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Collaborative Planning for Radical Innovation: Lessons from a Health Care Region in Denmark

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Abstract

In this paper, we explain the challenges that emerged when a Danish region tried to employ innovation planning structures, without taking into account already existing governance paradigms in the organisation. We present a qualitative case study of a large regional health organisation in Denmark, which in 2016–2017 had the aim of fostering collaborative innovation. Drawing upon the concept of governance paradigms, we analyse how the strategic initiative and planning process, which used collaborative design thinking methods, in line with the New Public Governance paradigm, was hampered and finally rejected by managers embedded in an organisational context dominated primarily by the New Public Management and Traditional Public Administration paradigms.

Innovation Planning in Hospitals

Governments throughout the Western world aspire to drive public sector innovation in response to challenges such as demographic changes, fiscal constraints and rising expenditure (Bryson, Sancino, Benington, and Sørensen, 2017; Moore, 1995). Public sector innovation is legitimate if it increases public value (Benington and Moore, 2011; Moore, 2013) in terms of improved service quality, higher productivity, extended capacity building or other aspects.

Public hospitals are increasingly calling for innovative solutions in response to one of the most pressing challenges: meeting rising citizen demands while preventing sweeping, ongoing, across-the-board cuts (Salge, 2012). Politicians and administrative managers have the ambition to create collaborative innovation structures (Sørensen, Torfing and Hartley, 2013) and build capabilities to enhance innovation capacity in hospitals, leading to disruptive forms of early prevention and new treatment procedures in the health sector. We define public collaborative innovation as 'complex, creative and open-ended search and solution processes that realise new ideas through prototypes and pilots creating value for society. Collaborative innovation processes are focused on relations and decentralised strategies, across sectors and organisations leading to step-changes transforming the way that things previously have been done' (Hartley and Torfing, 2016). Proponents of collaborative innovation claim that causal relations exist between collaboration and innovation (Torfing, Sørensen and Aagaard, 2014). Innovation may comprise disruptive technical devices, new services or changed work processes, including minor ones, that alter habitual practices and structures (Osborne and Brown, 2011). Ideas of innovation may originate both from the bottom-up or top-down in the

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organisation, which may cause different challenges such as 'lack of institutional and structural support' or 'lack of local ownership'. Innovation may be intentional, but is often filled with unplanned or unexpected action, iterations and feedback loops (Van de Ven et al, 2007).

However, although hospitals have long been arenas that facilitate many kinds of health innovation in everyday practice, planning for collaborative innovation has received scant attention in innovation studies (Thune and Mina, 2016). Hospitals are service providers that focus on productivity, capability and patient safety, and therefore, paradoxically, hospitals in general often lack generic structures, organisational facilities, and management competencies to systematically facilitate radical innovation structures and processes (Thune and Mina, 2016). Organising new facilities, culture and language for radical innovation which results in zero-faults is often limited in everyday practice. Nevertheless, the role of hospitals as arenas and context for innovation has become a topic of growing interest for political and administrative decision-makers and scholars. Thune and Mina (2016) call for better understanding of the role of hospitals as organisers capable of hosting radical innovation, embedded in large public organisations.

Since the early 2000s, New Public Governance (NPG) has emerged since the early 2000s as a parallel or intertwined governance paradigm facilitating venues where innovation may develop through distributed leadership (Bryson et al, 2014). Governance refers to the process of steering society, institutions and the economy in accordance with common goals (Ansell and Torfing, 2016). The NPG paradigm has been promoted by scholars as a way forward to better provide public value through collaborative networks and more bottom-up approaches. According to Crosby, 't Hart, and Torfing (2017), collaborative innovation is supposed to improve the conditions for finding new resources, facilitating more qualified prototyping, testing and improving the success rates in vulnerable implementation and diffusion phases. Further, as stated by Agger and Lund (2017) for example, many qualitative case studies have demonstrated the positive impact of multi-actor collaboration strategies facilitating co-creation, mutual learning and local ownership, leading to increased implementation of innovative solutions (Eriksson et al, 2019).

As part of the NPG paradigm, the use of design thinking tools has emerged as a method to tackle complex societal problems (Ansell and Torfing, 2014; Bason, 2010). Design Thinking is interpreted as a distinctive approach, where public and private actors collaborate in developing and testing innovative ideas that create public value outcomes (Hartley, Sørensen, and Torfing, 2013). The claim is, that design thinking offers an alternative to existing rational decision-making present in classic government paradigms by applying, for example, four human centred governance principles; 'Relational', 'Networked', 'Interactive' and 'Reflective', providing rather different frames of relations and dialogues (Bason, 2017; Torfing, 2018).

However, although the development of collaborative innovation planning structures may be relevant in certain contexts, scholars also emphasise that it is not an easy task in practice. Administrative managers at the strategic level play an important role in orchestrating collaborative innovation planning, inviting relevant and affected actors, not least physicians and other health professionals,

to work on different aspects of innovation (la Cour, 2016). The involved actors may, however, have conflicting perspectives, with healthcare professionals, for example, often finding themselves in opposition to strategic leaders in promoting innovation in a business-like approach (Liff and Andersson, 2012).

In this paper, we investigate the challenges that emerged when a Danish region decided to use design thinking tools in an organisation with institutionalised governance paradigms already in place. We contribute to the field of innovation by drawing upon the concept of governance paradigms to explain the different conditions for innovation in the NPG, TPA and NPM paradigms. We understand these paradigms as related, co-existing practices or ideas (Pollitt and Bouckaert, 2011) or, as in the literature on institutional forces, interwoven 'constellations of logics' (Waldorff et al, 2013).

Our qualitative case study was carried out in 2018-19 and includes archival documents, interviews and observation. The Danish region is governed politically by the Regional Council and the senior executive management is the Board of Directors. The region consists of seven hospitals, four health service organisations, and seven administrative centres. After years of downsizing, the Board of Directors asked the CEO of the Centre for Regional Development to organise a plan on behalf of the Regional Council aimed at creating collaborative innovation structures at all hospitals in the region. The CEO was to invite relevant administrative centres and hospitals to make a joint effort to deliver a decision document by the end of 2017, describing the framework, content, processes and budget for radical innovation structures at all hospitals. Furthermore, the CEO decided that the process should use design thinking tools and methods developed by the Danish Design Centre (DDC). The DDC's interpretation of itself was that it was mainly embedded in the NPG paradigm (Bason, 2018), and it had, at that time, been presented in the media as facilitating very interesting results in the Danish health sector using graphic design thinking tools. Despite knowing little about the DCC and its methods, the chairman therefore asked the DDC to facilitate the planning process to launch collaborative innovation structures in the region.

Firstly, this paper will present our theoretical framework, drawing upon the concept of governance paradigms to explain the conditions for innovation, according to the ideal types of NPG, TPA and NPM. We then conduct an empirical analysis of the lessons learned from the planning process in the regional health organisation which aims to employ permanent innovation structures by using design thinking methods and multi-actor collaboration in the planning phase. We focus on how the constellation of historically layered governance paradigms of TPA, NPM and NPG influenced the planning process and conceptualisation of innovation in a specific way and explain why the intended collaborative planning process collapsed. Finally, we discuss our contributions and the implications for practitioners, scholars and further research.

Theoretical Framework – Collaborative Planning and Governance Paradigms

A number of scholars emphasise the merits of collaboration. Torfing (2016) argues that public managers facing wicked and unruly problems should promote multi-actor collaborative planning. Collaborative leadership strategies encourage the exchange of knowledge and competencies between involved actors and stimulate processes of mutual learning, thus improving the understanding of problems and challenges, expanding the range of ideas that may solve problems (Eriksson et al, 2019). Collaboration enables co-creation, integration of ideas and prototyping through recruitment of different relevant stakeholders (Hartley, 2005; Sørensen and Torfing, 2012). However, scholars also highlight several challenges. According to Koppenjan and Klijn (2004), collaboration presents difficulties in hierarchical performance-measuring organisations, or it leads to processes of 'co-destruction' (Osborne et al, 2016). Thus, the specific context creates different conditions for collaborative innovation.

Our analysis of the context for collaborative innovation is theoretically informed by the concept of governance paradigms (Politt and Bouckaert, 2011). As such, we understand each governance paradigm as building upon a specific set of institutionally embedded ideas about how to organise, govern and lead the public sector. Thus, the paradigms provide different basic rules for the production of public service, although in practice, they will be interwoven. Table 1 presents an overview of the main characteristics of each of the three governance paradigms TPA, NPM and NPG as they have been conceptualised in previous research.

Table 1. Constituents of innovation in public sector governance paradigms (inspired by Waldorff, 2013a)

Co-existing layered institutional paradigms	Traditional Public Administration (TPA)	New Public Management (NPM)	New Public Governance (NPG)
Organisational features	Hierarchic Top-down structure	Performance management Competition	Distributed strategic (self-) management
Purpose of innovation structures	Consolidation Reliability Effectiveness	Results Better performance Efficiency	Development Learning-by-doing Effectiveness and efficiency
Role of managers	Implementing political ideas on time	Use tools from private sector to measure performance	Facilitate collaboration and co-creation
Role of professionals	Autonomous experts	Service providers	Collaborative skilled partners
Citizens	Clients	Customers	Co-producers
Stakeholder role	Informant	Consumer	Collaborators and co-creators
Stakeholder involvement	Seldom	In some areas	Crucial co-producers
Communication	Information	Involvement Co-operation	Dialogue Interaction

Literature focusing on predominant governance paradigms has explored how conditions for innovation are constructed differently (Waldorff, Ebbesen and Kristensen, 2014). Challenges have been identified that emerge when a new

governance paradigm arrives and co-exists with the existing ones. Previous research has considered each governance paradigm on its own, but organisations will be influenced by more than one paradigm, as we shall see in the analysis. This results in conflicting ideals about how public organisations can employ innovation structures (Waldorff, 2013a).

In a TPA perspective, the purpose of innovation is primarily about consolidation and continuity of professional expertise in a hierarchical organisation (Pollitt and Bouckaert, 2011). Politicians and top managers may envision innovation, while professionals such as physicians, play an important role in its implementation while ensuring quality and comprehensive procedures. Professionals may also create innovation as part of their incremental practice developments. Stakeholders, such as patients, are 'informants' and they are rarely involved directly in planning processes. Some claim that innovation in TPA-dominated organisations in general is constrained while some claim the opposite due to stable structures and organisations (Koppenjan and Klijn, 2004). The TPA hierarchical innovation strategy relies on a small group of powerful decision-makers who should know the organisation and inherent decision-making processes thoroughly.

Since the 80s, the neo-rationalistic NPM governance paradigm has been applied in public organisations, using different kinds of performance measurement tools as Key Performance Indicators (KPIs) (Hood and Dixon, 2015). The NPM paradigm is open to more actor involvement and innovation in public organisations. A 'competitive innovation strategy' in NPM generally invites more stakeholders to take part in goal achievement. From an NPM perspective, innovation is about reforming rigid and ineffective procedures and applying market conditions to the public sphere. This calls for 'hybrid managers' who can bridge and refine ideas of competition and performance from the private sector. Yet, NPM measurements are reported to counterproductively facilitate more short-term bureaucratic and KPI-rigid organisations rather than long term innovative public service providers (Hartley, 2005). Steering on the basis of short-term output, KPIs may hamper new formal or informal organisational change processes pursuing long-term public value creation (Teisman and Klijn, 2008; Torfing and Richard, 2017).

In an NPG perspective, innovation is the result of more bottom-up processes inviting multiple stakeholders into the planning and implementation processes through networking and distributed leadership practice (Osborne, 2010; Pollitt and Bouckaert, 2011). Different kinds of actors are co-creators and dialogue is the preferred communication tool, with a high ability to pursue constitutional changes (Stacey and Mowles, 2016). According to Borins (2001), successful public innovation depends on intra- and inter-organisational collaboration and dialogue. Multi-actor collaborative planning requires managerial competencies in terms of personal attributes, network skills, strategic leadership and enabling skills, thereby triggering transformative learning and planning processes while simultaneously creating synergy, commitment and ownership of new solutions (Steen and Tuurnas, 2018). However, intra-organisational co-creation may be contradicted by a lack of collaborative traditions, power asymmetries, low mutual trust, a lack of personal competencies, and uncertain cost distribution.

In our case, we saw that the intention was to use design thinking, which is a heuristic approach within the NPG paradigm. It is claimed that this approach brings together various actors dealing with wicked problems through open-ended and cross-disciplinary processes (Bason, 2017). Design thinking should offer alternative methods to the rational decision-making, the latter said to be predominant in TPA and NPM organizations (Crosby, t' Hart and Torfing, 2017). It requires a special kind of distributive network leadership skills (Bason, 2010; Hartley et al., 2013), in opposition to NPM performance management and risk avoidance. Design thinking can be characterised in terms of activities such as i) exploring the problem space by using a range of fieldwork and visualisation methods, ii) generating alternative scenarios by using visual design and creativity-inducing methods and iii) enacting new practices by using prototyping and user testing. Design thinking may be a method able to realise innovation structure planning, but design methods and collaborative planning call for new organisational and individual competencies (Bovens, 2007). However, this does not mean that all partners are either convinced or have the ability or capacity to collaborate (O'Leary et al, 2012).

Before the analysis, we briefly introduce the case and the empirical methods used.

The Case, Empirical Data and Method

This is a qualitative study, where we present and analyse a case study focusing on a planning process in a Danish region where politicians and managers demanded a plan and roadmap for permanent innovation structures.

The case region consists of seven hospitals, four health service organisations and seven administrative centres together employing more than 44.000 people. Permanent public innovation structures came onto the political agenda in 2016. Many years of sweeping across-the-board 2% cuts had stimulated interest in public health innovation as a bold alternative to the sweeping cuts. Therefore, the Regional Council required a decision document and plan from the administration which described how permanent collaborative innovation structures could be realised at the hospitals.

In late 2016, the Board of Directors, approximately 40 CEOs and COOs from the hospitals and the administration, ordered the Centre for Regional Development to organise a plan and a process aimed at creating collaborative innovative structures at all hospitals in the region. The CEO of the Centre for Regional Development was to invite relevant administrative centres and hospitals to collaborate to deliver a decision document by the end of 2017, describing the framework, content, process and budget for embedded radical innovation structures at all the hospitals.

The Board of Directors, of which approximately twenty have a background as health professionals, nurses or medical doctors, demanded a decision document, developed through collaboration with strategic administrative centres and hospitals which would prevent intra-organisational resistance and bureaucratic power struggles. Nevertheless, primarily administrative centres were invited to join the Innovation Working Group, which contradicts the idea of what Ansell and Torfing (2014) call 'multi-actor collaboration', in which more

relevant stakeholders, in this case clinicians and patients, should be recruited and not predominantly planners from the administrative centres.

The design thinking consultant, Danish Design Centre (DDC), was chosen by the chairman himself to facilitate the collaborative planning process. This was partly in line with recommendations by the Board of Directors which expected 'non-bureaucratic minds' able to 'think out of the box' and to provide agile innovation structures and processes at the hospitals. Interestingly, the Board of Directors claimed that administrative managers and planners might be short of visionary thinking and disruptive ideas. Hence, a contract with the CEO of the DDC as consultant for the planning was signed to facilitate a collaborative planning process throughout 2017. The DDC was to facilitate the planning process, using design thinking tools providing co-creation processes by, for example, embracing more visual and iterative design thinking methods (Bason, 2010; 2017).

In early spring 2017, the Centre for Regional Development and the DDC invited 15 experienced colleagues working with development and improvement in the region to a kick-off meeting, in order to provide input for the implementation process. However, patients, clinicians and external companies were not invited to this initial meeting according to the chairman and CEO of Centre for Regional Development due to lack of time.

Empirical Data

In March and May 2017, the first author and the DDC carried out 33 interviews with employees and with external persons from small and medium-sized companies, who had tried to develop innovative ideas within the region. The interviewees were identified at the kick-off meeting by employees from within the region working with development, improvement or related issues at the hospitals or in administrative centres. In order to minimise the selection bias, the 'snowballing' identification practice was applied. The 33 semi-structured interviews lasted approximately one hour and focused on the interviewees' experiences of trying to realise an innovative idea in co-operation with employees from the region. The report with findings was presented in June 2017 at a scenario meeting for the Research and Innovation Board in the region (CEO and COO members) which we will unfold in the analysis.

In August and September 2017, the first author carried out six semi-structured 90 minute interviews with CEOs and COOs at the hospitals in order to gauge their perspectives on innovation in general and to discuss their perspectives on future innovation structures. Finally, the first author organised four semi-structured 90 minute interviews with leaders from four semi-public organisations working on different innovation aspects and affiliated to a regional hospital or university. All interviews were carried out by the first author when he was working as a dual health innovation programme leader in the region.

The interviews focused on the experiences of the individuals in trying to develop a radical innovative initiative within the regional organisation. Examples of questions posed are: was it easy to find the right person or access to the innovation support facilities? What kind of help did you get? Were the

support facilities coordinated or fragmented? All interviews were recorded and transcribed afterwards before being coded for analysis by the authors.

We collected a number of documents, including the political decision to launch the initiative, strategic documents and summaries of meetings of the Board of Directors. Figure 1 illustrates the timeline of the process and the actors involved.

Figure 1. Timeline for innovation planning.

	2016 Spring	*2016 Autumn*	*2017 Spring*	*2017 Autumn*
Activity	The Regional Council requests a decision document	The Centre for Regional Development (CRD) is asked to lead the planning process A working group and 12 affiliated project groups are formed	A steering group is formed A kick-off meeting is run by DDC An Innovation Visionary Scenario meeting is run by DDC - findings are presented	The Board of Directors dismiss the decision document
Main actors	The Regional Council (politicians)	The CEO of CRD is appointed chairman for the planning process The Danish Design Center (DDC) is contracted as consultant 5 administrative centers and 3 hospitals are invited into the working and project groups	5 steering group members are designated Two CRD employees are appointed as programme managers DDC runs two meetings 15 experienced planners are invited to the kick-off meeting Participating centres' CEOs and COOs are invited to the Innovation Visionary Scenarios meeting	The Board of Directors The Regional Council Steering Group Working group DDC

Analysis Strategy

First, we went through the data and documents to understand which governance paradigms were at stake. Then we searched for the clashes between the paradigms. Finally, we selected three episodes to analyse in detail to unfold how the planning failed due to clashes between the paradigms. Our analysis strategy is to highlight three important episodes from the planning process where it is revealed that the collaborative planning process failed due to clashes between the paradigms.

The first author's position as an innovation programme manager in the region means that data for this article has been collected as 'a field study in own organisation' (Hastrup, 2018). The first author's participation in formal meetings and dialogues with stakeholders provided us with first-hand knowledge of the

planning processes and nuanced insight into communication, culture and decision-making processes. The participation was also in line with the concept of 'engaged scholarship' (Van de Ven et al, 2007), where the first author was, firstly, involved in the organisation and then later worked as a researcher at a university drawing up the analysis together with the second author. However, being involved in the process gave us an ethical challenge and means that the analysis and interpretation of the data may be biased. Thus, we continuously discussed the first author´s role as programme manager and his experience with the process. We decided to meet regularly and reflect critically on the research framework, process and findings.

In the analysis below, we will explore how the planning process was strategically organised by the chairman of the Innovation Steering Group and CEO of Centre for Regional Development. This enables a better understanding of what happened when the working group tried to apply design thinking methods without consciously considering how it could be aligned with the constellation of layered governance paradigms in the region.

Analysis of the Collaborative Planning Process for Innovation Structures

This section consists of three sub-analyses - three core episodes - where we demonstrate that the governance paradigms clash. First, we examine in more detail the chairman's role in the collaborative planning process. Next, we analyse how the purpose of forming innovation structures using design thinking methods was communicated to the CEOs at the hospitals. Lastly, we look into how design thinking tools were used at an innovation visionary scenario meeting held for CEOs at hospitals and administrative centres.

The Role of the Chairman in the Collaborative Planning Process

In early spring 2017, the Innovation Steering Group consisted of five CEOs and COOs; three from administrative centres and two from hospitals, personally appointed by the chairman. In between the four Steering Group meetings in 2017, the Innovation Working Group held regular meetings once a month. The Working Group, with senior planners from five administrative centres, dealt with tasks associated with the coordination of 12 affiliated project groups and the decision document which described the framework and content for permanent innovation structures in the region, to be presented to the Board of Directors at the end of 2018.

During the early pre-planning phase, the chairman of the innovation planning encouraged the programme managers to use design thinking methods, based on dialogue with the DDC and the planners from the administrative centres participating in the Working Group. The Working Group was tasked with the development of a decision document.

Two senior planners from the Centre for Regional Development functioned as coordinators facilitating Working Group and Steering Group meetings, project planning and documentation, decision document progress and communication.

At the first Innovation Steering Group meeting held in February 2017, the chairman said:

> *'We must facilitate a creative culture of innovation… It is about new competencies… Not just a new department… Yet, somebody must facilitate the processes… Development and tests must live locally in inherent entities at the hospitals….' The chairman went on: 'To create space for local innovation leadership, we must formulate clear steering principles that rule across hospitals and centres.'*

The first part of the chairman's statement which is about the importance of creativity and new competencies seems to agree with collaborative planning principles in line with NPG and NPM (see Table 1). However, the second part is more in line with a TPA paradigm, where top-down steering and formal hierarchical rules becomes essential. This shows that more paradigms were simultaneously at stake.

The chairman decided, as previously described, to personally choose members to join the Innovation Steering Group. This opened up a counterproductive process within the Working Group. where affiliated administrative centres questioned whether the chairman, the two programme managers and Centre for Regional Development, as project owner, really wanted to orchestrate networked interaction and mutual collaborative planning processes. Questions like 'Why aren't hospitals and not all administrative centres a part of the planning?', came up at the Innovation Working Group meetings. Administrative centre representatives questioned whether the Centre for Regional Development preferred 'the simplicity of control over the complexity of influence.'

Hence, mistrust characterised the planning process almost from the beginning in 2017. This became even more evident in late summer 2017 when the chairman, not satisfied with the Working Group's progress, declared: 'When the Working Group can't agree and make decisions, I hereby take over the mandate to make decisions.'

The chairman's decision led to increased lack of trust, lack of synergy and commitment among the Working Group members from administrative centres and hospitals. They interpreted the planning process as non-distributed with the chairman, who was from their point of view in charge of a non-transparent planning process. As a member of the Working Group from one of the administrative centres said, 'I can't see that the chairman of the innovation planning encourages distributed leadership or collaborative planning processes.'

The chairman was, from the start, under time pressure to deliver a decision document by the end of 2017. The collaborative planning processes, using design thinking methods, were time-consuming, which the performance measurement Key Performance Indicators, demonstrated as many 'red flags' throughout 2017. Eventually, in August 2017, the chairman decided that the Working Group process should be suspended in order to fulfil the Centre for Regional Development's obligation to deliver a decision document at the end of 2017. This decision reveals a strong hierarchical relationship between professionals and managers where KPIs and contract fulfilment is pivotal, and in

line with the NPM paradigm (Farrell and Morris, 2003). The intended decentralisation of power and coordination as in line with NPG, should have been accompanied by increased collaboration with stakeholders such as patients and medical doctors (Eriksson et al, 2019). However, this was not the case in the innovation planning. Due to a lack of design thinking competencies, distrust in the working group and time pressure from KPIs, the chairman decided to take over the mandate to make decisions.

To summarise, an unknown collaborative oriented design thinking approach was introduced to the Working Group in the pre-planning phase. In late summer 2017, the chairman suspended the collaborative innovation planning process. Although the chairman wanted to employ co-creation methods, it was de facto given up due to a prominent top-down oriented and performance measurement culture among the Board of Directors. The clash between TPA, NPM and NPG led to reinforced resistance within the Working Group, hence from the administrative centres and from the hospitals, and eventually the failure of the collaborative innovation planning process.

Prevalent governance paradigms guided not only the results of the planning process, but also the purpose and aim of innovation structures, as we will show below in the second sub-analysis.

The Purpose of Forming Innovation Structures in the Region

As part of the initial innovation structure mapping in 2017, six groups of hospital CEOs or COOs were interviewed. In general, their fundamental belief was that permanent innovation structures at the hospitals would be a good idea, however the CEOs expressed concern and distrust about the Centre for Regional Development as manager of the innovation structure planning. In their opinion, all hospitals in the region are such big organisations that innovation structures should be managed separately at each hospital.

One CEO at a hospital, experiencing annual across-the-board cuts in budgets, saw innovation facilitation as a crucial option to overcome the ongoing cuts:

> *'As a hospital, we must develop all the time. The hospital's Board knows that, when we move at the beginning of the 2020s, our annual budget will be cut dramatically. Hence, innovation is not "nice-to" but "need-to". For us, it is a means to prevent employee dismissals. …. We're trying to integrate a more innovative culture and innovation structures into our daily operations … during the last six months we have held at least 50 innovation workshops for employees.'*

The quote reveals that the CEO interpreted innovation as a vehicle to safeguard the organisation. The hospital must innovate in short- and long-term perspectives to avoid having to make employees redundant. Therefore, they integrated a new Building and Innovation manager as a COO at the hospital, to implement an innovative collaborative culture in the operating hospital. By paving the way for new meeting places and a more creative culture, where the needs and wishes of clinicians, professionals and patients could better find ways

into structures and functions, the Building and Innovation manager for the future hospital also became part of the Executive Board at the operating hospital.

This is in line with the reasons why the regional politicians ordered a decision document for a coherent innovation system at the end of 2017. The politicians assumed that many radical employee ideas could be implemented into processes, services and devices for the benefit of patients, citizens and the region's economy. However, the hospital had deliberately chosen a bottom-up approach to plan for innovation structures. The CEO explicitly underlined that they did not have much faith in the central top-down initiative. The administrative centres were, according to the CEO, too far away from everyday practice at the hospitals.

Other barriers to the purpose of innovation structures were revealed through the interviews. A professional working with patents in the region explained:

> *'Innovation should not be about saving money … If innovation is about saving money it becomes a controller, which decreases employees' commitment and motivation. It is very hard to facilitate motivation if the purpose is to save money.'*

In the NPM governance paradigm, innovation often becomes a means to perform 'more for less', or it may be interpreted this way by clinicians. Many health professionals and hospital managers feared that the radical innovation initiatives were about efficiency and productivity in an organisation embedded in the NPM paradigm.

Most hospital CEOs interviewed were also concerned about how disruptive innovation should fit in at an operating hospital:

> *'A hospital is an extremely bureaucratic and controlled system, a zero-failure culture – and it should be. We are implementing Lean- and Improvement Management Systems, and it is not easy. Disruptive innovation is about taking high risks. A modern hospital is the opposite of taking risks. We're challenged when it comes to disruptive or radical innovation; it's not a part of our culture, it's not in our DNA.'*

Although the CEOs in general were positive about new innovation structures, it was, at the same time, difficult for them to see radical innovation structures in a service-dominated hospital, which in everyday operations is focused on short-term reliability, performance and patient safety organised in a hierarchical manner primarily embedded in the NPM and the TPA paradigms. The CEOs pointed out several times in the interviews that operating hospitals do not have a language, a culture or an organisation adapted to facilitate new disruptive innovative processes and projects.

This discloses that the CEOs perceived innovation structures as something almost contradicting their daily efforts to reach their budgetary production targets in terms of for example KPIs. When the CEOs primarily understood innovation from an NPM point-of-view, focusing on performance management and short-term efficiency, the long-term innovation structure planning seemed

not to be prioritised. From the interviews with the CEOs it became clear that short-term KPIs played a central role in hospital management. In the previous quote, the CEO said at the end; 'it's not in our DNA.' By this, the CEO presumably meant that innovation was not a KPI at the hospital, and therefore they did not act on this topic. Hence, no hospital prioritised this topic; that which is not measured is apparently not prioritised in an organisation heavily influenced by the NPM paradigm. This tells us that politicians and managers, seeking to develop radical innovation structures by using additional NPG methods, may not be aware of how profoundly the NPM paradigm and performance management influences how managers and professionals act in their everyday practice.

To summarise, the operating hospitals in the region did not have a language, a culture or an organisation adapted to facilitate disruptive innovative processes because innovation outcomes were unsecure and risky and innovation structures are not measured on or described in KPIs or contracts. Nevertheless, one CEO did see innovation as a meaningful option, in a long-term perspective, to learn new ways of doing things to overcome yearly across-the-board cuts and work deliberately towards facilitating a more distributed, creative and innovation-oriented culture at the hospital.

Another aspect that exposes inherent conflicts between the governance approaches is the use of design thinking methods in the planning processes. Therefore, we now analyse an innovation scenario meeting conducted by Danish Design Centre for the Research and Innovation Board (CEO and COO members).

The Radical Innovation Scenario Meeting

In April-May 2017, two months before the scenario meeting for the Research and Innovation Board, the Danish Design Centre (DDC) and the Centre for Regional Development arranged 33 interviews to map existing innovation structures in the region (Strigler, 2017). The mapping enabled the DDC and Centre for Regional Development, to visualise existing innovation support facilities, by using a range of fieldwork and visualisation methods, all well-known design thinking tools. The mapping revealed four major challenges identified by the innovators trying to realise an innovative idea somewhere at a hospital. The visualisation of 'innovator or entrepreneur experiences', at the scenario meeting for the CEOs, showed that the innovation structures and facilitation of capacity building in the region in general were limited:

1. *Almost all innovative ideas emerged without help from existing innovation structures within the region.*
2. *Some support facilities exist, but most interviewees found it difficult to discover the right door to the innovation support facilities.*
3. *Existing structures and support are fragmented and uncoordinated.*

4. *When it comes to scaling of ideas, implementation and sale at the hospitals, innovators experienced great challenges (Strigler, 2017).*

The findings were presented by the DDC at the beginning of the 90 minute radical innovation scenario meeting held in June 2017 for the Research and Innovation Board, held as an extension of an ordinary Board meeting. After a short twenty minute visual presentation of the mapping findings, the CEOs were given fifteen minutes to write a visionary postcard showing a 'target image' for the year 2025. Afterwards, small groups of CEOs were given 20 minutes to design headlines at three levels for a newspaper in 2025, presenting 'innovation purpose', 'what is to become true, if we succeed in innovation' and 'effects of innovation structures for managers, employees and companies.' Using collaborative design thinking methods, the scenario meeting should have provided more visionary and creative out-of-the-box planning by the CEOs.

However, hospital CEOs and COOs were not trained to work with creative collaborative methods in their daily practice. Several weeks later, the dual-programme managers realised that the CEOs and COOs had difficulties understanding the visual presentation and the following scenario exercises. It was difficult for the CEOs to write a future postcard and newspaper without sufficient time for preparation. Practicing collaborative design thinking methods, providing input for the innovation structure planning, did not make sense to the CEOs and COOs. This may indicate an organisation being primarily embedded in hierarchical, rationalistic and performative paradigms. The CEOs claimed afterwards that they could not see how the DDC-led scenario meeting was of value for their organisation, which indirectly reveals that NPG approaches were unfamiliar for the CEOs and COOs.

During the planning of the scenario meeting, the Centre for Regional Development had many discussions with the DDC about communication through visual illustrations. The Centre for Regional Development was challenged to embrace visual communication and illustrations because the visualisation was layered with meanings presented in an 'unfamiliar language' seen from a hospital or administration perspective.

The planning process carried out by the Centre for Regional Development and DDC during spring and summer 2017 was characterised by misunderstandings, due to different communication epistemologies deriving from working in different paradigms. Furthermore, the scenario meeting agenda was changed in the last minute at request of the chairman, so the meeting focused on 'future targets' instead of 'dilemmas of choices'. The chairman estimated that it would not create tangible results to start a discussion about wicked problems and dilemmas. Yet, changing the agenda at the last minute contributed to some confusion about the aim and content of the visionary meeting.

> *'The prevalent NPM culture and vertical hierarchy in the region are big challenges hindering innovation. ... The region must have an innovation strategy. It should be need-driven, starting with the clinician's operational challenges. … It is crucial to have KPIs for innovation. Innovation structures are*

> *about moving the organization in a new direction and that is not necessarily popular among employees or managers.' (CEO, X Healthtech Cluster)*

The CEO stressed explicitly that NPM was hindering innovation and at the same time he used a NPM language to suggest that innovation planning should be carried out with KPIs. Thus, the quote clearly exposes, intentionally or unintentionally, that the NPM paradigm was embedded in the region. The poor output of the scenario meeting may also be rooted in managers' dislike of uncontrolled processes and unknown results. This may have been reinforced when the CEOs were invited into an unknown planning universe that they did not understand. It hardly made sense in their daily TPA and NPM context.

To summarise up, the scenario meeting was, on the one hand, experimentally built on the NPG paradigm. On the other hand, members of the Research and Innovation Board primarily operated in TPA and NPM governance paradigms. The CEOs therefore experienced difficulties in understanding and using the collaborative planning methods at the scenario meeting.

Discussion and Conclusion

In this paper, we have analysed the challenges that emerged when design thinking methods were used to provide innovation structures in a large regional health organisation with multiple institutionalised governance paradigms already in place. We used the concept of governance paradigms to identify the significant differences in constituents of innovation between TPA, NPM and NPG (Pollitt and Bouckaert, 2011).

In the analysis, we showed how TPA and NPM were the predominant governance paradigms in the region, when the Board of Directors in 2016 ordered the Centre for Regional Development to organise a collaborative planning process aimed at creating permanent collaborative innovation structures at all hospitals, using design thinking tools and methods. According to scholars, for example Sørensen, Torfing and Røiseland (2016), collaborative innovation planning and design thinking tools embedded in the NPG paradigm, using more dispersed, bottom-up steering approaches and multi-actor collaboration strategies, could facilitate co-creation, trust and mutual learning. However, in this case, the result was that the clash between the main TPA and NPM paradigms and the emerging NPG paradigm hindered a collaborative planning process, and eventually the implementation of permanent collaborative innovation structures in the region.

We contribute to existing knowledge by showing and explaining why it is complicated to bridge TPA and NPM with the NPG paradigm, although it was a planned and deliberative managerial strategic decision to do that. Conclusively, we will first focus on dilemmas between TPA and NPG. Second, we highlight NPM and NPG dilemmas present in this case, using the constituents presented in table 1.

First, when it comes to 'Organisational features' the TPA and NPG paradigms clashes. The chairman's hierarchical steering approach, suspending the distributed planning process, resulted in great resistance in the Innovation

Working Group. The 'purpose of innovation structures' was better performance, but the hospital CEOs were primarily focused on reliability and consolidation in a zero-error culture, while the chairman aimed to persuade the CEOs that innovation structures, in a long-term perspective, would help them fulfil their obligations. However, the CEOs were not convinced and they could not make sense of the collaborative planning and visualisation methods used at the scenario meeting, for example. From a 'Role of Manager' perspective, we saw conflicts between the TPA and NPG paradigms, when the chairman suddenly removed the distributed responsibility to make decisions. From a 'Stakeholder role' perspective, the Working Group members were seldom invited into the decision-room. The chairman prioritised the traditional TPA hierarchical approach, where leaders are powerful in making decisions. The chairman primarily used information as a predominant 'Communication' technology, although he, in the beginning, stressed that NPG design thinking dialogic tools would provide creative and visionary planning processes by opening up space for inter-organisational confidence, transformative learning processes and synergy effects. In the pre-planning phase, the chairman wanted to make way for a more dispersed and collaborative planning process, but he soon focused on delivering a result on time. The chairman's decision to prioritise and maintain the hierarchical TPA approach, to implement political ideas on time, reflects the absence of a culture, language and competencies, that are required to conduct more open and creative bottom-up planning processes with success.

Previous research (e.g. Bason, 2017) has underlined that collaborative planning and organising for radical innovation using distributed leadership principles and more bottom-up processes, is a huge paradigmatic change project. This is in line with our findings. In late 2017, the Executive Board seemed to have assessed the innovation planning project as too incalculable and risky due to growing resistance from the Board of Directors – primarily the hospital CEOs - who were focusing on and pressured on short-term costs and efficiency. Eggers and Macmillan (2013) stress that the management competencies needed to systematically facilitate radical innovation structures and processes using collaborative methods are often lacking in organisations dominated by the TPA and NPM paradigms. That is in line with our findings, but our research also reveals a hierarchical organisation searching for new ways to develop and organise differently which finds itself confined or caught by the predominant paradigms.

Second, when it comes to dilemmas between NPM and NPG and looking at the constituent 'Organisational features' from table 1, the analysis showed that the CEOs at the hospitals perceived collaborative innovation structures as something almost counterproductive in their daily efforts to reach their KPI budgetary production targets. Furthermore, they did not express a desire for more distributed management or self-management at the hospitals, presumably because it would mean less NPM managerial control. In the 'Purpose of innovation structure', the chairman was bound to deliver a decision document on innovation structures at the end of 2017.

KPIs regularly measured performance and progress in the innovation planning process, but not across sectoral learning or development processes. The hospital CEOs did not pursue KPIs on innovation thus this was not a topic in

their everyday practice. From a 'Role of manager' perspective, the chairman expressed a great time pressure from spring 2017. Hence, he decided to give up using the design thinking tools. Measuring of progress may be a reasonable steering tool, but the performance measuring on time, seems to provide an example of how the NPM paradigm counteract co-creation and long-term collaborative innovation planning. The control oriented NPM paradigm seemed to devaluate learning processes and inclusion of relevant stakeholders due to time pressure from contracts and KPIs embedded in the NPM approach. According to previous research on the NPG paradigm, organisational and personal learning processes require time and new arenas to facilitate processes of collaboration towards profound change (Torfing, 2016; Ricard et al. 2017). In 'Stakeholder' and 'Communication' perspectives, the process revealed some involvement, in delineated areas, but the chairman was primarily operating from the TPA and NPM paradigms, managing upwards in the organisation, which clashed with the NPG paradigm recommending profound interaction and dialogue, the latter given up in the planning process due to time pressure and a hierarchical top-down organisation.

Finally, our analysis contributes to practitioners. Previous research, for example Torfing and Ansell (2017), has suggested that public sector organisations should adopt new forms of planning and collaborative methods based on distributive, inclusive and relational management processes, which can provide synergy, learning and commitment, by more genuine involvement of internal and external users and actors facilitating public value creation. Thus, if health sector organisations are to develop collaborative innovation structures and outcomes embedded in the NPG paradigm, the whole organisation including managers and staff should acquire new skills and learn more about applying collaborative planning and communication. Otherwise, it may lead to co-destruction as in this case.

Based upon our findings we expect it to be complicated to apply NPG methods in organisations mainly governed from the TPA and NPM paradigms. It not only takes profound long-term organisational and personal learning processes to facilitate a framework for radical organisational and individual transformation processes based on new methods. It seems to be crucial to reflect upon and consider the impact of already existing governance paradigms in the organisation before introducing methods from an unfamiliar paradigm.

An avenue for future empirical research could be to focus on how collaborative innovation embedded in the NPG paradigm, for example design thinking methods, may be integrated in other fields. Perhaps smaller organisations and more decentralised sectors may facilitate more collaborative innovation while challenging the impact of the TPA and NPM paradigms.

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