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**A&S**

Adopt and Spread  
Programme

**COVID-19 and Beyond Series**

## **Make or Break: Adoption and Spread**

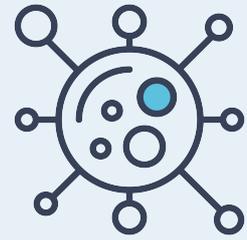
**Findings from existing research and early observations  
from the Adopt and Spread Programme**

**September 2020**

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Living in unprecedented times, COVID-19 has affected everyone's lives locally, nationally, and globally. As key workers respond to meet the needs of the communities around them, it was inevitable that many of the existing ways of working had to change.

In this series of publications, we share our analysis and insights based on our unique position leading a live national programme testing approaches to support successful innovation adoption and spread in Wales, the Adopt and Spread Programme. Here, we summarise the key themes from relevant research relating to adopt and spread in health and care at the time of infectious outbreaks and pandemics or when working in highly disruptive environments, as experienced during COVID-19. These have important implications for current/future policy and practice, with some immediate action points for COVID-19 and beyond.

This publication, *'Make or Break'*, brings together some of the highlights from the existing research and the early findings from the Adopt and Spread Programme. It concludes that people need to be encouraged, trusted and supported to adopt and spread new ideas, using the energy, motivation and enthusiasm of people. Realigning programmes and funding opportunities as well as building upon existing collaborations, networks and knowledge should help accelerate pace for adoption and spread of innovative ideas. The research and our early observations indicate that these factors are more likely to drive and translate innovative ideas into sustained practice locally, nationally and internationally.

## About the Adopt and Spread Programme

The Bevan Commission's national Adopt and Spread (A&S) Programme, supported by Welsh Government, was launched in July 2019 to test out what and how adoption and spread is most successful. The participating health and care adoption sites are being provided with support and guidance, mentoring, and coaching over 15 months. In addition, they are able to draw on financial support for innovation adoption, and access skills and resources from a wide range of collaborative and active networks associated with the Bevan Commission including universities and national health and care organisations. The programme is working with over 40 adoption sites to spread 15 successful Bevan Exemplar innovations.

The A&S Programme's primary purpose is to spread innovation whilst making the methodology more robust and transferable to other contexts in the future. The activities are underpinned by research and evaluation. With the programme continuing throughout COVID-19, the data collected were from adoption sites who were taking forward Exemplar innovations. The experience of the programme team continues to contribute to insights about innovation adoption in both stable and highly disruptive contexts. This learning is included in this publication series.

A search of the scientific literature related to innovation adoption has been carried out and informs the wider activities of the A&S Programme. We are using evidence on innovation adoption and spread in other highly disruptive contexts such as infection outbreaks, pandemics and experiences during disasters. The team continues to collate and analyse new research findings as they emerge for COVID-19. In addition, reports and live/recorded online sessions from key organisations working closely with the health and care teams are used to supplement our learning. We are working nationally across Wales and taking the learning global.



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Adopt and Spread Programme

Bevan Exemplars

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# Introduction

Within the context of innovation adoption and spread, the rapid nature of transformation in the health and care system during COVID-19 has been unmissable and there will be many lessons we can learn from and build upon.

Rapid reorganisation of health and care systems took place globally with a high level of visibility to the general public. Field hospitals emerged within weeks where previously it would have taken years to negotiate and furnish new sites for care provision. Reduction in and cancellations of routine services took place together with an increase in the introduction of new products and services enabling virtual consultations where previously in-person consultations would have taken place.

There are now a plethora of publications, blogs, ad-hoc analysis and anecdotal evidence that can inform thinking within innovation adoption and spread. There is a need for careful analysis of what has just taken place using the scientific literature and other data and information derived from health and care systems, professionals and the public during COVID-19.

Experiences from the national A&S Programme in Wales (1) have captured some of the early thinking and changes in the health and care system in real time. The A&S projects range from family-based preventative interventions for speech and language development in the early years to supporting end of life and palliative care in care homes. The main aim is to enable adoption of Bevan Exemplar innovations to new sites, organisations or new teams within the same organisations. This usually involved a number of adoption sites for a given innovation with a project lead or team to plan and implement activities. At the point where restrictions to travel and lockdown were mandated across the UK in March 2020, at least half of the adoption sites taking part in our programme had already carried out substantial work. Some were ready to go live with their projects or were at the tip of introducing new service innovations to their patients and service users.

The project leads and teams have worked closely with the Programme Team to continuously review and adapt to the changing circumstances and in some cases re-inventing the processes originally developed to support adoption and spread. These interactions have taken place alongside substantial changes to delivery of care in the health and care systems in Wales and across the UK.

#### **Box 1. Observations from the A&S Programme Adoption Sites**

- *One of the adoption site leads started managing a call centre. This has given insights into how to manage a different service with a workforce that is not on the frontline.*
- *Leads who have previously worked with a team found themselves on their own, managing urgent care delivery for their patients as their colleagues were redeployed.*
- *Many started providing remote telephone support for patients to manage some of their care, where normally they would have seen them in person.*
- *During COVID-19, there was recognition of some of the models of care as being particularly important for continuing to provide care within the restrictions. These models were either highlighted through dissemination activities or as part of national guidance.*

Global level efforts across teams and organisations emerged to contribute to COVID-19 including:

- Focussed action across communities to support the emerging problems associated with reducing transmission risk and improving care amidst a global shortage of equipment and devices in the health and care sector (2).
- Health and care professionals (HCPs) had to take quick decisions in the direction of redeployment, shielding at home, or working as a single member of a team to maintain a whole department and service delivery.
- In addition to supporting direct care, HCPs were finding new ways to fill the gaps left in their plans for innovation or improvement projects, seeking out technological solutions or refining new ways of working.

In the next section, we use five examples from existing research and our experience delivering the A&S Programme where responses, adaptations and re-inventions took place during COVID-19. The analysis uses insights from the behavioural sciences and the COM-B model to summarise the observations and provide a framework for this publication. The emerging themes highlight the importance of building on existing infrastructure and systems and following the motivations and the enthusiasm that cohorts of HCPs, research teams and industry partners bring to support health and care innovation adoption and spread.

# Examples of innovation adoption and spread during COVID-19

During COVID-19, there have been substantial gains for the health and care sector where HCPs, industry and the public have collaborated, contributing to and participating in a considerable number of research and development, deployment, innovation adoption and spread activities. The vast majority of the HCPs experienced changing environments and circumstances as they either needed to change, pick up pace or reduce service provision. Many have been involved in making flexible arrangements for service continuation and quick decisions to ensure safe care whilst introducing new places of work and processes.

The first three examples identified below include innovations that have been developed and deployed during COVID-19 and is based on the research literature. The remaining examples have been taken from our live A&S Programme showing the persistence used to work at pace, adapt and re-invent solutions regardless of the restrictions placed through COVID-19.

## 1. The COVID-19 Symptom Study App

One of the almost immediately successful innovation developments during COVID-19, leading to the deployment, adoption and spread of a mobile application is the COVID-19 Symptom Study App (3). This was developed in partnership with ZOE, a health science company.

This was developed in collaboration with global partners and with King's College London in the UK (4). There were 1.6 million users in the first five days in the UK reporting suspected COVID-19 cases. This multinational collaboration used established infrastructure already developed for personal nutrition studies and was able to launch in late March 2020 in the UK and the US.

The speed and successful deployment would have been difficult to achieve at scale without the prior work that had taken place and a combination of existing project teams and in-kind support for a number of organisations. Data generated from this app have been used to develop prediction models with the demonstration of how health planning in South Wales could take place using the app.

Similar observations about speed and success can be made about the development of vaccines for COVID-19 across the UK. Existing laboratory-based research and development facilities and teams played a crucial role to facilitate early commercialisation and become front runners within the industry as vaccines are being developed.

## 2. Demonstrations of frugal and fast innovations

Described as fast and frugal innovations, a number of attempts, collaborations and interventions took place during COVID-19 across the world in response to shortages and new clinical care requirements. Harris and colleagues brought together the innovations in a paper published in May 2020 and some of the innovations highlighted are shown in Table 1. Some of the characteristics of frugal innovation include bottom-up development, quick engagement and prototyping cycles, and an acceptance of the constraints within which the development is taking place.

It is important to note that these innovations took place within a relaxed regulatory environment with permissions given to take more risks than usual, but within the bounds of what was immediately available and taking into account the risk to life.

**Box 2.** Important caveats about the innovations that were developed during COVID-19

- *Some solutions may not meet the quality and evidence base requirements especially given the relaxed environments for regulation during COVID-19.*
- *There was a mixture of in-kind time contributed by individuals and organisations and this may not be viable for the longevity of the project. As a result, a number of projects may not continue or reach full potential in the short or longer term.*
- *It is also possible that some promising innovations do not quite make it over the line in time to be of use during the actual pandemic or crisis.*

**Table 1. Examples of fast and frugal innovations during COVID-19**

|   | <b>Features</b>   | <b>Frugal innovation approach</b>   |
|---|---|---|
| Ventilator multipliers                          | Open-source 3D-printed device available to connect multiple ventilator hoses to a single ventilator machine.  | Rapid production and reuse of existing ventilator machines.                                 |
| Portable and open-source designs of ventilators | Redesigning ventilators and sharing of designs.   | Repurposing of existing assets in the supply chain and reuse of the power of smartphones.   |
| Face masks and visors                           | A4 acetate sheet used for overhead projector presentations used for face shields and local 3D printing and manufacturing resources used to create a volunteer-led supply chain.   | Reuse of existing material and assets available widely in the office place and locally.     |
| Aerosol boxes for intubation                    | A transparent shelf made of acrylic or transparent polycarbonate sheet placed over a supine patient during intubation (sourced as the TracheoBox).  | Reuse of existing material.   |
| Task shifting in ICUs                           | ICUs can be reorganized to ensure more rapid, expanded care with a multidisciplinary workforce.   | Rapid transformation of existing operating infrastructure and repurposing of the workforce. |
| Prone self-ventilation                          | Although placing patients in a prone position is an acceptable practice for ventilated patients, clinicians have tried this for non-ventilated hospitalised patients.   | Simple, no-cost technique to improve outcomes.  |
| Frugal ventilator machines                      | Collaboration with the Mercedes-AMG Petronas F1 and University College London teams to reverse engineer a continuous positive airway pressure breathing aid in less than 100 hours. Mercedes-Benz and Tesla are applying their vast manufacturing capability to produce ventilator parts. | Repurposing and reuse of existing material for rapid production.                            |

Adapted From: Harris et al., (2020) [Fast and frugal innovations in response to the COVID-19 pandemic](#).(2)

### **3. Changes to medical and surgical training**

Substantial changes took place for medical and surgical training that was initiated during COVID-19. The impact cannot be underestimated as shown in the documentation of disruption in anaesthesia training across six continents (5). Using multimodal techniques, it has been possible for many to continue their medical education programmes to gain their qualifications. For example, in British Columbia, case-based learning is taking place through the same content being posted as part of videoconferencing sessions with resources such as YouTube teaching videos, mobile apps, and previously recorded didactic sessions (6). Simulation training may fill some of the gaps in experiential learning, however, there is evidence that longer term changes have now taken place increasing infrastructure development and capabilities for virtual learning as well as an encouraging shift in attitudes (7).

It is important to note that although the desire and the needs were recognised prior to COVID-19 (8), there was hesitation and varied levels of adoption and implementation. The general observations during COVID-19 were that the motivation and driver for change was that if the available technologies were not harnessed, the training would come to an entire halt.

### **4. Working as part of a shielding and remote workforce**

As part of the A&S Programme, there were and still are a cohort of HCPs who were shielding because of personal or family health reasons and based on government guidance (9) or working remotely to support service delivery. Working with this group has shown that they are willing to try new approaches and in a supported way enter new areas of work to continue to contribute. Where some would have walked the corridors in a proactive way to get their work completed, they are reliant on colleagues and others on the ground to support their project.

One of the A&S adoption sites was introducing learning sessions in the workplace (in this case, for Health Board staff members) to help increase staff wellbeing and reduce sickness absence. The project lead was working remotely during COVID-19, and proactively started working on an online programme to go live in September 2020. They:

- worked closely with colleagues who were present on location,

- followed other changes taking place in the department to introduce online services,
- developed and tested new processes for online registrations and data collections for evaluation purposes,
- completed the governance requirements to initiate a pilot project in the Health Board.

This adoption site is now live and actively recruiting Health Board staff members to join their learning sessions to support better health for people with irritable bowel syndrome.

What was observed during COVID-19 is that the A&S Project Leads were developing new skills in remote and virtual communications for delivery of their projects and generally increasing digital literacy and confidence in using technology. Some of the projects that have continued through COVID-19 were specifically due to HCPs who were shielding being able to give time and new energy to making adaptations and working through the detail plan required for implementation.

## **5. Moving from face-to-face training to online programmes**

There were at least four Exemplar innovations which included face-to-face training that had to reconsider their method of delivery following COVID-19. Here are just a couple of the projects that were adapting and re-inventing during COVID-19.

A General Practice based safeguarding training project aimed at new GPs, was not able to carry out their in-person sessions. As the topic was just as important during COVID-19 (and possibly more so in terms of need), the Exemplar worked fast using smartphone communication tools to engage groups virtually and enable real time peer support for safeguarding. There were also new e-learning training packs created contributing to a publication by the Royal College of General Practitioners (10) and media activities to increase awareness and ensure that the people in need of support were not forgotten during COVID-19.

'Be Here, Be Clear' was being adopted across four of the seven Welsh Health Boards through the A&S Programme. The in-person intensive workshops were due to go live in March 2020 with training scheduled to take place across Wales. Having developed a robust training package for

teams working with young families, the Exemplar had shown impact in her own Health Board for preventative care for speech and language development in the early years. The training had some complexities as the HCPs had to learn to interact differently with families in their home and make observations as part of the intervention. There was also a review of the video materials from families which needed to be viewed during training which could not be posted online. These were logistical details that the Exemplar had to adapt in order to replicate the training that was delivered face-to-face prior to COVID-19.

The Exemplar worked rapidly with the adoption sites to test the materials, make changes that might be needed and establish how delivery of the training may be possible online. Following a series of discussions and prototyping over two months, the training has been adapted with:

- video recordings from open online sources being added to the resources,
- the inclusion of Adoption Site leads in the training materials and assessment of local capabilities to support delivery of the training,
- the availability of online and face-to-face training for adoption sites,
- new training sessions which can combine teams from different Health Boards and organisations to join in and therefore increasing the numbers trained without increasing cost.

‘Be Here, Be Clear’ training is now live in some of the adoptions sites with a combination of face-to-face and online training offers. The Adoption Site leads take responsibility for supporting the delivery of the training. Since becoming an online training programme, the number of adoption sites has doubled and is now (in September 2020) across eight Health Boards.

## **Summary**

On the whole, the innovations highlighted here are not entirely new to the market and are built on existing technologies and collaborations. It could be argued that the willingness of different stakeholders to collaborate made a difference to the speed of the response both from HCPs and industry. New industry partners responded to COVID-19, such as Mercedes-Benz and Tesla, manufacturing parts for ventilators.

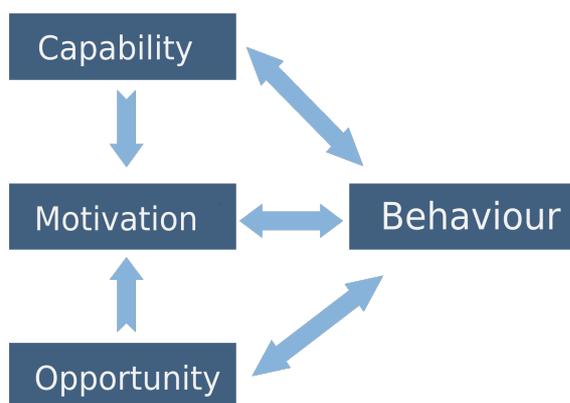
One of the interesting observations yet to be fully understood is that HCPs on the frontline participating in the COVID-19 work do not necessarily interpret what has happened as innovative or transformative. They have responded to the changes on a business as usual approach and have adapted operational functions in order to be able to complete their work. It is only in hindsight that this is being recognised as transformative. This is a known part of innovation adoption where there are hidden examples that may never emerge (11). Regardless of intent to participate in innovation adoption or transformation, it is likely that this type of participation may have resulted in psychological shifts regarding the role of innovation in supporting better care.

Some of what worked during COVID-19 is that social and professional networks were expanded with a common cause in mind and this in turn means that there may be new opportunities and motivations for innovation adoption and spread. It remains to be seen if newcomers such as Mercedes-Benz and Tesla remain as players in health and care and if disruptive innovation will be deployed as a result of their and other similar collaborations. Regardless, it is clear that the innovation adoption and spread that took place during COVID-19 is shaping, and will continue to shape what people within and outside of health and care view as the 'art of the possible' beyond this pandemic.

# Using the behavioural sciences to inform analysis

It is already well documented that past actions are good indicators of future actions on attitudes and responses to changing environments (12). The use of knowledge gained to date from the social and behavioural sciences was highlighted early during the pandemic (13, 14). One of the theoretical models that can be used to understand and frame the analysis of innovation adoption for COVID-19 and beyond is the COM-B model (15) published in 2011. This model has been used across multiple studies and projects in health and care for practice and policy.

## COM-B Model



**Capability** is defined as the individual's psychological and physical capacity to engage in the activity concerned. It includes having the necessary knowledge and skills.

**Motivation** is defined as all those brain processes that energize and direct behaviour, not just goals and conscious decision-making. It includes habitual processes, emotional responding, as well as analytical decision-making.

**Opportunity** is defined as all the factors that lie outside the individual that make the behaviour possible or prompt it.

Source: Adapted from Michie et al., 2011 (15). The single-headed and double-headed arrows in the Figure represent potential influence between components in the system.

# Analysis for COVID-19 and beyond

The question that has been asked often for COVID-19 and beyond is *'can the changes made be sustained beyond COVID-19 or could a return to 'how it has always been' be inevitable?'*. The answer needs to be *'yes'*, but the actual answer is closer to *'maybe'*. Taking an analytical approach, we put forward four opportunities for governments, policy and executive level decision-makers to increase the likelihood of sustainable change happening.

## **1. Changing how we seek permission and require predictability**

Introducing improvements prior to COVID-19 would have traditionally followed a form of plan, do, study, act (PDSA) cycles, taking an almost linear, step-by-step planned approach to introducing change. This changed with COVID-19, specifically with the redesign of health systems globally and locally. The need to urgently create new emergency and intensive care facilities meant having to work with patients and service users radically differently during lockdown.

The speed of change was certainly noticeable and resulted in quick outputs, for example, through rapid response workstreams for publishing relevant research evidence through systematic reviews (16,17) and new COVID-19 funding streams (18). Urgency may have been influenced by external factors, but innovation and improvement projects would have been seeking some sort of internal process and sign offs before making major changes. Organisational systems and processes work on timelines that take into account priorities, governance, funding and the capacity to assimilate and approve. Before COVID-19, this limited the pace considerably in many cases, especially where new innovations were up against 'usual work' which took precedence.

For some of the people involved in the change projects, it took weeks and months of effort to create the case for change (a perception shift) prior to innovation adoption and implementation. The efforts were about moving a group of people away from 'nothing is possible' to 'anything is possible', from 'this is how it's always been' to 'this is how it could be'.

Data collected from the SenseMaker® project (19) in Wales and the early insights (taken in May 2020) indicate that people have, on the whole, experienced a positive change to the way they work. COVID-19 brought about the ethos that if you want to change services, practices, methods or approaches, now is the time to do it!

Conversations captured during the time of COVID-19 and personal accounts from the health and care staff showed that personal motivation and the wanting to better serve the wider needs of society as key workers were strongly felt. This made some of the people working within health and care change the way they see their organisation, team, and role. The responses were also about the here and now with little said about long term planning. Working within the parameters of known rules, guidelines, and processes, staff were using 'trained intuition and experience' to guide their actions. Working together appeared to be common place with little regard for organisational or departmental boundaries whilst information was shared and used to overcome barriers speedily.

Opportunities were also in part created by the focused and combined efforts of senior leaders within the health and care sector as well as governing bodies including regulators. This created an enabling environment and 'permission' in which responses came in the form of adaptations and re-inventions. Ultimately, the simple rules that were set during COVID-19 with an opportunity to take action encouraged innovation adoption and spread. Reviewing executive and senior level contributions to the need for predictability and permission seeking will support longevity of the positive change witnessed during COVID-19.

All of the steps described here could be considered as part of an onboarding process that would have been required for newcomers to the health and care system. The ways in which formal and informal networks came together during COVID-19 showed the breadth and scale of the existing systems in which individuals and teams across practice, research, academia and industry have already completed onboarding processes of

some nature. They were then able to use their willingness and talents to make a positive contribution in a short space of time.

Even with the caveats about long term sustainability of the projects, there was a level of energy that went across policy and practice during COVID-19. From the point of view of the behavioural sciences, the alignment of capabilities, opportunities and motivations played a major role and the examples highlight the accelerated pace that came from existing collaborations. The key in moving forward is to harness the energy and learn to support, as well as build, new infrastructures and systems that continue to bring new opportunities for collaborations and teams working with each other across geographical and disciplinary boundaries.

## **2. Sustaining motivation when it is driven by a sense of duty**

For many HCPs, there were new technologies, processes and places of work including the home or redeployment to new clinical settings and new colleagues and teams to work with. It could be said that the behaviours and willingness to try something new at the time of COVID-19 was focussed on ensuring service continuity and appreciating the negative consequences of not being able to support patients and service users. These observations were echoed in research carried out with nurses and doctors following the outbreak in China (20). The emphasis at the frontline of managing COVID-19 wards was about feeling a sense of duty. In 'surviving' the experience, there was a sense of being qualified to work in unity, take up responsibility and enable continuity of care. Similar research findings have been reported following the impact of SARS and other infectious disease outbreaks such as C difficile and MRSA. As well as the psychological impact of being on the frontline during such outbreaks, research shows that HCPs learn from their previous experiences and apply it to the current context as teams (21).

Similarly what was observed in research communities was that when the pre-COVID-19 initiated research teams stopped work on their research projects, they switched quickly to helping solve COVID-19 challenges.

Motivation to change behaviour and actively take decisions to do something different is not a simple act and this has been known through decades of research (22, 23, 24). The environment in which behaviours are

asked to or expected to change is an important consideration. Carefully designed innovation adoption and spread programmes that give just enough time, find the right motivation, and an appropriate level of support can make a difference.

*There was emotion and recognition coming directly from the general public for the 'over and above' commitment shown by key workers to maintain services. This was visible through the #thankyouNHS #WelshHeroes street-based and multi-media expressions of gratitude. (25)*

### **3. Promoting new opportunities for partnership working at pace**

The responsiveness and multi-disciplinary collaborations have been successful in part because of the reduced time to set up and get started. They had already jumped through application processes through the existing infrastructure and systems prior to COVID-19. The examples from research brought together here and the data from the A&S Programme indicate that on the whole teams working together were more likely to have already built existing relationships. They were about to or had collaborated on projects together previously. It could be said that that they can more accurately determine the risks associated with working together and have sound foundation of trust to work from.

All of the steps described here could be considered as part of an onboarding process that would have been required for newcomers to the health and care system and to multi-organisational collaborations. This is important to emphasise as setting up new partnerships within an organisational system requires time and effort, and this was bypassed by teams already working with the health and care or academic organisations. Claims of having the capabilities and capacity to complete an important project could be assessed faster given the due diligence that had already taken place. In knowing each other's capabilities and capacities, the teams working together would be better able to allocate tasks and requirements without requiring time and opportunities to meet and get to know each other.

The ways in which formal and informal networks came together during

COVID-19 showed the breadth and scale of the existing systems and infrastructures in which individuals and teams across practice, research, academia and industry have already completed onboarding processes of some nature. They were then able to use their willingness and talents to make a positive contribution in a short space of time. With successful alliances and infrastructure in place, the key will be to maintain motivation and momentum and consider what will be required in the future. We have also developed new technological capabilities and better understand the influence of global environments to local health and care. It is now feasible to build much more ambitious partnerships and environments that will enable successful collaborations and partnerships together for future pandemics and challenges faced in health and care.

#### **4. Timing is key and right now really matters**

It is important to reiterate that time is of the essence. As with all the references to pace of change and the drive to make a difference, it is equally important to consider what this means for supporting innovation adoption and spread. It was shown during COVID-19 that governments and senior leaders were in a position to influence and create a conducive environment in which action can be taken at speed at both local and national level. Applying this to the opportunity that is now presented across health and care is the next step required for ensuring that changes can be sustained beyond COVID-19.

There are cohorts of HCPs, research, academia and industry partners who have recently experienced new ways of working and have knowledge to share or need additional support. A few of these are mentioned in Box 3 based on the observations made during COVID-19.

### Box 3. Cohorts within the health and care system who hold valuable experience or require additional support for future adoption and spread

1

**Infection control leads** in particular, have now gained a knowledge-base. They were experienced in responding to the UK services for Ebola and MERS in the last few years, and now have additional skills due to COVID-19. HCPs (often nurses) working in these roles were directly influencing procurement decisions and working at pace during COVID-19. They continue to work on supporting service provision whilst providing routine services and there are redesigns for clean rooms and transmission control procedures put into place.

2

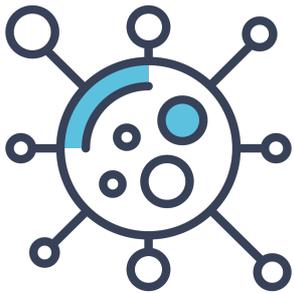
There are now HCPs within **the ambulance and specialist services, primary care, local authorities and care homes** who adjusted quickly to understand requirements and bring in new products and services that were previously not required within their teams and organisations. Redeployment rapidly brought people into contact with each other where they would have previously not seen or learnt from such a diverse range of professionals.

3

**The workforce that is adjusting to remote and online working** will bring new insights into how we can work across teams and widen geographical boundaries for service delivery. Team members who have experience of running departments almost alone may have much to contribute in terms of efficiencies and new ways of working. All of these experiences and newly learnt skills will be important to capture and use as levers for future improvement and innovation adoption and spread.

4

**Research and innovation development projects** that had to be halted may need to be reviewed, reflected on or be revised in light of COVID-19. Some of the work taking place could be groundbreaking and essential for solving today's health and care challenges. They may need support to adjust their plans and timelines that were made before COVID-19. Reducing the time lag between halting and restarting these projects is an important part of securing the future pipeline of solutions to be adopted and spread.



**Health and care professionals, researchers, and industry partners responded, adapted, re-invented and adopted innovation within a make or break context.**



**We now need to work with existing infrastructure and systems to support them and help sustain the learning and the energy.**



# In conclusion

COVID-19 has imposed a 'reboot' in thinking and in practice. It has presented a unique opportunity to stop and think differently, challenge the status quo and get things done in ways that would not otherwise have been possible. It is now essential we build upon this dynamic learning, applying this to the adoption and spread of innovation across health and care systems as it evolves.

People at all levels need to be encouraged, trusted and supported to move forward with the adoption of their own ideas, based on what they have seen and learnt, as well as the adoption of ideas from elsewhere. This will help find solutions that work in practice, especially where responsibility is devolved and acknowledging that absolutes and predictability are not needed in all aspects of health and care service delivery. There needs to be the right balance between learning and doing with a sense of urgency and the need to deliver.

Existing collaborations, programmes and funding opportunities should be realigned, using their existing infrastructures, networks and knowledge to help accelerate pace for the adoption and spread of innovative ideas. Based upon our experiences of COVID-19 to date, this should also maximise the energy, motivation and enthusiasm of people across both policy and practice. The research and our early observations indicate that these factors are more likely to drive and translate innovative ideas into sustained practice.

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