

# SOCIAL INNOVATION IN HEALTH AND SOCIAL CARE

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## **ABOUT THIS REPORT**

This report is produced as a deliverable of Social Innovation Europe (SIE) an initiative financed by the European Commission. It draws on and summarises work done within European Union funded projects on social innovation including TEPSIE, SIDRIVE, WILCO and INNOSERV.<sup>1</sup>

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<sup>1</sup> More information about these projects can be found on their project websites: [www.tepsie.eu](http://www.tepsie.eu); <http://www.si-drive.eu/>; <http://www.wilcoproject.eu/>; <http://www.inno-serv.eu/>

## REPORT SUMMARY

- European health and social care systems are facing increasing demands at a time when resources are increasingly constrained. There is a strong case for investment in social innovations that respond to the challenges faced.
- Social innovations are new combinations of practices and approaches developed to better address social needs. Five broad themes or 'practice fields' under which some of the most significant social innovations in health and social care are located are:
  - Patient or user empowerment in service design and delivery
  - Peer-to peer support
  - Changing professional roles (task shifting)
  - New locations of care
  - m-health applications
- Key challenges to the emergence and spread of innovation in health and social care systems include:
  - Managing the acceptance of risk and potential failure
  - Negotiating public expectations and demands
  - Measuring the costs and benefits of innovations accurately to align incentives
  - Integrating services for care and health
  - Difficulties for new entrants, including their capacity to engage in procurement processes and to break through entrenched professional cultures
  - A bias towards developing new innovations rather than engaging in the complex work of implementing existing innovation
- Governments and policy makers can contribute to the emergence and spreading of innovation in health and social care in two main ways:
  - Acting as an innovator itself for its own services: This entails recognising the scope of its role as a provider of public services, putting in place dedicated structures (such as innovation teams) and drawing upon existing learning about how large organisations are best structured to encourage innovation.
  - Acting as a facilitator of innovation: This entails helping to create the right enabling conditions for innovation through mechanisms such as funding, stimulating demand through appropriate procurement processes, investing in developing the evidence base for new approaches and supporting networking and capacity building.

# INTRODUCTION

Health and social care systems across the developed world are under strain. Established to deal with health problems of the nineteenth and twentieth centuries, they now find themselves ill equipped to respond to twenty first century challenges. Significant (and welcome) medical advances have turned previously life-threatening conditions into long-term conditions that now need to be managed. These conditions usually have a relational quality that means they can only be tackled in collaboration with citizens – requiring a shift from solving problems ‘for’ citizens to working ‘with’ them. And demographic change means an ageing population where many more people will experience long term care needs and multi-morbidity (two or more chronic conditions).

In addition, these challenges are set against a context of rising patient expectations. Citizens have become accustomed to high levels of personalisation, efficiency and responsiveness in private sector services such as banking and retail. While new technologies in theory offer real potential for changing the way public services are delivered, in reality the impact of technologies has been felt much more slowly in health and social care systems than in other industries.

The aftermath of the global financial crisis has also led to a renewed focus on efficiency and doing ‘more with less’. Post crisis, policymakers are typically “working with less time, trust and money to achieve their goals”.<sup>2</sup>

Finally, Europe is continually facing new challenges. The current wave of migrants and asylum seekers from Africa, the Middle East, and South Asia is placing a huge strain on the services of primary receiving countries.

With all these factors in play, the case for innovation is clear. Social innovations - new combinations of practices and approaches developed to better address social needs – will be need to be developed and implemented throughout health and social care systems. In many places, these innovations are already underway, albeit often on a small scale.

This report brings together the findings of recent European Union funded research and practice in this area in order to:

- Highlight the kinds of social innovation currently being pursued in health and social care systems
- Assess the challenges associating with innovating within health and social care
- Outline the role for government and policymakers in supporting attempts to drive through innovation in these sectors

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<sup>2</sup> Christian Bason, *Design for Policy*, Gower Publishing Ltd, 2014.

## What do we mean by social innovation?

Over the last decade, 'social innovation' has become an increasingly popular term and topic of study and debate within academic and policy communities. The term is currently used to describe a wide range of activities and concepts, from workplace innovation to social entrepreneurship, to societal transformation and system change, to new models of local economic development.

In this paper, we understand social innovations as **new combinations of practices and approaches developed to better address social needs**. Social innovations are:

- **New** – or at least new in the context in which they appear
- **Put into practice** – we use 'social innovations' to describe ideas that have actually been implemented; they are ideas turned into practical approaches
- **Designed to meet a social need** – social innovations are distinct from innovations that merely have a social impact (arguably all innovations have social impact of some kind). Often social innovations address needs that have been neglected by traditional forms of market provision or the services organised by the state.

Social innovations are also usually characterised by:

- A concern with the process of innovation, not just the outcome. Social innovations often engage beneficiaries with their development and/or governance. Many social innovations are developed by groups of citizens and emerge bottom up rather than top down, in a planned way.
- A high degree of uncertainty. Since social innovations are practices that differ from mainstream activity and have not been implemented before (or at least not in that context or at that scale) it is impossible to know at the outset whether the innovation will indeed provide a better, more just or effective approach to social needs. This can only be known in hindsight.

While the merits of the specific term and the field around it will continue to be debated, one important way forward is to go beyond more generic discussions and be clear about the kind of social innovations we are talking about so that we have a better understanding of the different finance, governance and growth challenges faced by different forms of social innovation.

For more on these issues of definition see 'Social Innovation Theory and Research: A Summary of the Findings from TEPsIE' Available at [http://www.tepsie.eu/images/documents/research\\_report\\_final\\_web.pdf](http://www.tepsie.eu/images/documents/research_report_final_web.pdf) and 'Social Innovations for social cohesion. Transnational patterns and approaches from 20 European cities' edited by Adalbert Evers, Benjamin Ewert and Taco Brandsen, Liege: EMES European Research Network, 2014.

## PART ONE: PRACTICE FIELDS OF INNOVATION IN HEALTH AND SOCIAL CARE

What does social innovation in health and social care look like? One of the challenging aspects of a term like social innovation is that it can refer to such a broad range of activities – everything from the work of a small social enterprise to provide services to the elderly, to the adoption of digital personal health records throughout a national healthcare system. In approaching this topic, it is helpful to unpack the different forms of innovation we might see. The following typology of innovation in health and social care from the INNOSERV project provides a valuable breakdown<sup>3</sup>:

Form of innovation	Definition	Example
<b>New service</b>	New or improved product of the scheme or process	Highly personalised instead of generic service
<b>New form of delivery</b>	New or improved means by which the outcome is achieved	Self-help, peer group or social enterprise instead of government agency
<b>New form of governance</b>	New or improved way the scheme or process is managed and where it draws authority from	Co-operative or user managed service instead of public service
<b>New form of resourcing</b>	New or improved financial human or physical inputs to the scheme or process	Grant funded service; service delivered by employees or volunteers; service purchased directly through personal budget
<b>New way of evaluating</b>	New or improved parameters by which success is judged	User assessment of effectiveness instead of professional determined criteria; assessments focused on long term preventative impact rather than short term results

It is important to note that these five innovation forms are not equally prevalent. While we see many examples of new services, often developed using new resources and new forms of delivery, new forms of evaluation and governance are typically less common. From the examples in the table above, we can also see that there is a high degree of crossover between the different innovation forms. A specific innovation practice may fit into several categories. Consider a traditional mental health support function run by the local authority being replaced with a new peer support system that involves very different activities and is organised by an employee owned co-operative group. Here the innovation practice involves a new service with a new form of delivery, involving new resources and new forms of governance. This reflects

<sup>3</sup> Table taken from INNOSERV Work Package 2: Theoretical trends and criteria for 'innovative service practices' in social services within the EU. Available at [http://www.dwi.uni-heidelberg.de/md/dwi/innoserv/literature\\_based\\_criteria\\_for\\_innovation.pdf](http://www.dwi.uni-heidelberg.de/md/dwi/innoserv/literature_based_criteria_for_innovation.pdf). Accessed 19th June 2015.

the reality that social innovations can be hard to capture neatly. While a product innovation is a tangible entity, an innovation in health or social care service provision can be a product or a process and can occur at different levels of service provision.

With these issues in mind, we have chosen to structure the innovations identified in this report using a thematic perspective: what kinds of changes in practice and values are these innovations concerned with? In what follows we set out five broad theme areas or practice fields under which some of the most significant social innovations in health and social care are located:

- Patient empowerment in service design and delivery
- Peer-to peer support
- Changing professional roles
- New locations of care
- Mobile health (m-health) and e-health applications

Each of these involves multiple forms of innovation. We have highlighted which of the five forms identified in the table above each practice field most commonly involves.

### **Patient empowerment in service design and delivery**

*Forms of innovation typically involved: new services, new delivery mechanisms, new forms of resourcing*

A major theme of innovations in health and social care is the redistribution of power towards service users. Innovations in this area are intended to challenge the idea that service users are passive recipients of care. Instead they are re-cast as active participants in health and social care teams, alongside professionals. This shift reflects a wider move towards 'asset-based' approaches, which focus on the capacities, skills, knowledge and connections already present amongst individual patients and communities, rather than only on their needs, deficits and problems. It also draws on the idea of *co-production* – an approach to delivering public services where there is an equal and reciprocal relationship between professionals and people using services. The emphasis on patient empowerment also has roots in disability rights movements that emphasise the importance of users having choice and control over the nature of the care and assistance they receive.

Greater patient empowerment can take many forms. A basic starting point is ensuring patients have sufficient information in order to make decisions about care. (This has been recognised at the European level with Directive 2011/24/EU requiring all patients to be given clear information about their condition.)<sup>4</sup> More substantive innovations involve giving users greater control over the nature of the treatment they receive. For example, personalised budgets enable users to pay for and choose their own package of care and support. Different models of personalised budgets are being rolled out, involving varying degrees of control and freedom,

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<sup>4</sup> See [http://ec.europa.eu/health/cross\\_border\\_care/policy/index\\_en.htm](http://ec.europa.eu/health/cross_border_care/policy/index_en.htm) Accessed 19th June 2015.

with patients across Europe including France, Austria, Germany, the UK, and the Netherlands.<sup>5</sup>

### **Richmond Users Independent Living Scheme (RUILS) – user led support for personal budgets**

RUILS is a user run and led organisation providing adult social care services to people in Richmond, UK with learning difficulties and mental health challenges. Its goal is to help people to live independently. Initially a grassroots organisation lobbying for direct payments in adult social care, RUILS now has a particular function to help people who receive direct payments and personal budgets to get the best possible outcomes for the care they purchase. As well as providing information and guidance, RUILS also helps individuals to pool their personal budgets. This can enable people to increase their purchasing power and expand their social networks by bringing people together around activities they enjoy. RUILS operates as a membership organisation so that people who use the services are able to shape key decisions about how it operates through voting. Over 70% of the board of directors is made up of service users.

For more information, see <http://www.ruils.co.uk/>

Others innovations relate to the delivery and on-going management of care. For example, in the Year of Care adopted by the UK's National Health Service (NHS), the aim was to put patients firmly in the driving seat of their diabetes care so that they were actively involved in determining how their condition was to be managed. The Year of Care approach has now been recognised and adopted by the National Institute for Health and Care Excellence (NICE) in their Quality Standard statement pertaining to care planning.<sup>6</sup>

User-centred approaches can also have a major impact on the way professionals think about health and social care as holistic systems. The Esther Project in Sweden involved a team of physicians, nurses, social workers and other providers working together to look at how the care system was operating from the patient perspective.<sup>7</sup> To do this, they developed a fictional persona, Esther, a woman in her late 80s with chronic obstructive pulmonary disease who lives alone. By committing to thinking through the system through the lens of this one user, they were able to identify places where there was a lack of coordination and poor information flows. Mats Bojestig, Chief of the Department of Medicine at Höglandet Hospital and one of the developers of the Esther Project, explained, "I think it is very important that we call this work Esther...It helps us focus on the patient and her needs. We can each imagine our own 'Esther.' And we can ask ourselves in our work, 'What's best for Esther?'"<sup>8</sup>

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<sup>5</sup> Erica Wirrman Gadsby, 'Personal budgets and health: a review of the evidence', Policy Research Unit in Commissioning and Healthcare Systems, February 2013. Available online at [http://cdn.basw.co.uk/upload/basw\\_20915-9.pdf](http://cdn.basw.co.uk/upload/basw_20915-9.pdf). Accessed 19<sup>th</sup> June 2015.

<sup>6</sup> For more information see the Year of Care website, <http://www.yearofcare.co.uk/> Accessed 19th June 2015.

<sup>7</sup> See <http://www.ihl.org/resources/Pages/ImprovementStories/ImprovingPatientFlowTheEstherProjectinSweden.aspx> Accessed 19th June 2015.

<sup>8</sup> Ibid.

## Ryhov County Hospital in Jönköping, Sweden – Patient-led dialysis

As a frequent and lengthy procedure, dialysis can have a major impact on patients' lives and on their families. Starting with a single patient who believed his side effects could be reduced if he had more control, Ryhov County hospital in Sweden has now trained just over half of its patients to do their own dialysis; they have an ambition to reach 75% self-dialysis.

Patients are shown how to use the dialysis machine, how to read and interpret lab results and to document their own blood pressure, weight, amount of water drawn etc. Patients have reported a reduction in side effects and with the procedure seeming less burdensome, they have dialysis more frequently, leading to a reduction in infection rates.

(Institute for Healthcare Improvement, 2012. See

<http://www.ihl.org/resources/Pages/ImprovementStories/APatientDirectsHisOwnCareFarmanSelfDialysis.aspx> ).

Recent research on increased user-involvement acknowledges that while innovations in this area hold great potential for improved services, it can also expose people to the threats and pressures of self-responsibility where that is not always desired.<sup>9</sup> Clearly then, it is important to recognise that patients will have different motivations and capacities to play a bigger part in the design and delivery of care.

### Peer-to-peer support

*Forms of innovation typically involved: new form of resources, new form of governance, new form of delivery*

A theme closely related to greater patient empowerment is the increasing use of peer-to-peer forms of support. This involves drawing on the experience and expertise of patient communities.

New forms of peer-to-peer support are becoming important in rehabilitation and recovery. For example, at Vejle Hospital in Denmark, patients who have undergone hip and knee surgery look to others who have recently had the same operation to support them, forming peer support groups to provide reassurance and share experience in the recovery phase. The scheme has resulted in major cost savings by reducing the amount of days patients need to stay in hospital recovering.<sup>10</sup> A 30-hour training programme was developed for volunteers who had to have lived experience as a carer or individual with stroke in order to participate. Assessment of the programme reports that the volunteers have integrated well with multidisciplinary teams, gaining respect and cooperation from their professional colleagues.<sup>11</sup>

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<sup>9</sup> Innoserv Work Package 2: Theoretical trends and criteria for 'innovative service practices' in social services within the EU. Available at [http://www.dwi.uni-heidelberg.de/md/dwi/innoserv/literature\\_based\\_criteria\\_for\\_innovation.pdf](http://www.dwi.uni-heidelberg.de/md/dwi/innoserv/literature_based_criteria_for_innovation.pdf). Accessed 19th June 2015

<sup>10</sup> TEPSIE, 'Social Innovation Practices and Trends', European Commission – 7th Framework Programme, European Commission, DG Research. Brussels, 2012. Available online at [http://siresearch.eu/sites/default/files/1.1%20Part%20%20-%20practices%20and%20trends\\_0.pdf](http://siresearch.eu/sites/default/files/1.1%20Part%20%20-%20practices%20and%20trends_0.pdf) Accessed 19th June 2015

<sup>11</sup> See <http://www.fabnhsstuff.net/2015/02/21/stroke-northumbrias-peer-support-programme/> Accessed 19th June 2015

### **Big White Wall, UK – An online community for mental health**

Online communities of support have proved particularly important for mental health conditions, where stigma still prevents many people from seeking face-to-face help. Big White Wall is a community of people experiencing common mental health problems, brought together through social media to help them better self-manage their conditions. The site offers a range of programmes for individuals and groups, covering topics such as anxiety, depression, sleep disorders and alcohol use. Trained professionals called Wall Guides support the community by making sure that members are safe and responded to. Any worrying behaviour by members triggers a response from the Wall Guides who are supported by a team of psychiatrists and other professionals.

According to members, one of the most important elements of the digital platform is the ability to talk freely, whilst remaining completely anonymous. Three-quarters of people on Big White Wall talked about their condition for the first time on the site, and eight out of ten people were self-managing their condition. An independent review found that 95% of people using the service reported one or more improvements in well-being.

For more information see: [www.bigwhitewall.com](http://www.bigwhitewall.com)

The growth in online communities represents a huge opportunity for peer-to-peer forms of support, enabling patients to connect and exchange experiences virtually. Online forums have emerged which allow patients, often with rare conditions, to benefit from one another's expertise. On the global PatientsLikeMe network, people connect with others who have the same disease or condition and track and share their experiences. The site provides customised disease-specific outcome and visualization tools to help patients understand and share information about their condition. In the process, they generate data about the nature of disease that can help researchers, pharmaceutical companies, regulators, and non-profits develop more effective products and services.<sup>12</sup>

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<sup>12</sup> See <https://www.patientslikeme.com/>. Accessed 19th June 2015

## RareConnect – a global platform for people with rare diseases

RareConnect is an online network for rare disease communities throughout Europe. It is a joint initiative between EURORDIS (The European rare disease non-governmental organisation) and NORD (the National Organization for Rare Diseases) based in the United States. The site brings together thousands of patients, families and groups who might otherwise be isolated. Through RareConnect, patients and those who care for them can communicate, sharing experiences and information in a safe, moderated online forum. A key feature of the website is that it offers human translation at no cost to participants, allowing patients from different countries to interact in English, French, German, Italian or Spanish.

A network of over 200 moderators, drawn from 400 partnering patient organisations, provides support for the conversations on the site. Currently, the platform attracts more than 60,000 visitors per month from over 200 countries.

For more information, see <https://www.rareconnect.org/en>

Online peer support platforms are available to help people in almost any situation, not just those with health conditions. Peer support programmes have also been developed in relation to social care. In Germany, AAL Pilots (AAL Lotsen) is a scheme whereby older people teach their peers about how to use mobile devices and other Ambient Assisted Living devices, which are designed to extend the time people can live in their preferred environment by increasing their autonomy, self-confidence and mobility.<sup>13</sup> Another example is the Hoogeloon Care Cooperative in the Netherlands. In this small Dutch village, the community formed a special care cooperative. It was originally founded to make sure that elderly people could stay in their own village as long as possible. People pay a small annual fee to join and the members decide on the social and care services to be provided. Other members of the community help as volunteers.

Other examples include Superhands, an Austrian platform for children and young people who care for family members, and babybalance which is platform for expecting or new parents in the Netherlands, which provides education and instructions about their baby.

## Changing professional roles

*Forms of innovation typically involved: new form of resources, new form of governance, new form of delivery*

The two themes identified so far both have a significant impact on professional roles in health and social care systems. The shifting balance of power between professionals and patients can inevitably create tensions between the professional interest in preserving autonomy and the wishes and needs of patients. In a world where patients are less deferential and are recognised as having important assets to self-manage their treatment, professionals often need to move from being 'fixers' to 'facilitators', requiring a different set of skills.

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<sup>13</sup> MOPACT (Mobilising the potential of active ageing in Europe), 'Case study handouts', 2014, Available at: <http://mopact.group.shef.ac.uk/wp-content/uploads/2013/10/D7.3-Built-tech-env-3-Case-study-Hand-outs.pdf> Accessed 19th June 2015

However, professional roles are also shifting for other reasons. In recent years there has been increasing support for the idea of 'task-shifting', which is defined by the World Health Organisation as "the rational redistribution of tasks among health workforce teams".<sup>14</sup> The idea is that specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications. The WHO has made particular recommendations related to task shifting to rapidly increase access to HIV services. For example, in South Africa, nurses have been given the task of prescribing anti-retroviral drugs, previously a task only performed by doctors.

In the European context, changing roles is described in terms of inter-professional practice – a team-based approach to health service provision, which requires a willingness to abandon traditional role boundaries and relinquish claims of exclusivity to health care practices and knowledge. This blurring of boundaries in the health care workforce may see different professions taking on practices previously 'owned' by others. In the UK in particular there have been moves to make better use of midwives, reflecting the evidence that midwives can effectively perform tasks that are usually performed by doctors without impacting on the quality of care. Similarly, in Germany, the UK and the Netherlands, the roles of the Physician Assistant (originally developed in the US) and Nurse Practitioner have emerged in order to preserve stretched doctor resources.<sup>15</sup>

### **National Network of Health Mediators, Bulgaria**

This programme builds on successful models trialled in other EU countries such as the Netherlands, Finland, Slovakia, Serbia and Romania to train Roma people to be health mediators for their community in order to try and increase the degree of inclusion of Roma people in health services. Traditional health care services and professionals were unsuccessful at engaging the Roma community resulting in severe health inequalities and poor health outcomes. Health Mediators now work to facilitate access to health and social services for everybody in disadvantaged position, to improve the quality of health and social services in Bulgaria, and improve awareness, understanding and promote healthy lifestyle choices amongst disadvantaged ethnic minorities.

The programme was highly innovative in Bulgaria. Health Mediators receive formal, training, accredited by the Ministry of Health, and work closely with local health institutions such as Regional Health Care Centres and Regional Inspectorates for Public Health Care. Over 150 Health Mediators have now been trained and evidence suggests that they are well received and respected within the Roma community.

For more information see [www.zdravenmediator.net/en](http://www.zdravenmediator.net/en)

Professionals are also increasingly interfacing with volunteers. For example, Irish Community Rapid Response is a voluntary group working in partnership with and supporting the Emergency Services. Rapid Response vehicles and volunteers (doctors and paramedics) are called simultaneously with the state services when an emergency occurs. The aim is to provide a "near Intensive Care level treatment for rural communities in the pre-hospital environment",

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<sup>14</sup> See <http://www.who.int/healthsystems/TTR-TaskShifting.pdf>. Accessed 19th June 2015

<sup>15</sup> F Merkle et al., 'The Physician Assistant: shifting the paradigm of European medical practice?' in *HSR Proceedings in Intensive Care & Cardiovascular Anaesthesia* 2011; 3(4): 255–262. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3484637/> Accessed 19th June 2015

to address the number unnecessary deaths or poor outcomes that can arise in areas where emergency services can sometimes take up to an hour to arrive. NESTOR, in Belgium, is a network of volunteers supported by professionals which provides additional services to senior citizens and other people with healthcare needs. At the far end of the spectrum, some tasks are being effectively shifted to lay people with no training at all, such as the installation of defibrillators in public places in countries like Austria and the UK.

There are also changes emerging in relation to how professionals work together. There is a growing realisation that in the past different parts of the same team were unable to challenge the hierarchic nature of the medical profession. For example, a nurse in an operating theatre would often feel unable to tell a surgeon if they were doing something wrong. New ways of simulating teamwork are beginning to break down these barriers and reduce mistakes at critical junctures and transitions – for example when paramedics hand over a patient from an ambulance to the emergency room. Similarly the use of a two minute checklist involving 19 checks has reduced the level of fatalities in operating theatres by as much as 50%. Some of the checks are simple such as ensuring that it is the right patient.<sup>16</sup> Others such as ensuring that there is the right blood available are more technical.

#### **4D Igualada Health Simulation Centre, Spain – a training platform to reduce error**

In Igualada, Catalonia, the Health Simulation Centre is the first full simulation environment for training professionals using real facilities. Launched in March 2015 after several years of preparations, the Centre is located on the site of the Igualada old hospital. The aim of the centre is to help prevent errors and increase patient security by providing an environment for professionals to practice their skills in different environments including simulations of a patient's home as well as hospital wards. This is particularly important given that more than 70% of errors in healthcare are caused by non-technical skills that relate to teamwork, communication and leadership and so on. These skills can be honed in the simulation environment.

For more information see <http://www.4dhealth.com/index.php/en/>

## **New locations of care**

*Forms of innovation typically involved: new service, new form of delivery*

How and where should health and social care be delivered? Fresh consideration of these questions is proving fruitful for innovation in health and social care.

On the one hand there are attempts to limit the reliance on hospitals and care homes as the locus of care. In part this reflects the need to control costs – hospital care is very expensive – but it also reflects patient demands to have care available either at home or close to home in their communities. On the other hand, there is also increasing evidence that there are significant benefits in concentrating certain services in a smaller number of highly specialist hospital settings; this has been the case with specialist stroke services in the UK for example. This approach does, however, carry with it significant challenges given levels of public opposition to attempts to close down or rationalise hospital services.

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<sup>16</sup> For an interesting discussion of the development see Atul Gawande, *The Checklist Manifesto*, London, Profile, 2010

One response has been to increase the availability of services available in the community. For example it is often possible for people to take intravenous antibiotics or some chemotherapy drugs as outpatients. In Norway, there have been experiments with bringing technological equipment to patients with Chronic Obstructive Pulmonary Disease (COPD) rather than re-admitting them to hospital. Some research has found that treatment of patients with COPD in a 'home hospital' setting seems to result in fewer re-admittances to hospital in comparison with patients who have been hospitalised with conventional treatment.<sup>17</sup> Other initiatives take care and support into the home, such as HIVmobil in Austria which provides medical care and specialised social guidance for people with HIV/AIDS.

A further response has been the development of 'halfway house' solutions such as 'patient hotels' in Sweden, intended to serve those patients who need to remain on a hospital campus but do not require intensive hospital care.<sup>18</sup> In Italy, the Casa di Michele (CDM) is a small residential facility (nine beds) in the city of Arezzo that provides short-term tailored assistance to frail and non-autonomous elders. CDM operates in close collaboration with the health care system and the family to ensure continuity and quality of care, whilst releasing hospital beds. There are significant cost savings using this approach compared to those patients occupying hospital beds but there are also health and wellbeing benefits: families can stay with patients which can aid their recovery, and long term guests, for example those receiving cancer treatment, can use the communal areas to socialise and discuss their conditions, providing peer support.

With increasing life expectancy throughout Europe, a key focus is on how to design care provision in ways that allow older people to live in their own homes for longer. This requires the development of more sophisticated models of extra-care/sheltered housing that is specifically designed with the needs of frail older people in mind and with varying levels of care and support available on site. The Tubbe model, developed in Denmark, is a housing model that was developed to give elderly people power to control their daily living at home. It focuses on helping people to retain control over issues such as the recruitment of carers, care practices and retaining influence over decisions within the housing complex. The model has since been adopted in other countries such as Sweden.

The desire to enable people to remain in their own homes also extends to palliative and end-of-life care, with projects such as Siatu in Spain, providing specialised in-home social care which is tailored to the needs of individuals with advanced illnesses, and their families.

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<sup>17</sup> See <http://www.kunnskapssenteret.no/en/publications/intermediate-care-units-and-hospital-at-home-for-acute-exacerbations-of-copd?vis=sammendrag> Accessed 19th June 2015

<sup>18</sup> See <http://www.innovationunit.org/blog/patient-hotels> Accessed 19th June 2015.

### **Hogewey - a 'Dementia village' in The Netherlands**

Hogewey in Weesp near Amsterdam is an innovative new model for how to design an elderly care environment for those experiencing severe dementia. The 'village' was built in 2010 and features a café, restaurant, theatre, minimarket and hairdressing salon. Half of the four-acre site is open space and residents are encouraged to explore. The site has a deliberately 1950s feel – this is the decade when most of the residents were children or adolescents and research shows that even in advanced dementia, long term memories can remain intact. Six or seven residents occupy each small two-storey house, alongside one or two carers – they have their own bedroom but share the living room and kitchen. Residents are grouped in houses according to one of a number of different lifestyles such as 'traditional', 'urban' or 'cultural' so that they are likely to share interests in common. There are more than 20 different clubs running at Hogewey to encourage residents to stay active as far as possible. Anyone can come and eat in the restaurant and local artists display their works in the gallery and schools use the theatre – in this way links with the surrounding community are maintained. The model is proving very effective. Long-term patients are observed to be calmer requiring less medication with more frequent moments of cognitive clarity.

For more information, see <http://www.vivium.nl/hogewey>

Another approach to enabling older people to remain in their homes is through the promotion of inter-generational living. This innovative approach simultaneously seeks to tackle the challenges of housing shortages and affordability for young and excluded groups. Abitare Solidale brings together older people in Florence, Italy who are in need of help for household maintenance and household keeping with younger people willing to offer assistance. Social workers match older people with those in need of affordable housing and women who have been victims of domestic violence. Homeshare, in the UK, and Gemeinsam Leben in Austria offer similar services.

There is also an important role for technologies in enabling people to stay out of institutionalised settings. Telehealth systems enable remote monitoring of patients, using biometric devices to record and monitor vital signs and videophones to support remote consultations in the home. These systems can be used to facilitate better coordination and continuity of care, preventing admissions and ultimately reducing the costs of chronic condition management. A multi-year randomised trial in the UK, involving over 3,000 patients, demonstrated that telehealth can reduce emergency admissions, deaths and hospital bed days<sup>19</sup>, although it did not have an effect on contact with General Practitioners or use of social care services<sup>20</sup>. Telecare also uses remote monitoring to help people maintain independent lifestyles, for example through falls sensors. It is also closely linked to the concept of patient empowerment in service design and delivery, since it enables patients to take more control over their own health. Nonetheless, telehealth is one of the fields with health and social care social innovation where the role of the private sector is essential in driving and funding new

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<sup>19</sup> <http://www.nuffieldtrust.org.uk/our-work/projects/impact-telehealth-and-telecare-evaluation-whole-system-demonstrator-project>

<sup>20</sup> Steventon, Adam, et al. "Effect of telecare on use of health and social care services: findings from the Whole Systems Demonstrator cluster randomised trial." *Age and ageing* 42.4 (2013): 501-508.

development of new solutions, in partnership with public sector services, academia and civil society. The Advancing Care Coordination and Telehealth Deployment programme, led by Philips but funded by the European Commission, is an example of this cross-sectoral collaboration.

Ideally, telehealth and telecare approaches will provide direct interaction with health and social care professionals, although this is not always the case. Novego, in Germany, develops web-based programmes to help and support people with mental illnesses. The "main programme" runs for twelve weeks and targets depression; other programmes run for four weeks and focus on burnout or anxiety disorders. In addition to the online services, feedback by professional psychologists is provided. At the European level, a new system is being developed to monitor behavioural and physiological information related to bipolar disorder. MONARCA combines a sensor enabled mobile phone, a wrist worn activity monitor, a novel "sock integrated" physiological (GSR, pulse) sensor, a stationary EEG system for periodic measurements, and a home gateway. The EU is also funding a number of other telehealth projects including solutions for arthritis patients (ELECTOR) and intensive care units (THALEA).

Delivery of care in new locations also extends far beyond older people and those with complex needs within traditional populations. The current refugee and migrant crisis means that existing health and social care services in receiving countries are unable to cope with the influx of new people requiring help. Public bodies and third sector organisations are therefore rapidly innovating new forms of services which can be delivered in refugee camps or which target homeless people. The NGO *Terre des Hommes* has been running Project Faro since 2014 to help unaccompanied minors who arrive in Lampedusa and Syracuse, Italy. It focus on providing psycho-social and psychological assistance to children, as well as providing guides and training for social workers.

Grassroots organisations are also springing up across Europe to try and help migrants and refugees. For example, there are dozens of online crowdfunding campaigns to raise money to support migrants living in Calais camps. Some of the largest online groups, such as *Worldwide Tribe* or *Calais, Ouverture et Humanité*, use money they raise and goods collected to support more established NGOs like Doctors of the World by providing medical and sanitary supplies.

## **Integrated care**

Across Europe there is a clear shift to focusing on models of integrated care. Although there are national and regional nuances to definitions and interpretations of integrated care, it can broadly be conceptualised as attempts to bring together often fragmented services to improve patient/ citizen care and outcomes. This usually entails bringing together health and social care services, and can also include aspects of public health promotion. Fulop (2005) suggested that integration can take multiple forms, including the integration of organisations, services, functions (such as electronic patient records), and culture (e.g. agreed guidelines and protocols), or at a systemic level.<sup>21</sup> The idea of integrated care is not new but it remains highly pertinent in the current socio-economic climate, and its challenging nature means it is fertile ground for social innovation.

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<sup>21</sup> Fulop N, Mowlem A and Edwards N (2005) *Building Integrated Care: Lessons from the UK and elsewhere*. London: The NHS Confederation.

Often such initiatives focus on the elderly or those with chronic conditions, but many seek to take a broader whole population approach at the local or regional level. Integrated care is an “organising principle” which can be achieved through a wide range of approaches, using a variety of tools, methods and processes. As such, integrated care approaches may combine ideas from across multiple practice fields: new locations of care, with changing professional roles for the provision care, increased levels of peer support, and capitalising on the benefits of new technology. Integrated care models often have an emphasis on patient empowerment and control.

The bringing together of health and social care services is increasingly at the heart of approaches, particularly for those with complex needs. In Pembrokeshire, Wales, the Community Care Closer to Home project brought together professionals from both fields into “community resource teams” to co-ordinate care for their residents, who predominantly live in rural areas. Patient-reported data suggests increased levels of confidence and independence. In Geraint, the Netherlands, a wide range of professionals from multiple-disciplines now provide an integrated dementia care service. Each individual patient has a designed case manager who then co-ordinates a team of medical professionals (General Practitioners, nurses, hospital staff etc.), specialists (psychiatrists, psychologists, dementia home care nurses), and social care/ welfare services from both public and third sectors.

#### **Norrtalje, Sweden**

Since 2004 Stockholm County Council and Norrtalje local authority have been working together through a joint governing committee to deliver health and social care services for the local population. Previously health was the responsibility of the County Council while social care was commissioned and delivered at the local level.

There is now a joint funding model and one organisation responsible for health and social care which has provided a more integrated and seamless service to patients. In particular there is an emphasis on providing patients with a case manager who coordinates care from across multiple services and plans individual patient pathways. At the same time, the joint committee has increased its focus on health promotion and preventative approaches to public health

Health and social care is delivered via TioHundra, a company which is owned and managed by the joint committee. Delivery by one provider means that digital patient records can be integrated and the potential for this is under continual development. The payment system in place, via a single funder, also serves to incentivise TioHundra to focus on health outcomes rather than the number of services provided.

Although much of the effort related to integrated care is focused on helping citizens who already have health and social care needs, there is also an increasing focus on taking an integrated approach which also combines preventative and whole population public health strategies. For example, the Regional Health System of Tuscany designed an Expanded Chronic Care Model designed to be preventative but also to improve the delivery of existing services. The benefit of integrated approaches can be seen in Denmark where all citizens over the age of 75 are offered two home visits a year from trained nurses who offer advice and support on health and social care needs. It is designed to promote overall health and wellbeing. The programme has been highly successful, increasing the physical activity and functional levels of older people, and reducing both the number of falls and the number of days in nursing homes.

## **South Karelia, Finland**

Since 2010, primary and secondary health care, dental care, and social care have been brought together as one service, delivered by Eksote, in the district of South Karelia. The district covers nine municipal areas, each of which commissions services from Eksote based on their population needs, with an aim to provide patient-centred and locally tailored care. All citizens in the region (around 133,000) are covered and services include family welfare and social welfare, as well as health and wellbeing promotion programmes.

Eksote a budget of approximately 370 million euros. The move to integrated service provision was driven not only by a desire to improve care and coordination of services for residents, but also by a need to create financial savings and efficiencies. Eksote has one administrative framework which covers all the services it provides and has developed a common set of cultural values.

The functional integration has led to saving across management, financial systems and in personnel costs. It also means that citizens have one Electronic Health Record (EHR) which can be accessed by any health care professional in the region, and one Electronic Social Care Record. The single electronic health records are also enabling Eksote to trial new e-/m-/tele-health and tele-care solutions in the region, important given the large rural population.

One example of how integration can be seen 'on the ground' is the development of new styles of welfare centres, replacing traditional health centres, which now house health and social care workers, e-services, and prevention and rehabilitation services. Mobil clinics which bring together medical and dental care, as well as health promotion activities, are also covering rural areas.

Results from the first few years show significant cost savings and improvements in health outcomes, such as a 15% reduction in costs for delivering home care, or significant reductions in waiting times for an integrated mental health and substance abuse service, while increasing productivity and reducing costs.

Other models of integrated care are characterised by an emphasis breaking down barriers between those receiving care and the wider communities in which they live. PueD in Dortmund, Germany, is a local centre where a nursing home, therapy centre, and pharmacy are in one building, alongside a bistro. Health and social care services are integrated within the nursing home but the aim is to also ensure a sustainable neighbourhood by providing spaces and amenities which bring together people from different generations and with and without disabilities.

### **Ammerudhjemmet, Norway – the open nursing home model**

People living in nursing homes are frequently socially and culturally isolated. Interaction with the surrounding community is often limited to special occasions with events usually designed around one-off visits from outsiders.

The nursing home Ammerudhjemmet in Norway inverts this model so that the nursing home is itself becomes a resource for the community, providing a central hub for a variety of activities. The centre includes a café, library, swimming pool, and hairdressers. It also acts as a cultural centre for the whole community with responsibility for arranging the annual “bydelsdagene” (the local urban district festival). It is the venue for a weekly timetable of concerts, film shows and so on. In this way the centre provides opportunities for the nursing home residents to be a natural part of the local community.

(You can see a film about Ammerudhjemmet, developed by the INNOSERV project at <http://www.inno-serv.eu/content/care-older-people-community-setting-ammerudhjemmet>)

In many regions, fully integrated care is still an aspiration. However, steps are being taken to improve working across health and social care sectors in other ways. For example there are also significant benefits to be gained from enabling professionals from different backgrounds to collaborate and share knowledge, either with or without direct connection to patients. ParkinsonNet is an internal network of over 2,700 medical and allied health professionals. It facilitates an exchange of ideas across disciplines and borders, promoting best practice and innovation to improve care for people with Parkinson's disease. LinkCare is a Spanish integrated care open platform which allows healthcare professionals to share clinical knowledge around a patient centric health care model. The LinkCare mobility module allows patients to also interact using their mobile.

### **M-health and e-health applications**

*Forms of innovation typically involved: new service, new form of delivery*

In the field of social innovation, there is considerable interest in the potential for digital technologies to contribute to developing new approaches to social challenges. The European Commission recently funded a large research project into the concept of ‘digital social innovation’, which sought to define and understand the potential of this area, as well as to map digital social innovators along with their projects and networks.<sup>22</sup> Technology clearly plays a major role in many of the innovations discussed so far, its use being an important enabler of new practices related to patient control and personalisation, peer support networks and new locations for care. So although ICT should not be thought of as a standalone area of innovation (but rather a tool used in myriad innovations in different ways) m-health is proving a rich area for innovation in health and social care in its own right.

The rapid and near universal spread of mobile technologies throughout the developed and developing world over the last decade has thrown up huge opportunities for new approaches

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<sup>22</sup> The project defined digital social innovation as ‘a type of social and collaborative innovation in which innovators, users and communities collaborate using digital technologies to co-create knowledge and solutions for a wide range of social needs and at a scale and speed that was unimaginable before the rise of the Internet’. For more information see <http://www.nesta.org.uk/project/digital-social-innovation> Accessed 19th June 2015

in healthcare. According to the European Commission's digital agenda for Europe, there are nearly 100,000 mHealth apps available globally.<sup>23</sup>

In the developing world, mobile health applications are being used to bridge gaps in healthcare delivery systems, particularly with remote populations. Medic Mobile is one organisation that has developed a mobile software and technology platform for community health workers (CHWs), typically the frontline individuals in healthcare in rural settings.<sup>24</sup> Medic Mobile's applications can provide checklists, protocols reminders, and other tools and information to CHWs, as well as the patients they serve.

In the developed world, many m-health applications have recently been used to develop innovations to help manage long-term health conditions, particularly where self-management is an important part of treatment. For example, the Buddy App helps individuals suffering from mental illness to record aspects of their daily life and then communicate these with counsellors and therapists.<sup>25</sup> Users can self-monitor their condition by texting details of incidents over the course of daily life. The flow of messages also helps therapists to get a more detailed understanding of why patients feel stressed or anxious at different times.

#### **TickerFit, mobile health app – Ireland**

TickerFit is an Irish based company, founded by chartered physiotherapist/exercise scientist, Avril Copeland and technologist, Greg Balmer. The TickerFit mobile application was built to empower health professionals to prescribe and deliver personalised lifestyle interventions to patients who are at risk or currently living with chronic diseases. Using the cloud based platform and smartphone technology, primary and secondary healthcare professionals can prescribe and deliver personalised programmes for an expanding range of conditions. Results are tracked in real-time using web based technologies enabling insights that drive improved patient outcomes.

For more information see <http://www.tickerfit.com/#home>

Innovations in m-health are hugely diverse and as well as enabling self-management and communication with professionals, can be used to help people with disabilities experience greater integration into social life, and widen the opportunities available to them. For example, the *Portale Context Aware* app developed by the Province of Trento, Italy, supports people with mobility problems - temporary or permanent - by providing information on places of interest and barriers/alternative routes to reach them. The app is tailored to the type of disability and provides information tailored to the needs of users, such as by geographical location, time of day, interests and personal preferences.

Innovations based around mobile applications are attracting much interest at present. However it is worth adding a note of caution here. Difficulties can arise if we begin with technologies rather than analysing the nature of the challenges inherent in health and social care systems. Evgeny Morozov calls this approach "solutionism: an intellectual pathology that recognises problems as problems based on just one criterion: whether they are 'solvable' with

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<sup>23</sup> See <https://ec.europa.eu/digital-agenda/en/mhealth> Accessed 19th June 2015

<sup>24</sup> See <https://medicmobile.org/> Accessed 19th June 2015

<sup>25</sup> See <https://www.buddyapp.co.uk/> Accessed 19th June 2015

a nice and clean technological solution at our disposal.”<sup>26</sup> And he argues that “solutionists err by assuming, rather than investigating, the problems they set out to tackle.” Given the ‘digital hammers’ at their disposal, “all problems start looking like nails, and all solutions like apps.”<sup>27</sup> Similarly, Kentaro Toyama, a technologist who worked for many years for Microsoft Research in India bringing computer technologies to poor populations, urges caution in how we think about the relationship between technology and social change. In his book *Geek Heresy: Rescuing Social Change from the Cult of Technology* (2015) he coins the ‘law of amplification’ which states that technology can only ever enhance existing aspirations and competence rather than make up for deficits in these.<sup>28</sup> With these critiques in mind, it is important to be alert to the predisposition for hype around technology solutions while at the same time acknowledging that mobile applications do indeed provide important opportunities for useful innovation in health and social care.

A field closely related to m-health and e-health is that of ‘gamification’ – the practice of making activities, usually but not always via technology, more fun and engaging to promote positive health and lifestyle behaviour. One such example of this would be *Kineage*, a serious game for the elderly developed in Spain. It is configurable for people with different physical disabilities, promoting exercise and leisure, using games to improve their health and well-being. In Finland, there is a Games for Health Finland Challenge which is a competition looking for new digital game innovations to support people's own activity and well-being. As well as encouraging individual citizens to take action, games are also being used to help health and social care professionals with their training and development. *Geriatrx* is one example, developed in the Netherlands, which enables trainee doctors to practice clinical reasoning skills in a stimulating game environment.

## **PART TWO: THE CHALLENGE OF SUPPORTING INNOVATION IN HEALTH AND SOCIAL CARE**

The practice fields outlined above offer real potential to bring important improvements to health and social care systems. How can such developments be encouraged and spread more widely? Research on innovation makes clear that supporting innovation is always a highly complex process.<sup>29</sup> Social innovations in particular require navigating complex social systems, which unlike mechanical systems, cannot always be planned and controlled in a meaningful way. What are the particular challenges of developing social innovations in health and social care?

### *Managing risk and potential for failure*

In health and social care, the stakes are often perceived to be very high – sometimes quite literally in terms of life and death - and this can contribute to a culture of risk aversion that does not leave sufficient room for experimentation. As argued in a recent report from UK think tank the Kings Fund, health systems need to be characterised by support for risk taking and

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<sup>26</sup> Evgeny Morozov, ‘The perils of perfection, The New York Times, 3 March 2013. Available online at [http://www.nytimes.com/2013/03/03/opinion/sunday/the-perils-of-perfection.html?\\_r=0](http://www.nytimes.com/2013/03/03/opinion/sunday/the-perils-of-perfection.html?_r=0). Accessed 19th June 2015.

<sup>27</sup> Ibid. For more on this argument see Morozov’s book *To Save the World Click Here*, London, Allen Lane, 2013.

<sup>28</sup> Kentaro Toyama, *Geek Heresy: Rescuing Social Change from the Cult of Technology*, Public Affairs, Philadelphia, 2015.

<sup>29</sup> See for example the summary in TEPsIE, An introduction to innovation studies for social innovators – A literature review of the methods and enabling conditions for innovation. Available online at <http://tepsie.eu/images/documents/tepsie.d1.3anintroductiontoinnovationstudiesforsocialinnovators.pdf> Accessed 19th June 2015

experimentation and “acceptance that failure is sometimes the price to be paid for innovation”.<sup>30</sup> Health innovation expert Johanna Ejbye notes that she has observed a change where there is actually now more discussion of failure and recognition that this is an inevitable part of experimentation. However, she points out that “we may talk about it more, but actually it is still hard to own up to failing”. Chris Hawker, researcher for the INNOSERV project, reflected that in his experience there is no shortage of professionals who are very interested and motivated to do things differently.

The enthusiasm of professionals, however, can often be tempered by best practice guidelines, the move to evidence-based commissioning and other regulatory practices that are designed to ensure that services are safe and to minimise risk. Crucially the risk that is inherent in carrying on with maintaining the status quo is all too often overlooked. There remains a significant challenge in managing the understanding and acceptance of risk of the wider public, commissioners and regulators.

The structure of financial systems for health and social care often inhibit social innovation and avoid any form of risk. These finance systems differ across Europe with a sharp contrast between the insurance based schemes often supplemented by private insurance and the publicly funded schemes that are ostensibly ‘free at the point of delivery’. Neither system can claim to be inherently innovative. Both lead to over-treating and a lack of preventative approach. Across the world perhaps Cuba can alone claim to be a truly preventive system.

Health and care systems are plagued by ‘wrong pocket’ problems. Savings achieved by one part of the system are pocketed by other parts either at different vertical levels or by other agencies at the same level. Costs saved (and thereby pocketed) by one agency are externalised and impact on another agencies costs. Policy integration between different agencies or between levels is difficult to achieve especially at times of austerity. Cuts to one type of agency have unintended consequences on other parts of the system – the pressure on emergency rooms in many European countries being a case in point. Similarly prevention strategies break down when key groups such as migrants find themselves excluded from health systems.

Governments across Europe are attempting to address these issues in a range of ways, often by creating innovation funds to stimulate cross-agency working. However, most of these funds are orders of magnitude smaller than the financial scale of the problems they seek to tackle.

This paper does not seek to delve into the complex world of financing health and social care systems and the relationship of such finance to social innovation. The broad question of innovative finance was the subject of the first Social Innovation policy paper and will be revisited in a future.

### *Negotiating the public and political challenge*

The majority of health and social care systems are either partly or wholly publicly owned. This creates particular challenges for innovation. Attempts to rationalise or shut down particular services can be met with fierce opposition because people form strong attachments to local services. Indeed, “producers, consumers and politicians all have powerful reasons to want to protect the pattern of provision with which they are familiar, rather than investing in less well-

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<sup>30</sup> Chris Ham, Anna Dixon and Beatrice Brooke, ‘Transforming the delivery of health and social care: The case for fundamental change’, Kings Fund, London, 2012. Available online at [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf) Accessed 19th June 2015

established alternatives”.<sup>31</sup> Even where there is a clear rationale for a reconfiguration of services there are often still high levels of concern and opposition. As Johanna Ejbye notes “people get it on an abstract level but it’s hard when it’s close to home.”<sup>32</sup> This issue is exacerbated when politicians use their influence to rally for services to be maintained, even if this is not well supported by evidence of what is needed for high quality care. However, there are examples where the challenge of decommissioning has been met – the recent rationalisation of stroke services in London is frequently cited as a particularly effective model.<sup>33</sup>

Deciding what kind of innovation is desirable also requires engaging with contested questions of value: for example, what levels of service do we deem acceptable; how do we weigh up competing priorities of different groups in society; how do we value fairness (everyone getting the same standards of service) against freedom to differentiate services? These are all complex and inherently political questions that typically need to be tackled when dealing with innovation in health and social care.

### *Measuring the costs/benefits of innovation*

Issues around health and social care impact people’s lives so broadly that it can be difficult to accurately measure the costs and benefits of innovation. For example, the benefits of a successful alcohol misuse project may benefit to budgets well outside healthcare, such as education and criminal justice. As savings do not always accrue to those who bear the initial investment there can be misaligned incentives to invest in long-term innovation projects. Further, many innovative services also require a relatively high level of up-front investment but the pay-back in terms of savings may not be seen for many years. For example, programmes which tackle obesity in younger people may only realise some benefits, such as a reduction in the number of Type II diabetes cases, years or even decades later. As Chris Hawker notes, “some budget holders will prefer to take the pain now for minimum cost rather than investing in a better way of using the money available to them”.<sup>34</sup>

However, increasingly, tools are being developed to enable more accurate tracking of costs and benefits around social projects. For example, Social Return on Investment (SROI) is a framework for measuring and accounting for a broader concept of value, telling the story of how change is created by measuring the social, environmental and economic outcomes and using monetary values to represent them.

There are also opportunities for innovative forms of financing to overcome some of the barriers to investment. “Payment by results” is one policy instrument that is gaining ground. At its simplest, in this model services are commissioned on the basis of the results they will deliver, rather than on the form of service provision and delivery. Countries such as the UK, US, Belgium, Netherlands, Portugal and Australia are piloting variations of Social Impact Bonds (SIBs), a type of payment by results contract. Typically, a SIB is a fixed-term bond based on a contract with a public sector body which agrees to pay for social outcomes achieved. Repayments by the contracting authority to investors depend on the outcomes achieved. To-date few have been applied in the health and care sector but this is likely to evolve.

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<sup>31</sup> Laura Bunt and Charles Leadbetter, *The Art of Exit*, Nesta, London 2012. Available online at <http://www.nesta.org.uk/publications/art-exit> Accessed 19th June 2015

<sup>32</sup> Interview with Johanna Ejbye, 16<sup>th</sup> June 2015

<sup>33</sup> See <http://www.kingsfund.org.uk/projects/reconfiguring-clinical-services/stroke> Accessed 19th June 2015

<sup>34</sup> Interview with Chris Hawker, 9<sup>th</sup> June 2015

Other countries are experimenting with other models of funding. In the Netherlands, “A year of care” model is being piloted.<sup>35</sup> This involves commissioning services on the basis of the whole care pathway for an individual patient on an annual basis. It focused on those with selected chronic conditions such as diabetes and chronic obstructive pulmonary disease (COPD). Early evaluations showed positive impacts on care coordination. Sweden is also testing a similar ‘bundled payments’ approach.

### *Challenges for new entrants*

New organisations with new approaches or governance structures can be a key source of innovation. However, it can be very challenging for smaller organisations to work at scale within fragmented health and care systems. Complex health and care systems which are made up of many organisations making autonomous purchase decisions require multiple negotiations with separate bodies and engaging in many procurement processes. This can be difficult for new entrants that lack the infrastructure or resource capacity to manage such processes. New organisations also find they come up against entrenched professional cultures that may be resistant to the emergence of new roles. Naomi Hasson, who developed a palliative care programme in the Basque country, found that many consultants were reluctant to lose control of their patients and would not refer families at a level high enough to prove the efficacy of the project.<sup>36</sup> However she also notes that they were able to work around this by making sure lines of communication were open and they were clear how their work and role fitted in with that of the consultants.

### *The allure of the new*

Developing a new approach or service is often exciting. Johanna Ejbye who has been involved in managing numerous innovation projects in the National Health Service in England notes that there tends to be a lot of energy as people gather supporters for an idea and win funding support.<sup>37</sup> However, it is much more difficult to get people excited about implementing something we already know works elsewhere. While much of the current discourse may suggest a realisation that diffusion and adoption of innovation is equally important to generating new ideas, this is not always matched by reality. There tends to be little reward or recognition for organisations that adopt systematically what others have already developed.

The benefits of scaling existing solutions, replication, and adaptation are all too often underestimated but there are many examples of the success of such approaches. In the UK, Emergency departments share anonymised information with the police about the location and nature of violent incidents. This approach has been demonstrated to improve the effectiveness of local targeted policing and in reducing the number of serious violent offences recorded, and violence-related hospital admissions. This model was originally piloted in Cardiff before being replicated elsewhere in the UK. It is also now being transferred to the USA. The costs of ideation and early stage innovation are saved by taking a systematic approach.

This problem is beginning to be more explicitly recognised. Vijay Govindarajan and Chris Trimble have argued that although ‘ideating’ is the more exciting, energising part of innovation processes, there needs to be just as much emphasis on executing good ideas as generating

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<sup>35</sup> de Bakker DH, Struijs JM, Baan CB, Raams J, de Wildt JE, Vrijhoef HJM, Schut FT (2012). ‘Early results from adoptions of bundled payment for diabetes care in the Netherlands show improvement in care coordination’. *Health Affairs*, vol 31, no 2, pp 426–33.

<sup>36</sup> Interview with Naomi Hasson, 4<sup>th</sup> June 2015

<sup>37</sup> Interview with Johanna Ejbye, 16<sup>th</sup> June 2015

them.<sup>38</sup> The work by the European Innovation Partnership on Active and Healthy Ageing with a focus on the potential for “scalability, transferability and replicability across Europe” at its “reference sites” is an important step.

There is also emerging support for more systematic attention to the challenges of implementing innovation in organisations. For example, Carl May has argued for the importance of well-developed implementation theory which uses an inter-disciplinary perspective to examine how individuals take actions in conditions of complexity and constraint.<sup>39</sup>

### **7 key themes for innovation in social services**

The INNOSERV project, which ran from 2012 to 2014, was established to identify, evaluate and reflect upon innovative practice in the provision of social services across Europe. A key output of the project was a set of seven themes that should be taken into consideration when thinking about service innovation going forward. The focus here went beyond health to look at social services in general, but the points are all highly relevant to health and social care. Any consideration of innovation within social services will need to consider:

1. User centred services and approaches – the importance of putting users at the heart of all service innovation
2. Institutional and organisational development – the need to consider not just the innovation itself but the surrounding institutional frameworks that represent the conditions for organisations to operate in and innovations to emerge
3. The policy framing of innovation – the need to consider how the policy discourses will affect the perception of legitimisation of social service innovations
4. The governance of innovation – the importance of looking at governance issues, for example with the introduction of new forms of provider
5. The embeddedness of innovation – a recognition that cultural context has a major impact and how and why innovations are taken up
6. New technologies – a recognition of the potential enormity of the impact of technology and particularly data on the provision and character of services
7. Outcomes and improvements – the importance of finding effective ways of measuring the impact of innovation

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<sup>38</sup> Vijay Govindarajan and Chris Trimble, *The Other Side of Innovation: Solving the Execution Challenge*, (Boston: Harvard Business School Publishing, 2010)

<sup>39</sup> Carl May, 'Towards a general theory of implementation'. *Implementation Science* 2013, 8:18

## The role of government and policy makers

The question of how to ‘scale-up’ or to spread and diffuse new approaches is a major preoccupation within policy discussions of social innovation. A 2010 report from the Bureau of European Policy Advisors argues “there is a need for more developed networks...to nurture and scale up social innovations”.<sup>40</sup> Similarly, a paper from the World Economic Forum and the Schwab Foundation entitled: ‘*Breaking the Binary: Policy Guide to Scaling Social Innovation*’ speaks of the need to “enhance and scale the impact of social innovation models pioneering solutions to many of the most entrenched social and environmental problems we face today”.<sup>41</sup>

A clear challenge for spreading social innovations is that unlike products, social innovations have to be *translated* to be effective elsewhere. Most innovations are developed to solve local health and care problems in a specific time and place. The question of wider diffusion is often of secondary importance to innovators when starting out. This means social innovations need to be adapted to fit the local context. These adaptations might concern the structure of an innovation (its formal organisational shape), the regulation that supports it, the resources used to implement it, or even the language that is used to describe and justify it.<sup>42</sup> A key finding of recent research is that the complex processes involved in adopting an innovation mean that, from the perspective of the adopting parties, it is not fundamentally different from developing an innovation in the first place. Adoption requires the same willingness to change institutional routines and dynamics that enable an innovation to emerge in the first place.<sup>43</sup> Therefore thinking in terms of two separate processes of developing an innovation and spreading an innovation may not be very helpful. Instead it may be more useful to focus on developing those factors that are conducive to innovation overall: openness, knowledge sharing, appetite for risk and so on.

What role can government and policymakers play in creating environments that are conducive to innovation within health and social care? Recent work from the TEPsIE project on social innovation suggests we understand the role of government as two-fold: as a source of social innovation itself and as a facilitator of innovation.<sup>44</sup>

*As a source of social innovation:* The public sector throughout Europe remains the central legitimised source of public value by providing public services and amenities to be consumed collectively. There is already widespread recognition that government acts as an important innovator in the technology and science fields by investing in the early stages of technologies and products when uncertainties are still too high for private companies. Now there are increasing calls for governments to recognise its status as an innovator in regard to the provision of public services. An expert group convened by the EU Commissioner for Research

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<sup>40</sup> BEPA, *Empowering people, driving change: Social innovation in the European Union*. Luxembourg: Publications Office of the European Union, 2010.

<sup>41</sup> Schwab Foundation for Social Entrepreneurship, *Breaking the Binary: Policy Guide to Scaling Social Innovation*, 2013. Available online at [http://www.weforum.org/pdf/schwabfound/PolicyGuide\\_to\\_ScalingSocial%20Innovation.pdf](http://www.weforum.org/pdf/schwabfound/PolicyGuide_to_ScalingSocial%20Innovation.pdf) Accessed 19<sup>th</sup> June 2015

<sup>42</sup> WILCO, Findings Summary, 2010-2014. Available online at [http://www.wilcoproject.eu/wordpress/wp-content/uploads/WILCO\\_findings\\_summary.pdf](http://www.wilcoproject.eu/wordpress/wp-content/uploads/WILCO_findings_summary.pdf) Accessed June 19<sup>th</sup> 2015

<sup>43</sup> Ibid.

<sup>44</sup> Victoria Boelman, Amy Kwan, John Lauritzen, Jeremy Millard and Rachel Schon, ‘Growing Social Innovation: A Guide for Policy Makers. A deliverable of the project: “The theoretical, empirical and policy foundations for building social innovation in Europe” (TEPsIE), European Commission – 7<sup>th</sup> Framework Programme, Brussels: European Commission, DG Research, 2015.

and Innovation, Máire Geoghegan-Quinn, to report on public sector innovation argued in its final recommendations that “there needs to be an attitude of experimentation and entrepreneurship (government itself needs to become bolder and more entrepreneurial)”.<sup>45</sup> It also suggested that “a new vision for the public sector is required, whereby public managers become public entrepreneurs”.<sup>46</sup>

One recent expression of this is the development of various ‘innovation-teams’ – units and groups dedicated to embedding innovation methods and practices into government.<sup>47</sup> For example, MindLab in Denmark is based in Danish Central Government and tasked with bringing a human-centred design approach public sector services. The group works on a project basis to help decision makers in the public sector to see issues from a citizen perspective. A recent project with doctors, nurses and patients at a cardio clinic at Rigshospitalet, Copenhagen involved workshops and interviews with patients to determine how they experience the physical environment of being at the clinic.

VINNOVA in Sweden has financed an Innovationsluss or sluice gate in Vasterbotten to facilitate the commercialisation of healthcare innovations within the Swedish health system. VINNOVA financed six different county council ‘sluice gates’. The idea was to stimulate the county councils to improve management and development of concrete ideas from healthcare personnel to lead to new innovations and the introduction of new technology by firms into the healthcare system.

As large complex organisations, public sector institutions can also draw on research findings about what factors are conducive to successful innovation diffusion in organisational settings. The box below summaries some of these.<sup>48</sup>

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<sup>45</sup> European Commission, Powering European Public Innovation: Towards A New Architecture - Report of the Expert Group on Public Sector Innovation, 2013. Available online at [http://ec.europa.eu/research/innovation-union/pdf/PSI\\_EG.pdf](http://ec.europa.eu/research/innovation-union/pdf/PSI_EG.pdf) Accessed 19th June 2015.

<sup>46</sup> Ibid.

<sup>47</sup> For more on this topic see the Nesta report, ‘i-teams: The teams and funds making innovation happen in governments around the world. Available online at <http://www.nesta.org.uk/publications/i-teams-teams-and-funds-making-innovation-happen-governments-around-world#sthash.AQngTatV.dpuf>. Accessed 19<sup>th</sup> June 2015.

<sup>48</sup> Findings summarized from Anna Davies and Julie Simon, ‘Growing social innovation: a literature review.’ A deliverable of the project: “The theoretical, empirical and policy Foundations for Building social innovation in Europe” (TEPSIE), European Commission - 7th Framework Programme, Brussels: European Commission, DG Research, 2013. Available online at <http://tepsie.eu/images/documents/d71final.pdf> Accessed 19th June 2015.

## Learning from organisational innovation

Given that most health and social care innovations need to interact with large existing systems, the literature on the nature of organisational innovation is highly relevant here. As recently highlighted as part of the TEPsIE project, there are key points to bear in mind when considering the adoption of innovations in organisational settings:

- It is important to think through what exactly constitutes the ‘innovation’ to be spread. Innovations are usually made up of a core irreducible element (e.g. the idea of a peer support programme for patients) and then a set of various structures and systems that surround it (the funding model, the training process for volunteers and so on) that are needed to support its implementation.
- While early research emphasised the importance of finding a ‘champion’ for an innovation within an organisation, more recent work focuses on the working of teams. For example, how do team leaders behave and does this encourage speaking freely about opportunities and challenges; how do leaders frame the benefits of innovation? Does the team culture allow for the behaviour change required by a new innovation?
- While evidence in favour of the effectiveness of an innovation is important, it is certainly not sufficient to ensure that an innovation diffuses in practice. Furthermore, researchers have challenged the idea that there is a single entity called ‘evidence’ – rather there are competing bodies of evidence that will be debated and discussed amongst professional networks.
- The ‘absorptive capacity’ of the organisation is key – how well does it value, acquire and apply new knowledge? This concept of knowledge as the critical resource for an organisation highlights the importance of an organisation’s relationships with the outside world.
- It is easy to think of innovation adoption happening in a structured and orderly way, but this is to misrepresent reality. As Tricia Greenhalgh et al (2004) note “organisations should not be thought of as rational decision making machines that move sequentially through an ordered process of awareness-evaluation-adoption-implementation. Rather the adoption process should be recognised as complex, iterative, organic and untidy.”

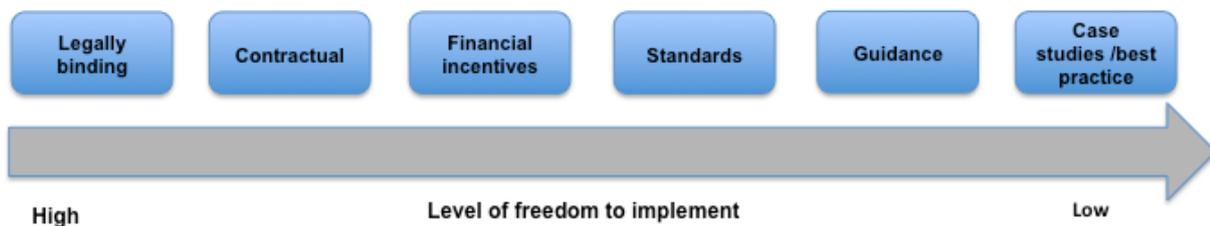
*As a facilitator of social innovation:* Governments can promote social innovation by using all the resources at their disposal to create conditions whereby actors from across sectors can develop new approaches and practices to respond to social needs. The measures at their disposal include:

*Funding* – developing financial instruments that are particularly suitable for those trying to fund innovations. An example is the emergence of social investment in recent years, which involves the use of repayable finance to achieve social as well as financial return. At the European level, the European Social Fund has been used to support innovative approaches and for 2014-2020, social innovation has been explicitly integrated into the structural funds regulations and reporting mechanisms. Member States have shared management of the Structural Funds and can encourage social innovation in the health and care sector recognising that in many cities and regions these two sectors are major employers and drivers of the local economy. The Employment and Social Innovation programme (EaSI) fund which has replaced PROGRESS will finance targeted social experiments as well as new financing models for social enterprise.

*Stimulating demand for social innovation through commissioning and procurement processes* – The EU has published a procurement directive that asks public authorities to consider social value in their procurement decisions<sup>49</sup>. These EU-wide regulations are converted into regulations in each of the Member States. For example, in the UK, the Social Value Act requires those who commission public services to consider how they can secure wider social economic and environmental benefits as well as achieving good value for money. However, a recent review of the Act found that there needed to be much more work done to promote understanding about how to apply it, including how to define social value and apply it within existing procurement rules.<sup>50</sup>

*Developing the evidence base for social interventions* – Governments have various levers available to them to support the diffusion of innovation, from hard aspects such as legally binding statutes, contractual terms and financial incentives through to softer approaches such as guidelines and the promotion and exchange of good practice. Despite these levers, the spread of innovation in this field is slow and more attention is needed to understanding how it can be accelerated.

**Figure 1: Levers that can drive diffusion of innovation<sup>51</sup>**



These levers all require strong evidence about effectiveness. Comparative analysis of evidence for health has been pioneered by the Cochrane Collaboration<sup>52</sup> which provides an open platform to review what is known about clinical trials and other evidence on treatments and care. Within new drug and treatment innovations for healthcare, there are regulatory bodies that play a key role in the adoption by making clear the evidence base – for example the National Institute for Health and Care Excellence in the UK<sup>53</sup> (NICE). There are increasingly calls to develop similarly robust evidence and recommendations concerning social practices. J-Pal Europe based in Paris has launched the ‘SPARK’ network (Social Policy Analysis for Robust Knowledge).<sup>54</sup> SPARK is part of a larger initiative from the EU Directorate General for Employment, Social Affairs and Inclusion to promote the benefits of social policy experimentation throughout the EU. In the new programme period (2014-20) the Employment and Social Innovation Programme (EaSI<sup>55</sup>) will continue this work.

*Support for networking and capacity building* – Bringing diverse groups together is often very fruitful for innovation. Government can play an important role in facilitating the development of these exchanges between different kinds of actors by providing funding and political support for such initiatives. The establishment of the Academic Health Science Networks in England

<sup>49</sup> [http://ec.europa.eu/growth/single-market/public-procurement/rules-implementation/index\\_en.htm](http://ec.europa.eu/growth/single-market/public-procurement/rules-implementation/index_en.htm)

<sup>50</sup> See <https://www.gov.uk/government/consultations/social-value-act-review> Accessed 19th June 2015.

<sup>51</sup> Figure adapted from ‘Cracking the innovation nut: diffusing healthcare innovation at pace and scale’ NHS Confederation. Available online at <http://imperialcollegehealthpartners.com/wp-content/uploads/2015/06/Cracking-the-innovation-nut-briefing-5-June-2015.pdf>

<sup>52</sup> See <https://www.cochrane.org> accessed 17 January 2016

<sup>53</sup> See <https://www.nice.org.uk/> accessed 17 January 2016

<sup>54</sup> See <http://www.povertyactionlab.org/node/9348> Accessed 19th June 2015.

<sup>55</sup> See <http://ec.europa.eu/social/main.jsp?catId=1081>

is a good example of this (see box below). At the European level, the European Innovation Partnerships (EIPs) were established to address major societal challenges that are of common concern across Europe, by scaling up and accelerating the development and deployment of innovative new approaches.<sup>56</sup> The first European Innovation Partnership on Active and Healthy Ageing (AHA) was initiated in October 2010 to tackle the common challenge of an ageing population across Europe.<sup>57</sup> EIPs are distinctive in that they are active across the whole research and innovation chain. This means that they bring actors together from all levels (EU, regional, national) in order to step up research and development efforts, coordinate investment in demonstrations and pilots, anticipate and fast track any necessary regulations and standards, and mobilise demand through better coordinated public procurement to ensure that innovation breakthroughs are more quickly brought to market.<sup>58</sup>

To accelerate innovation in health and social care policy makers need to take a systemic view and understand all the elements of the social innovation ecosystem including those levers mentioned above. There are no single policies that can achieve this, rather the orchestration of a wide range of policies, regulations, actors and ultimately services. This requires an understanding of how all these elements relate and work together across the public, private and social sector, across levels of government while at the same time finding new ways to engage citizens as users in the coproduction of next-generation services.

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<sup>56</sup> See [http://ec.europa.eu/research/innovation-union/index\\_en.cfm?pg=eip](http://ec.europa.eu/research/innovation-union/index_en.cfm?pg=eip) Accessed 19th June 2015.

<sup>57</sup> See [http://ec.europa.eu/research/innovation-union/index\\_en.cfm?section=active-healthy-ageing](http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing) Accessed 19th June 2015.

<sup>58</sup> The effectiveness of the EIP model has recently been evaluated: [http://ec.europa.eu/research/innovation-union/pdf/outriders\\_for\\_european\\_competitiveness\\_eip.pdf#view=fit&pagemode=none](http://ec.europa.eu/research/innovation-union/pdf/outriders_for_european_competitiveness_eip.pdf#view=fit&pagemode=none) Accessed 19<sup>th</sup> June 2015.

## **Academic Health Science Networks, National Health Service (NHS) England**

Academic Health Science Networks (AHSNs) were set up in England in 2013 in response to the recommendations of the paper *Innovation Health and Wealth: accelerating adoption and diffusion in the NHS*. Their task is to identify, adopt and spread innovation and best practice across the service. These networks connect health organisations with academia and industry in order to accelerate the process of innovation diffusion and facilitate the adoption and spread of innovative ideas and technologies across large populations. They are autonomous organisations with devolved powers to reflect and respond to issues within their local health economies. Fifteen AHSNs have been given licenses to operate and cover the whole of England. Each AHSN covers a population of 2-5 million and has an annual budget of around £3-5 million.

The idea is that these organisations have common objectives but there is flexibility in terms of the routes they take to achieve these. As Johanna Ejbye, former NHS England National Lead for AHSNs explains, this reflects the understanding that “it is really difficult to programme manage innovation; while you might have clear outcomes it’s hard to micromanage how you get there”. The AHSNs are designed to provide the right balance of support, accountability and freedom.

Although they are still in an early stage of operation, there are already some examples of success. In the area of chronic pain management, the South London AHSN has developed and rolled out a community based rehabilitation programme for joint pain with significant potential annual savings. And within telecare, Simple Health/Flo a text based telehealth system developed within the NHS is now being supported and rolled out by the AHSNs West Midlands, East Midlands, North East and North Cumbria.

For more information see the AHSN Network publication, *Spreading innovation, improving health, promoting economic growth: Impact review 2015*. Available online at: [http://uclpstoneuprod.blob.core.windows.net/cmsassets/150604\\_AHSN-Impact-Report-final.pdf](http://uclpstoneuprod.blob.core.windows.net/cmsassets/150604_AHSN-Impact-Report-final.pdf) )

# CONCLUSION

The case for innovation in health and social care is clear. Budgetary constraints combined with changes in the kinds of issues that these services must address such as ageing populations and the prevalence of long term conditions necessitate innovation to develop new processes, tools and delivery mechanisms. The statement that health and social care systems require social innovation is therefore non-controversial. But nor is it particularly helpful. Rather, we need to identify the specific kinds of innovation will be important to meeting the challenges in health and social care, and how these innovations can be brought about and spread. In this report we have set out five practice themes under which some of the most significant social innovations in health and social care are located:

- Patient empowerment in service design and delivery
- Peer-to peer support
- Changing professional roles
- New locations of care
- m-health applications

We have explored what each of these look like in practice using short case studies sourced from the across global policy community. In addition, there will need to be new financial models and incentive structures that seek to promote innovation rather than to stifle it.

Enabling innovations in these areas to take root more widely requires overcoming a number of key challenges:

- It requires a more nuanced approach to risk. Clearly, undertaking significant change in the way health and social care systems are delivered entails risk. But there is also risk associated with maintaining the status quo which with health cost inflation and an ageing population with high needs is hard to finance. Cultural shifts are needed in these systems where politicians and policy makers really understand that risk involves a real possibility of failure. Understanding risk, requires new forms of programme design which are able to distinguish between error and failure and which encourage robust testing at different scales of delivery.
- There needs to be careful negotiation of changes to public services because these are services to which citizens are deeply attached and which they frequently use at times of great difficulty and crisis. Not surprisingly, any change can provoke emotional reactions from users. This sensitivity requires more open discussion about the kind of services citizens want. Questions of values are unavoidable here: what minimum levels of service are acceptable? Is a consistent or uniform approach where citizens are everywhere entitled to the same levels of care more important than enabling local control and diversity? How are services personalised and built around individuals in a culture of service provision? These are questions that need to be debated openly and cannot be glossed over by introducing a bland commitment to innovation.
- Innovation is difficult in a monolithic system. One way forward is to encourage new entrants to the provision of health and social care services – such as social enterprises and new forms of use-led service. This entails ensuring that such organisations are able to engage in procurement processes and to break through entrenched professional cultures.

- Finally, it will be necessary to look beyond the allure of setting up something new and confront the challenge of implementing projects or processes that are known to have worked well elsewhere. Reinventing the wheel is as common in health and social care as in other fields.

What is the specific role of governments and policymakers here? This report has highlighted that social innovation cannot be micro-managed or even planned in a linear outcome oriented fashion. It is about changing work cultures as well as introducing new processes and techniques. Nevertheless, governments can contribute to the emergence and spreading of innovation in health and social care in two main ways. First, governments can themselves act as a source of innovation in relation to public services. One way of acknowledging this role is through the development of specific teams and units in government with a specific innovation remit. Second, they can also draw on existing learning about how large organisations are best configured to encourage innovation. Second, governments can act as a facilitator by helping to create the conditions for actors across different sectors to develop new approaches that respond to health and social care needs. This involves developing a strategy for initiatives such as:

- Developing financial instruments that are suitable for those looking to fund innovations
- Stimulating demand for social innovation through setting up favourable commissioning and procurement processes and particularly through exploiting new provisions in EU procurement legislations
- Investing in developing the evidence base for social innovations and ensuring that good practice is disseminated
- Supporting networking initiatives to promote exchange and learning to bring difficult actors together in a way that can stimulate innovation.

Health and social care are quintessentially multi-level policies in which financial models are determined at national level while most provision happens at regional or city and local level. Europe has very diverse systems which have different strengths and weaknesses. The EU can play a key role in enabling these systems to face unprecedented challenges and to learn from each other about how to innovate and integrate services and deliver them to better meet the needs of citizens.

