Northumbria Research Link

Prudence or speed: social enterprise and innovative health and social care in rural Wales

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Abstract

As social enterprise and third sector organisations have become more central to traditional public sector provision in Wales, there has been increased use in rural areas of multi-agency teams to deliver services. This paper draws on a study of twenty projects delivered under the auspices of NHS Wales and the first implementation phase of the Rural Health Plan (2010-11); key themes of which include access, integration and, community cohesion and engagement. The need for speed of induced innovation emphasises reactivity in some instances and transfer of practices from more developed (or urban) environments to rural communities without acknowledgement of cultural, social and economic contexts and conditions. Inclusion of social enterprise practitioners, particularly those with community development and capacity building expertise in co-production of services may allow for the development of integrated and innovative working across health and social care, which may also be more aligned with a Welsh focus on prudent healthcare. In this respect, the paper considers the role of social enterprise in identifying and fostering innovation in low income, rural areas in ways that provide close-to-patient/service user services and address local issues and health determinants to provide more sustainable and resilient community based health and social care provision.

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1.Introduction

There has been increased research and policy focus in the last twenty years on the relationship of place to health and well-being (Andrews & Moon, 2005), including investigation into 'rural issues'. This has often focused on defining what is meant by 'rural' even though the definition of rural in one context may not be appropriate for another. For example, while more 'objective' assessments may include measures of settlement areas, population density and sparsity, and indices of deprivation (see the Welsh Index of Multiple Deprivation, 2017), others focus on local perceptions of whether 'home' is rural or not. This may include consideration of the influence of culture, history, as well as socio-economic factors and employment characteristics of a region (Asthana et al., 2002, Ocaña-Riola & Sánchez-Cantalojo, 2005). As Malatzky and Bourke (2016) point out what many of these accounts hold in common is little consideration of power relations in rural health, together with a preponderance of a deficit discourse. In these instances, urban and institutional health and social care are the standard bearers against which rural health and social care must be measured. In turn, this privileges technical and process innovation and efficient and speedy transfer from urban to rural settings, from industrial to non-industrial communities, from secondary and tertiary health and social care to primary and community care practice.

The increased policy focus on rural areas such as Wales and Scotland in the UK and internationally (e.g. Bourke, Humphreys, Wakerman, & Taylor, 2012 in Australia) also makes 'rural health deficit' a political and policy construction. On the one hand, this has kept rural health and well-being on political and policy agenda but on the other, it also reinforces

an image of rural and remote health and social care as 'problematic environments in which to work' (Malatzky & Bourke, 2016, p. 159). The 'Rural Health Plan in Wales - Improving Integrated Service Delivery across Wales' (Welsh Assembly Government (WAG), 2009) is one such policy initiative, unusual in being specifically tailored to the needs of rural residents. The Plan identified three problem focus points: access to (and utilisation of) services; integration of services and health and social care; and community cohesion and engagement. The Rural Health Innovation Fund (RHIF) was set up to support local and national innovation. This was a £1million fund and included provision for evaluation of the development and adoption of 'innovative and sustainable solutions' through funded projects, as well as the establishment of two rural health development sites to pilot new models of integrated rural health and social care (WAG, 2010, p. 4). The initiative responded to a growing realisation that increased innovation is required to meet new challenges and address old ones more effectively and that to tackle these complex problems, there is need for multi-stakeholder partnerships in the co-design and delivery of services.

To receive funding, projects needed to demonstrate 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 (WAG, 2010, p.4). Emphasis was placed on new and/or improved cross-sector working that could 'strengthen local ownership, engagement and rural networking' that might result in 'supporting [health and social care] workforce development through new skills, roles and responsibilities' (WAG, 2010, p.4). In this way, once matched against key criteria and funded, projects were

conceived to be innovative or have innovation potential where innovative practice is both incremental and practice-based. This aligns with Rogers' (2003, p. 12) definition of innovation as 'an idea, practice, or object that is perceived as new by an individual or other unit of adoption' and give regard to the social processes underlying sourcing and diffusion of innovation.

This paper draws on a study of the twenty Rural Health Local Innovation Projects (RHLIPs) delivered under the auspices of the Plan and funded by the RHIF. The research study was undertaken by one of the authors and funded by a Prince of Wales Innovation Scholarship managed jointly by the RHIF and the University of Wales. The doctoral research was independent from the overall project evaluation (carried out by the RHIF steering committee), and the researcher (a previous health professional) had no previous experience of working with the overall team or any of the RHLIPs. She did, however, have regular contact with the steering committee and all the projects throughout the doctoral study (2011-13).

In order to try to redress the deficit focus to one which looks at the particularities and opportunities afforded by multi-stakeholder, multi-agency perspectives, the paper focuses on: the experience of individuals identified as being central to the development and delivery of funded projects (Ibarra, 1993); exploration of opportunities and challenges for third sector and social enterprise organisations working in multi-stakeholder partnerships to design and deliver innovative solutions to health and social care; and the tensions between the need for speed - and specifically expectations of immediacy (Tomlinson, 2007) resulting from a top-down push for transformational change and innovation. It starts with an overview of rural

health before a more focused view on Wales and place-based approaches to health and social care. Section 4 introduces the research design and methods, followed by findings, discussion and concluding remarks.

2. Rural Idyll and hidden rural issues and strengths

Historically, rural health has not received specific attention, which may be due to the perception of rural populations being healthier with a better quality of life than urban populations; the rural idyll. In the UK, as well as in Europe, there has been a rarefied image of rurality. This is often in opposition to the accounts of the hardships of town and urban life linked to early and growing industrialisation and where 'the country' becomes the destination of choice for those able to leave behind the grit and grime of urban life (Burchardt, 2011). These havens of peace and tranquillity - often 'English villages' rather than Welsh valleys - point more to industrial and agrarian dimensions of difference, rather than urban-rural per se.

The continued migration of wealthier people from towns to country - leading to gentrification, can further disguise the dispersed nature of social exclusion in rural and peri-urban communities (Philip & Shucksmith, 2003; Shucksmith, 2000, 2016). Many measures of deprivation, for example, have traditionally focused on dimensions such as car ownership and housing density - measures that do not reflect the experience of rural dwellers with little or no public transport infrastructure, and accommodation tied to employment. These factors of sociability, isolation, and individual and place-based experiences shape the stereotypes and images of rural that can influence interpretations and expectations of service delivery. They are important in that they move our focus from descriptions of place (statistics, geography) to

images and perceptions that provide an indication of how individuals understand and act in rural space (Yarwood, 2005). This also helps to move us beyond the rural idyll to a more complex relationship between country and community. Burchardt (2011), for example, charts the development and influence of the rural community movement in England and its leading figures, including Sir Horace Plunkett (who had close connections with the UK co-operative movement, and experience of American rurality, see Plunkett Foundation - www. plunkett.co.uk). The significance of the movement is in its network of organisations - particularly community and volunteer-based organisations - linked to social enterprise and entrepreneurial activities, such as the formation of subscription libraries and voluntary social services; a shift to rural regeneration; a sense of communitarianism; and 'inclusive citizenship' (Burchardt, 2011, p. 78). This further emphasises the perceived strength of rural communities to develop social capital and network ties, as opposed to the atomisation of urban communities.

The increased use in rural areas of more multi-agency teams to deliver services has become increasingly important to the process of innovation (Connell & Mannion, 2006). At the same time, even though social enterprises and third sector organisations have become more central to traditional public sector provision, there are still relatively low - or hidden - levels of social enterprise involvement in direct care provision in Wales. Social enterprise in the Welsh context at that time (National Assembly for Wales, 2010) was defined as 'a business' or 'a way of doing business' with 'primarily social objectives' and where 'surpluses are reinvested in the business or into the community rather than being maximised for shareholders' (p. 8 and 15). The types of organisations included in this broad definition included co-operatives, social

firms, and community development organisations, however, some note was also taken on the distinction offered between social enterprise - as requiring earned income - and social innovation that may involve social entrepreneurs or innovators 'doing new things in different ways, but not using earned revenue' (p. 9). Indeed, although several of the organisations working within the RHIF project income generate through contracts and diverse income streams (and may be regarded as social enterprises), they more generally self-identified as voluntary and community organisations. What is important for the purposes of this paper is the inclusion of non-statutory social and health care innovators and rural health practitioners, who because of their potential for community development activities that deliver social, health, and wellbeing outcomes, can be seen to be rural community or social entrepreneurs (Farmer & Kilpatrick, 2009).

3. Wales: space neutral or place-based recognition?

Many of the challenges facing health and social care providers are common to rural and non-rural communities. In this respect, if problems are the same then it can be argued that space-neutral policies and social innovation allow for the unproblematic and speedy transfer of innovation practice from urban to rural areas, thereby exacerbating the image of rural deficit. Yet these common issues may be compounded for rural communities by a range of composition and contextual factors. Contextual - or space-related - contingencies are therefore important in rural communities such as those in Wales that are also undergoing transition from rural areas with industrialised sectors (mining, steel) to communities with decline in traditional industries, and devolution of governmental powers.

A place-based approach (Bolton, 1992) allows for an appreciation not only of the geographical location of a community, but its socio-economic, political and cultural roots and provides a platform from which to consider the appropriateness of policy intervention and service innovation. It foregrounds local knowledge, local networks and communities of practice that may forego traditional sectoral and organisational boundaries. It supports approaches that are mindful of the local landscapes; increasing potential for locating 'blind' alleys and short-cuts that may inhibit or enhance innovation diffusion and implementation. In turn, this enables the potential for local (endogenous) interpretation of national (or exogenous) policy initiatives that benefit in-situ communities (Barca, 2009; Charbit et al., 2009). This, then, necessitates sensitivity to time and awareness of a two-way transfer for innovative practice, rather than uni-directional, which we return to later when considering the concept of the 'need for speed'. It is useful then to turn attention briefly to the geographical entity known as Wales.

Wales is a small country with close links to England. The population of just over 3 million (ONS 2012), is unequally distributed across the country with a focus around the more urbanised areas in the south and the eastern valleys of Wales, reflecting the industrial heritage of the country. Further highly populated areas are found in North East Wales close to the English cities of Chester, Manchester and Liverpool. Over two thirds of the population live in rural communities (ONS, 2013) and there has been a steady growth in the population between the years 1951 – 2014 from 2,873,000 to 3,099,100 people and accounting for 5% of the UK's population (ONS, 2013; ONS, 2015). Moreover, the Welsh population has a high

percentage of people who report a poor perception of their health, and an increasingly ageing society (ONS, 2012).

In the UK, the home nations have been free to adopt independent policy approaches to rural health following devolution in 1999. England has not pursued a specific rural health agenda. Northern Ireland does not have a rural health policy though the Department of Agriculture and Rural Development (DARDNI) has a set definition to be used in relation to rurality. There is an expectation this definition is used for policy development unless a justification can be given to the contrary, though there is recognition that different definitions of urban and rural might be appropriate on different occasions and in response to different policy objectives. The Scottish Government set up the Rural and Remote Implementation Group who developed Delivering for Remote and Rural Healthcare (2008). Like Wales, the Scottish rural focus emphasises multi-stakeholder approaches, co-production, and partnership with individuals, communities, and voluntary and community social enterprises.

4. Research design and methods

The overall research project consisted of several phases with the purpose of investigating the process of innovation from the viewpoints of health and social care practitioners, and employed an explanatory sequential mixed methods approach (Creswell & Plano Clark, 2007). Research methods, data analysis and participant involvement were reviewed and approved by the University ethics committee. This was followed by both organisational and individual participant consent. The first phase involved secondary data and document analysis of papers related to the purpose and development of the RHLIPs to ascertain consensus or

otherwise on the strategic intent and impetus for innovation. The next phase involved quantitative analysis of questionnaires, which in part, served to provide a sampling tool for the final phase of the research: in-depth interviews with key participants. Unlike many mixed methods approaches that provide more weight to quantitative methods, the weighting of the phases for this study rested on the final qualitative stage, which is the focus of this paper.

The Innovation Involvement Scale (Ibarra, 1993) was included as part of the survey tool to identify, through self-assessment, the degree of centrality of involvement in the innovation project linked to role, individual attributes, and formal position (multiple bases of power and the enactment of power in innovation domains). This self-assessment - by ticking the comment most closely related to individuals' involvement in the project (see Table 1) - was then corroborated with colleagues in the same RHLIP.

I was, along with or in conjunction with others, the initiator of the innovation, that is, the introduction or running of the project was in a large portion my idea *(This is the statement to tick if the innovation would not have happened without you)*.
I was not the initiator but played a major role in the development of the innovation as a whole *(This is the statement to tick if you played an important role in shaping the innovation - it would not exist in its present form without your contribution)*.
I was associated with the development of the innovation in a more limited capacity, for example, providing advice to the initiator on specific aspects of the innovation *(This is the statement to tick if you played a minor role in bringing the innovation to the organisation)*.
I know about the innovation but had nothing to do with it.
The innovation is not applicable to my work and is one I know nothing about.

Table 1: Dimensions of Ibarra Innovation Involvement scale - self and other identification of involvement in innovation processes

The tool has been used in various settings to provide a means of identifying individuals who perceive themselves and are perceived by others as being highly involved in innovation processes: Highly Involved Innovation Practitioners - HIIPs (Ibarra, 1993; Obstfeld, 2005). For purposes of anonymity, participants in the research are referred to as HIIPs (HIIP1, HIIP 2, etc).

In total 18 HIIPS were identified and invited to interview. Two were unable to attend. Sixteen semi-structured, in-depth interviews were undertaken by one of the authors at a venue of the participants' choice (in all cases their workplace) and focused on their perceptions on the activity of innovating in rural communities – including generation of ideas, adoption and diffusion of ideas, and implementation. The interviews, each on average 90 minutes in length, were audio recorded. The interview schedule enabled narration of and reflection on the innovation journey of those highly engaged in the process of innovating (Newell et al., 2009) and took the form of guided interviews to allow comparison between interviews and to enable freedom of expression (Van der Stoep & Johnstone, 2009).

Interview data were fully transcribed and NVivo 10 (QSR International, 2012) was employed for data management and analysed using the Framework method (see Ritchie et al., 2003). The Framework method provides comprehensive and transparent data analysis calling for sequential data management and then interpretation of data: moving through phases of taking key phrases from transcripts (with minimal interpretation), through data abstraction to identify 'elements/dimensions' and finally a second level of abstraction to develop 'categories' formed from the dimensions while retaining the link with the original data.

As mentioned above, the RHIF provided short-term funding (one-year) to 14 principal project teams delivering 20 RHLIPs (some teams delivered more than one project - See Table 2). Each project had to involve a named Health Board (HB) as part of the funding agreement. Those projects where third sector organisations (TSOs) were significantly involved or were the lead partner in the project are shown in italics in Table 2, with additional descriptive information.

RHLILP	Stated aim of project
Care Farming Stakeholders: TSO+, H	
Community Networks *Stakeholders: H, TSO*	To develop an integrated network of community bases to support service users experiencing suicidal thoughts or following self-harm. Outputs: Development of 'Emotional CPR' course, Train the trainer and GP practice training
Community outreach *(volunteer information)* *Stakeholders: H, TSO*	To explore opportunities to test a wider range of integrated services that could be provided including volunteering opportunities to remote and rural communities. Outputs: Purchase of outreach bus and set up hiring out to TSO, LA and H
Coping communities *Stakeholders: TSO+, H, LA*	To establish community hubs including Volunteer Village Wardens and a Dawn Patrol scheme. Outputs: See vignette below
'Designed for competence' Stakeholders: H, LA	
Health & Well-being *Stakeholders: TSO, H*	To increase the knowledge of third sector services by health service and social service personnel and of those living in the rural community. Output: Series of "information events", promotional DVD
Investors in carers *Stakeholders: H, LA+, TSO+*	To develop an innovative infrastructure to stimulate expansion of the Investors in Carers accredited GP Practice Scheme across the local health board. Outputs: See vignette below
Community Outreach (MIND *DORIS bus)* *Stakeholders: TSO, H*	To improve access to health social care and wellbeing advocacy and information services. Outputs: See vignette below

RHLILP	Stated aim of project
Long term conditions *Stakeholders: TSO, H*	*To broker links between national organisations and their corresponding representatives in rural Powys. Output: Development of Infoengine database to allow sharing of TSO to share their knowledge*
Nurse led health intervention Stakeholders: H, HPC	
Outreach Speech and Language Therapy Stakeholders: H	
Palliative care *Stakeholders: H, TSO+*	*To build further palliative care capacity linking with Third Sector organisations providing hospice at home services on the borders of Powys. Outputs: Revision of pathways of care to enable more people to die in their place of choice*
Public Health - Heart health Stakeholders: H, AH	
Public Health - Smoking Cessation Stakeholders: H, AH	
Rural mapping (carers needs and expectations) Stakeholders: H, LA+, TSO+	
Rural transport *Stakeholders: TSO, H*	*To increase the number of health and social care and wellbeing transport services for those who live in rural areas and have no means of independent transport. Outputs: Increased utilisation of resources and improved partnership working with TSO and LA.*
Technology enhanced referrals Stakeholders: AH	
Tele-rehab Stakeholders: H	
Technology supported information transfer Stakeholders: H, HPC	
Technology supported therapy Stakeholders: H, AH	
Notes: Organisation Type: H = Health/Health Board; HPC - Health, Primary care; AH - allied health (e.g. pharmacists); LA - local authority (social care); TSO - Third Sector Organisations - social enterprise/voluntary sector	

Table 2: Rural innovation projects.

5. Findings

Undertaking interviews with those practitioners involved in projects on the ground helped to explore the perceptions and congruence of rhetoric and practice. A high degree of consensus was evident in relation to the strategic intent of the RHIP and the organisational aims of the funded initiatives, specifically regarding the need to 'stimulate and support innovative and sustainable solutions supporting the key themes outlined in the Rural Health Plan' (WAG, 2009). Even so, the tensions between different norms and practices was of interest and how these can be managed and knowledge shared to achieve the implementation and spread of social and public service innovation (Connell et al., 2003; de Vries et al., 2015).

Health and social care professionals appeared to respect the need to work collaboratively and indicated that they worked in close collaboration and as frequent partners with primary care professionals and voluntary sector organisations. There was also evidence of 'mutual adjustment' (Lindblom, 1959, p. 85) and adaption towards the wider group interests brought about by proximity to and frequency of collaboration and exchange between stakeholders:

> "It doesn't have to be the things that I am interested in because that's sort of
> not how we work...we have overarching principles, we have overarching
> mission, vision" (HIIP 3).

The push for speedy and efficient changes in service provision, however, often means that social enterprises and voluntary sector organisations – specifically umbrella and apex development agencies - are a quick route to - or substitute for - involvement of patients,

carers, and service users. At the same time, health professionals were wary of direct involvement with individual patient and self-help groups:

"There are chronic conditions groups, focus groups in the north and south but... they may not represent chronic conditions patients as a whole, they are interested chronic conditions patients, with a desire to sit on a committee and a support group; they are not necessarily who the service is designed for" (HIIP 1).

The capacity for engagement was also seen as problematic:

"…we would like them to be engaged in many ways and on many levels. When you ask them then they want to, they really want to. When it comes down to it, they can't because they have a [another] role and it's always very unpredictable whether they can make the time or not" (HIIP.7)

The hegemony of some professions, while permitting innovative practice of which they approve, may act in some instances to limit others (Benôit et al., 2010). By contrast, a profession or sector may equally become restricted by its professional persona which may limit how others perceive it and so stifle potential innovative activity (Wilding, 2011). This track record holds the potential to influence how credible the organisation is perceived to be, which seems to be open to amendment and improvement dependent on capacity to develop purposeful networks and spheres of influence. In this respect, there are degrees of hierarchy in

the public service arena (Gabbay & le May, 2004; Rees et al., 2012) with some organisations assuming and carrying greater levels of credibility.

The shaping of strategic intent may also be confined in arenas where risk taking is discouraged and where rules and norms also influence the interaction with other network members (Harrison & Kessels, 2004). Change is often limited to 'variations from present policy' (Lindblom, 1959). The risk associated with designed-for rather than designed-with innovation, which this limitation may produce, may only become apparent over time in evaluating the penetration and the (lack of) take up of services. For example, one of the RHLIP technology, projects designed for an adult population found instead that it attracted a largely adolescent cohort, revealing a previously unmet need. In most cases, though, involvement with voluntary sector partners and increased community outreach meant that patient /user involvement appeared to increase as the projects became more established and as the quality and frequency of communication and feedback improved, allowing for more input and flexibility of reach at least in delivery, if not always in design of services.

Many of the projects tackled complex social and mental health needs. Isolation and the risk of suicide - particularly in isolated farming communities - is a key concern (Welsh Government, 2012) and Community Networks was a project specifically set up to reduce suicide and self-harm. The impetus for the project was to build capacity of local communities to provide timely and appropriate interventions to people experiencing suicidal thoughts or following incidents of self-harm. This involved looking at new and different ways of integrating third sector and community networks with community mental health teams and statutory services.

The project survived until the end of the funded period, but was very much seen as a stepping stone for further service development by the large social enterprise leading the pilot. The following case examples illustrate the different trajectories of the funded projects (see Welsh Government, 2011 for further detail).

MIND DORIS – rural advocacy service

As stated earlier, all projects had a Health Board as the anchor partner in each of the funded initiatives and this was a requirement of project funding. In the Denbighshire Outreach Information Service (DORIS), the local health board partnered with a long-established countywide mental health charity to develop an information service and referral route to advocacy services. The MIND DORIS mobile outreach vehicle was staffed by paid workers and volunteers. DORIS has reached out to 185 people, with 32 people referred to the advocacy service. By carrying nurses to farmers' livestock markets, to carry out blood pressure checks for example, experience has shown that traditional hard to reach groups in rural communities are not necessarily hard to reach, but are expensive to reach; making the DORIS bus an effective part of community health and mental health outreach (see [www.valeofclyydmind.org.uk/doris)](www.valeofclyydmind.org.uk/doris). Support outcomes were recorded for the duration of the RHIF period using Outcomes Star – a recognised tool used to measure individual progress towards self-reliance against different criteria, including: feeling positive, feeling safe, managing money, being treated with dignity, looking after yourself, keeping in touch with others, and staying as well as you can.

With MIND Doris, the reframing of a problem from 'hard to reach' to 'expensive to reach' provided the means to deliver the project through the simple provision of dedicated transport to link directly to local communities. Additionally, offering on-site health checks (blood pressure checks), provided opportunities to raise issues of mental well-being and preliminary screening. This intervention also took account of key rural activities for optimal reach; going where people are (rather than trying to get them to where you want them to be). From initial observation, the project may seem to be a typical outreach service, but the multi-stakeholder involvement has enabled much more to be achieved. Here, 'innovation' is not about introducing new services but in combining resources in ways which provide existing services 'in settings previously considered to be uneconomical' (Muñoz and Steinerowski, 2012, p. 50).

In contrast, the example below, demonstrated that innovation transfer from previously urban settings - the Dawn Patrol scheme - may be less successful. The failure of this prevention strategy was compensated for by a sister scheme addressing similar issues but from a different direction and combination of resources.

Capable Coping Communities
This project brought together health, social care, and third sector organisations. Key agencies included the British Red Cross, the local health boards, the local authority, and Gwent Association for Voluntary Organisations (GAVO- a local development agency). The aim was to build the capacity for self-help and community action to improve the health and well-being of the local population. This was to be achieved through the establishment of

Volunteer Village Wardens (VVWs) whose role was to assist in social care activities, and a Dawn Patrol Scheme. The latter encouraged school children to check daily on the welfare of older residents, a scheme that had worked well in urban areas, but did not transfer to a rural community with probability of greater distances between dwellings. By contrast, the VVWs was well received by local communities and received around six new referrals a month with an average of seven visits per person. The most sought after services included: accessing local amenities; companionship; transport; and help with completing forms. The VVW scheme has continued as a project funded by the Big Lottery Fund. In this instance, the RHIF acted as a safe prototyping pilot to secure further project funding (for more detail of findings see, http://gov.wales/docs/dhss/publications/111223ruralen.pdf)

The VVW scheme above had resonance for older members of the rural community and provided multiple benefits: helping to build trust and social networks within the community and bringing health and well-being benefits to both recipients of the service and to the volunteers. Similarly, Investors in Carers shows the benefits from collaboration in building on existing knowledge and resources to realise the expansion of an established service and to identify avenues for growth and development of significant improvements in service delivery: intersecting and crossing boundaries and shifting the locus of professional expertise, in this instance from primary care to TSO, and embedding new or developed practice in existing systems.

Investors in Carers
This project built on work already delivered to support carers and brought together the Local Health Board, Local Authorities and several charities. The aim was to stimulate expansion of the Ceredigion Investors in Carers (CIiC) across the whole of the Hywel Dda University Health Board. Investors in Carers (IiC) is a framework to raise awareness and provide credit for good practice and support services provided to carers by GP practices. As a result, the scheme helped to identify over 100 carers who were not receiving carer allowances. The main benefits for carers included: improved choice and access to services; signposting to respite care; and recognition of carer contribution. In the period 2011, 33 GP practices attained bronze accreditation (100 per cent increase on the previous year, with more in the pipeline); and three gained silver awards. In 2012, the Carers Strategies (Wales) Measure 2010 came into force placing, for the first time, a legal duty on the NHS in relation to services for carers in Wales. The project leads have been mindful of the need to share the learning and value from the project providing information, evidence and guidance on Hywel Dda University Health Board website (http://www.wales.nhs.uk/sitesplus/862/page/66977).

Each of these vignettes illustrates repeated themes from the interviews related to capability, significance of timing and speed, and the role of the rural innovator, which will be looked at in more detail in the following sections.

5.1 Future capability

When sourcing new ideas within the multi-agency projects, we see a shift in relationships and progress in the ways of thinking. Rather than the capacity and capability of an individual service to reach target populations, attention is given (albeit as an unintended outcome in some instances) to building local networks and utilising local knowledge. There was strong feeling across health and the voluntary sector that the frontline workforce is best placed to deliver solutions:

> "…it is the people that work on the front line and the people that are affected by things that come up with innovation. They know what will sort their problem out ...I can remember being really surprised at what had been proposed by just asking different people. And being really astonished at what innovation was out there just by reaching people" (HIIP 2)

> "I just contacted my network of people… and that sort of went out virally I suppose, so we threw it out to, you know, I went to VGA, VGA went out to the voluntary sector, "Anyone got any ideas?" [...]You surround yourself with people who you think have got rich experience that they can add" (HIIP 12).

HIIP 12 saw this way of working very much as an antidote to top-down knowledge transfer from experts, to the generation (and appreciation) of more grounded, local experience and expertise. In the longer term, this was perceived to support sustainability, and build community capacity and resilience. In some respects, it was also seen as a means to re-

interpret top-down policy drivers in ways that were relevant on the ground. Giving time to incubate and "provide headspace" (HIIP 12) to re-examine and try out different ways of working was pivotal here. So too was the re-imaging of individual public sector professionals from what Lipsky (1969, p. 2) refers to as 'street level bureaucrats' where clients/service users/patients are not 'primary reference groups' for the health and social care professional except in terms of delivering government policy, to mediators or negotiators between statutory sectors and communities. Where this worked well, it enabled stakeholder relationships that allowed for a diversity of views, and which had potential to support more developed and nuanced approaches to complex problem solving (Lindblom, 1959; 1979).

Even when faced with pressures to perform combined with time and resource constraints, there were examples of positivity in trying to get around structural and systemic difficulties, showing both resourcefulness and improvisation. HIIP 4, for example, exemplifies what Levi-Strauss (1962) refers to as bricolage:

> "if you're painting a picture, you're governed by the colours that you have, or that you've bought. You can mix the colours and you can shade them but if you've got x number of colours those are the colours that you have to mould your thinking." (HIIP 4)

While these may not be dramatic changes, there is demonstrated potential of where multi-stakeholder alliances can support ideas creation, provide platforms to identify opportunities within existing constraints, and in some instances, utilise resources more effectively and in

non-traditional ways by initiating and supporting community-based activities and place-based solutions. This social or community bricolage also draws on local knowledge embedded in communities, thereby taking notice of and being sensitive to locality needs and pressures.

Many of the sustained practices are indicative of relationships built over time and support the development of non-institutional ideas in the co-production of rural health and social care. This, in turn, emphasises the development and expansion of health and social care professional roles to enable cross-sector working and a concomitant shift away from prescriptive approaches to service delivery mechanisms.

5.2 Tempus fugit to tempo giusto

While induced innovation and policy demands may have a part to play in catalysing social entrepreneurial activity, there has been limited evidence of impact in addressing health inequalities and access to rural healthcare (Dixon Woods et al., 2012; Snooks et al., 2011). The emphasis on performance and a more business-like approach to management of health and social care, which has been exacerbated by new public management reforms and target driven culture, has not necessarily stimulated the growth of innovation in the sector (Wynen et al., 2013). The need for speed and culture of immediacy (Tomlinson, 2007), the push for efficiency and how quickly an innovation is adopted has been a constant focus of government policy emphasising the need to 'accelerate' uptake and transfer. As seen from this participant's evaluation, there is often a knee-jerk and reactive response to induced innovation:

*"…*You've got to operationalise these ideas quickly because we are always

reactive in [health and social care], aren't we? So, if we identify a problem we

have to be very, very reactive and sometimes you act in that particular moment

and you haven't got the time to research and edit things" (HIIP 4).

Yet, there was also resistance to piecemeal approaches that prioritise target-driven and more passive approaches to more systemic considerations, taking into consideration community insight and experience, and active involvement:

"You only generate change at the speed of the people who are changing want

to change not to a political timetable" (HIIP 12).

Even so, this type of reaction relies on social and relational capital to trigger change and to allow learning from mistakes, and trial and error. Speed may be important, but timeliness needs also to be considered. As seen in the case examples above, while it is important that a pilot innovation succeeds, success may not be in the continuation of the service as is, but in the networks and relationships that endure after the project has ended or where services have morphed into larger or more mainstream provision. This rural future proofing can then support the incubation of embryonic innovation and foundations for longer-term collaborative actions and communities of practice.

5.3 From rural innovator to rural social entrepreneur

The drive to innovate in public service provision has been perceived as low, and the risk associated with it has been high, and thus traditionally viewed as an 'optional extra or added burden' (Mulgan & Albury, 2003, p. 5). Gallouj and Savona (2008) counter this and argue that this view has developed due to a lack of clarity around the definition of innovation in different settings - with the public and voluntary sectors less likely to label a new activity or process an innovation. As was evident from the research, there is often reluctance to acknowledge innovation. Indeed, there is a steer away from the need to innovate towards recognition of existing good practice. Several third sector participants found the "call for innovation not helpful" (HIIP 3). As one respondent explains:

> "We already very clearly know what the needs are on the ground and so you
> don't need to innovate. You just need to respond to the needs that are there."
> (HIIP 7)

Third sector organisations felt the call for innovation also led to short-term fixes linked to pockets of project funding, rather than long-term sustainability and viability of quality services. At an international level, similar findings call for more effective management of programmes and for longer term investment to avoid short termism (Larson et al., 2011). This could also allay the issues of initiative and innovation fatigue for both service users and providers.

The ideal of "real" innovation may be further compromised by the common prompt for innovating to solve immediate everyday problems, thus leading to further difficulty in the recognition or valuing of innovative work:

"You can see people at the NHS Wales Awards who are very comfortable in that kind of lifestyle. They are serial innovators – the people who come up with new things and they get the funding and they publicise them...[leading to a question,] Is what I have done innovative enough?" (HIIP 1).

Here the concept of 'everyday innovators' (Damanpour et al., 2009) is appealing. Using innovation to resolve local challenges links with normalising innovation to some extent and contextualises it to the local situation. On the surface this appears a positive development for the local community providing solutions to their specific needs. Conceptualising innovation as an ongoing social process, where relationships and organisational meanings, goals, and targets are both intertwined and negotiated, provides space to observe the same phenomenon through different lenses, and where 'the everyday is seen as the site for agency, for innovation' (Hartmann, 2008 p.3). Thus, innovation becomes less the quick flash of the genius innovator as described by HIIP 1 above, and more about shaping activities through the development of everyday sustainable relationships and coupling resources.

Additionally, resisting temptation to indiscriminately import wholesale solutions and ways of working developed out of context, puts emphasis on more 'bottom up' ways of working and resonates with the concept of the rural entrepreneur, as mentioned above, as bricoleur. Here,

resistance to the push for innovation, supports the creation of 'something new or more fit for purpose' (Phillimore, Humphries, Klaas, & Knecht, 2016, p. 7). This may in turn shape and influence new relationships and endeavours, such as inclusive governance and approaches to design, delivery and managing services and, moreover, in new models of care, including social business and multi-stakeholder ownership and control.

Here, as one participant suggests, it is about recognising and valuing rural approaches:

> "I think there are pockets of excellence within rural communities that urban communities don't get. Even within rural parts of Wales you will still get innovative in inverted commas at 'ways of working and 'round issues' around travel time and access and things like that." (HIIP 9)

This contextual knowledge of working around issues focuses on rural human rather than system or project needs. A focus on population health also supports the transfer of ideas specifically designed for rural communities to be delivered to a broad spectrum of populations from isolated to urban areas. Rural social entrepreneurs, however, are aware how rural solutions can be transferred to urban settings but acknowledge that selling the message will not be easy:

> "This [project] was concerned [with] the early identification of the rurality issues and obviously, the equality and diversity issues. I think that was key because I think we were in a good position to look at the rural model as opposed to something that would be an urban model ... It goes from very

isolated communities, community opportunities, to large urban areas. I think the framework we got for the [project] fits all those without having any barriers." (HIIP 10)

"[in rural communities…] if you're 83 and you've cut your shin, you really do not want to be taken 45 minutes down the road to hospital, to then have to get a taxi home that costs you £100… I think we just have to work a bit harder in the urban areas to get an appetite to change the model." (HIIP 6).

In the latter response, the required change required to keep people out of hospital is perceived to be compounded in the urban setting by ease of access. Rural social entrepreneurs can use the challenges that rurality can pose to initiate potential nation-wide solutions that break through not only sector but also geographical boundaries:

"They [rural communities] have to think [about] sustainability, they can't just think of tomorrow, they've got to think sustainable in a rural background, much more than I see in urban areas, where everything's convenient and so forth….so they've got to be more creative." (HIIP 13).

Much time and energy was also spent in re-framing existing ways of working to fit the requirements of funders to support short-term innovative projects, of which the RHIP was one. For TSOs, re-packaging of everyday activities that are seen to work on the ground as 'innovative' is an 'occupational hazard' of working in a sector that has increasingly become reliant on short term projects funds. It was felt that the focus on short-term, speedy, and

induced innovation needed to be countered and shifted to include community well-being as well as individual health outcomes that supported building sustainable and resilient health and social care provision.

6. Discussion

As suggested above, the narratives of those central to the innovation processes - the HIIPs - tended to see their innovation or entrepreneurial activity as an accumulation of multi-stakeholder processes over time and combinations of different ways of working to achieve an overarching goal (as expressed in their project descriptions). The benefits of moving from bi-lateral funding relationships to multi-stakeholder, multi-agency active alliances, offered space to identify new and different routes to providing rural health and social care and to engage in networking and outreach activities that moved the focus of provision beyond traditional institutional boundaries into rural communities. This was not without its problems - institutional and professional protectionism, local bureaucracy, deficit of time and resources. There remained a risk that inclusion of TSOs was out of necessity with a paternalistic approach giving lip-service rather than wholesale commitment to TSO and non-statutory input. The flip-side to this was the changes in how health and care professionals, particularly in multi-agency partnerships, changed their perceptions of TSOs and this was also seen as a benefit in shifting the loci of control away from local health boards to community initiatives.

This shift in perception of control also highlights the move from or resistance to the top-down push and need for speed to the pull of local collaboration in building potential for longer term relationships and readiness for change. Timing was of critical importance for HIIPs who

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wanted to ensure any new or adapted service and mode of delivery was *of its time* to maximise its potential acceptance by all stakeholders.

The timescale with which projects had to be up and running was demanding and highlighted further difficulties around the 'need for speed'. This provides important lessons on development of multi-stakeholder innovation more generally and questions the likelihood of embeddedness and sustainability of innovation projects over time. Moreover, the attempted importation of urban to rural innovative activity and the lack of fit in some instances raised awareness of choosing wisely (see www.makingchoicestogether.wales.nhs.uk) to increase the potential for local and place-based community development and entrepreneurial activities making a difference to those communities.

Tomlinson (2007) also discusses the notion of immediacy denoted both in time and spatial terms. The projects support the shift to proximal relationships - direct contact through co-production of services and patient participation and cultural alignment. Tomlinson (2007, p. 74) talks about the latter in terms of cultural and life experience, yet we could also think about this in relation to the development of trust and reciprocity between (rather than homogenisation of) diverse organisational cultures and ways of working that support increased inter-organisational communities of practice and interdisciplinary connectivity. The 'slow movement' (Honoré, 2005), promoting balance and interconnectivity - meaningful connections in time, place, and with others - may help to protect from induced innovation while supporting the speed of ideas formation, dissemination, and implementation for 'bottom-up' and horizontal designs in service delivery. As the Bevan Commission (n.d., p. 6)

points out, this 'includes consideration of broader social, economic and cultural issues to avoid unnecessary medical and therapeutic interventions to resolve health care needs', which in turn requires innovative combinations of skills, knowledge, and resources from partnership working, specifically with third sector and social enterprise organisations.

This approach may well be supported by the Welsh Government's adoption of the Bevan Commission report on Prudent Healthcare (Aylward, Phillips and Howson, 2013), which puts emphasis on place-based initiatives and building capacity across communities, the need for tempered speed - privileging rural speed over urban speed - and contextualised innovation. In a Welsh context, this has been interpreted as ensuring no harm in the ways in which health and social care is conceived, managed, and delivered to fit the needs and circumstances of citizens; a 'wise' and 'cautious' approach.

In some respects, this appears counter to the general acceleration of practice mediated by technological innovation and the 'overwhelming popular power of the discourse of progress' (Tomlinson, 2007, p. 25). Moreover, it places the concepts of social and public value at the heart of a social model of health and social care provision. Here speed is considered in terms of the lightness (lack of bureaucracy) and appropriateness of what is being provided and how: ease of access, and avoidance of what Seddon (2003) refers to as 'failure demand' (the failure to do something, or do something right). Equally, prudent healthcare also places some responsibility for active engagement with consumers of health and social care. This is where engagement with social entrepreneurial practitioners - whether third sector, social enterprise or hybrid organisations of social and health care professionals - may allow for the

identification and fostering of multi-sector social enterprises in rural areas that provide close-to-patient/service users services that can address local issues and health determinants.   This would require a further shift from multi-stakeholder provision of services (co-production) to the commissioning of re-designed services based on co-creation and place-based solutions; a longer-term, strategic and integrated approach to (rural) health and social care provision incorporating a range of social and community entrepreneurial actors.

6. Conclusion

As suggested by Cieslik (2016) the conceptualisation of community as space and a context for change is relatively limited in literature on social entrepreneurial activities. This is further compounded when the focus is on rural rather than urban community development. A place-based analysis which emphasises history, location, socioeconomic and geopolitical dimensions can support a contextualised view of service design and delivery that, in this case, draws on the strengths rather than limitations of rurality. It provides alternative ways of viewing, understanding, and appreciating 'rural practice, rural residents, and rural health [and social care] systems' (Malatzky & Bourke, 2016, p. 159).

While there is potential for co-creation of design of services, the case provided here emphasises multi-agency co-production of services. Even so, rural innovation projects provide integrated models from which metropolitan urban areas can learn, specifically in creating cross-sector policy and multi-stakeholder delivery of policy initiatives, which take into consideration diversity and difference of rurality. The opportunities afforded through rural integration and cross-sector services correspond with the Welsh Government's call for

prudent healthcare over and above the need for speed of innovative technology and practices that are place neutral. Yet, despite the call for integrated working, found in much social policy, such as Setting the Direction (WAG, 2010), health and community care practitioners continue to work within professional silos. Ferlie et al. (2005) investigated the non-spread of innovation focusing on the underpinning social and cognitive boundaries between professional groups. They found strong social boundaries between professionals hindered re-definitions of roles and work even within multidisciplinary teams, which has potential to negate the potential benefits of co-productive working and collective interpretation of practice.

The rurality lens may support potential for multi-sector approaches by starting from the premise of limited resources and reduced options that necessitate integrated practice to achieve effective and efficient outcomes for citizens. Recognising rural and remote communities as sites for more autonomous and networked ways of working - specifically in relation to community-based health and well-being promotion and prevention - may also reimagine rural communities as diverse and 'exciting' practice sites for a range of health, community, and social care professionals (Malatzky & Bourke, 2016). This has potential to keep, combine, and develop specialist skills in rural locations.

Pressures on communities to find localised solutions is high (Steinerowski & Steinerowska-Streb, 2012) aimed at increasing citizen involvement in service delivery (Hughes, Mullen, & Vincent-Jones, 2009), with the concomitant assumption that they (the patient and/or service user) assume some responsibility for that service delivery and for their own health

management (Nimegeer & Farmer, 2016). Collective action and multi-stakeholder governance can also support capacity building and sense of community through sustaining social capital and network ties; and improving trust relations across organisational and sector boundaries. Social enterprise and third sector organisations can often be brokers in improving cross-sector alliances, that support capacity building and community development. That said, the importance of external actors and triggers to mobilise assets (Shucksmith, 2016) cannot be underestimated. Munoz, Steiner and Farmer (2015, p. 487) for example point to the catalysing role of project managers; others provide examples of community health workers as animateurs (Tucker, 2014). In the current study, although in many respects the capacity of the multi-sector partnership itself is emphasised, there is also the presence of those recognised as central to the projects' development and process (HIIPs). There is therefore a continued need for evaluation of initiatives such as the ones highlighted above to further understand the dimensions of sustainable rural innovations. This together with further research that explores if and how prudent healthcare that values the place, context and strength of rural practice can bring together diverse communities of practitioners, patients and the public to facilitate the co-design and co-production of innovative health and social care services.

In many respects, the RHIF acted a trigger for what Shucksmith (2016, p. 2) describes as neo-endogenous or networked development. The Fund enabled multiple actors from health, social care, allied health professions (e.g. pharmacists) and third sector providers to extend and, in some instances, re-design health and social care services. The accompanying push to build community capacity and shift from a focus on acute care to community-based health and social care (Evans, 2016; Millar, Hall, & Miller, 2016) also helped to identify and counter a

stereotypical image of rural health and of social care workers as 'country cousins' (Bourke et al., 2010; 2012). Instead, identifying professional and networked practices that considered more holistic approaches to care and co-production of service.

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