***Innovation in home care: The holy grail or old wine in new bottles?***

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**Abstract**

In the UK, social care – and home care specifically – have been described as being ‘in crisis’ due to a combination of factors including: reduced public expenditure in a period of austerity, an ageing population and difficulties in recruiting and retaining care workers. These challenges have been met with increasing calls for innovation in the sector as a means of creating sustainable improvements in care quality and supply.

This paper identifies and maps how ‘innovation’ in home care is conceptualised in terms of its characteristics, drivers and obstacles. This is important because the increasing call and opportunity for technological and service innovation in home care (e.g. Transforming Care agenda and the NHS Five Year Forward View in the UK) is generating a bewildering and confusing set of descriptions of what innovation is and how to achieve it (e.g. Seelos and Mair 2012). We report on a narrative summary review (Dixon-Woods, 2005; Greenhalgh et al., 2018) of academic and grey literatures, triangulated with the opinions of 14 leaders in adult social care provision (gathered through 1:1 semi-structured interviews). Narrative review approaches draw on interpretive and discursive methodologies and are therefore appropriate for examining a concept such as ‘innovation’ which requires further elucidation and insight (Greenhalgh et al., 2018).

We draw on and expand Osborne’s (1998) category of public service innovation to identify and categorise innovations that are a) *total* (including change of client group and service model, referred to as ‘revolutionary’ in the grey literature), b) *expansionary* (using an existing model to meet the needs of a new group), c) *evolutionary* (providing a new service for an existing client group), and d) *developmental* (which modifies existing services for an existing client group). Our findings indicate that ‘innovation’ in home care is primarily *developmental* focusing on modifying existing services for an existing client group. The drivers for innovation reported in the grey literature were argued to be strategic or produced ‘by necessity’, whereas most innovations in academic literatures were reported to be instrumental in that improvement to efficiencies, particularly in relation to cost and value for money were emphasised. Key stakeholders tended to identify examples of current innovation at the evolutionary level (new forms of service within existing models) that are in operation at the level of particular home care provider organisations. In all cases, focus is placed on the positive outcomes of innovation, rather than on the process of innovation *per se*, leading we argue, to the assumption that innovation can be said to have occurred when positive outcomes are observed.

The implications of the mismatch between the ideology of innovation badged by policy as a means to transform care and the more modest, incremental changes instigated ‘by necessity’ to achieve efficiency savings in the UK are discussed.

**Introduction**

In the UK, social care – and home care specifically – have been described as being ‘in crisis’ due to a combination of factors including: reduced public expenditure in a period of austerity, an ageing population and difficulties in recruiting and retaining care workers. Stark warnings of the crisis proliferate from the media (e.g. Marshall, 2015; Collinson, 2016; Mortimer, 2016), national campaigning bodies (e.g. Age UK, 2014; SCIE, 2017), and researchers (e.g. Wittenberg and Hu, 2015), prompting numerous enquiries and policy papers from the UK government. However, this crisis is not confined to the UK and has been a growing concern globally (OECD, 2017). Due to an ageing population and the associated increase in demand for care and support, public service institutions are faced with increasing costs of welfare provision. Policy makers have emphasised the need for a strong economic base with which to fund these public services, to be achieved through innovation (Sirovatka and Greve, 2016). Perren and Sapsed (2013) claim that innovation has become a dominant discourse within UK parliamentary debate; this advocacy of innovation to prompt economic growth with the promise of social benefit, is reflected in the establishment of funding arms such as *Innovate UK*. Innovation too has been repeatedly cited in social care policy discourse as a means to both produce improved outcomes (put in reference to examples of such citations) but also a necessity in the face of the above outlined challenges (put in references to examples of such citations).

However, it is argued that the increasing call and opportunity for technological and service innovation in home care (e.g. Transforming Care agenda and the NHS Five Year Forward View in the UK) is generating a bewildering and confusing set of descriptions of what innovation is and how to achieve it (e.g. Seelos and Mair 2012). In this paper we report on a narrative summary review (Dixon-Woods, 2005; Greenhalgh et al., 2018) of a) academic and grey literature that has focused on examining innovation in home care, and b) practice-based knowledge of adult home care provision (gathered through 1:1 semi-structured interviews with 14 key informants from the social care sector including local authorities and clinical commissioning groups; third sector organisations operating in the field of social care; and regulatory bodies and professional associations of care providers and care workers. We selected to use a narrative review method because its entailing interpretive and critical approaches can elucidate and illuminate how a concept tends to be understood (Greenhalgh et al., 2018).

The review aimed to identify how innovation in home care tends to be understood across academic and grey literature and by policy makers and practitioners working in the field. We reviewed 33 papers and 35 reports and analysed 14 interview transcripts with an initial aim of identifying and extracting definitions of innovation. This process identified a range of opaque and ill-defined concepts of innovation. We then drew on Osborne’s (1998) category of public service innovation to assist us in exploring how innovation tends to a) be defined in the literature (both academic and grey) and by key informants working in the field of social care., and b) to identify and categorise a range of examples of ‘innovation’ in home care provision cited by these sources. Osborne framework consisted of 4 key themes which characterise innovation creating a four-fold typology. By drawing on these criteria to frame our analysis of how innovation in home care tends to be conceptualised we both unpack how the innovation concept tends to be utilised and illuminate and assess the types of activities or outcomes considered that tend to be considered innovative. We first outline the policy focus on innovation in the UK which provides the context to our paper and highlights how the concept has been presented as the ‘Holy Grail’ which will cure social care ills, before discussing Osborne’s (1998) criteria and typology in more detail and describe and discuss the review methodology in more detail.

**Innovation: The Holy Grail**

Elements within social care policy – and policy more broadly – present innovation not only as a path to achieve economic growth but as being instrumental for tackling societal challenges. Innovation in the UK is argued to be a *“tacit but embedded policy agenda”* (Edmiston, 2015: 1), borne out perhaps by the creation of several government supported organisations, including the Innovation Unit (originally part of the Department of Education and now an independent body), NESTA (formerly the National Endowment for Science, Technology and the Arts) with a significant endowment of £250m from the National Lottery Fund, the NHS Institute for Innovation and Improvement, Innovate UK (formerly the Technology Strategy Board) and the Government Innovation Group. Funding opportunities have also supported innovation (e.g. the Social Incubator Fund, Centre for Social Action Fund, Innovation in Giving Fund). More recently, there has been the creation of the Industrial Strategy Challenge Fund (UKRI, 2018) by the UK Research and Innovation which supports schemes for research and innovation under one umbrella. Regulatory and legal frameworks are also shown to have increased support for innovation, particularly those with a ‘social’ focus (e.g through supportive legal frameworks available for social enterprises such as Community Interest Companies and regulatory bodies have enabled organisations to use these legal frameworks by providing tools such as model constitutions; Boelman & Heales, 2015). The outcome of the European Innovation Scoreboard (EC, 2018), comparative assessment of research and innovation performance of EU Member States, placed the UK as an innovation leader, identifying the UK’s attractive research systems and human resources as its strongest innovation dimensions.

During the previous 2 decades four White Papers, two Green Papers (with another forthcoming in 2019), four consultations and five independent reviews and commissions into social care have been published. Innovation’ does feature in most and from the 2000 Green Paper – and tends to conceptualise innovation as a means to stabilise costs and/or improve care quality and outcomes. The 2000 Green Paper on social care (*A Quality Strategy for Social Care*) included the establishment of the Social Care Institute of Excellence (SCIE), designed to be both innovative in the way it disseminates information and also to encourage the social care sector to innovate. SCIE, alongside *Think Local Act Personal and Shared Lives Plus*, have in 2019 been funded by the Department of Health and Social Care to create a network to bring together “innovative providers, commissioner and interested citizens”[[1]](#endnote-2) to encourage the ‘scaling up’ and spread of localised innovative approaches in social care. Funding too has been made available to support innovation, such as for the Partnership for Older People pilots (2006/7 and 2007/8, set out in the 2006 White Paper *Our Health, Our Care, Our Say*), established to test innovative approaches that integrate health and social care to improve outcomes for older adults (Department of Health, 2006). Social Impact Bond ‘trailblazers’ were created for social care by the 2012 White Paper (*Caring for our Future: reforming care and support*), proposed to offer an innovative approach to investment in the sector. This White Paper also included support for local authorities in drafting their market position statements to encourage providers to *“rise to the challenge and to develop innovative and high-quality care and support options that are rooted in the community and that support people to achieve their goals and aspirations”* (HM Government, 2012: 45) and also to stimulate innovation through their commissioning arrangements by *“commissioning on the basis of quality, outcomes and value for money, and by paying care providers according to the results they deliver”* (ibid: 45-46). More recently, the former Secretary of State for Health and Social Care, Jeremy Hunt, outlined in a speech (20/03/18) seven key principles to inform the awaited social care green paper, again stressing the importance of innovation in the sector. Moreover, Hunt announced the Government had invested in the £98 million Healthy Ageing Grand Challenge to *“catalyse public-private investment in technologies and innovations so that we don’t just invent great ideas here, we see them taken up throughout our system”*.

Common to these sets of government policies is a discourse that conceptualises ‘innovation as technological’, linking enabling game-changing technological and product revolutions as the means for achieving economic growth. The primary purpose of Innovate UK – the UK’s innovation agency –, for instance, is stated *“to drive productivity and growth by supporting businesses to realise the potential of new technologies, develop ideas and make them a commercial success”[[2]](#endnote-3)*. The prioritisation of technological forms of innovation is perhaps reflected in the wealth of digital care strategies, such as, the Social Care Digital Innovation Programme (2017-19), NHS Digital, the National Information Board (NIB) and Scotland’s Digital Health and Social Care Strategy, that emphasise digital services, telehealth and telecare, business and clinical intelligence, and predictive analytics. Under the banner of the government’s Industrial Strategy, the life and social sciences aim to bring development of a range of new diagnostic tools, and therapies for conditions that could potentially enable healthier ageing. The NIB helps take forward the ambitions of the Care Act 2014, the Government Digital Strategy (2013), the Department of Health’s Digital Strategy: Leading the Culture Change in Health and Care (2012) and the proposals in the Department of Health’s Power of Information (2012). As reported by NIB’s framework, innovation diffusion facilitated by standardisation is one of the processes that underpins wide-scale change driven by technology and data in the sector: *“many advances come from new, non-traditional, smaller suppliers, often working outside structured, planned initiatives. But while non-traditional suppliers frequently make key, sometimes opportunistic innovations, large traditional suppliers remain important not only as a source of scalable, resilient developments but for driving dissemination and diffusion at pace”* (NIB, 2014: 10).

The UK social care sector straddles the public-private divide, with a large proportion of private and outsourced provision. Around 873,500 people in the UK are receiving home care (673,000 in England, 112,00 in Scotland, 47,300 in Wales and 41,200 in Northern Ireland), amounting to 318 million hours a year. State expenditure on home care is valued at £3.83 billion annually; self-funders (228,000 people) contribute £713 million to the home care market each year (UKHCA, 2016). However, with such a long history of calls for innovation in social care, we might ask ourselves why the innovations purported in the literature have failed to gain purchase at scale as potential solutions to transforming social care. With this in mind, we have approached the literature around innovation in social care with a view to understanding how innovation has been defined and conceptualised, not just what works and why.

**Defining Innovation**

The term innovation has witnessed exponential growth within public and social policy, linked to the growth in managerialism and the promotion of new Public Management during the 1980s, to a point where it has become almost ubiquitous, or what has come to be known as a ‘pro-innovation bias’ (Godin and Vinck, 2017). The term ‘innovation’ became a dominant theme of parliamentary discourse, although the way the term has been employed has changed over time from a narrow technical focus to a broad meaning encapsulating non-technical innovations such as business models, management practices and service provision (Perren and Sapsed, 2013) and intrinsically linked to policy (Fagerberg et al., 2013). Its rather unbounded definition permits multiple possibilities for how innovation can be conceptualised and deployed – it comes to mean different things to different people with a range of foci and perspectives (Linton, 2009; Crossan and Apaydin, 2010). However, in its broadest sense innovation refers to something new or improved, therefore in management studies debates it refers to *“attempts to improve, refine and manage innovation in more economically efficient ways”* (Segercrantz et al., 2017: 276).

Osborne (1998) has argued that public service innovation can be defined by four criteria: 1) newness; 2) in use (as opposed to an idea); 3) as a process or an outcome; and 4) whether it represents continuity or discontinuity with the past. He makes a distinction between ‘change’ and ‘innovation’ with change referring to the gradual improvement and/or development of the existing services, representing *continuity* with the past; innovation is the introduction of new elements in the form of new knowledge, a new organisation, and/or new management or processual skills and it represents *discontinuity* with the past. As a way of classifying innovation and change Osborne developed a typology based around the distinctions of continuity and discontinuity in relation to whether this was focused on services and/or clients (see figure 1). For Osborne, incremental change within an existing service which doesn’t include ‘new’ clients or a ‘new form of service’ does not constitute ‘true’ innovation but developmental change. Where there is a ‘discontinuity’ to service users (clients) and/or a ‘discontinuity’ to the service provided then this can be said to be innovative. This typology of public service innovation allows therefore a mapping along two intersecting axes to categorize innovations that are a) *total* (including change of client group and service model), b) *expansionary* (using an existing service model to meet the needs of a new client group), c) *evolutionary* (new forms of service for an existing client group), and d) *developmental* (which modifies existing services for an existing client group). Osborne’s innovation criteria and typology provides a framework for understanding what might be defined as innovation or just incremental developmental change within an organisation, and also whether innovations focus on services provided or clients.

**Figure 1: Osborne’s (1998) Typology of Change in Social Policy Implementation**

*New end-user (client) groups*

*Existing end-user (client) groups*

*New Services*

*Existing Services*

Source: Osborne, 1998: 1140

**Methodology**

This paper reports on a narrative summary review (Dixon-Woods, 2005; Greenhalgh et al., 2018) of the academic and grey literatures related to social care (and home care in particular), triangulated with responses from 14 interviews with key stakeholders in adult UK social care provision. When exploring a contested concept such as ‘innovation’, a narrative review approach was appropriate as it combines interpretive and discursive methodologies (Greenhalgh et al., 2018) to provide clarification and insight. Narrative reviews, as a means to synthesise or ‘aggregate’ qualitative studies can be a key method for theory-building and the construction of narratives (Hammersely, 1997). In addition, by bringing together themes and findings from across multiple studies, *“it can therefore overcome the problem of isolation associated with qualitative research”* and develop hypothesis for future fieldwork (Dixon-Woods et al., 2004: 4). The themes identified from the narrative review were then triangulated with key informant interviews which not only explored how innovation was conceptualised in relation to social care, but also its drivers and obstacles.

The review included academic literature from different disciplines, grey literature encompassing policy and practice documents as well as key informant interviews with stakeholders in the social care sector which allowed for us to *“incorporate a broad range of knowledge sources and strategies for knowing”* (Greenhalgh et al., 2018: 2). As Dixon-Woods et al. (2004) note, the appraisal of the relative quality of qualitative papers for inclusion in a narrative review is problematic as this assumes there is a unity of methods and ignores the diversity of methodologies within qualitative approaches. Nonetheless, the lack of transparency over the selection process of the papers included has been identified as a weakness of the narrative review method. As such, we adopted the following processes:

1. In searching the academic literature, we used the search terms ‘innovation’ AND ‘home care’ AND ‘UK’ which initially returned 13,793 results. This was narrowed further to examine articles from social care-focussed journals (Ageing and Society, British Journal of Social Work, Journal of Integrated Care, Age and Ageing, Journal of Social Policy, Gerontologist, Working with Older People, International Journal of Public Sector Management, Healthcare Management Forum, Local Government Studies, Journal of Care Services Management) to leave 172 articles. These were manually reviewed to remove articles which did not focus on paid care delivered at home (such as residential care homes or hospital settings) or the commissioning of paid care at home, theoretical papers which did not report on empirical research, those which did not specifically mention innovation in the main text and those which reported on research from outside the UK. Articles which included international comparative studies were included if there was a UK element to the comparison. Further targeted searching was carried out using examples of innovation mentioned during the key stakeholder interviews, which resulted in the return of 33 articles.
2. The grey literature (encompassing government reports, policy statements/ papers; conference proceedings; research reports; fact sheets and funding calls) included in this paper were sourced from a number of search facilities and websites, such as those collating policy documents (<https://www.gov.uk/government/publications>; www.bl.uk/social-welfare) and organisations relevant to social care (SCIE, Skills for Care, Association of Directors of Adult Social Services, Local Government Association, the Kings Fund). The search terms used were ‘innovation’ AND/OR ‘social care’ AND/OR ‘health and social care’ AND/OR ‘home care’. The examples included were limited to the UK context, as per the academic literature search. A total of 35 documents were collated which included the search terms, of which 13 included a definition of innovation, eight had specific examples of innovation related to home care (but did not define innovation) and only three contained both a definition and examples. Eleven did not include a definition of innovation and / or featured examples in insufficient detail to enable classification.

Once the papers and documents were selected from the academic and grey literatures, they were subject to a thematic analysis. Thematic analysis can either be data or theory-driven in that themes either emerge from the examination of the literature, or a particular theory is evaluated through the exploration of the literature (Dixon-Woods et al., 2004). The approach taken in this paper is driven by theory – in this case, Osborne’s (1998) criteria for defining innovation and his typology outlined above – as we evaluated explicit themes through the interrogation of the grey and academic literature. As this typology focuses on whether there has been discontinuity/or continuity to both services and user groups, we needed to be clear of the baseline for change. In order to map the examples cited in the literature on to Osborne’s criteria of innovation, we used the following criteria:

1. ‘New' was defined as something which had been created or established in a specific context within 5 years of when the paper was produced/published;
2. ‘In use’ was defined as to whether it was in use at the time of publication, with categories of ‘not in use’, ‘pilot’ and ‘in use’;
3. ‘Outcomes/Processes’ described whether the source included any reference to barriers, drivers or implementation of any change, which would indicate the conceptualisation of innovation as being something more than an outcome in and of itself.
4. ‘Continuity/discontinuity’ was taken from Osborne’s typology relating to continuity of services or markets (user groups), i.e. was there a change to how the care is delivered or organised, and to whom, or a deviation from a 'traditional' model of care which we define as discontinuous.

Thematic analysis within the narrative review method has also been critiqued as *“limited in its ability to deal with contradictions, other than by describing them”* (Dixon-Woods et al., 2004: 15). However, while demonstrating the presence of contradictions may appear ‘descriptive’, it is important to highlight how a term such as ‘innovation’ – which has been repeatedly advocated as a means to alleviate the pressures in social care – is in actuality poorly defined and articulated. The use of qualitative interviews with key stakeholders allowed us to explore in more depth these contradictions and relate them to practice in social care, in particular, home care. Key stakeholders were selected on the advice of the wider programme team and included representatives from third sector organisations operating in the field of social care, including the provision of services, research and funding; regulatory bodies and professional associations of care providers and care workers; and local authorities and clinical commissioning groups. Fourteen key stakeholders were interviewed using a topic guide focused on: the kinds of innovative home care that exist or are emerging in the sector and the main drivers for and obstacles to innovation within the home care sector and/or for provider organisations. The notes from these interviews were coded in accordance with the approach above in that key themes were mapped onto Osborne’s four-fold criteria of innovation and the typology, as well as compared with the examples of innovation cited by the two literatures. The following section outlines the findings from the academic and grey literatures before bringing in the analysis of the key informant interviews.

**Findings**

*Defining innovation in social care: the academic and grey literatures[[3]](#endnote-4)*

Given the plethora of calls for innovation in the media, policy discourse and grey literature it is surprising that very few academic papers mention or discuss innovation in relation to paid home care, and only one provided a detailed definition of what the authors meant by innovation. Best and Myers (2017: 2), in a discussion of innovations adopted in Wales, included projects which were described as:

*“…testing or piloting of a new idea, or be part of an initiative that met several criteria, including: how the project would address the three focal points; how the project would be sustainable, aﬀordable and transferable; and how services and health outcomes might be improved for rural communities*”.

The three focal points mentioned relate to access to services, integration of health and social care services, and community cohesion and engagement. For their review, projects were considered to be innovative or have innovation potential where innovative practice was ‘both incremental and practice-based’. This fits with the innovation model criteria of being ‘new’ but concentrates on incremental change which would not be classified as innovation under Osborne’s definition. Best and Myers outlined some of the issues around implementing innovations without acknowledgement of the cultural, social and economic context. There were few other papers which had any in depth discussion of innovation: Burns et al. (2016) was a call for more radical innovation in social care and provided examples of how this might be achieved; and one further paper (Munt and Hargreaves, 2009) was an exploration of the terms innovation and creativity as understood by the health and social care workforce, which acknowledged the lack of clarity for the term. Many papers made scant reference to the term innovation and appeared to use it as a proxy for ‘new ways of working’, ‘new models’, or ‘new initiatives’. Despite a focus on ‘newness’ within the academic literature, we found that many of the proposed ‘innovations’ were not in fact ‘new’ if considered to be something within five years from implementation to publication.

The second of Osborne’s criteria focuses on initiatives which are ‘in use’ as opposed to an idea. Here we found that the academic literature overwhelmingly reported innovations which were in use, with all but one paper reporting innovations in use (Burns et al., 2016. was a call for radical innovation). In respect of the third criteria, discussion of innovations was predominantly as outcomes with almost two thirds (20/33) being described as such. However, there was some discussion of both outcomes and processes in 7 cases and a further 6 where the focus was mainly on processes of innovation. This may reflect the ‘standard’ academic script which is expected to presents ‘findings’, but while academic papers may present ‘what works’ there is often little discussion of why something works and the drivers and/or barriers to implementation and roll out.

With regard to Osborne’s fourth criteria of continuity/discontinuity, around two thirds of papers reported on some form of discontinuity to either service users or the service itself when judged against a ‘traditional’ model of care at home. However, the lack of detail in many cases made it very difficult to map definitions of innovation in the academic literature related to home care on to Osborne’s innovation criteria and four-fold typology.

The grey literature provided a more fruitful source of definitions of innovation. However, this is not to say all sources did include an explicit definition: an issue encountered when reviewing some of the grey literature related to health and social care was, like the academic literature, that though ‘innovation’ was included in the title or description, the concept itself was not explicitly defined in the text. As a result – and in line with Osborne’s (1998) argument that part of the innovation literature treats the concept as a policy imperative whilst not providing an adequate definition – though many of these documents emphasised the importance of innovation in improving health and/ or social care service delivery and/ or sustainability and some also included examples of what they classed as ‘innovation’, they did not provide a clear definition of what was meant by the concept. Indeed, as will be explored below, some of these texts included examples of innovation which did not meet Osborne’s four-fold criteria.

Where innovation was defined in the grey literature, there appear to be some core elements, akin the Osborne’s four characteristics. First, ‘newness’ or a ‘difference’ in a product or service was cited a condition of innovation in several (OECD, 2005; The Resolution Foundation, 2008; DoH, 2011a, 2011b, 2011c; Skills for Care, 2014; Golden Jubilee Foundation, 2015; SCIE, 2018; Mulgan et al., 2007; Heales et al., 2017; Murray et al., 2010), in line with Osborne’s (1998) criteria. The Department of Health are clear that innovation has to include a novel aspect, the idea itself can have originated elsewhere: “*innovation is as much about applying an idea, service or product in a new context, or in a new organisation, as it is about creating something entirely new. Copying is good*” (DoH, 2011b: 9, c.f. Skills for Care, 2014). Hall (2019), in a report produced by *Think Local Act Personal*, cites Mulgan et al. (2007), arguing that the ‘newness’ of an innovation can relate to a new combination of existing ideas and elements *“rather than being wholly new in themselves”* (Hall, 2019: 2). This conception of innovation is described elsewhere in the grey literature as ‘combinatorial’ (Government Office for Science, Office for Life Sciences, the AHSN Network, NHS England, 2015), which rather than describing a single development, refers to *“different innovations working together”* (ibid: 3)*,* including innovations in technology, workforce, service delivery, etc. to produce better outcomes *“at the same or lower overall cost”* (ibid: 2).

Improvement too was at the core of many definitions in the grey literature (OECD/ Eurostat, 2005; The Resolution Foundation, 2008; DoH, 2011a; 2011b; 2011c; SCIE, 2018; Mulgan et al., 2007; Murray et al., 2010). The Resolution Foundation in their paper on innovation and efficiency in the supply of care state: *“‘innovation’ is widely used as a positive expression of ‘new’ and ‘different’. In reality, however, innovation has little meaning unless it is linked to some form of improvement”* (2008: 3), and outline seven dimensions of performance innovation can enhance: 1) effectiveness; 2) efficiency; 3) safety; 4) timeliness; 5) equity; 6) coordination; and 7) people-centredness. The Foundation argue that efficiency and people-centredness are the *“most relevant to the current care market and its future development”* (p. 3). In addition, the several of the grey literature sources include ‘in use’, ‘implemented’, ‘into actual use’, ‘made available to potential users’, ‘useful’ as criteria (DoH, 2011a: 5; Ylab, 2017), in line with Osborne’s assertion that an idea is invention but an idea put into practice is innovation. Innovation was argued in the grey literature to be able to occur in a variety of areas:

* Products, processes or governance (OECD, 2005).
* Products, processes, services (Howaldt et al., 2017).
* Products, processes, marketing, organisational. (OECD/ Eurostat, 2005).

Like Osborne (1998), some documents within the grey literature distinguished between different types of innovation, which can be mapped on to his typology (Figure 2). The Department of Health (2011a) outline three types: incremental (building on/ improving existing practices), radical (a new approach to existing problems) or revolutionary/ disruptive (an innovation that creates a new market). Howaldt et al. (2017) in their report from the EU-funded SI-Drive project create a typology of innovation based on the ‘degree of novelty’ and also include radical and incremental innovation types. Radical innovation denotes a *“whole new direction of thinking”* (ibid: 102) and represents *“extreme points of novelty”* (ibid: 102) from incremental innovation which introduces minor changes. The authors also include two further types which are juxtaposed with one another: ‘modular innovation’ (citing Henderson and Clark, 1990), or *“innovation that does not change the architecture of an existing product, but introduces new components that add additional functionality to it”* (using the example of the change from the analogue telephone to a digital one) and ‘architectural innovation’ which alters the architecture of a product but not its components (using the example of a ceiling fan and an small portable one). The authors also discuss sustainable and frugal innovations, which consider environmental, economic or social sustainability or are doing more with less, and still evolving through the *“reconfiguration and the reuse of existing assets and components in an affordable way”* (ibid: 106) respectively. Boelman and Heales (2015), also reporting on the SI Drive project, include three types of innovation: 1) incremental innovation *(“focuses on products and services and attempts to address identified market failures more effectively but does not have any impact on the way in which markets, institutions or structures function”* p.18); 2) institutional/ substantial innovation (*“focuses on markets and attempts to reconfigure existing structures and patterns to create new value. It may adapt or shape existing markets and institutions”* p. 18); 3) disruptive innovation (which *“change the frames of reference around markets and issues and to change social systems and structures themselves. It represents a direct challenge to existing structures, markets, institutions or power dynamics”* p. 18).

*Figure 2: Grey literature mapped onto Osborne’s Typology of Change in Social Policy Implementation*

*New end-user (client) groups*

*Existing services*

*New Services*

*Existing end-user (client) groups*

Notes: In the ‘developmental’ segment, citations are included from the grey literature though there is disagreement as to whether ‘incremental innovation’ constitutes innovation (DoH, 2011a; Howaldt et al., 2017; Boleman and Heales, 2015) or change (Mulgan et al., 2007).

There was some degree of disagreement as to the inclusion of ‘incremental’ as innovation or change within the grey literature. Whereas the Howaldt et al. (2017) and Department of Health (2011a) argue innovation can be incremental insofar as it builds on or improves existing practice, Mulgan et al. (2007) argued: *“Innovation is often given complex definitions. We prefer the simple one: ‘new ideas that work’. This differentiates innovation from improvement, which implies only incremental change; and from creativity and invention, which are vital to innovation but miss out the hard work of implementation and diffusion that makes promising ideas useful*” (Mulgan et al., 2007: 8). The Social Care Institute for Excellence (SCIE, 2017) adopts a normative position to incremental change or innovation, arguing: *“Incremental change is not an option. Now is the time to re-build adult community care and health systems from the bottom up”* (p. 2).

*Examples of innovation in social care: the academic and grey literatures*

Following Osborne’s definition of innovation based on the four criteria, we found that less than half of the reported innovations from the academic literature could be described as ‘new’ at the time of publication (defined here as within five years of publication); of the 33 papers examined, 14 could be described as new models of care and 19 not new. For example, co-operatives and social enterprises are not new concepts, although they are not a dominant business model within social care. Similarly, Shared Lives and Homeshare have been in existence for decades although again, are still not prevalent within social care. Most of the ‘new’ innovations have some form of technological element, such as for recording or monitoring care (Cooper and Urquart, 2008; Christopoulou, 2013). All the papers reported on innovative examples which meet Osborne’s criteria of ‘in use’, except one which was a call for radical innovation and gave examples of how this might be achieved (Burns et al. 2016).

The papers included in the review of the academic literature were much more likely to discuss the outcomes as opposed to the processes of innovation. We found that 20 papers reported outcomes, seven discussed some aspects of the process as well as the outcomes, and six discussed the processes in more detail. While it is not surprising that academic papers present outcomes due to the nature of research, it is surprising that there are not more discussions of the processes involved.

Osborne’s final criteria for innovation was whether it involved a discontinuity from the previous service. This was in many cases hard to judge; however, we have assessed this in terms of whether this was a deviation from a ‘traditional’ model of care for people at home. Two thirds of the papers (20/33) reported some discontinuity, mostly in terms of a change to the service.

When examining the grey literature, of the 35 documents around a third included examples of innovation practice in home care specifically in sufficient depth for some analysis. The vast majority of these, however, were those sources which did not define innovation, or include the criteria used to assess a particular model as ‘innovative’ (SCIE, 2017; 2018; Clarence & Gabriel, 2014; DoH, 2000, 2005; 2010; Shared Lives Plus, 2017; Bennett et al., 2018; HM Govt. 2010; HM Govt. and NHS, 2006). [[4]](#endnote-5)

Of the eleven documents which provided examples of innovation[[5]](#footnote-2), only three – Hall (2019), Murray et al. (2010) and the Resolution Foundation (2008) – included definitions of innovation. The latter includes the criteria of 1) new; 2) results in improvement, while Hall cites Mulgan et al. (2017) to argue innovations are in practice usually new combinations existing elements, as opposed to than being entirely new in themselves and have a transformative aspect in that *“they leave behind compelling new social relationships between previously separate individuals and groups which matter greatly to the people involved, contribute to the diffusion and embedding of the innovation, and fuel a cumulative dynamic whereby each innovation opens up the possibility of further innovations”* (p. 2). Murray et al. (2010) focus specifically on social innovations, which they define as ‘new ideas’ for products, services and models which meet social needs, *“In other words, they are innovations that are both good for society and enhance society’s capacity to act”* (3).

In the eleven documents containing detailed examples of innovation in home care, a total of 52 examples of innovation in home care were included in this part of the review.[[6]](#footnote-3) Of these, nine examples were discussed across several sources (1. Shared Lives; 2. Personal Budgets; 3. Community Catalysts; 4. The Deal, Wigan; 5. Local Area Coordination; 6. Community Circles; 7. Homeshare; 8. Wellbeing Teams; 9. In Control). Each discussion of an example was treated as discrete as one of the purposes of the review was to consider how the grey literature discussed and conceptualised innovation, and different sources provided different accounts of the same example it was describing as ‘innovative’.

What is apparent from the analysis is that more than half of the examples included did not meet the criteria of ‘new’, or even ‘new’ to a particular context. Of the 52, 23 were new, of which eight were new to a particular context, and 27 had not been created within five years of the publication (with a further two where there was insufficient information). Nine of the examples were pilots, one had ended seven years before the publication and the remainder were ‘in use’ as opposed to ideas at the time of publication. Unlike the academic literature where sources tended to focus on innovations as outcomes, as opposed to the process of innovating, or creating specific innovations, the grey literature included more references to the processes related to innovation: 20 focused on the examples purely as outcomes and a further 16 principally described them in these terms with some brief discussion of aspects such as drivers or obstacles to diffusion or spread. Fifteen discussed the examples in terms of the drivers, facilitators and barriers as well as the considering the innovation as an outcome (one example did not include enough information for classification). The degree of ‘radicalness’ or discontinuity to the existing model or service, only seven could be categorised as not representing as delivering a new service or to a new client group (45 therefore could, with one not providing sufficient information for classification).

**Triangulating the literature: innovation explored by the key stakeholder interviews**

In our interviews with key stakeholders we asked for examples of innovative provision, as well as discussing the drivers and barriers to innovation. Several people talked about examples we had also found within the academic and grey literatures (see Table 1). Integrated health and social care was cited by the academic and grey literatures and the key informant interviews, as well as Personal Budgets/ Direct Payments and outcomes-based commissioning. None of these examples however, would be identified as ‘new’, with integrated health and social care emerging in the 1980s (Shaw et al., 2012), outcomes-based commissioning in use in adult social care since 2000s, (Willis and Bovaird, 2012), Personal Budgets introduced in 2007 and Direct Payments in the 1990s.[[7]](#endnote-6) Similarly Home Share and Shared Lives have been part of adults social care since the 2000s. The use of technology too is not new to social care with the first personal alarm systems introduced in the 1960s but the examples cited included ‘third generation’ technologies (Doherty et al., 1995) utilizing broadband and wireless technology, as well as mainstream technologies such as voice-activated systems to alleviate loneliness have emerged more recently. Several of the key stakeholders interviewed acknowledged the examples they were citing were not new, but were relatively ‘niche’ and not scaled up. This difficulty in spreading and scaling up good practice was frustrating, as one key stakeholder noted *“We already know what good care looks like”*. Between the grey literature and key informant interviews, there was consensus that self-managing care teams (e.g. Buurtzorg model; Well-being teams); place-based, community driven care; care organisation platforms/ app for informal carers and online-matching models were all areas of innovation. However, key stakeholders also suggested provider models for which we found no examples within the academic literature.

The key stakeholders interviewed were more forthcoming as to the barriers to innovation than the potential drivers or enablers. Some of the drivers of innovation cited by the key stakeholders included: cost savings for commissioners; customer expectations, particularly of self-funders; the desire/need to create better jobs in home care to improve recruitment and retention; and the integration of health and social care. There was also a theme which emerged from the interviews that most innovation in home care is driven from the bottom up. Barriers included: lack of trust in providers by local authority commissioners who are reluctant to innovate/change; inadequate funding of local authority commissioned care (*“Providers are too busy trying to stay afloat”*); social care sector run largely ‘for profit’ so what money there is drains out of the system; funding for pilots but not for supporting roll-out or scaling up/out; some innovations don’t scale well (e.g. Shared Lives); issues around integrating public services and private providers; the low status of care work; inappropriate application of technology; and the use of efficiency standards and metrics not appropriate for the care sector *(“19th century manufacturing model of efficiency we have now makes no sense in terms of care which is built on relationships”*).

**Table 1: Innovations in social care as cited in academic and grey literature and KI interviews**

|  |  |  |  |
| --- | --- | --- | --- |
| **Example** | **In academic literature?** | **In grey literature?** | **In KI interviews?** |
| Integrated care (health and social care) | Yes[[8]](#endnote-7) | Yes[[9]](#endnote-8) | Yes (1) |
| Personal budgets/Direct payments/ Facilitated personal budgets | Yes[[10]](#endnote-9) | Yes[[11]](#endnote-10) | Yes (1) |
| Technology for care recipients including sensors/reminders and mainstream technology | Yes[[12]](#endnote-11) | Yes[[13]](#endnote-12) | Yes (1) |
| Technology for care workers/providers to record care given  | Yes[[14]](#endnote-13) | Yes[[15]](#endnote-14) | Yes (2) |
| Outcome-based commissioning  | Yes[[16]](#endnote-15) | Yes[[17]](#endnote-16) | Yes (1) |
| Live-in care/Shared lives/Homeshare  | Yes[[18]](#endnote-17) | Yes[[19]](#endnote-18) | Yes (3) |
| Self-managing care teams (e.g. Buurtzorg model; Well-being teams) | No | Yes[[20]](#endnote-19) | Yes (4) |
| Place-based approach, community driven | No | Yes[[21]](#endnote-20) | Yes (1) |
| Care organisation platform/ app for informal carers | No | Yes[[22]](#endnote-21) | Yes (1) |
| Online-matching models  | No | Yes[[23]](#endnote-22) | Yes (3) |
| Niche providers of person-centred care for specific groups, e.g. LGBT | Yes[[24]](#endnote-23) | No | Yes (1) |
| Assisted living/housing with care  | Yes[[25]](#endnote-24) | No | Yes (2) |
| Technology for family carers – surveillance, CCTV, monitoring. | Yes[[26]](#endnote-25) | Yes[[27]](#endnote-26) | No |
| Micro-enterprises, and organisations that support micro-enterprises  | Yes[[28]](#endnote-27) | Yes[[29]](#endnote-28) | No |
| Technology for care workers/providers - robotic arms which reduce need for ‘double-handling’ | No | No | Yes (1) |
| Community-based preventative approach - Social prescribing | No | No | Yes (1) |
| ‘Enabling’ model of care delivery | No | No | Yes (2) |
| Assets-based (community and personal) model  | No | Yes[[30]](#endnote-29) | No |
| Values-based recruitment | No | Yes[[31]](#endnote-30) | No |
| Co-produced services | No | Yes[[32]](#endnote-31) | No |

When we returned to Osborne’s fourfold typology to examine the data from the key stakeholders interviews, like the mapping of academic and grey literatures, there was little to suggest a role for innovation in creating new service users and this may reflect the emphasis within policy literature to reduce the need for care. Innovations of the *total* type tended to be focussed on preventative health initiatives which aim to maintain people’s health to reduce the long-term need for care, and also forms of integrated health and social care. One model of integrated care which was mentioned by several key stakeholder interviewees was the Buurtzorg model, which incorporates self-managing teams of health care professionals who care for a group of clients. Whilst this was suggested to be very effective, concerns were voiced over the cost. Indeed, cost was a strong feature of the key stakeholders’ interviews, and described as a barrier to innovation itself or as a reason for innovations not being scaled up. Evolutionary innovations included new types of providers such as micro-enterprises, niche providers, shared lives and home share, and online agency matching businesses. The online matching service is a growing area but did not feature in the academic literature and only twice in the grey literature. An enabling model of care delivery was also a strong feature, including when it was combined with a Shared Lives approach, or integrated with health care following hospital discharge. Technology featured strongly in ways of improving provision or as ‘add-ons’ to existing services, but these did not focus on changing the present care structures or provision.

**Figure 3. Mapping of innovations suggested by key stakeholders** **in interviews**



**Discussion: Old wine in new bottles?**

In this paper we have sought to understand how innovation has been conceptualised in the academic and grey literatures relating to home care, and in the sector more broadly. We have shown that as a concept, innovation is often advocated as integral to the future of social care and home care, but the concept is often poorly defined, and in some cases, not defined at all. Rather understandings of innovation tend to be both implicit and presumed intrinsically ‘good’. We agree with Osborne’s view that innovation to a large extent is a normalised *“policy and research buzzword which has apparently risen above the need to define it”* (1998: 1135).

In our mapping of innovations cited within the academic and grey literatures and examples from 14 key stakeholders, we have identified areas of consensus and categorised emerging types of innovation. However, though cited as innovations, their characteristics did not necessarily align with the way innovation is defined within Management and Critical Management Studies academic literature or the and grey literature related to social care. Taking the first of Osborne’s (1998) criteria for defining innovation as something ‘new’, which also corresponds to several definitions withint the grey literature (OECD, 2005; The Resolution Foundation, 2008; DoH, 2011a, 2011b, 2011c; Skills for Care, 2014; Golden Jubilee Foundation, 2015; SCIE, 2018; Mulgan et al., 2015; Heales et al., 2017; Murray et al., 2010), we noted examples of ‘innovations’ cited in the academic and grey literatures and by the key stakeholders interviewees have been in existence for decades. For instance, one key stakeholder suggested a patch-based model of organising social care was being labelled as innovative but this model had been described as such in the 1980s (Osborne, 1998). Similarly, Shared Lives was described by key stakeholders and in the grey literature as innovative, but has been around in some form since at least the 1970s, although initially for people with disabilities it has for a long time been used for older people (Callaghan et al, 2017). A further example from one of our key stakeholders described their frustration as someone working in the home care sector at seeing the ‘same innovations’ time and time again, which they felt intrinsically meant they were not innovative. However, using Osborne’s criteria related to ‘discontinuity’ of service/service users, many of these innovations, though not new, could be classified as at least partially ‘innovative’. We suggest therefore that the way innovation is being tacitly conceptualised through the use of examples in the academic and grey literatures related to social care and by some key stakeholders in the field as not necessarily ‘newness’ or complete novelty, but as a way of highlighting models of care which are not part of mainstream provision.

In addition, through the lens of Osborne’s typology, many of the reported innovations cited by academic and grey literatures and key stakeholders in the field can be described as developmental improvement. This abundance of developmental change suggests tweaks around the edges rather a transformation of the social care system. The perceived crisis in social care perpetuates the policy imperative for answers, so it is not surprising that there are also examples of evolutionary, expansionary and total innovations; however, this should not privilege the latter types of innovation above developmental change, as sustained and long-term commitment to incremental improvements may be just as impactful as quick-fix innovations (Osborne et al. 2008; Seelos and Mair, 2012). Indeed, the key stakeholders interviewees highlighted many barriers to change, in particularly more radical, total innovations including inadequate funding and a lack of trust between commissioners and providers which make bottom-up incremental change more practical and palatable.

Osborne’s typology can therefore be used to explore the types of innovation which are emerging within UK social care. However it does not help us to understand why some innovations have developed, been scaled up or transferred and whilst others have not. We have drawn therefore on Critical Innovation Studies literature to help us make sense of the innovations identified in the academic and grey literatures and interview, and also to see what is missing. Seelos and Mair (2016) have argued there is a lack of acknowledgement of ‘when innovation goes wrong’ due to the overemphasis on innovation as an outcome, rather than looking at innovation as a process. A focus on outcomes fails to acknowledge that innovation is a process and misses the learning that may occur though failure (Vinck, 2017). In studies of social enterprises they argued that:

*“Applied studies tend to treat innovation primarily as an outcome and therefore imply that social innovation occurs when desired outcomes such as positive change can be observed. Meanwhile, organisations that are the main locus of innovation activities are mostly treated as a black box and we know little about how social innovation develops within these organisations”* (Sellos and Mair, 2012: 45).

Their studies challenge the notion that *more innovation is better* [their emphasis], that assumptions around transferrability can be misleading and pushing innovation can stifle progress as much as enable it (Seelos and Mair, 2012). We should, they argue, approach innovation with an expectation of learning, and as researchers therefore we need to shift the emphasis to ask not what works but why it works. Looking at our examples of innovation cited in the academic and grey literatures, it soon became clear that more were reporting outcomes of what worked, rather than the processes involved. The vast majority of the academic literature and a significant part of the grey literatures reported innovation by describing outcomes, which may reflect the narrative around innovation within the policy discourse, which is clearly focussed on finding ‘solutions’, as well as the dominant research approach to reporting ‘findings’. However, a focus on outcomes fails to acknowledge the nuanced cultural and contextual factors which determine whether an innovation works, is sustainable, or scalable and while it is important to know ‘what works’, it is important to understand why something works if some of the innovations discussed are to be scaled up/out or transferred to other contexts. A further explanation for the focus on outcomes is that if we view innovation as a process or a cycle of learning, it can be difficult to assess or evaluate the impact, particularly if this is over a short timescale as is the case with many pilot studies. This was noted by one of the studies we reviewed (Best and Myers, 2017), which argued that the need for speedy results is not helpful and suggests a more prudent approach, paying attention to the contextual and cultural factors involved, to ensure sustainability. In addition, in describing innovations as outcomes in and of themselves, limited attention is given to the outcomes they produce. In the grey literature, there was little information on any evaluation of the outcomes of the innovations, either for service users or those delivering care. The risk of neglecting to explore the outcome of innovation is that innovation is presented not therefore a means to an end – such as good care – but rather than an end in and of itself, intrinsically positive due to its ‘newness’.

**Conclusion**

This paper has sought to examine how innovation is both defined and exemplified in relation to home care using narrative reviews of the academic and grey literatures, and findings from key informant interviews. In the academic literature, it appears to be taken for granted that there is a shared understanding of what innovation is as it is rarely defined, whereas in the grey literature, definitions could be found which could in turn be mapped onto Osbourne’s typology. Some of the grey literature was in agreement with Osborne that incremental change is not innovation per se, whilst other sources defining innovation felt this was an important part of progress and change in the social care sector. Parts of the grey literature defining innovation in social care also included reference to it as a process, as well as an outcome (DoH 2011a and c; Mulgan et al., 2007; Murray et al., 2009), but did neglect to examine the outcomes of innovation for service users and those delivering care, treating innovation as the inherent outcome.

In both the academic and grey literatures, examples of innovative practice in social care were included (though not always in grey literature documents which included a definition of ‘innovation’). Some of the innovations included in the academic and grey literatures were not ‘new’, defined here as within five years of publication, though some were new to a particular context or setting. What was striking however, was that in the academic literature, the focus was placed on innovation as outcomes, rather than on the *process* of innovation *per se*. We found little evidence in the academic or grey literature of ‘when innovation goes wrong’ (Seelos and Mair, 2016), and suggest that we are witnessing what Gripenberg et al, (2012) argue is a ‘pro-innovation bias’, which sees innovation as an undeniable ‘good’ (Godin and Vinck, 2017). This lack of focus on the process of innovation means that there is little discussion of *why* something works within particular contexts. We argue that the need for ‘answers’ in a time of crisis creates a climate for innovation that focuses on incremental changes instigated ‘by necessity’ to achieve efficiency savings, which is misaligned with the ideology of innovation badged by policy as a means to transform care in the UK. We suggest that this mismatch needs to be addressed if progress is to be made in transforming social care.

We suggest that researchers and policy makers need to be clearer about what they mean by innovation if it is to have greater impact, as well as a focus on the outcomes of innovation, rather than the assumption that the innovation is the outcome, and by virtue of its ‘newness’ is automatically positive. A focus on the process of innovation will lead to a better understanding of why innovative care delivery works in one context but might not be easily transferrable to other contexts (Seelos and Mair, 2016). We need to bear in mind that not all innovation is positive and deliberate strategies to ‘slow’ innovation (Leitner, 2017) or ‘NOvation’ (Canibano et al, 2017) which focus on developmental change may be just as useful. As one of our key stakeholders stated, *“we mustn’t throw the baby out with the bathwater”*. There is an implicit assumption that innovation or ‘new’ is always better: by searching for the ‘new’, we risk throwing out kindness and compassion for the sake of innovation.

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1. https://www.scie.org.uk/transforming-care/innovation/network [↑](#endnote-ref-2)
2. https://www.gov.uk/government/organisations/innovate-uk/about [↑](#endnote-ref-3)
3. The themes emerging from the analysis were mapped onto Osborne’s criteria and typology of innovation. Further details of the studies identified are presented in appendices I and 2. [↑](#endnote-ref-4)
4. For example, Clarence and Gabriel (2014) cite Shared Lives as a ‘radical social innovation’ but provides no definition beyond *“The adoption of Shared Lives in these areas has the potential to transform the way in which public services are delivered*” (p. 39). Similarly, Bennett et al. (2018) include ‘technology and digital’ (in particular assistive technologies and monitoring technologies) as areas of focus in their report ‘New Models of Home Care’ and include it in a table headed ‘innovation in adult social care’. At the same time, they do not provide a definition innovation or criteria for assessing innovation or ‘newness’, and argue *“While there are multiple examples of technologies and tools that may be very effective at promoting independence, preventing falls and helping to manage risks, the impact these have on changing the approach to statutory home care services is limited and there is a question about the extent of demand for them”* (p. 12). [↑](#endnote-ref-5)
5. Other grey literature sources included examples of innovation in passing and have not therefore been included in this analysis (e.g. DoH, 2010). [↑](#footnote-ref-2)
6. Some of these sources included other examples of innovation outside of the scope of social care (e.g. HM Govt. and NHS, 2006), or home care specifically, or included reference to examples with insufficient detail (e.g. SCIE, 2017). [↑](#footnote-ref-3)
7. However, at the time of publication, in some cases these could still be classed as ‘new’. [↑](#endnote-ref-6)
8. Trappes-Lomax and Hawton (2012) [↑](#endnote-ref-7)
9. Waltham Forest, Leeds (Hunt, 2018); Age UK Personalised Integrated Care Programme (SCIE, 2018); Innovation Forum West Sussex (HM Govt. and NHS, 2006). [↑](#endnote-ref-8)
10. Baxter et al (2013); Brewis (2009); Norrie et al (2014); Rabiee et al (2014) [↑](#endnote-ref-9)
11. Personal budgets (DoH, 2010, Bennett et al., 2018; Murray et al., 2010); Speaking Up (DoH, 2010); client cards for care (HM Govt. and NHS,2006); In Control (HM Govt. and NHS, 2006; Murray et al., 2010: DoH, 2005); Individual Service Funds; Integrated Personal Commissioning (Bennett et al., 2018) [↑](#endnote-ref-10)
12. Christopoulou (2013); Milligan et al (2013); Palm (2014) [↑](#endnote-ref-11)
13. Scotland National Telecare Programme (Bennett et al., 2018); Liverpool Telecare (DoH, 2005). [↑](#endnote-ref-12)
14. Cooper and Urquart (2008). [↑](#endnote-ref-13)
15. Vida, Cera (Bennett et al., 2018) [↑](#endnote-ref-14)
16. Smith et al (2017) [↑](#endnote-ref-15)
17. Wiltshire County Council (Bennett et al., 2018); Oldham Council (The Resolution Foundation, 2008). [↑](#endnote-ref-16)
18. Brookes and Callaghan (2013); Brookes et al. (2016); Callaghan et al. (2017); Fox (2011) [↑](#endnote-ref-17)
19. Shared Lives (Clarence and Gabriel, 2014; Bennett et al., 2018; Hall, 2019; SCIE, 2017; 2018; Shared Lives Plus, 2017); Homeshare (Bennett et al., 2018; Shared Lives Plus, 2017; DoH, 2005); Vernon Gardens Brighton (Bennett et al., 2018). [↑](#endnote-ref-18)
20. Wellbeing Teams (Bennett et al., 2018; Hall, 2019; Shared Lives Plus, 2017); Buurtzorg, Love2Care Devon (Bennett et al., 2018) [↑](#endnote-ref-19)
21. Helping Hands Suffolk (DoH, 2005) [↑](#endnote-ref-20)
22. Tyze (DoH, 2010); Breezie, Mindings, Casserole Club, Jointly, OnCare, Patients Know Best (Bennett et al., 2018) [↑](#endnote-ref-21)
23. SuperCarers (Bennett et al., 2018; SCIE, 2018), Care.com (Bennet et al., 2018) [↑](#endnote-ref-22)
24. Ross (2016) [↑](#endnote-ref-23)
25. Blood (2013) [↑](#endnote-ref-24)
26. Milligan et al. (2013) [↑](#endnote-ref-25)
27. Scotland National Telecare Programme (Bennett et al., 2018). [↑](#endnote-ref-26)
28. Lockwood (2013); Glasby et al (2018) [↑](#endnote-ref-27)
29. Community Catalysts (Hall, 2019; Bennett et al., 2018; Shared Lives Plus, 2017); Somerset Microenterprise Project (Bennett et al., 2018); micro-enterprises, Thurrock (Hall, 2019). [↑](#endnote-ref-28)
30. Community Circles (Hall, 2019; Bennett et al., 2018; Shared Lives Plus, 2017); Community Agents, Community Connectors (SCIE, 2017); Local Area Coordination (SCIE, 2017; Shared Lives Plus, 2017; Hall, 2019); Living Well in Cornwall, Careview, Bennet et al., 2018); The Deal, Wigan (SCIE, 2018; Hall, 2019); Age UK Living Well (SCIE, 2017) [↑](#endnote-ref-29)
31. St Monica’s Trust, Bristol (Bennett et al., 2012) [↑](#endnote-ref-30)
32. London Borough of Camden (DoH, 2010). [↑](#endnote-ref-31)