International Futures Forum

# Understanding, forming and fostering a culture of transformative innovation in health and social care

**A knowledge exchange programme of the Scottish Universities Insight Institute**
**SUII, Glasgow, 24 August 2016**

## Summary

This was the third workshop in a series to explore how to foster a culture of transformative innovation in health and social care. The first, in May, had prepared for an intensive two day session at the Boathouse in Aberdour in early June.

That workshop had explored the landscape of change and transformation relating to health and social care, had envisioned and imagined a radically different system for the future and had finished by inviting participants to inhabit that future through role-playing – in specific roles in specific organisations.

The June workshop had revealed a potential new viable pattern for health and social care. This follow up workshop was convened to conduct a deeper dive into that pattern:

- To look again at the design work already conducted to see if it stands up to scrutiny in the cold light of day;

- To think more carefully about the pattern and the system as a whole, rather than just the individual elements/organisations, interrogating it from a number of different angles;

- To enrich the model, validate it, find a language to communicate it to others; and

- To identify the next areas of research, action and inquiry required to put the model into practice.

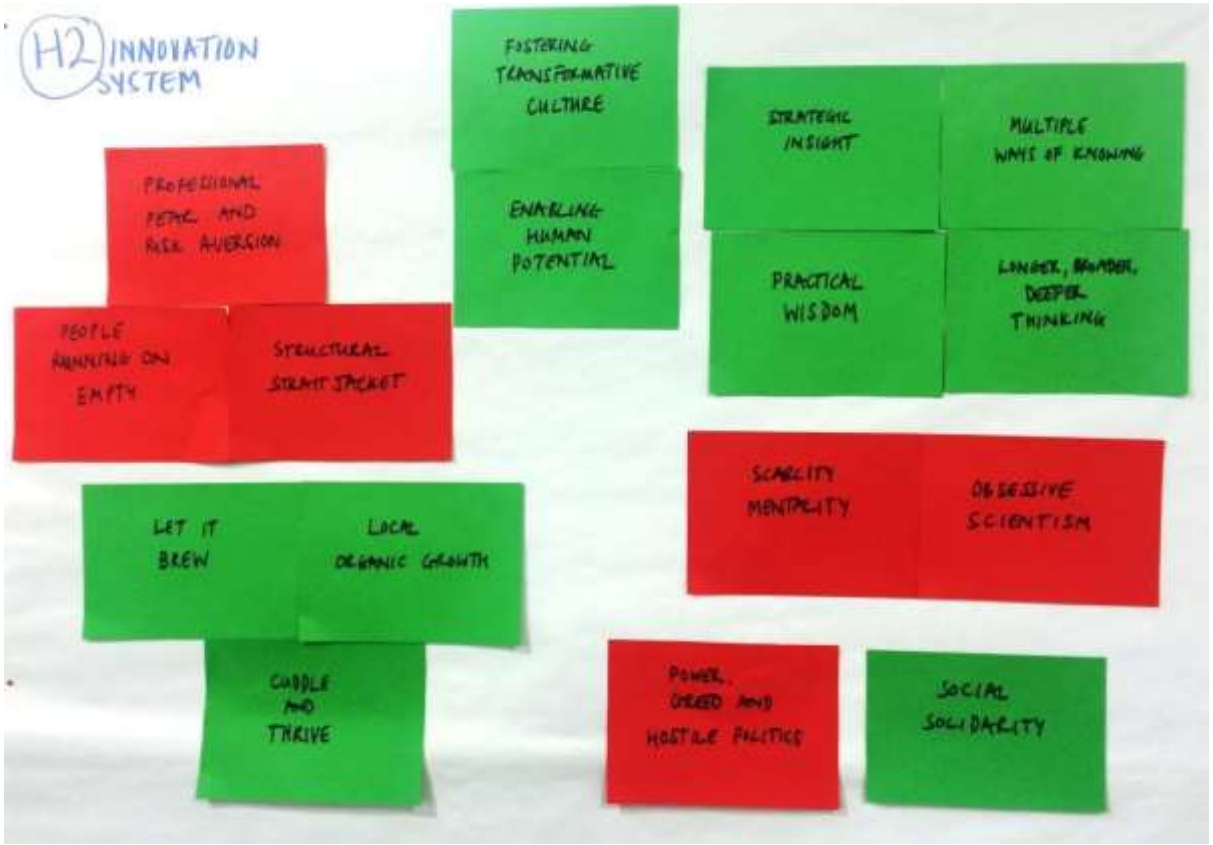
## Getting Started

Partly to draw a link with the previous workshop, but also to settle minds and hearts for the present one, Margaret Hannah again offered a minute's silence and a presence card (breathing exercise) to open the space.

She then read the e e cummings poem that Barbara Hrovatin had offered on leaving the workshop in June:

*How fortunate are you and I*
*whose home is timelessness.*
*We who have wandered down*
*from fragrant mountains of eternal now*
*to frolic in such mysteries*
*as birth and death*
*A day, or maybe even less.*

Graham Leicester then welcomed participants to the workshop, especially those who had not been able to be at the previous session in June. A full report of that event had been circulated. Graham recapped the process, pointing in particular to the three horizons framework, the characteristics of the desired third horizon that had been identified and the clustering of enablers and constraints for transformative innovation in health and social care that had emerged out of the previous conversation (see below).




He recalled that we had discovered in the previous workshop that to be effective transformative innovation needs both a process for transforming practice *and* a description, as detailed as possible, of the new system we are trying to bring into being. These two processes are intimately related. Once we have invented the new system and brought it into being then we can use 'sustaining innovation' and all the usual mechanisms for improvement in order to maintain it over time.

We also noted that the new system is inherently local. In the present system locality is anathema – 'the postcode lottery'. In the new system it is inherent since it will inevitably be more complex and will draw on local sources of abundance. And we

had noted that the same word will show up differently and mean different things in the different systems – eg ‘integration’ or ‘complexity’.

Having progressed a long way towards inventing a new system in the previous workshop, the task today would be to take a deeper dive into those original ideas and in particular see whether they stack up in the cold light of day as a viable pattern of activity, a system that might conceivably provide in the future the kind of stability that our first horizon systems have offered in the past.

Magdalena Schamberger of Hearts and Minds Ltd then led the whole group in an exercise designed to wake up and stimulate our bodily intelligence – which involved all of us running around the room at one point waving our arms above our heads.

**Reconnecting with our Third Horizon Organisations**

After this preparation, Graham handed over to Bill Sharpe to guide the group through the substance of the day. Bill recalled the programme he had watched the evening before about the development of the first jumbo jet. Our task today was similar: we have had the great ideas, but now we need to finish the job of putting them all together, inventing a system that will ‘fly’. We are the creative integrity and it is our role to bring the things we have been imagining into reality. Our role is to finish the job of inventing the system.

The Three Horizons framework is a systemic model – illustrating how we live our lives in systemic patterns, not just as a succession of events. The first horizon is ‘patterned’ in that if we were to remove any piece of the system (eg an acute hospital) then it will be replaced with another because the pattern requires it. This system is constantly innovating – in order to maintain the pattern as the world changes around it. Part of its power is that it absorbs new discoveries coming along in order to maintain and extend itself (as it is now using new technologies and big data for example). Transformative innovation reconfigures relationships so that new entities can come into being and be maintained.

Transformative innovation is innovation that helps shift the system to a new place – very quickly in the technology world, much slower (perhaps a generation) in the healthcare system. When the new system is established then it will require sustaining innovation to maintain the new pattern of relationships. We will need to consider the sorts of innovation that need to go on in the system we design in order to keep it healthy and lively. But those are logically distinct from the innovation needed to shift us into the new pattern in the first place.

Bill invited the group first to look back at the three entities that had been envisaged in the June workshop: the Live Well Centre, the Fife Community Benefit Organisation, and the Local Care Exchange. Looking at the descriptions of these organisations and the roles that they play in the landscape, do they still stack up as reasonable, viable, potentially practical? Or do they now look fantastical, flaky, unrealistic in some ways? Each entity was examined in turn and discussed in the group.


**Live Well Centre**

The elements of the Live Well Centre that look attractive are:

- Offering a range of accommodation to diverse needs
- Facilitating journeys of recovery
- The reinvention of healthcare as educative and integrated care (not in the headless chicken sense)
- It is local, for 5-10K people
- It is community designed and owned
- It represents an interdisciplinary approach at its core
- It is about actively generating and processing knowledge and learning, and the 'knowledge ninja' role is an attractive concept that has already stuck
- We can point to examples in present, so it is practical
- The idea of a quality mark for the kind of practice the Live Well Centre supports is something that looks practical and useful

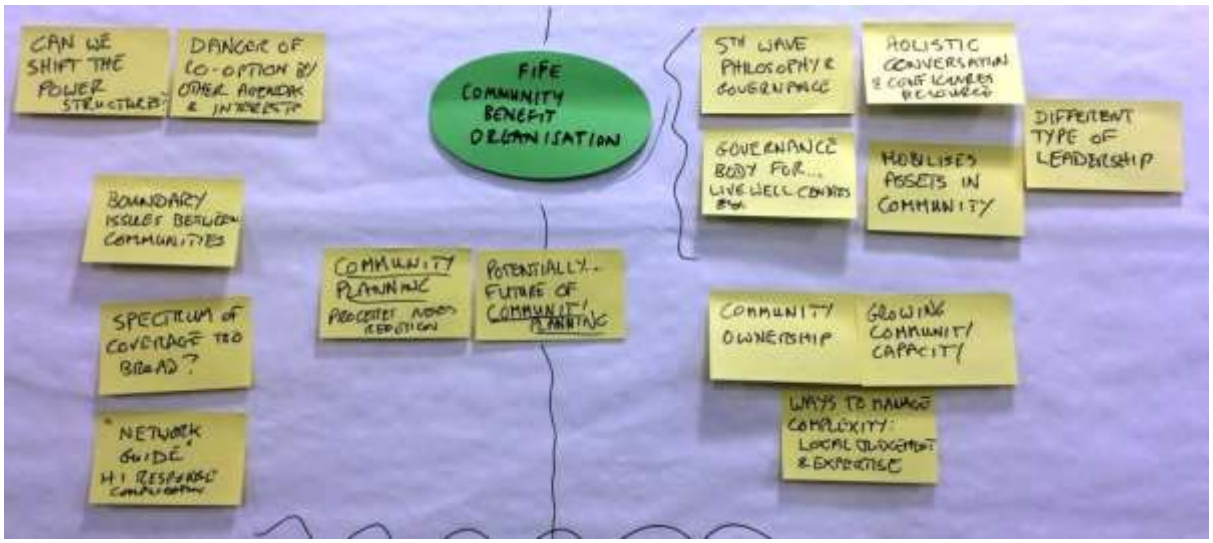
At the same time there were elements that might need more work or that might be misinterpreted, notably in relation to the last two positives listed:

- The fact that there are already examples around raises the danger that this model might get trapped in a first horizon pattern
- The quality mark needs to be carefully designed to satisfy the first horizon too: 'no quackery'
- There might be a danger of this model being competed out of business by more efficient first horizon offerings

**Fife Community Benefit Organisation**

People found it more difficult to get inside the Fife Community Benefit Organisation again. But the discussion showed that a number of elements remain attractive in the idea:

- It embodies a Fifth Wave philosophy as discussed at the previous workshop and reflects that in its governance
- It encourages a holistic conversation and configures local resource
- It offers a different type of leadership
- It mobilises assets in the community
- It can be the governance structure for other institutions, including the live well centres
- It is about growing community capacity
- It entrenches and extends community ownership
- It offers a way of managing complexity by drawing on local judgement and expertise
- This could be the future of community planning



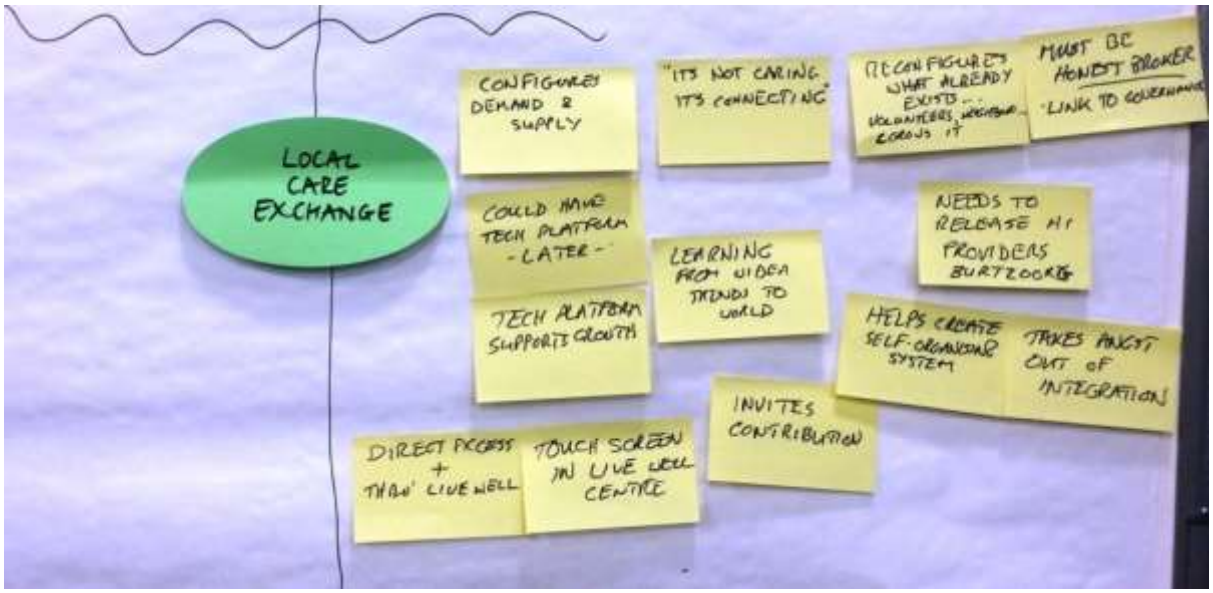

And there are aspects that are less convincing or that still need to be addressed:

- Community planning as is could well frustrate the emergence of the Community Benefit Organisation, unless community planning processes are redesigned
- There is a danger of co-option of the model by other agendas and interests
- The model implies considerable shifts in existing power structures – is that really possible/feasible?
- What happens at the boundary between one community and another and who gets to draw those lines?
- The spectrum of coverage may in practice be too broad?
- The idea of a “Network Guide” that was one of the offerings discussed at the last workshop now feels like a first horizon response to complication rather than a creative response

**Local Care Exchange**

Finally the group turned to the Local Care Exchange. By this point the conversation was less about assessing the more or less convincing elements of the idea and more about redesigning the basic model to improve it. The suggestions for what works in the Local Care Exchange model and how it might be embellished or improved were:

- It configures demand and supply
- “It’s not about caring it’s about connecting”
- This seems feasible because it is reconfiguring what already exists (eg volunteers, neighbours) and growing that resource
- There is a link to governance: to work it must be seen as an honest broker, not corrupt or beholden to some special interest
- It needs to release existing first horizon providers to work in new ways – like eg Buurtzorg
- The design includes a commitment to learning from wider trends in the world
- It can develop into a tech platform – although that is likely to come later
- The tech platform will support growth
- This model takes the angst out of integration (no need to run round the room screaming any more)
- This model will help to create a self-organising system
- The Exchange invites contribution
- We can imagine touch screen access to the Local Care Exchange in the Live Well Centre (as well as in other venues)




**Exploring the System**

Each of the organisations imagined at the previous workshop had now been stress tested in the cold light of day and found to be largely sound. These felt like individual pieces of the final jumbo jet – but we still had to assemble them together.

Already a number of features of the transition to our desired third horizon system were becoming clear:

- The step forward is into a more complex system. The process of life generates patterns of ever-greater complexity. This is a source of abundance. At the moment we have a complicated system, not a complex one. The goal is a complex system which offers more freedom to create;

- The third horizon system will also be local. In the current system locality is anathema: ‘the postcode lottery’. Yet locality is the source of abundance. What we envisage is a complex pattern of inherently local systems;

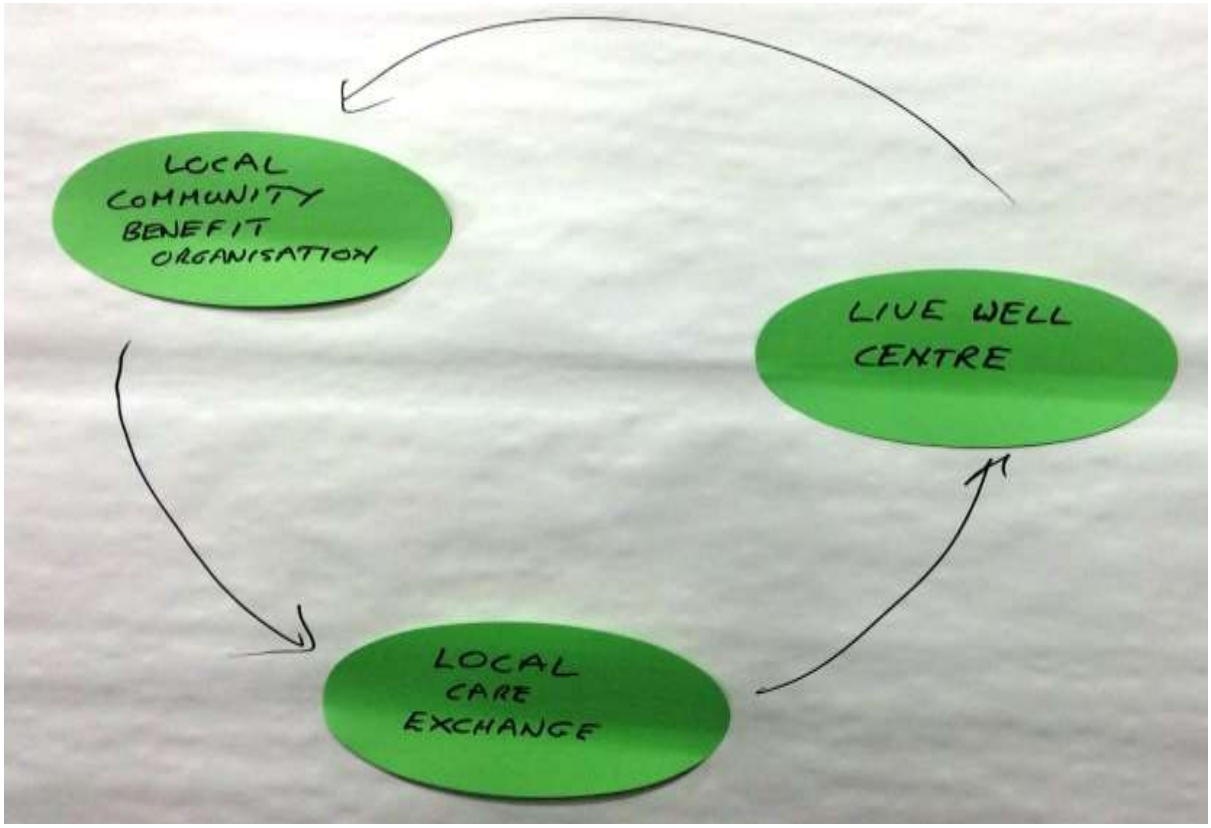
- What is needed is the institutional infrastructure to configure that complexity. In technology this is the 'platform' – that enables millions of different apps. Systems will be inherently local, but the platforms will be in common. They offer the connection between H1 and H3, a bridge and a guarantee of inter-operability. Ideally the platform, like the Local Care Exchange, will enable a self-organising system, releasing the skills and capacities (and the health) of the people.

Bill observed that a viable pattern of activity, a 'patterned integrity' that grows out of a single instance project or 'creative integrity', typically configures three functions: providers, users and governance.

The providers in a new system typically are mobilising a 'sleeping resource' such that it becomes a new source of abundance (think Uber or AirBnB).

The governance maintains the integrity of the new system, paying attention to results and reinvesting resources to enable the integrity to grow. It is the governance that makes this a systemic integrity.

The users provide the 'moment of truth' for the system. Does it work? Does it deliver? Is it providing what people want? This is where the truth of the system is manifest.




As it happens the three organisations considered map very well on to this pattern. The Community Benefit Organisation provides governance, the Live Well Centre is the point of use, and the Local Care Exchange configures provision.

Bill then used an interview format with Margaret Hannah to open up a discussion with the whole group about this system as a whole.

***Does this look convincing?***

- Yes it does. The Community Benefit Organisation will need to be commissioning innovation itself as well as governing the system. For example, exploring alternative currencies and timebanking. The CBO will need to be looking for the next move(s) to support growth. This is not only about maintaining integrity. There will be a skills development aspect as well: 21st century councillors?
- The Fifth Wave philosophy is about a sense of human potential. It explores and expresses a greater sense of what we can be. So growth should be natural, and attractive to others.
- Can people prepare to participate in this system by learning elsewhere? Is there a curriculum to follow? The disciplines of research and different from the disciplines of practice. Might this new pattern need a distinctive training system of its own?
- Higher education/ universities *could* prepare people for this system. We might need a bridge, a temporary CPD pathway, to help get people in. That could sit naturally as an adjunct to existing courses. Not an alternative but an option, a specialism. Like becoming a GP.
- The training for 'practice' needs to be expanded to include skills in conversation and in relationship, marrying H1 and H3, science and humanity. Part of the shift is to recognising and valuing individuality: individual style and authenticity, a sense of oneself and one's own special skills. There will be lessons to be learned from other more 'personal' disciplines, eg the expressive arts, and from the more enlightened medical schools. Students are already learning in this way – and are delighted to find places (like the SHINE project) to practice.
- The learning and CPD is not just for staff, it is also for citizens. What we are saying is "we want your humanity, authenticity, individuality, locality" – rather than asking people to tune it out. This is not 'training' but a process of social learning – learning from and through each other and from practice.

***What made the Nuka system work in Alaska? Can we do it here?***

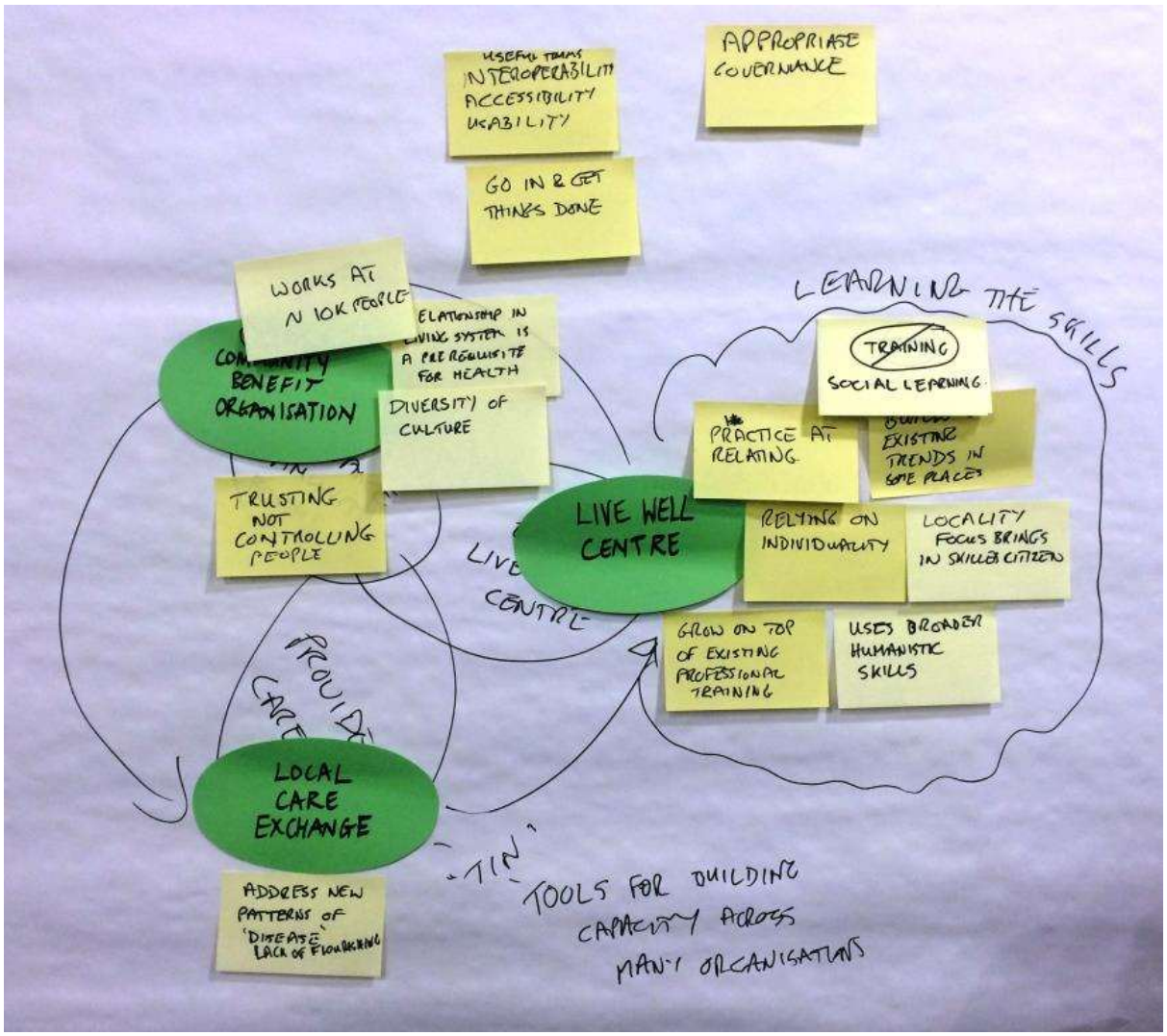
- Nuka is a native Alaskan word for a vast living system. The Nuka system of care is based on the primacy of quality relationships, which emerge from good quality conversations. The patient in this system is renamed the 'customer owner' – a jarring term, deliberately so to emphasise the change in power/status. Power lies with the community. The Nuka system belongs to them.
- If you visit the Alaskan system you get a sense in all interactions that you are deeply valued. The place itself makes you feel good. A pattern of quality relationships in a living system is a fundamental prerequisite for health. There is a strong sense of place and of seeing individuals in the context of their families, their culture and their people.

- This cultural aspect might be difficult to translate across into our context. We need to tread carefully around that now that the independence debate has made it such deeply political territory. It is true that in Alaska this was a political movement too: the native people taking back their rights. There is something to be said for that – and the land ownership debate here in Scotland touches on it.
- We need to get beyond the surface manifestations of 'culture' to the bedrock values of dignity, entitlement, identity. Lesley Riddoch touches on some of this in her book on flourishing.
- The GalGael project in Govan taps into many of these deeper cultural elements. But it struggles to maintain its own culture in the presence of the other cultures and demands that surround it. It can slip into demanding more space from the first horizon rather than growing its own third horizon pattern and systems.
- Nuka in Alaska started with a two year listening programme, a participatory process. And it has kept that ethos going – it is part of the mode of governance now. It has been transformative in the ways we have been describing, drawing on new forms of abundance. For example, many former sufferers and now care providers.

***What about the Local Care Exchange – how might that relate to existing care providers?***

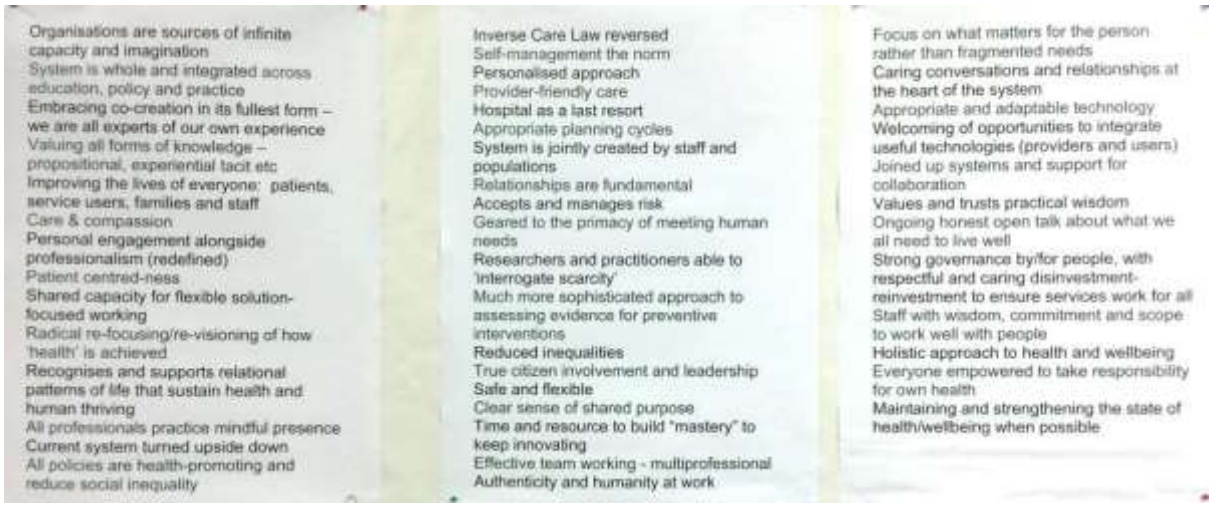
- We are the system – the practitioners in it. This is about a change of practice and philosophy for players already in the system. But it is a big system, and those of us already practising in new ways form only a small minority.
- We see our capacity growing through our own change of practice starting to uncover a local abundance. The 'competition' we face is not really with the existing system but with no provision at all. We are meeting currently unmet need – the new pattern of disease that the existing system is not set up to address (loneliness, frailty, multi-multi-morbidity).
- Having said that, we must recognise that there is *some* competition, eg home carers. So there may be job losses and there is certainly fear about that in the system. There is also a temptation from the first horizon systems to offload cases into 'community care'.
- We need the TIN – Transformative Innovation Network – in order to keep at the learning edge, maintain international links and to grow capacity across many organisations.
- The existing pattern of activity sees large amounts of money allocated to a small number of people and into the last two years of life. A *marginal* shift in that pattern (5%?) will be enough to fund everything we are inventing here.
- We are talking of a new pattern of need. It is not about disease but ill-being, lack of flourishing. This is socially shaped frailty – and there is a lot of this in older people and those approaching the end of life (but not exclusive to those groups). Hence the need for a Live Well Centre. The new epidemics are of obesity, mental distress, loneliness.
- This is an important point. We are not looking for a small share of a large 'market'. Like the best venture capitalists, we are aiming for 100% of a clearly designed segment – those languishing in ill-being. We are not seeking to improve a system: for them we *are* the system.

This part of the conversation is summarised in the snapshot below.




**Broadening The Pattern**

There followed another interlude of playful body work led by Magdalena (in which wolves chased chickens, and the old system chased the new system, in a game of tig). Then Bill invited the group to look again at the language we had previously used to describe our desired third horizon in preparation for the June workshop (see below). This helped to load up the third horizon language again.



Organisations are sources of infinite capacity and imagination
System is whole and integrated across education, policy and practice
Embracing co-creation in its fullest form – we are all experts of our own experience
Valuing all forms of knowledge – propositional, experiential tacit etc
Improving the lives of everyone: patients, service users, families and staff
Care & compassion
Personal engagement alongside professionalism (redefined)
Patient centred-ness
Shared capacity for flexible solution-focused working
Radical re-focusing/re-visioning of how 'health' is achieved
Recognises and supports relational patterns of life that sustain health and human thriving
All professionals practice mindful presence
Current system turned upside down
All policies are health-promoting and reduce social inequality

Inverse Care Law reversed
Self-management the norm
Personalised approach
Provider-friendly care
Hospital as a last resort
Appropriate planning cycles
System is jointly created by staff and populations
Relationships are fundamental
Accepts and manages risk
Geared to the primacy of meeting human needs
Researchers and practitioners able to 'interrogate scarcity'
Much more sophisticated approach to assessing evidence for preventive interventions
Reduced inequalities
True citizen involvement and leadership
Safe and flexible
Clear sense of shared purpose
Time and resource to build "mastery" to keep innovating
Effective team working - multiprofessional
Authenticity and humanity at work

Focus on what matters for the person rather than fragmented needs
Caring conversations and relationships at the heart of the system
Appropriate and adaptable technology
Welcoming of opportunities to integrate useful technologies (providers and users)
Joined up systems and support for collaboration
Values and trusts practical wisdom
Ongoing honest open talk about what we all need to live well
Strong governance by/for people, with respectful and caring disinvestment-reinvestment to ensure services work for all
Staff with wisdom, commitment and scope to work well with people
Holistic approach to health and wellbeing
Everyone empowered to take responsibility for own health
Maintaining and strengthening the state of health/wellbeing when possible

Bill then turned to the longer list of candidate organisations that might be interested in the Third Horizon system we were imagining. Would it be possible to find a place for them in the new pattern we had created? The third horizon grows because of its power to *enrol* others (not to coerce them). Could these other players be enrolled in our imagined system? Just as Apple make the decision to find ways to recruit the content industry and make it possible to download legally and expand the system from there rather than prosecute illegal downloaders. We need to make it easy for others to play in the space that we are creating.

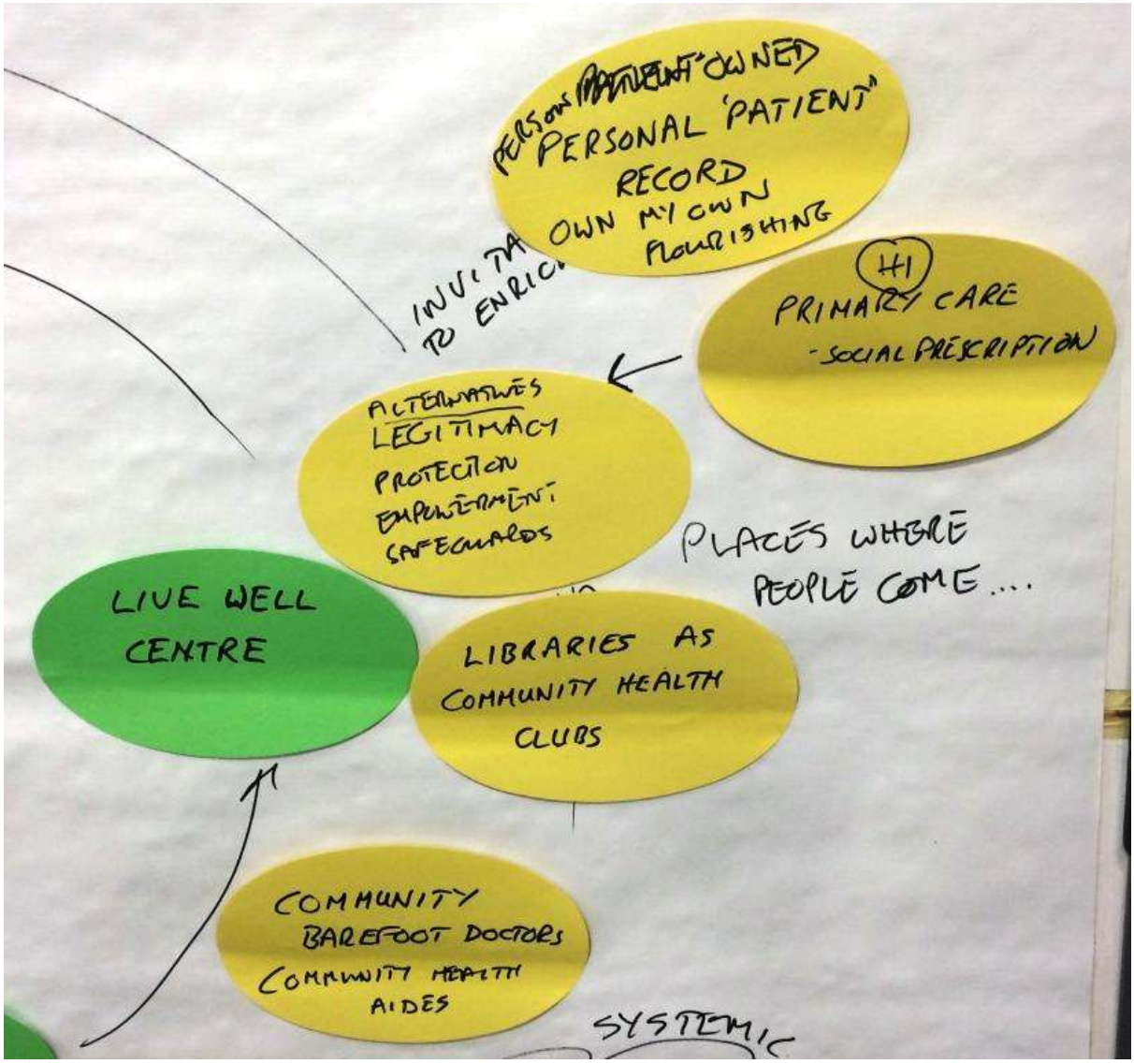

The conversation started with the notion of 'Community Barefoot Doctors'. This raised the question of standards and – at least the perception of – 'quackery'. These might more accurately be described as 'community health aides'. There would need to be some level of licensing or accreditation in order to meet the 'first do no harm' injunction and to protect people from exploitation. The same would be true of 'alternative' or complementary therapies – which would need to find their place in a broad, person-centred framework providing safeguards but also empowerment and legitimacy to what works.

The Community Health Aides would naturally find themselves drawn to the Live Well Centre. Some of the first horizon system might find connections there too: for example the GPs interested in social prescribing (we can envisage replacing the language of 'prescription' with something like an 'invitation to enrich'). It was noted how valuable people find 'places to gather'. There were examples of the 24hour McDonalds, or the Borders bookshop in Dundee and the many community groups that it effectively supported before it closed. Where do people congregate and gather today?

Libraries are a good institutional growth point. They already configure multiple activities in the communities where they are thriving, and are more likely to thrive the more overlapping activity they can attract. We might see libraries in the new pattern as community health clubs.

The discussion about person-centredness considered access to information and to patient records. In the new pattern of activity these would be co-owned and co-

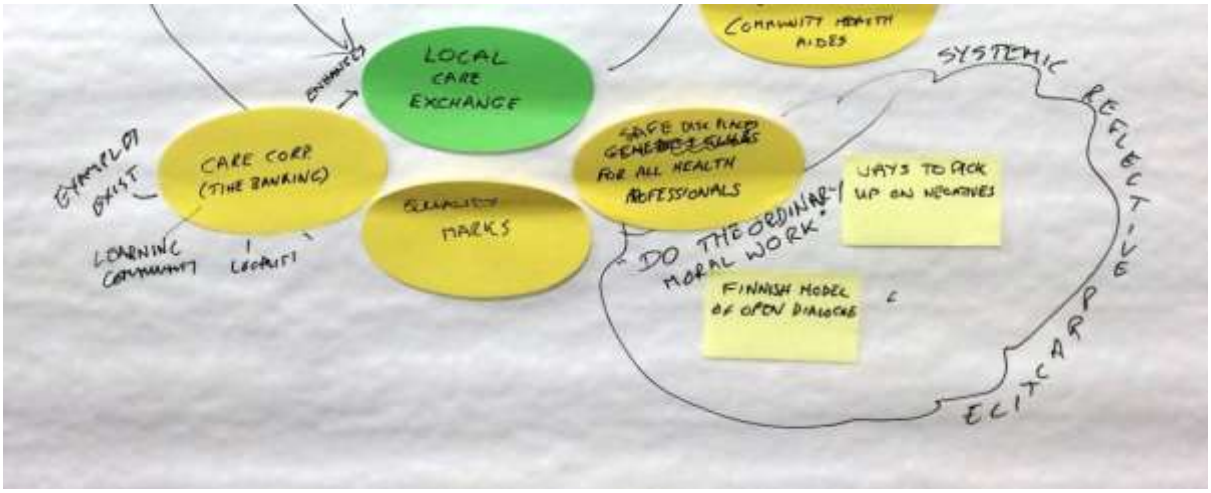
created with the patient. And they would be records of flourishing rather than just abstract biomedical data. The patient would be able to own their own flourishing, in their own terms.



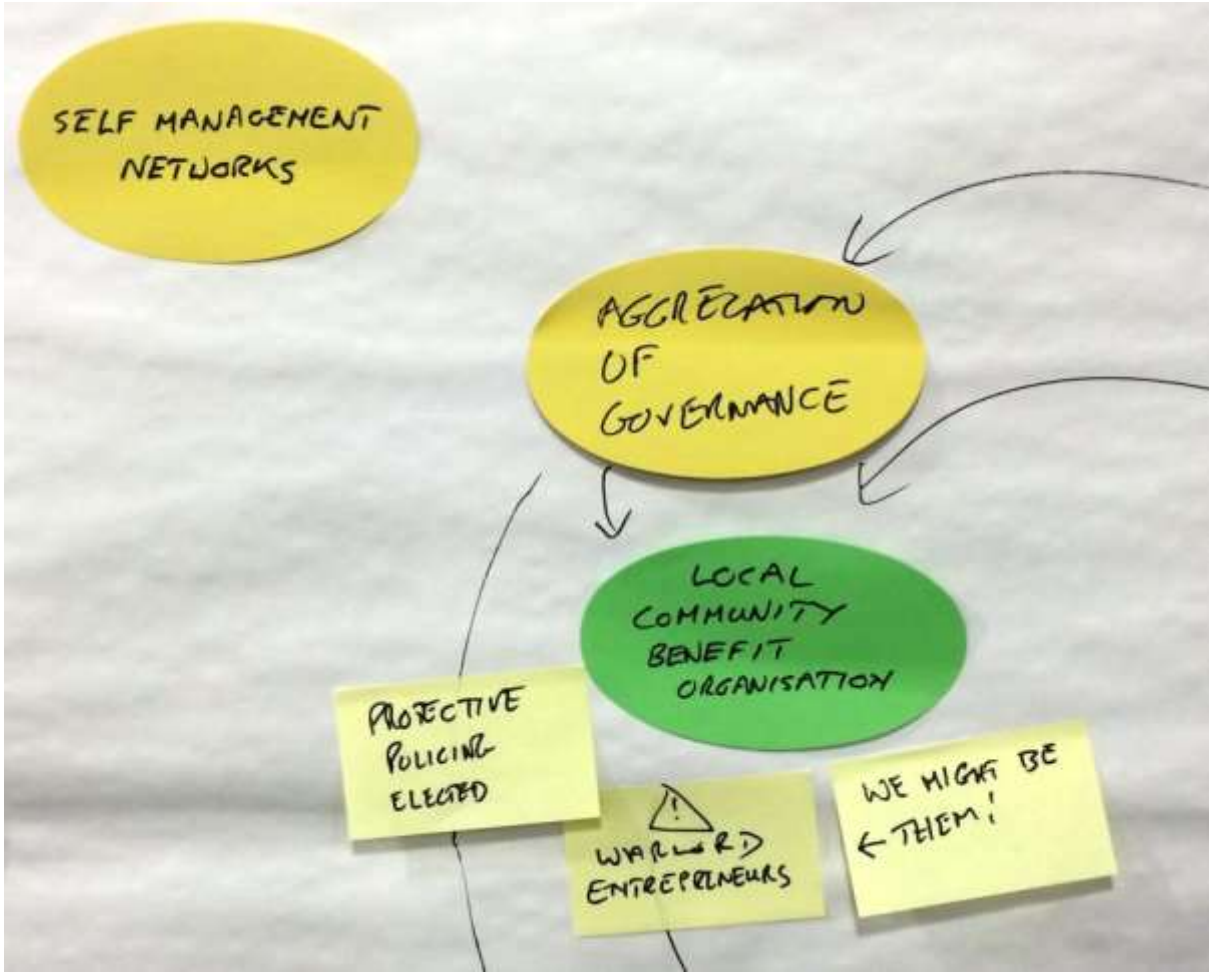

The discussion also began to flesh out the activities around the Local Care Exchange. The idea of a 'care corps' (like the peace corps), perhaps enabled by timebanking, fits well as part of the Care Exchange and there are existing examples of this practice to draw on. It configures resources at a local level and can encourage local learning. Quality marks for care and care providers clearly also relate to the Care Exchange.

Much of the discussion related to learning and how the providers themselves would continue to improve and develop their practice in this model. This related to the ideas for a new kind of 'Fifth Wave Academy' explored in the previous workshop. Here the discussion focussed on providing the conditions to enable 'systemic reflective practice'. We must accept that there will be mistakes and charlatans in this model as in all other systems. Hence the need for a safe space to air these issues and discuss them. A space for peer support for practitioners to enable them to do 'the ordinary moral work' of health and care. The Finnish model of 'open dialogue'

was mentioned as a good example of the kinds of participatory processes that would need to inform the operations and development of the Local Care Exchange. The Scottish Government's experiment with 'Tings' (ancient tribal gatherings in Scotland and in Scandinavia that considered the big issues of the day) were also referenced.




Many of the themes in the discussion of the wider system related to governance – which is the focus of the Local Community Benefit Organisation. This organisation would effectively have to provide governance for the system as a whole, including policing and safeguards and democratic accountability. It was recognised that this



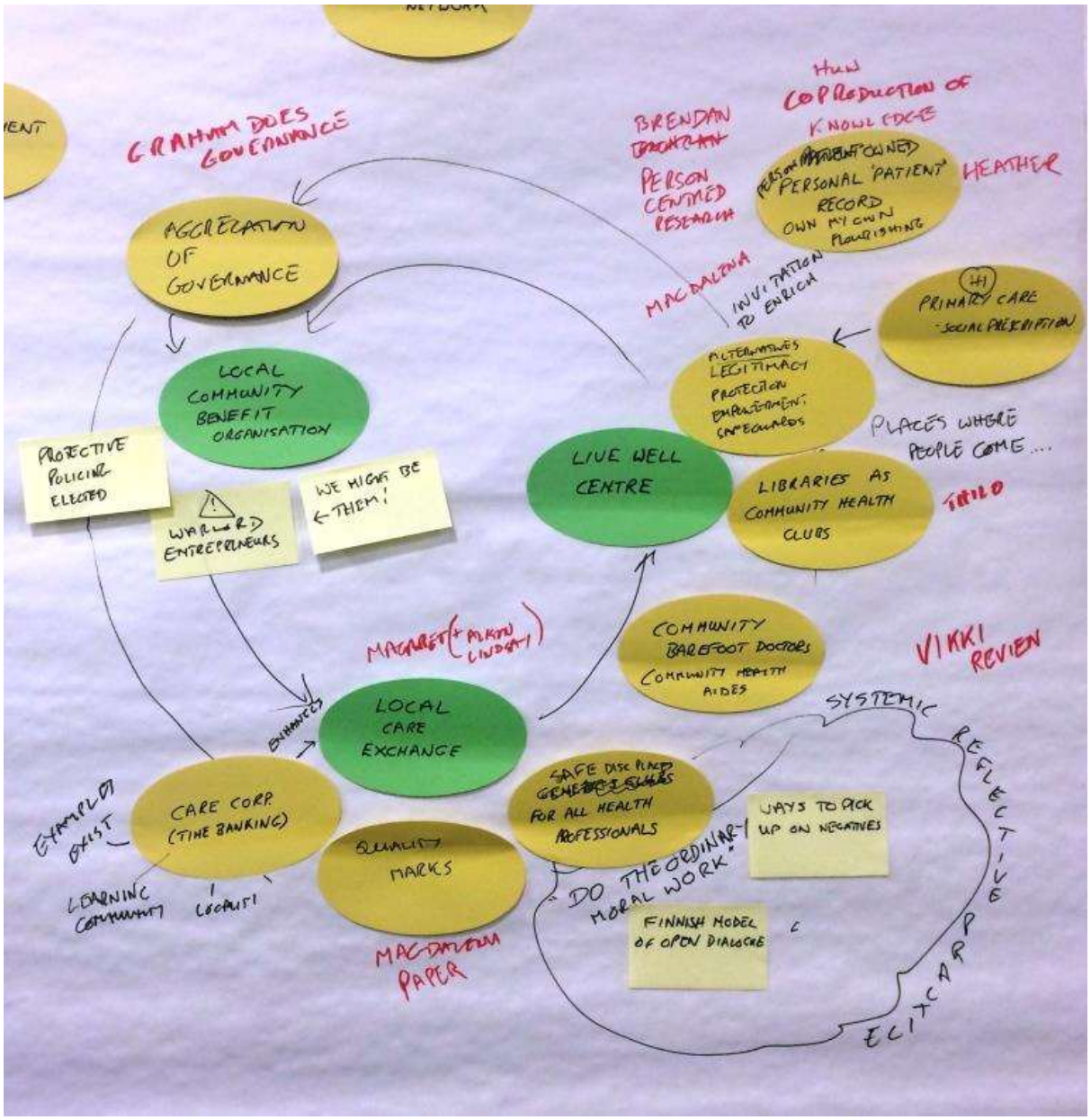
would be a powerful organisation and could easily fall into the wrong hands. 'What about the warlord entrepreneurs?' asked one participant, 'how do we protect ourselves against them taking over this structure?' More troubling was the thought that we ourselves might be seen as warlord entrepreneurs by some, hijacking the system of care to pursue our own vision, which may not be shared by others. There is an ethical minefield, for example, around the gathering of data and the ownership of its implications (see Fitbit). There will be questions of justice, values, accountability and other tricky governance issues to resolve.

**Next Steps?**
Over the course of the day the conversation had effectively moved from a consideration of three individual organisations and their design to see these firs as part of a self-sustaining and self-reinforcing system and then as potentially linking to and configuring other elements in a wider pattern.

Yet the discussion had also revealed substantial areas in the system design that need further work and exploration. Bill invited individual members of the group to identify where they might be best placed to offer a contribution to that further work, assuming that a framework for continuing the programme could be developed.

This elicited the following offers of contribution:

**Vikki** has just started doing a review of different ways to support systemic reflective practice and will contribute this;
**Graham** offered to have a first go at the principles of governance to inform the new system;
**Alison** suggested that Fife Council has done a good deal of work about 'risk enablement' for self-directed support which might be useful for finding the balance between being open to everything and yet maintaining standards of quality etc;
**Margaret** (with Alison and Lindsay) offered to contribute more on the Local Care Exchange, building on the work to be enabled by a small grant from SISCC to explore the 'last mile' challenges of the SHINE programme. That will be an opportunity for our own 'systemic reflective practice';
**Brendan** has just submitted a book manuscript on person-centred research. He can provide a summary/synthesis of the critical principles and practices;
**Huw** the co-production of knowledge in a situated setting. Knowledge mobilisation field the users are largely marginalised (outside of user-centred design). There is a need to bring these strands together. Offer coproduction of knowledge in service situations. Brendan, Huw and Vikki could get together to share ideas. The participatory turn;
**Thilo** has an interest in non-traditional spaces (eg libraries, green spaces) that could be linked to the Live Well Centre by extension and could offer to map some of those examples;
**Heather** (not present) would have a lot to offer on the theme of technology and 'personal flourishing records';
**Magdalena** is part of a European group investigating ingredients for organisations that offer freedom and structure in the context of promoting and evaluating quality (quality marks). She will share the existing study.




Margaret thanked everyone for these offers and for their contributions over the course of the day, especially Bill Sharpe for guiding us through the process. She was pleased that we now have a vision of the whole plane – which gives a conceptual framework for all those innovators already out there designing wings and engines. We are building a platform rather than just another initiative. And we have maintained and extended the creative integrity interested in putting this into practice.

After a closing exercise in pairs, led by Magdalena, the group parted – in laughter.

Graham Leicester
International Futures Forum
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**Participants**
Margaret Hannah, NHS Fife
Vikki Entwistle, University of Aberdeen
Lindsay Wilson, NHS Fife
Alison Linyard, NHS Fife and IFF
Graham Leicester, IFF
Lesley Reid, NHS Lothian
Huw Davies, St Andrews University
Magdalena Schamberger, Hearts and Minds
Brendan McCormack, Queen Margaret University
Bill Sharpe, IFF