Co-creating new meaning: towards the patient-centric hospital?

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Abstract

The Department of Cardiology at the Heart Centre at Rigshospitalet, Copenhagen University Hospital, has conducted a management experiment in collaboration with MindLab, a Danish governmental innovation unit. The experiment may be characterised as a user-centred and employee-driven innovation process involving an interplay between qualitative research and user involvement; a directed co-creation process involving continuous learning through the measurement of outcomes and value.

The paper concludes that this type of innovation process appears to be a powerful management tool for generating a change of meaning among professional staff members. In the present case, new insights were generated through systematic confrontation with the patients' voices. This confrontation catalysed changes in the professionals' perceptions of themselves, of their concept of professionalism and of the patients. The process triggered the development of a new governance model with a focus on taking seriously the patients' subjective experiences and the time they spend. Rigshospitalet developed a shared language to describe innovation that will serve as a new, shared approach to developing professional practices and processes. It became clear that all management and staff actions must ultimately create value for patients. Furthermore, the Department of Cardiology's management and staff came to understand that innovation comes from the people in the organisation, not from the organisation itself. This triggered an important recognition of professional leadership as it made the management team realise the employees' significance as a future innovation resource in the Department's organisation and work processes.

Introduction

In Denmark and globally, healthcare systems are being challenged. At Rigshospitalet, there is awareness that future patients will expect even higher levels of care and individualisation; and simultaneously costs are continuously being reduced to increase

productivity. Even if these demands may seem contradictory, key actors at Rigshospitalet, specifically the team running the Department of Cardiology, have come to consider this a more or less permanent condition. Essentially, from a managerial point of view, the thinking is that the best approach may be to accept the contradictory demands as a premise rather than trying to fight the inevitable. However, choosing a path that seeks to reconcile potentially highly conflicting demands requires that we reflect on our professional and organisational actions and priorities (Schön, 1983). A key question raised in the project, which is also addressed in this paper, was whether patients may help us with this reflection. Could they help us to think innovatively without compromising on professionalism or patient safety? The question, then, is whether a user-centred, employee-driven innovation process might be a way forward.

The Department of Cardiology, the Heart Centre, at Rigshospitalet, Copenhagen University Hospital, is a highly specialised unit with around 350 employees. The department has traditionally been able to balance its budget; and over a period of several years, it has improved its internal working processes to meet a required average annual productivity increase of 2%. The department expected that coming years would be marked by continued budget cuts and demands for more productivity increases, and the Department's management team felt that it would not be tenable to continue exclusively on the previous path aiming to implement efficiency improvements if the department was to maintain a dedicated staff and provide highly professional and experienced-based quality for patients and their families. The aim of the project was, therefore, to introduce a process of innovation that would also potentially serve as a new management tool at the Department and subsequently to analyse the experiment in the context of Karl E. Weick's theory of sense-making (Weick 1995).

Theoretical framework

We apply two main theoretical frameworks in our analysis. 1) Innovation – drawing on Christian Bason's 'Leading public sector innovation' (2010), which has as a basic premise that the generation of value for citizens is, ultimately, the public sector's raison d'être. Additionally, Bason emphasises that the systematic creation of new ideas in the public sector must be management-driven, but carried out in practice by employees. 2) Sense-making – drawing on Karl Weick's extensive work on sense-making in organisations (Weick, 1995) and his description of seven key elements for sense-making. Weick is a social constructivist, and his research focuses on how sense is made and re-made, both within organisations consisting of individuals, and within individuals. Leadership, in Weick's perspective, means creating meaning in social processes and thus influencing how employees come to make sense of their professional practices. Sense-making is thinking that creates action, and vice versa.
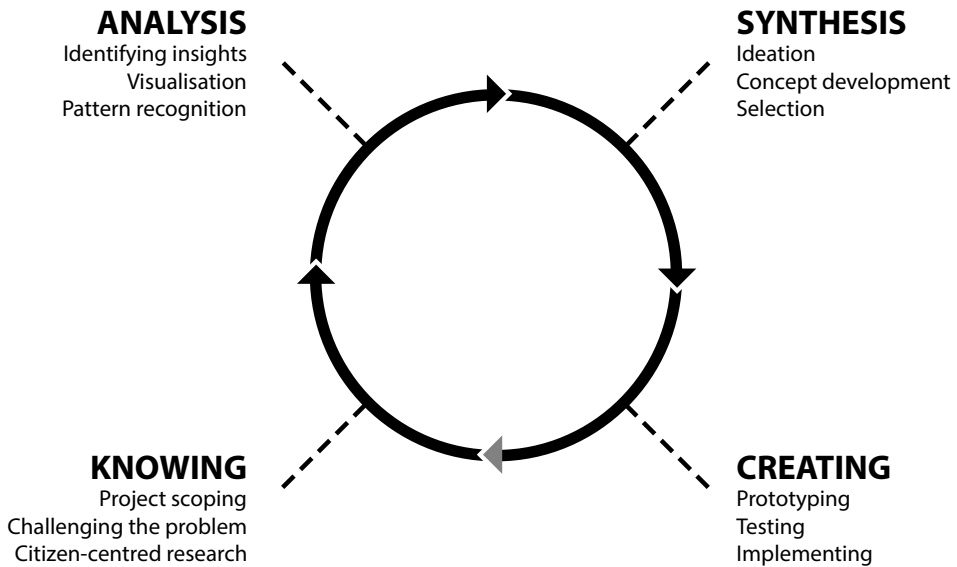
In this analysis, we take our point of departure in the notion of user-centred and employee-driven innovation because the '*user perspective is essential in any form of innovation, especially in the public sector*' (Jensen et al. 2010:33). In the specific project analysed in this paper, user-centred innovation becomes the framework in which polyphonic sound clips of patient experiences initiate and catalyse the innovation generated by the professional staff.

Public innovation as defined by Jensen et al. (2010) and Bason (2010) concerns the development of new and better practices that are implemented to provide measurable value for citizens and society. The innovation process is essentially experimental, because it starts with a 'What if...' question that enables new thoughts and ideas, and which is ultimately concerned with the creation of value. In an innovation perspective, public value (More, 1995) can be understood as shifts in the value of a public organisation's activities along four dimensions: productivity, service experience, outcomes and democracy (Bason, 2010). According to Jensen et al. (2010) and Bason (2010), '*people driven innovation*' is a key starting point for a process of discovering potential new value because it can provide insights into user experiences and thus provide a basis for both concept development and implementation with and by the employees. Alternative terms for this approach may be *human-centred design* or *co-creation*.

Co-creation in design can be viewed as a shared creative process among managers, employees and users, largely informed and driven by collaborative design approaches (Sanders & Stappers, 2008). At Rigshospitalet, and more generally in healthcare and in the public sector as such, there is a tradition for developing new initiatives based on professional insights, knowledge from the academic literature, and a rational, analytical approach that is largely driven by professionals. According to Bason (2010), it is important that the manager sees him-/herself as responsible for the innovative process, not as someone who solves the problems (as usual), but rather as someone who gives others the strength and courage to be solution-orientated by displaying trust, confidence and recognition. One might also argue that public managers need to approach the innovation process with a particular human-centred attitude or mind-set (Bason, 2012).

Co-creation is a learning and change process consisting of four main elements: knowledge, analysis, synthesis and creation (see figure 1). We have used the Model of Co-Creation (Bason 2010:175) as a framework for the innovative process, which is briefly described here.

Figure 1: Model of Co-Creation

ANALYSIS
Identifying insights
Visualisation
Pattern recognition

SYNTHESIS
Ideation
Concept development
Selection

KNOWING
Project scoping
Challenging the problem
Citizen-centred research

CREATING
Prototyping
Testing
Implementing

Knowledge concerns the collection of rich, in-depth qualitative data through field research, e.g. to explore the experience of being a patient. Data are typically gathered by means of ethnographic methods such as participant observation, shadowing and open-ended interviewing (Corbin & Strauss, 2008). Qualitative data focusing on the user experience are deemed to be critically important as they facilitate an outside-in perspective on the results achieved through the organisation's efforts. Bason (2010) suggests that it may be particularly impactful to ensure that data are not only recorded in written media, such as field notes or interview transcripts, but also captured as audio, photo and video media to facilitate a more visceral experience when connecting with it and to generate 'professional empathy'. Often, there is more going on, and more is at stake in the interactions between users and public systems, than professionals and managers assume. This poses a fundamental challenge related to the perceptual lenses through which employees and management see the world.

Analysis brings an inductive approach to the co-creation process. Qualitative data are carefully structured, categorised and described as emerging thematic patterns. Selected bits or 'snippets' of data connected with the thematic categories are then presented, e.g. in the form of polyphonic audio clips. The purpose at this stage is not immediately to judge or interpret the significance of the material. Rather, the participants should allow themselves to be surprised/disturbed by the raw expressions of user

experiences – such as the narratives told by hospital patients. The emotional connection with audio-visuals paves the way for new insights, which in turn inspire potential new courses of action. The thematic material comes into play along with tacit and professional knowledge and everyday life experiences and is transformed into a common body of knowledge – a set of shared reference points.

Synthesis denotes the processes of idea generation, concept development and selection of ideas. A very large quantity of ideas is required to bring out a few that are deemed potentially valuable (Ulrich, 2009). The generation of many ideas is facilitated on the basis of the analytical insights, which give thematic direction to the process of brainstorming and 'ideation'. One such approach, which was used in the present project, is 'brain-writing', in which participants iteratively draw on each others' ideas for inspiration. Like most brainstorming approaches, the principle is that quantity is given a higher priority than quality in order to avoid restricting the generation of the largest possible number of ideas.

This part of the process focuses on actions and what the organisation can control. Boundary conditions may include what is, e.g., realistic in financial, political, strategic and practical terms. Constraints are often a useful driver of innovation (Jensen et al. 2010:111-120, Bason 2010:86-191). In a group setting, it is thus the task of the facilitators to help the participants see opportunities and to provide tools and templates that may help them explore potentials for change. Workshops involve the use of specific tools, such as a prioritisation matrix, which is essentially a two-by-two grid used to arrange ideas to facilitate systematic selection.

Subsequently, it is necessary to develop nuanced and more subtle descriptions of ideas, including considerations about solutions, actions and benefits based on one of two fundamental processes: 1) an opportunity-driven process (looking at new ways to explore one's own world) and 2) a problem-driven process, which is a very specific and more traditional approach (Snowden & Boone, 2007). The type of problem or problem area is essential in determining which approach to take. Co-creation involves an outside-in process where participants seek to redesign systems, services and products that may signify new meaning in the new context. Concept development is thus a further expression of the contents of selected ideas (prioritisation). Concepts denote who is responsible and how a new approach may benefit both the users and the organisation.

Creation considers the process of prototyping, 'rehearsing' new ways of managing, organising and working; these new approaches are represented graphically or enacted in a relatively raw form (Halse et al., 2010). The purpose is not to shape a refined 'solution', but to manifest a concept in ways that may be tested through direct engage-

ment with users. A prototype is an embodiment of an idea that one wants to apply in an unfinished form. Its shape and direction thus sets the stage for the idea to be tested, modified, re-tested and potentially implemented – if the idea seems to work and to be valuable to users and to the organisation.

In order to analyse the utility of this innovation method in the specific context of Rig-shospitalet's Department of Cardiology, we formulated the following research themes and associated questions based on the model:

Knowledge: Do we find that the citizen's experience sets the direction for the innovation work? Do the employees reflect on inconsistencies between the organisation's values and the actions that are carried out? Do the employees see their professional roles from an external perspective?

Analysis: Do the employees allow themselves to be disturbed by the users' experiences? Does this generate new insights? Is new shared knowledge created among the employees through the connection of their own everyday experiences with the patterns emerging from the qualitative data?

Synthesis: Does the material contain examples of new ways of thinking? Is the complexity of everyday life reflected in the empirical data as represented by an emphasis on opportunity-driven rather than problem-driven approaches? Does the systematic approach of co-creation as an innovation method provide new opportunities for the development of ideas? Do we find that new approaches – new ways of working – are being explored?

Creation: Is there a willingness among the participants – including management, professionals and support staff – to redesign the specific organisational processes?

Sense-making

Sense-making is concerned with giving or creating meaning and takes place in individual as well as organisational processes. It is a process that has no start and no end, since sense-making goes on continuously. We cannot avoid making sense, and the sense we make is bound to be adjusted or transformed. Sense-making is described by Weick as reflection and intention (1995:6) and may be described as an individual and organisational process of co-creation that involves understanding, explaining and creating. Sense-making may be understood as a process that collectively underlines organisational identity and is characterised by seven qualities: 1) Grounded in identity construction, 2) Retrospective, 3) Enactive of sensible environments, 4) Social, 5)

Ongoing, 6) Focused on and by extracted cues, 7) Driven by plausibility rather than accuracy (Weick 1995:17).

According to Weick, it is a prerequisite for human action that we transform risky or problematic situations into something that makes sense – and it is exactly this process we are seeking to explore here.

Method

The co-creation experiment was facilitated by MindLab (www.mind-lab.dk/en), a cross-governmental innovation unit, and the management at the Department of Cardiology, Heart Centre, Rigshospitalet. The MindLab team first conducted a pre-study where they briefly observed the work of doctors and nurses, interviewed one patient and the department management. The team presented these early observations to a selected working group; and on this basis, a very open and explorative focus was formulated: *What is the meaningful patient experience in the Department?* A loosely structured interview guide was prepared (Kvale 1997:133-39) around basic questions such as, Can you tell me about your hospital stay? Describe what it was like. Who did what? What did you have to do? etc.

Patients were asked verbally about participation and informed in writing that they would be guaranteed full anonymity. Patients were invited to participate whenever MindLab's team was present at the hospital, and the participants were thus selected randomly.

Twenty patients were interviewed over a period of two weeks; the dialogues were recorded digitally as audio files. The material was subsequently reviewed by MindLab, classified by topic and edited into selected audio clips on the basis of a careful catego-risation of the patterns that emerged from the data.

The working group (doctors, nurses, secretaries, service employees managers) par-ticipated in a workshop where the thematic audio clips from patient interviews were played. Each clip was introduced by MindLab's team with a short elaboration on the character and contents of the theme. Based on the thoughts and feelings that the au-dio clips elicited, the workshop participants articulated their immediate reactions and thoughts; What did they hear, experience, feel, think? These responses were written down on Post-it notes, put up on a board and briefly discussed at the workshop. The process was repeated through playback of one audio clip for each of the identified themes – seven in total. The staff were then divided into three groups, which were asked each to formulate three development issues for each audio clip, based on the reactions they had formulated.

The next part of the process was to 'brain-write' – a collaborative process aimed at generating a wide range of ideas – on the development themes that had been identified. Each participant wrote down an idea for each development issue; the next idea would then be inspired by the first; and against this background, the participant would come up with his or her own idea, and so on. This process generated a large number of ideas.

The next step was to prioritise and select ideas. Each person was asked to choose what he or she thought was the best idea and place it in a system of coordinates with 'ambition' on the y-axis and 'importance for patients and citizens' on the x-axis. An idea was then selected from the upper right part of the system of coordinates in each working group. Subsequently, the group attempted to expand on the idea by describing it in terms of benefit for patients, benefit for the organisation, and by describing who would be driving the change, who would be running the day-to-day operation, and by presenting arguments in favour of the change in relation to management. This material was used to prepare a concept poster.

Results

Below, the results of this process are described as follows: First, the thematic sound clips; next, development issues; and finally, concept posters and the longer-term results that flowed from the co-creation process.

Results based on the focus question 'What is a meaningful patient experience?'
Thematic audio clips
The interview material was analysed and edited into seven themes related to patients' experiences of being admitted to the cardiology ward: 1) Discretion, waiting time, noise. 2) Clarifying expectations. 3) Ward rounds. 4) Physical conditions. 5) Atmosphere 6) Cleaning. 7) Home.

Here is an example of a patient quote for the theme 'Clarifying expectations': *'You come in the morning, well, then you're admitted, so I actually think that, no, now I have to be careful what I say. No, I actually think that it may be a bit of a mess, because you are already there at 07.00, and it seems like there is someone there who is about to go home, and there is someone who is about to come in just then. You arrive right in the middle of the shift handover, so I think it's odd that you can't wait until, say, 08.00, when the morning shift has arrived. But you are taken good care of,, there is no doubt about that.'*

Another example: *'The staff, I can hear they're actually extremely busy, I actually feel slightly sorry for them. They're very good at helping each other, taking care of that. They help each other, you can hear that.'*

Listening to the audio clips affected the participants emotionally. The staff felt that they might not be doing their jobs well enough, especially with regard to being the patient's advocate. The audio clips generally reflected a high level of satisfaction and quality in the unit, but they also showed that professionals tend to act on the basis of internal disciplinary sets of logic and interests. The patients have considerable understanding for the actions of the staff and how busy they are, but they are also widely mystified as to *why* they do what they do. See Fact Box 1 for examples of development issues (selected from two main themes):

Fact Box 1: Development issues; an example	
Thematic sound clips	**Development issues**
Clarifying expectations	How can we: Make sure that the patient feels expected and welcome? Minimise waiting time and clarify expectation about inevitable delays? Talk about the dilemma of 'our time versus the patient's time'?
Ward rounds	How can we: Create a ward round that simultaneously makes sense for the patient, the doctor and the nurse? Define patient-doctor contact in an accelerated patient pathway? Together with the patient, define what type of ward round he or she needs?

Based on the development issues, an idea generation process was conducted, and some 210 ideas were formulated, some of which overlapped, and which had a rather wide variation in quality. The following six ideas were ultimately selected, as they were deemed to be characterised by a high level of ambition and high significance to the patients: 1) *I-day*, 2) *From ward rounds to admission/registration agreement*, 3) *Do the patients expect that they will have to participate in ward duties – clarification of the distribution of responsibility,* 4) *All new patients must have a room/bed and be admitted by their nurse within five minutes of their arrival,* 5) *No waiting time for scheduled patients,* 6) *Patients should participate in working groups on discharge models.*

See Fact Box 2 for examples of concept posters; 1) '*I-Day'* (from the audio clip on clarifying expectations and 2) *'From ward round to admission/registration agreement'* from the audio clip 'ward round'.

Fact Box 2: Concept posters, an example			
Ideas: From ward rounds to in-patient agreement			
Describe the idea: A patient pathway figure to guide the conversation between patient and nurse, including different types of ward rounds and patient participation Task slippage from nurse to patient *Possible ward rounds:* - History taking - Discharge conversation - Follow up on test results	**Benefits for the patient:** A greater sense of control in the hospital situation Experience of having a right to speak Clarifying expectations Possibility of planning question and time of conversation **Benefits for the organisation:** Time-saving Better patient pathway Clarity about the patient's expectation in relation to the professionals	**Change leadership:** Team management Clinical nurse specialist **Day-to-day leadership:** Doctors Nurses	**Arguments in relation to management:** Better patient pathway Higher patient satisfaction Time-saving

The innovation project led to the immediate results displayed above, but also had other types of impact over the next two years. The Department has now developed a new governance model, which is concerned with how the notion of 'quality' is perceived and defined. Good 'quality' not only pertains to objective treatment aspects as defined by the doctors and nurses, but also includes the patients. Quality, then, is also the patient experience, the logistics the service pathway. This fundamental insight has led to two major changes.

The first change is a complete physical re-design of a ward section in the Department. The Department was able to attract funding for an innovative renovation project. In this project, sound clips and concept posters were used as inspiration for collaboration with an architectural firm and other relevant stakeholders (professionals, hygiene specialists, the catering unit, the fire department and others) to create a redesign based on the metaphor of 'a hospital-free zone for patients'. The physical redesign was evaluated through follow-up interviews, which found that the patients experienced the new space as supportive of relaxation and peace of mind; the interviews also indicate how important it is for the patients to be able to choose whether they should be included in social interactions.

The second change (which is ongoing) is an organisational re-design based on in-patients' and out-patients' experiences. The Department is re-structuring its ward sections from being organised around the kind of procedure (operation) the patient is there to receive to being organised around the patient pathway. In the future, the patient pathway will vary according to whether the patients have an acute condi-

tion, a complex and long-term condition, or whether they come in for a scheduled procedure with a minimum of waiting time. This redesign aims to ensure the optimal patient pathway, drawing partly on the innovation project and partly on input from the professionals based on their assumptions about patient needs. In this process, the Department again uses innovative tools and tests ideas with patients.

Analysis: The significance of the co-creation process

In relation to the dimensions of 'knowledge and analysis' in the co-creation process, the participants were clearly surprised and emotionally affected by the audio clips. For the early **start-up workshop**, there was only one interview and little contextual information, and the same feelings did not come into play as in the final workshop. The focus in the two workshops was different. The first was concerned with agreement about the scope of the project, or the desired focus, and it was based on limited data, which were mainly used for illustrative purposes and to give the management and staff a sense of the proposed methodology. Nonetheless, the participants were enthusiastic and subsequently referred to the project as '*the exciting project*'.

The **final workshop** was focused on the development of ideas and on redesigning organisational processes. Here, the seven thematic audio clips were essential. At the workshop, MindLab emphasised that the polyphonic sound clips were characterised by data saturation, implying that no new significant analytical categories were emerging (Corbin & Strauss, 2008). For example, one audio clip in which a patient was asked by a nurse to leave the office caused the participants to focus on '*Who was the nurse?*' – they clearly viewed this as unacceptable behaviour. However, in the process of listening to several similar audio clips, it became impossible to stick to '*Who was the nurse?*' as a metaphor. MindLab emphasised that the patients showed a high level of general satisfaction. This statement from MindLab could have been exploited by participants to establish that the qualitative data simply represented one-off situations, but they did not, probably because the participants enjoy a high level of professional pride. Nurses and doctors could not accept that patients have bad experiences; it simply was not right. The participants therefore tried to put themselves in the patients' shoes as a first step towards redesigning the organisational processes. This endeavour might, to reference Bason (2010), be characterised as 'professional empathy'.

The information used in the innovation process deals specifically with qualitative data. 'Daring to assume the human subjective experience of public and other elements in their lives as a basis for the innovation work' (Bason, 2010). The process showed that the participants were open and prepared to challenge their everyday knowledge and together the employees reflected on how everyday interventions are done, and how there could be such a vast difference between their perception and the patients'

experience. As the thematic material was addressed in the light of both professional and everyday knowledge, it was thus transformed into a form of common knowledge. In these processes, the awareness of all participants shifted for the first time, creating new common meaning and thus establishing the precondition for other, more value-creating activities.

The knowledge that was communicated to the participants through the audio clips triggered an emotional response in everyone, but the photographic images also established a focus on patient experiences – highlighting how grim and disordered the hospital can also be. Together, these insights clarified a lack of correlation between formulated and implemented values, which can be characterised as cognitive dissonance (Festinger, 1957), and which determined the scope of the ensuing innovation work. It was not possible to determine whether the participants were given a fully 'external' perspective on the organisation or not, but they did obtain an external-internal understanding of their shared work with the patients, which led to reflection.

The first synthesis work in the co-creation process was a brainstorming session during the start-up workshop. Here, the focus was mainly on adjustment and testing of patient letters, and the mood was slightly cautious – perhaps it would be possible to do things differently. The participants were not involved and disturbed in the same way as they were in the final workshop, where the process of formulating the 18 development issues took place. The development issues beginning with 'How might we...' illustrate a synthesis of user experiences and everyday knowledge and offer significant insights and potentials. The development issues provided a well-defined focus for continuing the innovative process. Many ideas were produced for each development issue; many of them overlapping and of varying quality. The three selected ones, which were subsequently developed further, are not necessarily the ideas that are the most effective for the patients; they may simply be the ones that participants intuitively agreed to carry forward. The most important part was the testing process, being disturbed and creating a common language of innovation, experiencing the importance of the time constraint and realising that constraint was an advantage, which, overall, shaped a joint innovative approach (and perhaps the beginnings of a new culture).

There emerged a general understanding that transcended the specific development issues and concept posters: *'What if the patients' time was more important than ours?'* This is a paradigmatic question that concerns the Department's fundamental approach to organising its professional work with the patients. It is tempting to say that the patients' time is not more important than the staff's, for what about operations and efficiency? Addressing this issue and taking it seriously would imply completely restructured workflows, e.g. ward rounds – what would happen if the ward rounds and

their timing were to be driven by the patients' needs? Is the ward round done when the doctor makes it his or her priority? Are the contents of the ward round based on the nurse's needs rather than the patient's? When is it important for the doctor or nurse, or both, to participate in ward rounds? And why do doctors and nurses not ask patients about their needs and plan accordingly? There were many audio clips concerning waiting time where patients expressed that the staff is not ready for them, and that everything seems to be done for the convenience of the professionals rather than to serve the patients' needs. These insights created a new understanding within the organisation, particularly in relation to the patients' time versus the professionals' time. The clips also produced significant insights concerning the waiting situations as such, including the role of physical spaces and arrangements, mutual expectations and the ways in which the Department involves and justifies the use of time in relation to the patient.

When the Department takes further steps in the innovation process to implement actual changes, and the management and staff create new prototypes for the work, the organisation will need to revisit their emotions and empathy again – the emotions that the professionals experienced when they heard the audio clips at the workshop. They will need to keep an open mind – and stick with it until the new solution or workflow is tested with patients and then implemented. It is probably wisest to choose a single development issue and to repeat the questions 'How' and 'What' again and again. An essential part of the task is about reconciling manageable values and actions and understanding how an organisation's actions are perceived. The challenge is to get to the core and to insist on the features and qualities that really have an impact on the lives of patients and their families.

We will now venture a bit deeper into the analysis, using Weick's seven properties of sense-making (1995:6). According to Weick, there is a close connection between the identity of the employees and the image of the organisation. The polyphonic sound clips used in the project challenged the staff and management's self-perception because their actions are not always perceived by users the way management and staff think they are. Through the use of 'emphatic' material, such as sound clips sharing the patients' voices, the project participants collectively reflected on the gap between their own and the patients' perception. This (retrospectively) created a basis for new and different sense-making, and thus for new and more valuable actions. Human beings co-create their environment and act according to their possibilities, and action is critical for sense-making. The sense that emerged from the sound clips, that something is not good enough, led to insights about important patient experiences. These insights created actions, in this case in the form of concept posters, and thus the first steps towards new patterns of behaviour. Through such actions, new interpretations and ex-

pectations emerge based on an expectation of achieving a higher degree of coherence between what the staff think they do, and what the patients experience (enactment).

According to the management, the organisation was characterised by rather common values about patient pathways, but these were challenged when they were found not to be reflected in the patients' voices. This destabilisation created a new starting point, a common need to act differently and the values in a sense thus became stable again. A key challenge here – from an innovation perspective – is to maintain the tone or intent of renewing or redesigning the organisational processes. Expressions such as 'What if we take the patients' time seriously' or 'How do ward rounds become meaningful to the patients' can be viewed as symbolic language acts, which demonstrate that the staff is making progress (socially). People are always part of ongoing contexts. One day, the staff treat patients, which involves aspects of practical work, reflection, business and emotional reactions to a patient's serious condition. The next day, they listen to sound clips and are emotionally disrupted. Their everyday work does not give them the opportunity to step back and reflect on their practices; however, as they listen to the patients' narratives, they are disturbed as they have to embrace both their everyday experiences and an intent of creating a different future. This is evident not least from the language used in formulating the development or innovation questions, which serve as the basis for the ongoing process.

We will now attempt to connect the analysis to a more general interplay between insights, innovation questions and the contents of the concept posters. The innovation questions have an implicit logic of action, since they all begin with 'How might we...', and the contents clearly mirror the insights generated from the patient voices and the paradigmatic question 'What if we always took the patients' time seriously?' The contents of the concept posters did not concern whether the patients' time is taken seriously, but addressed how the patient might take more control over the time the staff schedules and also the issue of increased individualisation. The staff reported that they found it difficult to develop the concepts. They perceived it as hard, firstly because the suggestions were required to be specific and (potentially) binding. Secondly, the concepts had to show a close correlation between the values reflected in the innovation questions and the daily professional reality of operations, finances, rules and guidelines, etc. The management expects that as the results of implementing the concepts become more visible in the organisation, new cues will be created, which will facilitate the development of a new organisational identity. In this respect, the organisational sense-making will help the organisation find a way to make sure that the objectives – a more meaningful patient experience and patient journey – become natural considerations in everyday practice. A prerequisite for this is that the Department's management can facilitate processes where complex and uncertain situations

are transformed into something meaningful. This, in turn, influences the cues which the staff use to make sense of their own professionalism.

Discussion and methodological critique

According to Bason's interpretation, user-centred innovation draws on a range of well-known approaches, among others, participatory design, service design and design management (Parker & Heapy, 2006; Bate & Robert, 2007; Cooper et al., 2011) as well as the wider user-driven innovation field (von Hippel, 2005). These domains suggest a range of methods that have been tested empirically in various public sector contexts and have produced proven results. However, the research-based academic knowledge about the effects of these innovative methods in the public sector remains rather limited.

User-centred innovation also relies on a set of assumptions about how the world is interconnected, and how these assumptions interact with the methods employed and results achieved. In their concrete expression, many of the methods do not differ essentially from the facilitation methods used by HR departments and some consulting firms. The difference seems to lie in the starting point. Reflection and the development of ideas are grounded in qualitative, research-based fieldwork and the insights this brings. The Department of Cardiology chose to put its trust in these methods and processes and decided to test them in the organisation. The experiment that was launched led to action, and this action led to thinking (and sense-making), which in turn led to action, etc. Bason's co-creation model is not very different from that of Jensen et al. (2010:28), which consists of four steps: analysing and learning, generating possibilities, incubating and prototyping, replicating and scaling up. There is thus some degree of consensus about the approach. Bason describes the methods, which Jensen et al. do not. Both Bason and Jensen argue that the public sector is facing certain challenges related to up-scaling because the public is not effective enough in disseminating new ways of working across organisations (Bason, 2010; Harris and Albury in Jensen, 2010:28-29). Albury emphasises that the public sector is over-focused on the importance of leaders and developers at the top of hierarchies and on best practice instead of 'next practice'. Thus, innovative thinking does not emerge from outside or from the bottom up. Andersen et al.'s (2012:18) public policy discussion paper supports this and says of the public sector that; *'we must constantly ask ourselves whether we can make the public sector better by thinking and doing things in a new and different way'*. These approaches, largely drawn from Røvik's (2007) translation theory perspective, relate to ideas or management recipes that are translated during their journeys through organisations. It is a conceptual representation that is transferred, not an idea or a recipe. We argue, therefore, that both Bason and Jensen have a somewhat simplified approach to the problem of scaling up, and thus also to the possibility of implementation. The insights and realisations that were obtained in the

innovation process cannot easily be transferred to other organisations, but the *idea* can. The process is a circular process of co-creation between disturbances caused by the users' experiences, insights of employees/managers and the subsequent interaction between the development of ideas and shared opinions. This process, as an idea or a methodology, can be transferred to other organisations as a next practice rather than a best practice. When Bason and Jensen et al. write about innovation processes, they do so to identify new approaches that may create value for the user. The question is whether this concept of value clarifies sufficiently that what is in play here is both the immaterial value experienced by patients or relatives and an added value in the sense of better and more inexpensive ways of working.

Conclusion

The aim of this paper was to determine if the user-centred and employment-driven innovation process may be applied as a management tool to generate change of meaning among professionals. In short, the answer is affirmative. The insights that were created through the voices of patients had considerable impact on the participants and on the the organisation. The process changed their perception of themselves as professionals, and it changed their view of the patients. During the process, the emotional impact was important. How far did the process ultimately move the staff towards a change of opinion? This is a difficult question to answer, but the process was effective and has become the platform from which the Department develops the organisation and the patient pathways. The project has contributed to the integration of a new business (or governance) model; a model where quality is defined not only as a high level of professional expertise, but where the individual needs of patients are reflected, where the patients' time is prioritised, and where the organisation can see new opportunities for change and choose them. The group was disturbed and developed a common language of innovation, a common innovative approach. The paradigmatic question *'What if the patients' time was more important than ours?'* is probably too radical for our future innovation work. But the guiding principle has now become, *'What if we always took the patients' time seriously?'*

'Organisations don't innovate, people innovate' (Bason 2010). This quote has important implications for the management of professionals because we perceive employees as a force driving positive change. The employees can drive innovation if they are sufficiently disturbed in their professional assumptions. When employees take ownership of the process, innovation and implementation become two sides of the same coin – and in the case described herein, managers and employees have taken the first step towards the formulation of critically important development issues.

Perspectives

It seems relevant to consider why an organisation such as the Department of Cardiology, Heart Centre, at Rigshospitalet has not always adopted an innovative and user-centred approach. Why has management not played a significant role in attributing patients the role as a driving force?

Many in the organisation would say that the management was, indeed, already doing this – but the empirical research presented herein shows otherwise. The innovation project – and particularly the polyphonic sound clips – has been a catalyst for redesigning the Clinic's structure, for fresh thinking, and it has made it easier to introduce leadership initiatives that make sense from the point of view of the staff. Should the management team be stronger and clearer? What about the 'prima donna' staff members? Will they be willing to work in a different manner than previously? And what about the project experiment – is it perhaps merely a self-fulfilling prophecy? Will the creation of new meaning simply become part of past experience because the staff does not continue the innovation process? The management team has always sought to create an organisation characterised by high quality and a good use of resources. Time will tell whether the structural changes introduced will ultimately provide a better patient experience. However, the Department can already now document a significant reduction in cost because beds can be closed on weekends and holidays. Such productivity increases are also a part of the management challenge and were, in fact, part of the initial reason why the project was launched. Many conflicting and ever more intensive demands are brought to bear on public managers, creating a need to balance issues of efficiency, use of resources, individual needs and employee needs, etc. Therefore, it is becoming increasingly difficult to find the right management path. The user-centred and employment-driven innovation approach is not in itself a management path, but is part of the professional management toolbox.

In early 2012, a number of prominent Danish researchers published a management policy discussion paper entitled *'An innovative public sector that creates quality and shared responsibility'* (Andersen et al. 2012). The researchers are; *'committed to creating an efficient public sector, but specify another way of increasing efficiency which focuses on raising the intrinsic motivation of public employees, promotion of public innovation, better coordination and interaction, as well as mobilisation of the numerous resources found in businesses, citizens and volunteers'* (Andersen et al. 2012:1). The focus here is on diversity rather than uniformity, on trust-based interaction rather than control and on strengthening rather than overriding the knowledge and experience of professionals. The researchers recommend that internal management be reformed to; *'create meaningful and result-focused management and promote learning, motivation and innovation'* (ibid: 1). The researchers argue that the public sector

needs; *'new mental models, changed organisational frameworks and management restructuring'* (ibid: 6), where; *'public innovation is created, and that the innovation becomes a systematic and continuous activity'* (ibid: 7), where citizens are actively involved. They further argue that the role of the professional needs to be redefined; *'to make it more open, dialogue-based and holistic'* (ibid: 9). The experiment at Rigshospitalet may be seen as a small contribution to changing mental management models, introducing models where the innovative element is a strong user focus – on both the patient and the professional, without placing the patient in the driver's seat.

As described previously, innovation is a current trend. In 2012-14, a large number of innovation-focused articles were published. Thus, the user-centred approach to innovation employed at Rigshospitalet is just one approach among many, and there is probably a need for many different innovative approaches. In the organisational and professional context of Rigshospitalet, the management sees it as its responsibility to translate the innovation mind-set to make it practical and useful. At the same time, there is a need to be very explicit with respect to those employees who did not take part in this specific innovation process. The question is whether it is possible to understand the process without having participated in it. The thematic polyphonic sound clips used were a powerful empathy-building material of great importance in the creative process.

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