environments have been conceptualised by triple and quadruple helix models, there should also be openness towards the potential of developing new conceptual models describing actors' relations and functions in social innovation.

Research focus 7: Drivers and Barriers

In order to establish a systemic view upon social innovation, it is suggested to put an additional research focus on the drivers and barriers of social innovation - including the influence of power, the role of conflict, and the relation to inequality.

Various concepts reflected in this report have been helpful to understand drivers, barriers and governance of innovations and because of their pertinent clarity they are also widely diffused in political programs and strategies to support innovation.

There is a lot to learn from these concepts for scholars of social innovation and it should be thoroughly tested, in how far concepts of innovation studies are applicable to study the systemic dimension of social innovation and thus are of relevance for better understanding of particular drivers, barriers and governance.

Research Focus 8: Civil Society and Citizen Empowerment

We have to put a strong focus on the role of civil society (citizens, NGOs, social movements, communities) in the innovation process. In particular, we should analyse how the social innovation cases in SI-DRIVE have diffused and whether this facilitated the empowerment of citizens.

However, given the fact that SI-DRIVE is a research project of global reach, the conception of what is considered as civil society might need adjustment to the specific contexts of the diverse world regions. Alongside civil society, the social economy is environment equally often mentioned as an important source of social innovation. It is thus

suggested to pay particular attention to the environments of civil society and the social economy in order to understand their particular distinctions. Studying these distinctions is of special relevance for public decision makers, as it provides the relevant background against which supporting infrastructures can be developed. So the research focus will be to understand the particular distinctions of these areas/fields, especially related to the set-up of supporting infrastructures for social innovation.