



JÖNKÖPING UNIVERSITY
School of Health and Welfare

Licentiate Thesis

What is best for Esther? Facilitating co-production and improving care with a simple but challenging question

– a qualitative case study

Nicoline Vackerberg

Jönköping University
School of Health and Welfare
Dissertation Series No. 143 • 2025



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I would also like to express my gratitude to all inspiring people I have encountered throughout my career as an improvement leader and researcher. Countless people contributed to this thesis through their experiences, thoughts, research, support, and energy. It would be wrong to claim that this work is solely mine; it is truly the collective effort of many, written down in my words.

Abstract

Background: Persons who require services from multiple care providers often struggle to navigate between them. Coordinating and connecting various health and social care providers presents a common global challenge for all parties involved. This thesis was based on the experiences of a local quality improvement project called ESTHER, which started in Sweden and has since spread to other countries. ESTHER aimed to create a seamless structure between municipalities and inpatient and outpatient care providers. This coordinated approach was designed to bridge the gaps between different care services and ensure that care was delivered based on Esther's perspective. Research suggests that involving persons in need of care in the improvement process can lead to more effective solutions. However, the literature does not clearly define the prerequisites for this involvement. This thesis aimed to enhance our understanding of the roles of power and psychological safety in co-produced improvement work. The studies conducted for this thesis explored the experiences of developing ESTHER and co-production practices within that context.

Methods: Two studies were conducted in a health and social care setting in the Highland area of Jönköping County. A case study design was used with a practice-oriented and interactive approach, framed by improvement science including co-production. Qualitative methodology was employed, incorporating interviews, blended focus groups discussions, document analysis, and modelling. Data collection included contributions from managers, frontline health and social care professionals, persons receiving care, and project-related documents.

The data was analysed using inductive thematic analysis and deductive modelling. Throughout the research process, Franzen's Power Triangle and Gustavsson's extended knowledge model for continual improvement, were applied to provide theoretical and analytical grounding.

Findings: Both studies demonstrate the importance of collaboration, openness, and shared commitment in improving care. This involves promoting partnerships between care providers and with persons in need of care,

grounded in the creation of a respectful and permissive climate in which power is shared.

Study I demonstrated how a person-centered quality improvement project evolved into a mindset, emphasizing the role of co-production in enhancing services for persons with care needs. This transformation was guided by systems thinking and the integration of change psychology into multidisciplinary improvement dialogues. Essential factors included trust in frontline staff, simple rules, and support from senior management, along with ongoing learning, local improvement coaches, and the co-production of improvements, all of which helped integrate these practices into daily work.

Study II emphasized the need to reflect on various power-related factors regarding co-produced improvements in health and social care. Resources were found to be crucial and context-dependent, similarly attitudes and perceptions among professionals and persons in need of care played a key role. To achieve co-production, the power dimension should be considered. This study introduced the power triangle of co-production which recognizes different power dimensions and their interconnections.

Conclusions: The development of ESTHER was guided by the unifying question, "What is best for Esther?" which summarized the shared purpose of the initiative. This simple yet powerful question flattened hierarchies, promoted collaboration, and maintained a focus on co-production with persons in need of care. Psychological safety and power-sharing emerged as essential elements in this quality improvement initiative in health and social care. Sustainable collaboration and co-production are supported by a shared vision, willingness to share power, promote mutual trust, and engage in continuous reflection to ensure a power balance.

Svensk sammanfattning

Bakgrund: Personer som behöver insatser från flera vårdgivare har ofta svårt att navigera mellan olika aktörer. Att samordna och skapa en fungerande samverkan mellan hälso- och välfärdsorganisationer är en global utmaning. Denna avhandling bygger på erfarenheter av ett lokalt kvalitets - förbättringsinitiativ vid namn ESTHER. Det startade i Sverige, på småländska höglandet, och har sedan spridit sig bl. a. till andra länder. ESTHER syftar till att skapa en sammanhållen struktur mellan kommuner, slutenvård och öppenvård. Målet är att överbrygga glapp mellan olika vårdgivare och säkerställa att vården utformas utifrån Esthers perspektiv. Forskning visar att involvering av personer i behov av vård, leder till mer effektiva och hållbara lösningar. Syftet med denna avhandling är att fördjupa förståelsen för betydelsen av makt och psykologisk trygghet i samskapande förbättringsprocesser. Studierna undersöker erfarenheter av utvecklingen av ESTHER och samskapande - aktiviteter inom ramen för denna kontext.

Metod: Två studier genomfördes inom hälso- och sjukvård samt vård och omsorg i höglandsområdet i Jönköpings län. Båda är fallstudier som använder ett praktisknära och interaktivt angreppssätt, grundat i förbättringsvetenskap med samskapande som centralt tema. En kvalitativ ansats tillämpades, där datainsamlingen omfattade intervjuer, blandade fokusgruppsdiskussioner, dokumentanalyser och modellering. Empirin inhämtades från chefer, personal inom hälso- och sjukvård samt omsorgen, vårdtagare och projektrelaterade dokument. Data analyserades med hjälp av induktiv tematisk analys och deduktiv modellering. Under hela forskningsprocessen användes Franzéns makttriangel och Gustavsson's "extended knowledge model for continual improvement" som teoretisk och analytisk grund.

Resultat: Båda studierna betonar vikten av samarbete, öppenhet och ett gemensamt engagemang för att förbättra vården och omsorgen. En central aspekt är att stärka partnerskap mellan vårdgivare och de personer som

behöver vård, med fokus på att skapa ett respektfullt och inkluderande klimat där makt balanseras.

Studie I visade hur ett personcentrerat kvalitetsförbättringsprojekt utvecklades till ett etablerat tankesätt (mindset) och betonade betydelsen av samskapande för att förbättra vård och omsorgen. Övergången från ett projekt till en långsiktig förändring i både tankesätt och praktiskt arbetssätt drevs av ett systemtänkande och en medvetenhet om förändringspsykologi. Bland de centrala faktorerna för att uppnå hållbar förändring framhövdes kontinuerliga multidisciplinära och gränsöverskridande förbättringsdialoger, förtroendet för personalen, tillämpning av enkla regler samt kontinuerligt stöd från ledningen på alla nivåer. Vidare spelade kontinuerligt lärande en avgörande roll i processen, där lokala förbättringscoacher och samskapade förbättringsarbete aktivt bidrog till att integrera tänkesättet i det dagliga arbetet. Detta ledde till en varaktig förändring i organisationens kultur och strukturer.

Studie II betonade behovet av reflektion kring olika maktrelaterade faktorer som var kopplade till samskapande förbättringar inom hälso- och sjukvård samt omsorg. Resurser visade sig vara avgörande och kontextberoende, på samma sätt spelade attityder och uppfattningar bland både professionella och personer i behov av vård en nyckelroll. För att uppnå samskapande bör maktdimensionen beaktas. Studien introducerar en reflektionsmodell som stöd till att balansera makt relaterad till samskapade förbättringar. Modellen lyfter fram och tydliggör de olika maktdimensionerna och deras inbördes samband.

Konklusion: Utvecklingen av ESTHER vägledades av den centrala frågan: "Vad är bäst för Esther?" som sammanfattade den gemensamma visionen. Denna enkla men kraftfulla fråga bidrog till att bryta ner hierarkier, stärka samarbetet och bibehålla fokus på samskapande med personen som är i behov av vård. Psykologisk trygghet och att adressera maktfaktorer framstod som avgörande faktorer för detta framgångsrika kvalitetsförbättringsinitiativ inom hälso- och sjukvård samt omsorg. Ett hållbart samarbete bygger på en gemensam vision, viljan att dela makt, skapa ömsesidigt förtroende och kontinuerligt reflektera för att upprätthålla en balanserad maktfördelning.

Original papers

The following papers are enclosed as appendices.

Study I

Vackerberg, N., Andersson, A. C., Peterson, A., & Karlton, A. (2023). What is best for Esther? A simple question that moves mindsets and improves care. *BMC Health Services Research*, 23(1), 873.

Study II

Ärleskog, C., Vackerberg, N., & Andersson, A. C. (2021). Balancing power in co-production: introducing a reflection model. *Humanities and Social Sciences Communications*, 8(1), 1-7.

Additional papers/book chapters

Vackerberg, N. (2013). The Esther approach to healthcare in Sweden: A business case for radical improvement. *CO-PRODUCTION*, 96.

Vackerberg, N., Norman, A., Jutterdal, S., & Thor, J. (2015). Utveckling och förbättringsarbete är ömsesidigt beroende och berikande.

Vackerberg, N., Levander, M. S., & Thor, J. (2016). What Is Best for Esther? Building Improvement Coaching Capacity With and for Users in Health and Social Care—A Case Study. *Quality management in health care*, 25(1), 53.

Vackerberg, N., & Andersson, A. C. (2022). Commentary: Bridging the silos: A comparative analysis of Implementation Science and Improvement Science. *Frontiers in health services*, 2, 964489.

Goldgruber, J., Vackerberg, N., & Hartinger, G. (2023). ESTHER-Thinking in der (integrierten) Gesundheitsversorgung–Ein radikaler Ansatz für mehr Customer Centricity: Praxisbeitrag Grazer Geriatriische Gesundheitszentren (GGZ). In Kunden begeistern: Konzepte und Praxisberichte aus Finance, Automotive und Gesundheit (pp. 229-245). Wiesbaden: Springer Fachmedien Wiesbaden.

Mulvale, G., Green, J., Robert, G., Larkin, M., Vackerberg, N., Kjellström, S., ... & Craythorne, S. L. (2024). Adopting, implementing and assimilating coproduced health and social care innovations involving structurally vulnerable populations: findings from a longitudinal, multiple case study design in Canada, Scotland and Sweden. *Health Research Policy and Systems*, 22(1), 42.

Kirvalidze, M., Boström, A. M., Liljas, A., Doheny, M., Hendry, A., McCormack, B., ... & Calderón-Larrañaga, A. (2024). Effectiveness of integrated person-centered interventions for older people's care: Review of Swedish experiences and experts' perspective. *Journal of Internal Medicine*.

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1. Prologue

In 1999, the CEO of Eksjö Municipality asked me to represent the six highland municipalities and coordinate the newly formed ESTHER Network, as the project phase and funding ended. The vision of the ESTHER project was to create a sustainable and empowered network, so that Esther (the person in need of care) could experience security and independence, and live self-sufficient lives.

At that time, I was working as a physiotherapist and had seen gaps in the care system: however, I had no idea how to continue the Esther Network and improve care. In retrospect, that uncertainty was the perfect starting point. I focused on listening and learning while pursuing studies on organizational management, quality improvement (QI), and network leadership. Simultaneously, I continued working as a physiotherapist for several years. We formed an enthusiastic team, composed of members from the hospital and municipalities, with support from the region. We learned together, (recognizing that no one had all the answers), explored ways to improve collaboration between health and social care and how to lead a network without formal authority. I quickly realized that attracting people to the ESTHER vision was crucial. Cooperation could not be forced; instead, we became aware of the power of narratives to inspire and engage.

Initially, we focused on learning improvement methods, over time, we strengthened the role of persons in need of care as active participants in this process. Continuous learning was stimulated through Plan-Do-Study-Act cycles, study visits, courses, conferences, and networks. Much of this learning occurred organically, through daily work, in meetings, new improvement projects, and ongoing activities. However, working across organizational boundaries and collaborating with those in need of care requires an awareness of power dynamics. Although we frequently discussed building trust, promoting motivation, and creating a sense of safety, I did not encounter a course addressing the critical issue of balancing power. I am eager to further

explore this topic. This thesis sparked new questions and provided fresh insights.

Over the past two decades, my commitment to improving complex care systems has deepened, which led me to leave my role as a physiotherapist to focus more on ESTHER and start an academic career as a faculty member at Jönköping University. My journey in QI began as the coordinator for The Esther Network, Sweden, and later expanded to ESTHER International. Although my experience with ESTHER in Sweden, along with similar initiatives in countries such as Singapore, England, Austria, Estonia, and Denmark, provides unique and valuable insights, it also brings about the challenge of potential bias, an issue I address in this thesis. Today, ESTHER continues to give me hope for the future and reaffirms my decision to pursue a career dedicated to health and social care improvement.

2. Introduction

The Esther story

Esther is envisioned as an older lady depicted in a picture of her at home, sitting at her bedside, with a home-care worker supporting her.

Esther is 88 years old and lives alone in a small apartment. Over the past few nights, her breathing has worsened, and her legs have become so swollen that she cannot lie down and must sit up all night. Aware that she needs medical assistance, she calls her daughter who lives in another town. Her daughter advises her to contact her home nurse. The home nurse visits, assesses Esther's condition, and determines that she needs to see her primary care physician. However, Esther lives on the third floor and cannot climb down the stairs.

The home nurse calls an ambulance, and Esther is taken to her physician. After an examination, the physician concludes that she needs to go to the hospital. By this time, three hours have passed. An ambulance transports her to the hospital emergency room, where she meets an assistant nurse and waits for another three hours. Then, she sees a doctor who examines her again, orders an x-ray, and decides she must be admitted. Once in the hospital ward, she meets more nurses and must answer additional questions.

This story underscores several issues: repetitive care processes, where Esther has to explain her story and problems again, long waiting times, and encountering numerous new healthcare personnel, which could confuse her (Vackerberg et al., 2023). The story was used in a collaborative project involving six municipalities, primary care facilities, and a medical clinic in the highlands area in Jönköping County, which began in 1997. The project was named ESTHER to remind everyone of the older woman and her journey to the hospital and back home. The foundation of the project was Esthers's story, enabling professionals from different caregiving organizations to see their part in the bigger picture. Through this story, they gained a better understanding of their role in the care chain and the roles of others, leading to the development and improvement of services (Peterson, 2006).

2.1. Navigating the health-care system

In this thesis the word health care system is based on the World Health Organization's definition of health as "a state of complete physical, mental, and social well-being," emphasizing a broader notion beyond the mere absence of disease or infirmity (World Health Organization, 2020). Because health also includes social well-being, both healthcare and social care were regarded as natural elements of this thesis.

Health and social care systems in most countries are organized separately, with distinct laws, guidelines, and documentation governing each. These systems can be complex and involve numerous interdependent components that interact and must adapt over time (Greenhalgh et al., 2023; Greenhalgh & Papoutsi, 2018). In such environments, the outcomes of interventions are often unpredictable, because individuals within the system use creativity to develop locally relevant solutions (Greenhalgh & Papoutsi, 2018; Palmberg Broryd, 2021). In practice, this implies that the relationship between the cause and effect is rarely straightforward. (Greenhalgh et al., 2023; Greenhalgh & Papoutsi, 2018; Palmberg Broryd, 2021). Additionally, the interdependency between different parts of the system can be specifically challenging, as changes in one part can affect others. This requires strong cooperation between the different parts of the system.

All countries face challenges in terms of quality, delivery, and cost of services. The concept of healthcare systems varies significantly, particularly when defining their boundaries (Anell, 2020; McKee & Figueras, 1997; President's Council of Advisors on Science and Technology, 2023). The most widely accepted definition comes from World Health Report 2000 (World Health Organization, 2000). This definition describes healthcare systems as encompassing "all the organizations, institutions and resources that are devoted to producing health actions" (World Health Organization, 2000, p. xi). Expanding on this, in 2007, the WHO stated that a health system includes "all organizations, people and actions whose primary intent is to promote, restore, or maintain health", and also addresses the need to compensate for permanent disabilities, regardless of whether the health agents are public,

governmental, nongovernmental, or private (World Health Organization, 2007). The social care system is a component of a broader social welfare framework, that encompasses education, social services, and home care.

Healthcare systems differ significantly worldwide and are shaped by each nation's economic development, political structure, and societal needs and norms. These systems reflect unique cultural expectations, resource availabilities, and values that influence healthcare priorities, accessibility, and delivery methods. Despite these differences, it is built on trained and motivated healthcare workers who work together to create care for patients (Nelson et al., 2011). The mission of a health care system's is to address the needs of patients, families, and communities (Nelson et al., 2011). This approach requires professionals to start by identifying the needs and preferences of persons in need of care, rather than relying solely on diagnoses or organizational guidelines. Core value and quality of care are generated within the smallest functional units, known as clinical microsystems, in which persons in need of care and providers co-create value through direct interaction (Batalden & Foster, 2021). These microsystems represent the critical points at which persons seeking care engage with the healthcare system and, generate true value in these encounters (Nelson et al., 2011).

For persons requiring care from multiple care providers, navigation among them often presents a significant challenge (Cribb, 2017; Fjeldstad et al., 2012; Lord, 2019). This difficulty stems from insufficient coordination among various providers across hospital, primary, and home care services, attributable to differing steering mechanisms such as funding, legislation, strategies, regulations, and organizational boundaries (Anell, 2020; Palmberg Broryd, 2020). What constitutes a clear and established routine in one care system, such as for the management of heart failure, may vary considerably in another. When disparate care systems intersect and treatment continuity is essential, particularly for chronic conditions, there exists the potential for patient-related issues such as interrupted care provision. Such interruptions can detrimentally affect the well-being and recovery of persons in need of care, constituting a common challenge in healthcare coordination (Akner, 2004; Anell & Mattisson, 2009; Fjeldstad et al., 2012; Gurner & Thorslund, 2003).

Several national programs in Sweden have been introduced to address the collaborative challenges between different care-giving organizations, each with a varying focus. Currently, Sweden has an initiative called “Nära vård,” or “Care Close to Home,” which emphasizes local, and accessible healthcare (Palmberg Broryd, 2020). Another example is “Better Care for the sick older persons”. These programs and projects tend to share a common feature: they define start and end points. However, ESTHER is not just another program but a guiding concept and—a lasting commitment (Gray et al., 2016).

2.2. ESTHER

In the late 1990s, the ESTHER network was established in the highlands area of Jönköping County. This network aimed to create a seamless structure between municipalities and inpatient and outpatient care providers. This coordinated approach was designed to bridge the gaps between different care services, ensuring that care was delivered based on Esther's perspective, needs, and preferences (Region Jönköpings County, 2019).

In this thesis, some terms need to be clarified (Table 1).

Table 1.

Clarification of ESTHER related terms

Esther	Originally, an older person requiring care from multiple providers. Today it addresses anyone in need of care or services.
ESTHER	
The project	The initial project time: 1997-1999
The Network	The following years: 1999-2016
The concept	The way of working today, integrated into everyday activities and established in 2016
The ESTHER coaches	Health and social care professionals who, in addition to their normal work, are trained as improvement coaches to initiate and support organizational co-operation improvements to make care better for Esther: started in 2006 From 2011, a stronger emphasis was placed on co-produced improvements by incorporating several persons in need of care as faculty in the ESTHER coach training

**Esther = patient/ client/ person/ user*

**ESTHER (in upper-case letters) = the way of working*

2.3. Rationale

Improvement research—the science aimed at understanding how QI methods and efforts can enhance high-quality care— evolves. According to Deming (2000), QI encompasses four key perspectives, with the psychological lens receiving less attention than the others (Lachman, 2024). As QI practices have increasingly incorporated co-production as a core dimension (Lachman et al., 2023; Batalden & Foster, 2021), the importance of understanding power dynamics between actors has gained recognition. These dynamics relate to the

psychological lens of QI, as they can influence the effectiveness of co-produced improvements.

Over the two decades of developing ESTHER, the complexity of achieving improvements with and for persons in need of care—particularly across organizational boundaries—has become evident, underscoring the need for deeper investigation. As ESTHER has garnered interest both nationally and internationally, systematic research to explore and capture associated learning and insights has become essential. Additionally, research has highlighted critical concerns about the power dynamics between professionals and persons in need of care, emphasizing the importance of examining ESTHER from a scientific perspective. The rationale for this thesis was to provide valuable insights into the roles of power and psychological safety in improving care.

3. Purpose

The overall aim of this thesis was to contribute to the understanding of the role of power and psychological safety in co-production and collaboration to improve care. The thesis was divided into two studies; exploring the development of the ESTHER concept and the role of Esther coaches in promoting a more balanced, co-produced approach to care improvement; and developing and introducing a reflection model related to power-dynamics in co-production.

3.1. Study I

This study aimed to contribute to the understanding of how several care providers improved care for Esther, including the practical implications thereof, by answering the following research questions:

- What motivated the initiation of the ESTHER project and what circumstances facilitated its development?
- How was the ESTHER project transformed into a mindset, and how was it integrated into daily operations?

Study I was part of a larger research project initiated by McMaster University in Toronto Canada, which aimed to explore the adoption, implementation and assimilation of coproduction in public services with structurally vulnerable groups (Mulvale et al., 2024).

3.2. Study II

This study developed, described, and introduced a reflection model related to power-dynamics in co-production. The goal was to contribute to better power balance when co-producing and improving care. The study was built on secondary data from interviews with ESTHER coaches, grounded in the perspectives of improvement coaches regarding power-related conditions.

4. Background

4.1. The role of the researcher and world view

As the researcher and author of this thesis, I have been the coordinator for the Esther Network in Sweden since 1999 and became the Coordinator of the Esther Network International in 2016. I am also a Senior development leader in Qulturum, Region Jönköping County, and a lecturer at the Department of Quality Improvement and Leadership at Jönköping University.

As an ESTHER Network International coordinator, I coach several ESTHER collaborations across Europe and Asia. Several researchers have studied the spread of ESTHER (Lim et al., 2022; Mulvale et al., 2024). My role as an ESTHER International coordinator, influenced my research, driven by the ambition to understand “what can be useful in Sweden and other countries” (Study I). Discovering the core elements of ESTHER and identifying what can be generalized were central to both studies. My role also led to an awareness of the areas needing focused attention in developing co-produced improvements (Study II). Co-production with persons in need of care has deepened within ESTHER over time. My colleagues and I faced challenges in seeing persons in need of care and other stakeholders as true partners—a vision that is often easier said than done—which sparked my interest in power dynamics.

Region Jönköping County has a long history of promoting practice-oriented research, driven by the desire to bridge the gap between knowledge and practical applications (Jönköping University, 2008). The core principle is that knowledge informs practice, whereas practice simultaneously enriches knowledge. This intertwined approach, rooted in Ellström et al. (2020) theories of interactive research has been foundational in shaping my research. Ellström et al. (2020) suggested that reflective and interactive dialogues, between academia and practice, offer a powerful way to bridge theoretical knowledge with real-world experience. This approach aligns with my pragmatic world view, as it enhances the practical relevance of research and

strengthens the connection between academic knowledge and real-world applications. Pragmatism concentrates on what is useful instead of focusing on “what is true” (Perla et al., 2013; Simpson & den Hond, 2022). Pragmatism can be defined as a philosophical and epistemological framework for interrogating and evaluating ideas and beliefs in terms of practical functioning (Kelly & Cordeiro, 2020). Pragmatism focusses on navigating an unpredictable world where action is necessary (Simpson & den Hond, 2022). Furthermore, it highlights the importance of valuing each individual's unique experiences, shaped by their pre-existing perceptions, and recognizing them as valuable tools for predicting future process outcomes (Perla et al., 2013). This approach aligns deeply with my personal values, as I strive to embrace complexity and honor the richness of diverse perspectives. The complexities of being closely connected to the research subject will be further described in the section on ethical considerations.

4.2. The need of integration and co-production

Delivering effective care to persons with complex needs require a holistic approach (Huljev & Pandak, 2016) which entails addressing the entirety of a person, and encompassing the physical, mental, and social dimensions (Huljev & Pandak, 2016). However, in practice, meeting persons complex needs is challenging because of the fragmented nature of care provision across multiple disconnected systems. This disconnection extends beyond the separation between health and social care, including the separation of primary and hospital care. Instead of separation, the need for integration should be acknowledged to deliver high-value care (Blanken et al., 2023).

The ESTHER initiative represents an endeavor to bridge the divide between different healthcare subsystems, such as primary care, hospital care and municipality care, by orienting care around the perspective of the person in need of it, thereby establishing a well-functioning healthcare continuum. A viable pathway toward organizing care from this perspective involves engaging the person as a valuable resource for health and social care delivery (Batalden & Foster, 2021). Greenhalgh et al. (2011) provided the following quote:

“Delivering a service that is truly patient-centered is an enormous challenge which can only be overcome by actively engaging patients as a valuable resource” (p.x foreword)

(Greenhalgh et al., 2011)

Enhancing the role and engagement of persons in need of care is widely recognized as a key factor in improving health and social care systems at both the national and international levels (Batalden, 2018; Bate & Robert, 2007; Bergerum et al., 2019). The underlying premise of this involvement lies in its potential to promote care that is more person-centered, integrated, and efficacious (Plsek, 2003; Plsek & Greenhalgh, 2001). In theory, the concept of person-centered care is embraced as a progressive approach, however implementation has proven challenging, particularly across the entire care continuum (Britten et al., 2020; Ekman et al., 2011). Despite the existence of national regulations promoting collaboration and the imperative to deliver care in partnership with the persons in need of care, translating these principles into practice remains a formidable task (Hedberg et al., 2022; Socialstyrelsen, 2015).

5. Theoretical frame

The following section briefly outlines the development of QI, co-production, and its relationship with power balance and psychological safety.

5.1. Development of QI

The field of improvement science informs the continuous development of QI methods. The field is relatively new, starting in the 2000s and intends to bridge the gap between ideal and actual care to enhance healthcare quality, thereby improving patient and population outcomes (Dixon-Woods, 2019; Nelson et al., 2011). The QI epistemology emphasizes knowledge derived from "doing" rather than prior "knowing" with improvements intended to be practically useful (Nilsen et al., 2021). Consequently, improvement science is rooted in a pragmatic worldview, concentrating on what works, for whom, where, and why (Lachman, 2024).

Improvement science emerged from the broader QI movement, that became widespread in healthcare in the late 1980s. Inspired by Deming and Juran, Batalden and Stoltz (1995) developed a well-known model showing that two types of knowledge are required to improve healthcare: professional knowledge is described as the knowledge, ethics, values, and experiences one has as a healthcare professional: improvement knowledge encompasses the domains of understanding systems, variation, change psychology, and theory of knowledge. The model proposed by Batalden and Stolz was expanded to include a third field: patient knowledge (Figure 1). This field recognized that a patient's understanding of their own life, aspirations, and experiences provides valuable insights for improving healthcare services (Gustavsson et al., 2022). The model illustrates the concept of co-production for continual improvements of healthcare services to achieve improved patient outcomes. Co-production refers to a collaborative process in which multiple stakeholders, including professionals, patients, clients, users, and other key participants, work together to improve systems, services, and outcomes (Gilardi et al., 2016). Although there are many definitions, no single definition is universally accepted (Masterson et al., 2022). This thesis, the focus is on

co-production within improvement efforts, where the core principle is that collaborative engagement between all parties leads to more effective changes and the creation of greater value.

The center of the model below shows the importance of co-production, where healthcare professionals, patients, and improvement experts work together. This combination of knowledge leads to ongoing improvements in healthcare services, and ultimately, better patient outcomes.

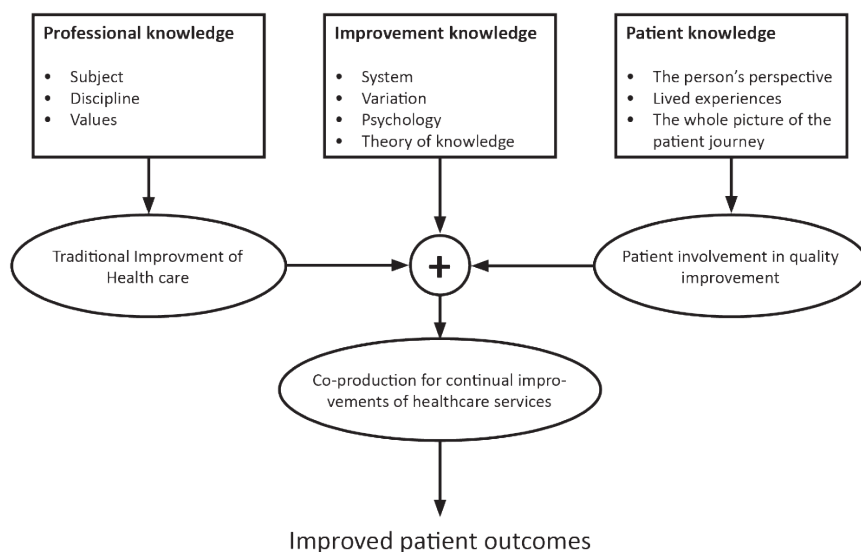


Figure 1. The extended linkage of knowledge required for continual improvement by Gustavsson et al. 2022 (Printed with permission).

Additionally, Lucas (2016) emphasized the significance of co-production within improvement models and extended the discussion by outlining the essential habits of an “improver”. He argued that improvement is not solely dependent on knowledge but also on mindsets and attitudes. Merely possessing knowledge or being skilled in a particular task does not lead to improvement. Central to Lucas’s model is co-production, positioning it as the core element in the process of improvement (Lucas, 2016).

Furthermore, several researchers have described the evolution of QI approaches, shifting from solely ensuring and monitoring quality to

collaboratively co-producing quality with persons in need of care, professionals, family, and other stakeholders (Andersson, 2024; Batalden & Foster, 2021; Batalden et al., 2023).

5.2. Co-production

5.2.1. Co-producing improvement work

Co-producing improvement has increased and there has been a significant shift in the role and involvement of persons in need of care, in health and social care settings (Masterson et al., 2024; Robert et al., 2024). Rather than simply receiving passive care, persons in need of care now actively participate in co-producing healthcare and social care services (Batalden et al., 2016; Bovaird & Loeffler, 2012; Börjeson & Karlsson, 2011). The underlying principle is that collaborative efforts lead to effective changes and value creation (Boyle & Harris, 2009). Co-production involves partnership aimed at generating, sharing, and negotiating diverse forms of knowledge to enhance care (Vindrola-Padros et al., 2019).

Achieving high partnership level is challenging, because the relationship between caregivers and persons who require care is often unequal (Barile et al., 2014; Kirkegaard & Andersen, 2018; Skau & Jonsson, 2018). Information and power imbalances, coupled with caregivers' concerns about relinquishing control, can impede co-production efforts and perpetuate unequal power dynamic (Barile et al., 2014; National Board of Health and Welfare, 2013). Coldham (2018) outlined the key features of co-production, with sharing power as a central element, which is discussed in the next section.

5.2.2. *Power in co-producing improvements*

In this thesis, power signifies the ability to influence the process of improvement. Allen (2002) stated that power arose from collective action and emerged through shared efforts undertaken with others when working toward common goals. This aligns with improvement work because there is a common goal. As the influence of persons in need of care is essential for

achieving co-production, it inherently requires the ability to exert influence. This demands an awareness of the power dynamics at play (Arnstein, 2011; Batalden, 2018; Rose & Kalathil, 2019; Vindrola-Padros et al., 2019).

Power is a challenging concept with various dimensions. As Dowding (2012) reviewed, some view power as a property of agents, individuals or collective entities, such as firms and governments—whereas others see it as a property of systems or structures. There is debate on whether power is inherently conflictual or consensual. It can also be seen as an enabling force to get things done (van Baarle et al., 2024). Additionally, power can be defined in terms of 'power over' others or 'power to' achieve aims (Dowding, 2012). Inspired by the relational power perspective, which views power as a complex and multifaceted phenomenon co-created in every interaction (Lilja & Vinthagen, 2009), power is conceptualized as "power with" rather than "power over" or "power to" in ESTHER.” Power with “can be found in co-production, by how people connect with one another, even within hierarchical structures, igniting a shared passion and motivation to create change together (Farr, 2018). The relational power perspective focuses more on the exercise of power than on its definition (Lilja & Vinthagen, 2009). According to this view, power operates through relationships and can be shared, not merely as a tool for domination (Franzén, 2010). Even though the power dynamics in a relationship may be temporary, we can still strive toward balance. However, it can be difficult to measure, as power arises between persons when they act together, and can change every moment or vanish the moment they separate (Allen, 2002).

Franzén (2010) introduced a power triangle with three dimensions: resources, discourses and context all of which are intertwined and can be used to reflect on power (Franzén, 2010). Resources are shaped by relationships, affecting their availability and effectiveness. Discourses, as complex constructs, link words and images to underlying beliefs, shaping perceptions and understandings. Contexts help identify key power relations, recognizing that the meanings and effects of these relations differ across dynamic settings.

Ongoing critical reflection and dialogue are crucial to effectively challenge the existing power dynamics (Drinkwater et al., 2024). These practices are essential for promoting more equitable relationships within these systems and

driving change across individual, local community, and organizational levels (Farr, 2018). However, constructive group reflection requires participants to feel comfortable expressing themselves and not judging one another, leading us to the next section.

5.2.3. *Psychological safety*

Psychological safety refers to individuals' perceptions of taking interpersonal risks within a specific context, such as the workplace (Edmondson & Lei, 2014). Sharing or balancing power depends on how safe one feels when doing and often means letting go of control and “leaping into the unknown”. Similarly, stepping forward and making one’s voice heard can be as challenging as relinquishing control in certain situations. Psychological safety is defined as “*a shared belief that the team is safe for interpersonal risk taking*” (Edmondson, 1999). In the microsystem theory (Donaldson & Mohr, 2001) (and this thesis), the person in need of care is always considered part of the team. Both professionals and persons in need of care should feel safe when speaking and being heard. Therefore, psychological safety and the balance of power are closely intertwined.

Psychological safety was initially studied by leading organizational scholars in the 1960s, with renewed interest since 1990s. Research on organizational behavior has highlighted psychological safety as a crucial element in understanding concepts such as voice, teamwork, team learning, and organizational learning (Edmondson & Lei, 2014). Without psychological safety, learning can be hindered, and patient safety can be at risk (Tucker & Edmondson, 2003). Psychological safety enables people to broaden their perspectives, learn from the active exchange of new ideas, and achieve greater creativity and innovation (Kwon et al., 2020). As professionals and persons in need of care learn how to co-produce improvements the need for a psychologically safe environment can not be underestimated. However, a sense of comfort or acceptance does not automatically lead to improvement; rather, improvement requires both a push into disruptions and a pull toward psychological safety to be in place (Kwon et al., 2020).

To my knowledge, psychological safety as well as power balancing in co-production has not received much attention in QI efforts and improvement

science. "Psychological safety" was first added as a Medical Subject Headings (MeSH) term in 2024, indicating its recent formal recognition as a significant topic in the biomedical field. However, "co-production" has yet to be included, suggesting that it is still not fully recognized as an independent concept within standardized medical and health sciences indexing. MeSH term is a standardized keyword used in the biomedical and health sciences to consistently categorize topics for indexing and searching literature. Using MeSH terms allows researchers to find relevant studies more efficiently, as it organizes information by specific subjects (National Library of Medicine, Jan 2024).

6. Methods

6.1. Local context

In Sweden, healthcare services are predominantly delivered by the public sector, divided into 21 regions and 290 municipalities, each possessing taxation authority and a high degree of autonomy (SALAR [Sveriges kommuner och landsting], 2011). Regions primarily oversee hospital care, primary care, and advanced home health services, whereas municipalities are responsible for social care, home assistance, group accommodations, older adult care, and day care activities. Funding for hospital care is not contingent upon bed count, but rather on the sophistication of care provided and service volumes. Historical data from previous years inform budget allocations for the subsequent year, supplemented by decisions regarding budget increases.

In the late 1990s, a comprehensive healthcare initiative commenced in the highland area of southern Sweden aimed at redefining the care experiences for persons needing such services. This area, comprising 100,000 inhabitants, was characterized by a relatively high proportion of older adults. The overarching objective of this system-wide initiative was to deliver person-centered care across primary, hospital, and community care settings. To underscore this commitment, the initiative was named after the fictional person, Esther. The premise was that the establishment of effective and efficient inpatient and outpatient care processes would bridge the gaps between disparate care providers, enabling them to coordinate and deliver care aligned with the perspective, needs, and preferences of 'Esther.' (Cribb, 2017; Davies, 2012; Gray et al., 2016; Loeffler et al., 2013; Vackerberg et al., 2023).

Initially focused on older adult care, Esther symbolized an older woman with specific care requirements necessitating seamless coordination and integration across hospital, and primary, home, and municipal care services. However, over time, Esther came to represent persons of any age who need care. This evolution reflects the understanding that effective collaboration and coordination should transcend age or specific diagnoses, and instead embracing a holistic perspective on persons' health conditions and requirements.

The region's ethos is underpinned by a commitment to "quality as a development strategy" as documented in previous studies (Andersson-Gare & Neuhauser, 2007; Bodenheimer et al., 2007; Persson et al., 2021; Staines et al., 2015). Over the years, the ESTHER project, later known as the ESTHER Network, has been awarded for its innovative approach in prioritizing a person's needs. This methodology has contributed to several notable outcomes, including a reduction in hospitalizations coupled with an increase in home care utilization. Consequently, the number of hospital days for persons with heart failure decreased from approximately 3,500 in 1998 to 2,500 in 2000, hospital admissions fell from approximately 9,300 in 1998 to 7,300 in 2003 (Loeffler et al., 2013) and the medical clinic shut down 20 % of their beds in 2003 (Peterson & Bojestig, 2003). This reduction was driven by a combination of factors, including: enhanced support for home care services in the district, more efficient care within the hospital, increased outpatient clinic visits, and increased self-care for persons with heart failure. Furthermore, the region achieved high national rankings for patient satisfaction and trust in the healthcare system. The project also empowered Esthers and frontline staff to engage in collaborative improvement endeavors and began to train professionals as ESTHER coaches (Vackerberg et al., 2023).

6.1.1. *The ESTHER coaches*

ESTHER coaches are improvement coaches who promote the development of the entire system, span organizational boundaries, focus on meeting Esthers needs and achieving the network's vision (Vackerberg et al., 2016). They emphasize co-produced improvements, actively engaging both persons in need of care and professionals in shaping better care processes together. Although an Esther coach aims to co-produce improvements, their improvement reports reveal a spectrum of co-production in practice (Region Jönköpings County, 2024). This ranges from engaging by gathering perspectives to achieve a deeper partnership, where co-production is embedded from the initial planning stages through to execution and evaluation.

6.2. Design and analysis

This thesis incorporates the results of a case study divided into two studies, (see Table 2), drawing on empirical data from a systemwide QI project, ESTHER, spanning various health and care sectors in Jönköping County. This thesis presents individual studies, followed by a summary explaining their overarching results and how they are interconnected.

The participants in these studies included professionals from municipalities, primary care units, a county hospital, and persons in need of care. This thesis used an interactive research approach to enable learning for researcher and the practitioners (Ellström, 2007; Kjellström et al., 2019).

Table 2

Overview of Studies I and II

	Study 1	Study 2
Title	What is best for Esther? A simple question that moves mindsets and improves care	Balancing power in co-production: introducing a reflection model
Design	Retrospective case study	Conceptualization of a model
Participants/ data material	Professionals (n=13) Persons in need of care (4)	Results from interviews, secondary data (Professionals, n=12)
Data collection	Individual interviews, focus group interview, documents	Result from interviews and Franzens power triangel
Analys	Qualitative thematic analysis	Modelling
Theoretical framework	Quality improvement	Relational power perspective

An exploratory, qualitative approach was chosen because the intention was to explore the participants' perceptions and experiences. Qualitative methods are particularly effective at capturing experiences and the contexts in which they occur (Ahrne & Svensson, 2011; Hammarberg et al., 2016). This method is preferable when working with large volumes of data and extensive empirical evidence (Ahrne & Svensson, 2011).

6.2.1. Study I

This study utilized a retrospective longitudinal case study framework, with a qualitative approach (Ahne & Svensson, 2011; Baker, 2011; Yin, 2017). A qualitative longitudinal case study can be used to capture and theorize long-term organizational change (Langley, 2023). An advantage of studying change retrospectively is the ability to assess what has already occurred and to discover the extent and nature of any changes. A retrospective approach can also make data collection more efficient (Langley, 2023).

This case is defined as the ESTHER project and includes the start, the development during, and the period after the project ends. The study includes individual interviews, focus group interviews, and document analysis. Interviews are valuable and provide access to factual events and underlying thoughts and perceptions. This dataset is a rich source of experiences. The interview analysis was conducted using an open inductive thematic approach (Braun & Clarke, 2014; Braun & Clarke, 2022).

Criteria and data-collection

Data were collected through qualitative interviews both individually, in focus-groups, and relevant documents. Data collection was conducted in spring 2021-2022.

A purposeful selection was used, professionals and persons in need of care, involved in the ESTHER network, were included. Interviews with managerial initiators explored ESTHER's beginnings, followed by focus groups with frontline professionals and persons in need of care to trace its evolution. The participants were multidisciplinary, representing diverse roles, organizations, and professions. This ensured that the participants' experiences aligned with the purpose of the study. The documents consisted of date-stamped archival materials, such as project plans, strategic plans, meeting minutes, and brochures, spanning from 1995 to 2020.

Data analysis

Utilizing a qualitative approach with different data sources offers several advantages and contributes to a more comprehensive understanding of the research question. Qualitative methods enable researchers to delve into the

depth and richness of human experiences, perceptions, and behaviors. The combination of individual interviews, focus groups and documents as data sources provided an opportunity for triangulation which involves cross-verifying findings from different methods, thereby increasing the trustworthiness of the study (Adler, 2022; Lincoln & Guba, 1986; Stahl & King, 2020). Trustworthiness can be strengthened through transparency and member checking (Adler, 2022; Donkoh & Mensah, 2023; Stahl & King, 2020). The participants were invited to review the study results to verify their accuracy. Triangulation also refers to cross-verifying information from multiple perspectives (Heale & Forbes, 2013). In this case, the participants came from various organizations and held diverse professional roles, providing a rich mix of perspectives.

Focus group interviews are a pragmatic approach to gathering profound insights and diverse perspectives on a given subject and provide insights into how various experiences are perceived (McGrath, 2019). The choice of focus groups in this research was motivated not only by their convenience but also by the researcher's commitment to ensure that the research contributes to practical applications. The significance lies in the researcher's learning and simultaneously facilitating learning for the study participants (Ellström, 2007; Ellström et al., 2020). Focus groups are helpful in group learning and are instrumental in informing and enhancing practice (Krueger, 2014).

I conducted the individual interviews. There was an existing preunderstanding, that I addressed through reflexive entries in my diary. Because these interviews focused on the early days of ESTHER (i.e., a time before I was involved) they revealed perspectives that were new to me. Focus group interviews were performed by two researchers, aiming to have approximately 6 - 8 people in the group. According to Wibeck (2010) and Krueger (2014), groups comprising four to eight members allow the researcher to engage in depth enquiry regarding specific behaviors and perceptions.

To minimize bias, my role in the focus groups was limited to observer and note-taker. The focus groups had a blended composition, including persons in need of care and professionals, as all participants preferred this collaborative approach. Although mixed focus groups are rarely used in healthcare research, they can generate valuable new knowledge (Femdal & Solbjør, 2018). The

moderator guided the interview process, posed initial questions, and presented follow-up inquiries. Toward the conclusion of each interview session, a second researcher or participant provided a comprehensive summary of the discussion. Subsequently, participants were invited to assess the accuracy of the summary and confirm whether their perspectives were correctly comprehended. Furthermore, participants were allowed to supplement or amend the summarized information by adding pertinent details that they considered necessary. This iterative and interactive approach aligned with the overarching goal of ensuring that the research outcomes not only benefit the academic community but also contribute substantively to informing and improving practical applications in the studied context.

The transcribed data were analyzed using an open, inductive thematic analysis approach, as outlined in the literature (Braun & Clarke, 2014; Braun & Clarke, 2022; Johnson & Christensen, 2000). The transcriptions were subjected to iterative examination, discussion, and coding by all authors. The initial coding was consolidated into themes via a web-based interface through multiple iterations using interview questions. Subsequently, the material was organized, leading to the identification of subthemes, which were then categorized into three overarching themes based on the study's objectives and research inquiries. The themes and subthemes were continuously reviewed and deliberated upon by all authors involved in the study.

Table 3

Example of the text-analysis from Study I

Data unit	<i>Thanks to the strong and passionate driving forces within ESTHER, we have nevertheless managed to return to this and bounce back most of the times when we have found ourselves in situations where there is a risk of starting to think only 'we' [our organization] instead of 'us' [cooperation over organizational boundaries]</i>
Codes	Driving force, motivation
Subtheme	Passion
Theme	Work in practice

6.2.2. *Study II*

The study was based on secondary data from semi-structured interviews to gather qualitative insights related to power-dynamics in co-producing care improvement. In this study, a power reflection model was developed.

Criteria and data-collection

Secondary data were gathered through qualitative interviews conducted by a master's student in spring 2017. The participants were municipally employed ESTHER coaches from highland municipalities, including 12 individuals with varying levels of experience in the coaching role, ranging from one to ten years. Their professional backgrounds spanned 8 - 40 years in care-related work, with most being assistant nurses, although nurses and social workers were also represented.

Analysis

The interview findings were analyzed and conceptualized using Franzén's (2010) power triangle. This process involved several iterative steps to connect the results to the framework's three dimensions: discourse, context, and resources. The factors within these perspectives were collaboratively refined by the research group through discussions aimed at reaching consensus. Deductive analysis led to the creation of a reflective model based on the power triangle framework. This model was developed through multiple meetings, iterative refinements, and input from colleagues with academic expertise. Whiteboards facilitated visualization and adjustments throughout the process. Rooted in Franzén's (2010) theoretical foundation, outlined in Section 5.2.2, the model highlights how power operates within co-production efforts. A three-step cycle was added to the triangle to support this action (Figure. 4). Examining the interplay of resources, discourses, and contexts, offered a structured approach for understanding how power dynamics influence collaborative improvements in systems and practices.

6.2.3. *Overarching analysis*

Visual mapping was employed in this thesis as a complementary method to illustrate the relationships between the studies and to trace significant events

in the evolution of ESTHER and the development of co-production over time. Documents were analyzed to secure and construct a timeline of key events, focusing on decisions and activities that influenced the ESTHER approach, such as involving persons in need of care in the steering group. Langley (2023) highlighted that visual mapping is particularly well-suited to longitudinal studies, as it helps identify events that significantly impact the trajectory of change.

6.3. Ethical considerations

The studies were conducted according to the Declaration of Helsinki (World Medical Association, 2024). Study I was part of a larger research project initiated by McMaster University in Toronto Canada. Participants received an information letter before the interview stating that the interviews would serve as the foundation for scientific articles. Study I received approval from the Swedish Ethical Review Authority (dnr: 2019-04113).

In Study II, a master's student collected the data. No sensitive personal data were collected, meaning that the project did not need to be tested for research ethics. The studies were conducted according to the four main general requirements for research: information, consent, confidentiality and utilization (Vetenskapsrådet, 2024), which are described below.

Information requirement

Information on the background of the interviews was provided to all participants, both orally and in writing. This information included the purpose of the study, voluntary nature of participation, right to withdraw at any time, identity and contact information of the researchers and intended use of the results. Participants were also informed about how to reach the researchers afterward, with any questions or comments regarding their consent. Further information about the study was provided at the time of the interviews.

Consent requirement

All the participants were informed that their involvement was voluntary and that they could withdraw at any time without providing a reason. Written and verbal consent was obtained before the interviews began. In Study I, the

author, known to participants as the ESTHER coordinator, invited them to participate. Although this could raise ethical concerns regarding potential power imbalances, the participants were accustomed to receiving information about ESTHER from the coordinator. An external researcher served as the contact for any questions regarding the study and moderated the focus group interviews.

Confidentiality requirement

Participants were informed that their responses would be treated confidentially, ensuring that no individual participant could be identified and that the study results would be reported in a manner that prevents individual identification. However, maintaining confidentiality during group interviews can be challenging. Group interviews can create a dynamic in which participants are more inclined to share information or comment on others' responses, which can be beneficial for obtaining a comprehensive understanding of the topic, but also poses a risk of disclosing confidential information. The research group aimed to create an atmosphere of respect and curiosity, leading to an open conversational climate, and helping participants feel comfortable sharing their thoughts (de la Croix et al., 2018). Data were analyzed and reported at the group level, which reduced the risk of identifying individual participants based on their responses or opinions. Quotations in which individuals could be identified were included only after consent was obtained.

Utilization requirement

Participants were informed that the collected data would be used for research purposes and practical implications. The persons in need of care highlighted the importance of the latter. In Study I, the participants were informed that the results would be used to produce a scientific paper and disseminated at conferences and through other media. The intention was to share practical implications for ongoing sustainable development work both locally and internationally. In Study II, the model was specifically developed for use in the education of improvement coaches or others interested in co-producing improvement.

6.3.1. Ethical challenges in research

Pre-understanding as a researcher

Being close to the case, I had a pre-understanding of the context, organization, and culture. Yet, this could be both beneficial and risky. It allowed for a deeper connection with the target group, aligning the research with local values and enhancing data collection and analysis (Alvesson & Sandberg, 2022; Coghlan, 2019; Vindrola-Padros et al., 2019). However, if left unrecognized, it could lead to a research bias (Palmér et al., 2022). Strategies for managing pre-understanding include practicing reflexivity (Dodgson, 2019) and reporting roles in the study context (Malterud, 2014). My role and influence on this research are described at the beginning of the thesis. Reflexivity is described as critically questioning one's role and impact on research (Dodgson, 2019). This was done using a reflective diary and having several critical friends over the years.

Holmes (2020) described the risk of participants not communicating all the information, perceiving it as obvious knowledge of the researcher. I used techniques such as feigning ignorance during interviews to counter biases so that they could tell in their own words what might have been obvious to me. In addition, the participants reviewed the study results to ensure accuracy. Despite these challenges, openness to new perspectives and critical self-reflection helped shape the final outcomes.

6.3.2. Use of artificial intelligence

I used ChatGPT to optimize my text and language during the writing process as I am not a native English speaker. I reviewed the suggestions provided by ChatGPT and incorporated parts with better flow into the text. Artificial intelligence was not used in any other manner.

7. Main findings

This chapter presents the main findings of each study, followed by an overarching summary highlighting the relationship between the two studies.

7.1. Study I

Study I explored ESTHER's development, showing its evolution through three overlapping periods: from a formal project to a network, and finally to an ingrained mindset (Figure 2). Initially, a two-year formal project with a steering committee and a diverse project group laid the groundwork. This evolved into a network phase lasting two decades, that was still supported by a steering committee, which refined the collaborative approach among care providers. Regular meeting points over organizational boundaries and initiating collaborative improvements projects kept the momentum. As the ESTHER mindset became more integrated into daily routines and policies, the need for a steering committee diminished. Over time, the emphasis on co-produced improvements increased.

What stood out most in Study I was "persistence," highlighting the enduring nature of the ESTHER mindset. Development is characterized by three main themes: Incentives, Work in Practice, and Integration. These themes emerged from six subthemes that detail specific aspects of evolution. This persistence was evident as the ESTHER approach has remained active and influential for more than twenty years. Figures 2 and 3 illustrate the development process and themes that characterize the transformation.

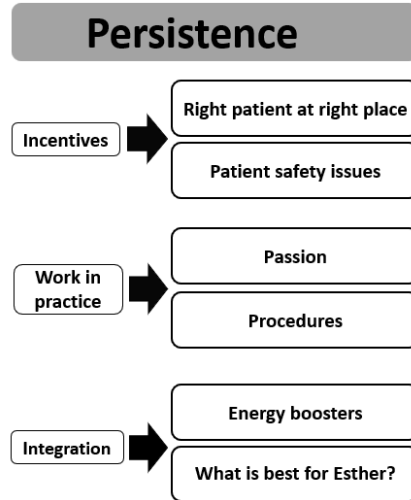
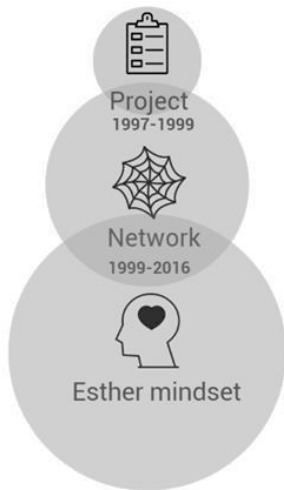


Figure 2. The development of ESTHER from project to mindset Figure 3. The themes emerging of the data analysis

Incentives

The first theme, Incentives, consisted of two subthemes: "right patient at the right place" and "patient safety issues." The ESTHER project emerged because of the need for better care continuity and patient safety. The project included a medical clinic at the hospital, six municipalities and primary care units. The "Esther story" illustrated the patient's journey, creating awareness among care professionals about the broader care system and their roles within it. This narrative emotionally connected the professionals, encouraging them to improve their care delivery.

Work in Practice

This subtheme detailed the practical aspects of the project through five components:

- Cross-professional forum: representatives from all care providers, combining bottom-up and top-down approaches to ensure practical solutions from frontline staff, were prioritized.

- The health process reengineering method: Applied to redesign care processes to improve efficiency and patient outcomes.
- Learning by doing: Encouraged hands-on, experiential learning to adapt and improve care practices in real-time.
- Networking: Facilitated connections and collaborations across different care providers to foster a unified approach.
- ESTHER coaches: Guided further development of the project and ensure adherence to its principles and goals.

According to the participants, the success of the project relied on the knowledge and experience of the frontline staff, who were trusted to provide practical solutions. The participants described that the question “What is best for Esther?” cultivated a unified goal among healthcare professionals, breaking down the "we and them" mentality and promoting collaboration.

Learning by doing: Emphasis was placed on quick, practical actions and learning by doing. Small tests and Plan-Do-Study-Act cycles were used to promote continuous improvement. Professionals appreciated this hands-on approach. Managers’ roles were described as supporting improvement work by scheduling time and appreciating frontline staff’s efforts.

Networking: Post-project, the ESTHER Network expanded to several clinics and was coordinated by two professionals, one from the hospital and the other from municipal care. The network's motto, "all have to do their job and improve it," emphasized collaborative improvement without special economic arrangements. Over time, new managers unfamiliar with this approach made participation more challenging.

ESTHER Coaches: To sustain and develop the network, local ESTHER coaches were introduced through funding from the European Social Fund. These coaches, trained since 2006, were professionals with various care backgrounds, primarily working on the frontline. They focused on maintaining Esther's perspective and improving the local care units and processes. ESTHER coaches integrated improvement work into their daily

roles as care professionals, ensuring that all efforts benefit both Esther and the health and social care organization.

Integration

Energy boosters

The integration of the ESTHER mindset into daily work relied on intrinsic motivation. Several participants used the word “passion” to describe the ongoing drive for this work. Further, rituals like celebrating Esther's name day with pastries and the symbolic use of the ESTHER flag bearing the question "Is this best for Esther?" reinforced commitment to patient-centered care. The participants experienced that these practices helped to sustain their connection to their passion and focus on what is best for Esther. Further, the documents showed that ESTHER received multiple awards, such as the acknowledgment from CNN in 2014 and the European Prize for Social Innovation in 2017, which inspired similar initiatives in other Swedish regions (e.g., LINNEA, HILMA, HELGA). Participants mentioned that this recognition boosted their pride and motivation to continue.

What is best for Esther?

The participants described this simple question as very powerful as well as actively involving "Esthers" in meetings and improvement work. Involving persons in need of care generated new energy and, above all, prevented assumptions about the answer to the question: “what is best for Esther?” This engagement ensured that care improvements were aligned with what was genuinely important to persons in need of care. Over time, the ESTHER mindset became embedded in daily activities with a less formal structure, guided by ESTHER coaches and supported by Jönköping County's health and welfare policies.

7.2. Study II

Study II explored ESTHER coaches' role and their ability to stimulate co-produced improvements. Study I focused on an overarching perspective, whereas Study II focused on creating a model for reflecting on the power balance.

A reflection model was developed, based on all dimensions of power identified in the secondary data (Figure 4). The model promoted action and learning through reflection and included a three-step cycle: reaction, interaction, and action. Reaction involves identifying barriers and enablers; interaction focuses on deeper reflection and understanding of the interplay between power dimensions; and action entails implementing measures to address barriers or reinforce enablers.

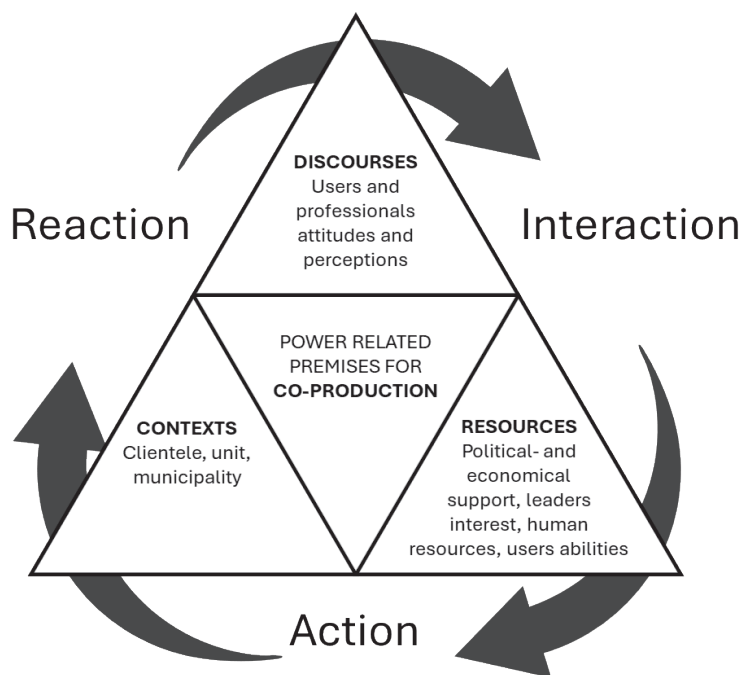


Figure 4. The power triangle in Co-production

The power triangle of co-production was proposed as a reflection model to promote symmetric co-production in health and social care, aiming to minimize barriers and enhance user involvement.

7.3. Overarching summary and related findings

This chapter provides a summary and timeline of the overarching results of the relationship between the studies I and II. The connected timeline (Figure 5) illustrates the chronological expansion of ESTHER. The analysis of the project documents and quotations from study I illustrates the progression and key milestones of the ESTHER initiative, showcasing its expansion from Sweden to countries such as Singapore, Austria, Denmark, and the U.K. The timeline is structured into two sections: the left section details the overall development of ESTHER, whereas the right section emphasizes the evolution of co-production efforts over time. Throughout the years, regular study visits have taken place both nationally and internationally and continue to do so. Participants in Study I specifically highlighted the "Esther red flags" as a remarkable and easy-to-use reminder of the ultimate question: "*For whom are we making improvements?*" The timeline also showcases the notable awards received and key studies conducted during this period, emphasizing the impact and recognition of ESTHER's initiatives.

ESTHER

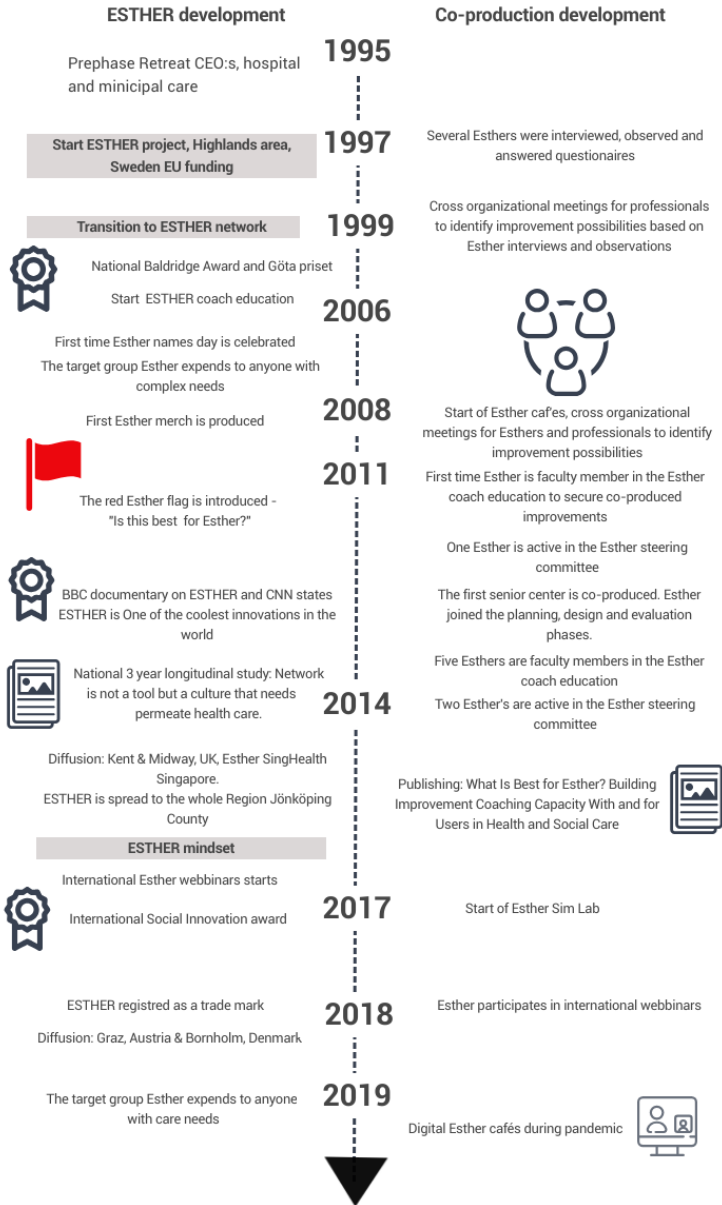


Figure 5. ESTHER time line, showing the development of ESTHER and co-production within it.

Both studies in this thesis emphasized the need for shared purposes, collaboration, openness, and the willingness to learn and improve. This includes collaboration with other care providers and Esther herself based on the creation of a permissive and respectful climate where power is shared. The importance of this is illustrated by quotations from interviews with participants in study I.

“This positive attitude of trying to push each other's responsibility and not blame each other was crucial.” (I2)

Empirical data indicate that successful collaboration can only be achieved by sharing power, building on a psychologically safe environment, mutual trust, and reflection. The participants described their feelings at the ESTHER meetings below.

“A very warm and wonderful feeling that we do this work together.” (I4)

“They [the leaders of the ESTHER project] had the ability to create an open and positive climate” (I2)

“I felt an informal sense of belonging and we could talk to each other, and it's a very important development to actually have a bit of trust in one another [different care providers]” (I5)

The combined results of both studies suggest that people may need a sense of psychological safety to engage fully in and contribute to meaningful, lasting improvements.

8. Discussion

The thesis focused on two aspects. "What is best for Esther?" (Study I) provides a broad historical and systemic perspective of the project (Vackerberg et al., 2023) and "Balancing power in co-production" (Study II) offered a focused analysis of a critical element within that system, contributing to a more nuanced understanding of ESTHER's complexities and continued evolution (Ärleskog et al., 2021). The research presented in this thesis is in the field of improvement science and seeks to understand how QI efforts and methods can further develop and enhance care.

8.1. Psychological safety as a catalyst for long-lasting QI commitment

Improvement science builds on three types of knowledge: professional, patient, and improvement, which encompass understanding systems, variation, change psychology, and the theory of knowledge (Deming, 2000; Gustavsson et al., 2022). Further details are shown in Figure 1. Although the model outlines what should be included in the improvement work, it does not address how to integrate these domains.

In Study I, the persistence of the ESTHER mindset was linked to simplifying the concept into a guiding question and creating an open, psychologically safe atmosphere during meetings (Vackerberg et al., 2023). Psychological safety relies on power-balancing practices that ensure that all voices, including those of persons in need of care, are valued equally (Edmondson, 2018). Study II further explored this through continuous reflection on power dynamics (Ärleskog et al., 2021), aligning with other researchers emphasizing the importance of addressing power in co-production (Batalden & Foster, 2021; Farr, 2018; van Baarle et al., 2024). Goldman and Wong (2020) also stressed the need to prioritize reflection in improvement efforts. These elements are absent from Gustavsson et al.'s (2022) model of continual improvement in healthcare (Section 5.1). Building on ESTHER's insights, I suggest enhancing the model by integrating knowledge of psychological safety and power-sharing, represented through an additional blue cloud.

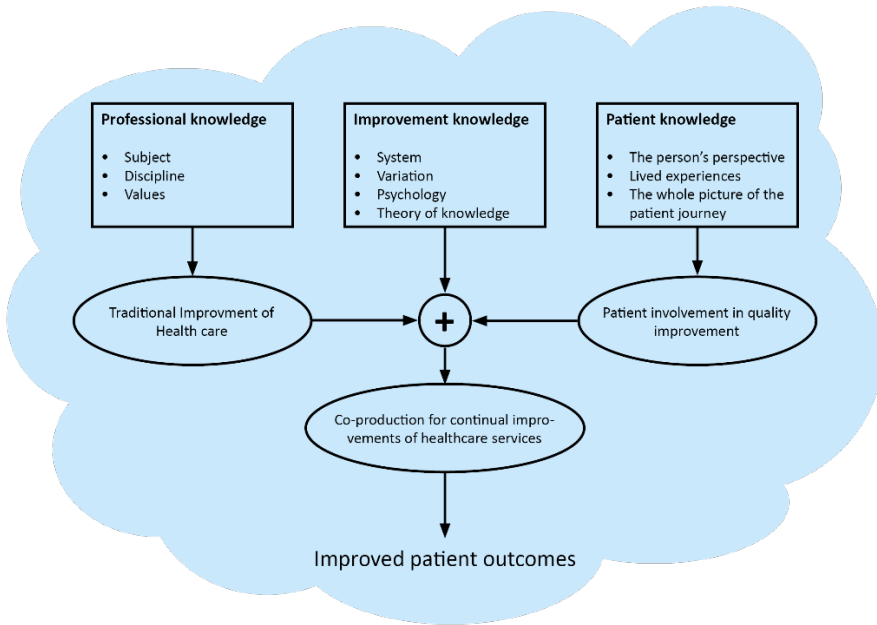


Figure 6. Integrating improvement knowledge and psychological safety

This cloud represents the fleeting nature of psychological safety, which can exist but may disappear unexpectedly (Edmondson, 2018). When psychological safety disappears the power play changes, affecting ongoing dialogues and decisions (Allen, 2002). The soft, undefined edges, in contrast to the rigid, structured boxes, underscores the importance of recognizing complex and often unclear power dynamics that cannot be easily confined to a framework (Drinkwater et al., 2024; Farr, 2018; Franzén, 2010a).

Some might argue that psychological safety is merely one aspect of psychology in improvement knowledge; however, I disagree and believe that it risks being undervalued if limited to that domain. This view is supported by other research, emphasizing that human skills are as important as improvement tools and deserve greater attention (Bate et al., 2008; Goldman & Wong, 2020). By representing psychological safety as a cloud, it becomes clear that it can have a broad influence, permeating all the areas represented in the boxes—professional, improvement, and patient knowledge. Pedagogically, the cloud also serves as a visual cue, potentially signaling the

importance of addressing psychological safety in every aspect of the improvement process.

8.1.1. Sense of belonging

Nembhard and Edmondson (2006) described the importance of inclusiveness to create successful improvement whereas others have highlighted that a sense of belonging boosts individual performance and engagement (Bevan & Henriks, 2021; Carr et al., 2019; Nembhard & Edmondson, 2006). Inclusiveness and sense of belonging may be grounded in feelings of psychological safety. In all ESTHER activities, a sense of belonging was stimulated through the Esther narrative, improvement activities and various mutual celebrations across organizational boundaries together with patients/users (Vackerberg et al., 2023). Making improvements and change is hard work that requires time both for reflection to learn and celebration to keep the spirit (Lachman, 2024). Celebrations are sometimes perceived as unnecessary and costly; however, in the case of ESTHER, annual celebrations boosted for a sense of belonging for both staff and persons in need of care without significant expenses. For example, local bakeries, churches, and volunteers participated, making ESTHER day a special occasion.

8.1.2. Persistence related to improvement science

Improvement science explores what works, when, for whom, where, and why, considering the context (Lachman, 2024). As the ESTHER case illustrated that regularly engaging in "Keeping up the spirit" moments significantly benefited the endurance of the whole approach, I suggest one more question to be added regarding persistence: "What is in place to sustain motivation, commitment and engagement?" Addressing this question could provide more insights into the human side of improvements which is described as important as the technical side (Bate et al., 2008). Regular celebrations and acknowledgment are mentioned in improvement literature (Langley et al., 2009).

8.2. Storytelling as a driving force

The Esther narrative, as outlined at the outset of this thesis, represents a significant innovation in improvement efforts and has become a hallmark of the ESTHER concept (Peterson, 2006; Vackerberg et al., 2023). This method underscores the importance of storytelling for engaging stakeholders, stimulating empathy, and identifying areas for improvement. A substantial body of literature supports the use of storytelling to enhance understanding, which in turn fosters learning at the individual, group, and organizational levels (Bate, 2004; Brown, 2005; Grace & Kaufman, 2013; Long et al., 2022; Prasetyo, 2017; Robertson et al., 2023). The true power of the Esther narrative was its ability to appeal to both the emotions and intellect of the participants. This dual engagement facilitated a deeper understanding of the complexities involved in care coordination across organizational boundaries (Vackerberg et al., 2023). Its effectiveness lied in its ability to render abstract concepts tangible and relevant. By illustrating real-life scenarios and challenges, the Esther narrative helped participants connect with the material on a personal level, thereby enhancing their comprehension and commitment to the improvement process. This approach bridges the disparate worlds of theory and practice and makes complex issues accessible and actionable.

To build on the success of the Esther narrative, future improvement efforts should consider systematically integrating storytelling into various stages of improvement initiatives (Long et al., 2022). This could involve the development of a range of narratives that reflect diverse experiences and challenges within care systems. Such narratives can be used not only as introductory tools but also as ongoing references throughout the improvement process to maintain engagement and reinforce key messages.

Additionally, exploring the use of different storytelling media—such as digital platforms, could further enhance the impact of these narratives (Hardy & Sumner, 2018; Park et al., 2021). These media can be tailored to various learning preferences and can broaden the reach of the storytelling approach.

By continuing to innovate and adapt the use of narratives, the ESTHER concept and similar cases can further strengthen its role in improving care coordination and promoting collaborative, patient-centered care.

8.3. “What is best for Esther?” A simple but challenging question

The perseverance of ESTHER was anchored in a simple yet profound and challenging question: “What is best for Esther?” This question served as a unifying force across diverse stakeholders, breaking down organizational silos and flattening hierarchies. It offered a clear and compelling direction for reimagining healthcare systems, ensuring that the focus remains steady on Esther, the metaphorical representation of a person in need of care (Cribb, 2017; Gray et al., 2016; Vackerberg et al., 2023). It facilitates co-production, as probably no one knows what is best for Esther other than Esther herself.

However, this is not without challenges. It promotes person-centeredness, which requires a shift in mindset and practice to prioritize the individual’s needs and experiences (Lim et al., 2023). Simultaneously, the healthcare sector increasingly embraces standardization to enhance efficiency, ensure consistency, and streamline processes. Although standardization can lead to more effective and predictable systems, it risks overshadowing the unique needs and values of individuals. This tension underscores the need for guiding principles that navigate complexity without sacrificing person-centered values. Research indicates that, in complex systems, simple rules serve as more effective guiding stars than detailed regulations (Greenhalgh et al., 2023; Greenhalgh & Papoutsi, 2018; Palmberg Broryd, 2021). Straightforward directives, such as the question “What is best for Esther?”, provide clarity and flexibility, allowing individuals and teams to adapt to dynamic environments while remaining aligned with the overarching goals.

By focusing on core values and essential actions, simple rules help balance the drive for standardization with the fundamental purpose of healthcare: to meet the unique needs of persons (Nelson et al., 2011). Research has emphasized that person-centered foundations are at the heart of effective care (Ekman et al., 2011). The ESTHER approach exemplifies this balance by, using its guiding question to adapt standardized processes in ways that prioritize individual needs while maintaining system-wide efficiency. Involving persons in need of care in improvement work, empowers those receiving care to actively shape the processes and outcomes. In doing so, it

demonstrates how a simple value-driven question can navigate complexity and drive meaningful and sustainable changes in health and social care.

8.4. Methodological considerations

8.4.1. Case study design

ESTHER is about improving organizational processes with and for the best for Esther. This thesis used a pragmatic approach, described in the literature as a relevant and valuable paradigm for qualitative research on organizational processes (Kelly & Cordeiro, 2020). One advantage with pragmatism is its ambition to create useful knowledge that can make a difference in practice (Allemang et al., 2022). A longitudinal case study design provides multiple benefits (Baker, 2011): they are especially valuable for understanding complex relationships in healthcare and can significantly contribute to knowledge on improving care. The case study design enabled an in-depth exploration of the ESTHER experience in its context capturing the nuances that broader methodologies might have overlooked. Detailed and multifaceted findings were obtained using diverse data collection methods (Ahrne & Svensson, 2011). Furthermore, the rich data generated practical relevance, offering actionable recommendations directly applicable to similar cases.

However, the case study design also has limitations. Focusing on specific cases can restrict the generalizability of the findings, making it challenging to draw broader conclusions. The interpretation of data can be influenced by the researcher's perspectives, thus introducing potential subjectivity and bias. My role as an ESTHER coordinator and how its influence on the research are described in Section 4.1. To handle the risk of bias, I had my reflective diary and several supervisors with diverse backgrounds who supported me in thinking scientifically and critically. I have exposed my research findings to the scientific community through seminars, presentations, and similar events and am privileged by a network of critical friends. This informed the final version of the thesis.

8.4.2. Data collection

The empirical data were built on interviews and ESTHER related documents. Other interesting methods, such as observing power dynamics could have been considered, which would have been particularly fascinating. This method was utilized parallel in the Canadian research, of which I was an active part. Therefore, I chose not to use it in this thesis.

Blended focus groups

In the first study blended focus groups consisted of persons in need of care and staff members. It is common for studies involving focus groups to separate patients and professionals, to create a comfortable environment in which each group can speak freely about their unique perspectives and experiences (Burton et al., 2015; Rose et al., 2015). However, in this particular context which had a long history of embracing co-production, all participants favored inclusivity. Although power dynamics emerged as a notable concern, the overarching commitment to the principle of "nothing about me without me" guided the decision against separate focus groups for persons in need of care and staff. Through a comprehensive examination of the advantages and disadvantages, an experiment was conducted with blended focus groups, followed by a survey to solicit feedback on the chosen format. The survey was used only to ensure that the participants were comfortable with the blended approach and was not used as data in the research. Considering the potential power dynamics inherent in the research context, the moderator for the focus groups demonstrated a heightened awareness. Throughout the sessions, the moderator proactively implemented pauses, strategically reflecting on the ongoing discourse to ascertain whether the voices of all participants were adequately heard and valued. This deliberate approach aimed to mitigate any disparities in power and ensure more inclusive and equitable participation within the blended group. By promoting an environment that encouraged reflection and equal participation, the moderator sought to uphold the principles of fairness and respect, thereby enhancing the trustworthiness of the collected data.

8.4.3. *Strengths and limitations*

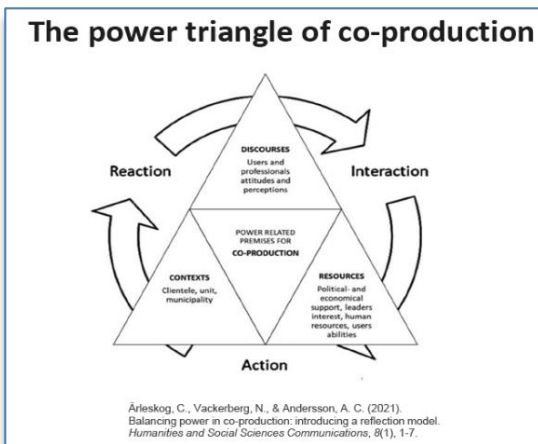
This thesis was based on the case study of the ESTHER experience. It would have been interesting to explore other similar cases, however this was not within the scope of this research. It included a retrospective study. It might have been interesting to conduct a prospective study; however, such studies are inherently influenced by hindsight, often leading to less detailed and thinner narratives (Langley, 2023).

One strength of this research is that the findings draw on more than 20 years of experience, which provides a rich and comprehensive foundation for this study. Participants came from multiple organizations and represented various professions, contributing to diverse perspectives that might otherwise have been overlooked. Triangulation was performed to strengthen the results. Persons in need of care were also interviewed, and all participants reviewed the findings from Study I before finalization. This process helped strengthen the trustworthiness of the study.

A notable aspect of this thesis is the dual role of the researcher, who was deeply involved in the development of the ESTHER concept. This dual role, which is natural in interactive research, can be seen as both a strength and a limitation (Coghlan, 2019; Ellström et al., 2020). The researcher's active involvement provided unique insights, deep contextual understanding, and access to rich data that might not have been available to an external researcher (Coghlan, 2019; Ellström et al., 2020). This closeness allowed for a nuanced exploration of the complexities and dynamics within the development of ESHER. However, this proximity also posed potential challenges, such as the risk of bias or difficulties in maintaining objectivity. To address these concerns, this thesis provides a transparent and detailed description on how potential biases were managed throughout the research process. Strategies such as reflexivity and member checking were employed to enhance the credibility and trustworthiness of the findings (Dodgson, 2019; Malterud, 2014). By openly acknowledging and addressing these challenges, this study not only mitigates potential limitations but also strengthens its overall rigor and trustworthiness (Palmér et al., 2022).

8.5. Relevance to practice

Study II offered a reflection model used in the Esther-coach education program, the co-production course at Jönköping University and internationally. Its presence has been noted at several conferences and through ESTHER International, although its full reach is not completely trackable. To embrace co-production, the model was taught by two Esthers and the author. However, in practice, the reflection model in Study II presented several challenges. We decided to create cards as a pedagogical tool featuring the model along with three additional questions suggested by Esthers and ESTHER coaches, which made it easier to use in education.



Reflect together with Esther*

Please take advantage of the different perspectives and voices in the room.

1. What did we all do to create better power balance?
2. What could we pay more attention to next time?
3. How can we train this together as professionals and Esther?

* Esther is the person in need of care.

Figure 7. Power triangle and reflection questions.

9. Conclusions and future research

9.1. Conclusions

This thesis, drawing on two decades of ESTHER experience, underscores the importance of simplicity, and embraces psychological safety and power-sharing in QI initiatives within health and social care. The three main conclusions are as follows:

What is best for Esther? The enduring achievement of the ESTHER concept was driven by a single question: "What is best for Esther?" This question promoted co-production and power-sharing. It unified stakeholders, broke down hierarchical barriers, and guided the development of a new approach and mindset, consistently centered on Esther's needs.

Psychological safety and power-sharing: Both psychological safety and power-sharing are essential to encourage effective co-produced improvement work. The lens of psychology in Demings profound knowledge might need to receive more attention in QI, whether it is about driving organizational change or co-producing improvements.

Building persistent improvement, the human dimension: The success and endurance of improvement projects relies not only on technical expertise but also much on addressing human aspects — efforts need to be made to inspire continuous motivation, engagement, and create a long-term sense of belonging. Encouraging, recognition, celebrations, storytelling, and ongoing reflections, can support and maintain commitment and ensure a lasting impact.

9.2. Future research

As ESTHER expands into additional countries and contexts, it would be valuable to examine its ongoing development and assess how cross-country learning contributes to further advancements in improving care systems with

and for ESTHER. Moreover, investigating the role of psychological safety within improvement teams that embrace co-production could provide valuable insights. Such exploration should consider the perspectives of both persons in need of care and the professionals involved.

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Appendix 1.

Individuell intervjuguide studie I

1. Vad betyder Esther för dig?
2. Vad var din roll i starten av ESTHER och vad är den nu?
3. Kan du kort beskriva hur ESTHER startade?
4. Hur utvecklade det sen?
5. Vad förändrades under tiden och varför?
6. Kommer du ihåg några viktiga händelser eller aktiviteter som påverkande utvecklingen av ESTHER, både internt och externt? På vilket sätt påverkades det?
7. Finns det några organisatoriska faktorer som har bidragit till att ESTHER utvecklades på detta sätt?
8. Vilka utmaningar/ svårigheter ser du med Esther, hur anser du att man kan hantera det på bästa sätt? Vad är det som gör att inte alla vill/kan vara med?
9. Hur skulle du beskriva de personerna som drev ESTHER, finns det något som kännetecknades dem? Kompetens eller egenskap?
10. Vilka aktiviteter skulle du säga är viktiga i Esther för att behålla fokus och ständigt förbättra vården?
11. Gällande co-production och att man gör saker tillsammans med Esther. Kan du berätta i vilken utsträckning det händer, hur det utvecklades och dina tankar kring detta.
11. Vilka lärdomar har du själv efter 20 år Esther?
12. Om du skulle börja om från början med Esther vad skulle du göra annorlunda då?

Fokusgrupp intervjuguide studie I

Fokusgruppsfrågor

1. Tänk på höjdpunkter i ditt engagemang i ESTHER. Vad var minnesvärd och varför? Vad fungerade bra i det ögonblicket?

2. Skriv i padlet: Vad i ESTHER har verkligen varit en höjdpunkt för dig?

3. Varför är du engagerat och kommer tillbaka till ESTHERs olika mötesplatser?

4. Tänk nu på minnesvärda stunder i ESTHER som inte fungerade lika bra ur ditt perspektiv och varför?

5. Vad kunde ha varit bättre eller annorlunda?

Padlet: Ta dig tid att anteckna dessa ögonblick på padlet - ett ögonblick per post-it
Diskutera om vad som inte har fungerat bra.

Endast för ESTHRAR. Kan du ge några exempel på hur ditt engagemang har format:

- service;vården och / eller
- själva arbetssättet ESTHER?
- Varför är det viktigt för dig att vara en del av detta?

För personal:

Om du jämför ditt engagemang i ESTHER med andra icke-samskapande projekt?

Fanns det saker som hindrade dig att göra saker tillsammans med Esther på det sätt du skulle ha velat?

Vissa människor föreslår att samskapa kan fungera bättre med vissa grupper än andra. Vilka är dina tankar om vilka grupper det kanske inte fungerar bra med?

Appendix 1

Vad fungerade bra och vad kunde ha varit bättre för olika grupper? Hur välkomnades samskapandemetoder till ett brett spektrum av människor? De som kanske känner brist på makt och kanske inte känner att deras åsikter har betydelse?

Slutsats: Sammanfattning någon som vill sammanfatta? Något som behöver betonas, kompletteras? Detta avslutar den första delen av fokusgruppen och vi tar en bensträckare på 5 minuter.

ESTHER har funnits under en längre tid. Vad har förändrats sedan du har varit inblandad? Varför uppstod dessa förändringar?

Tror du att ESTHER har förblivit troget mot sina ursprungliga avsedda syften och principer?

- Vilket inflytande har det haft på organisationen? Hur?

Tänk på vad du värdesätter med ESTHER och vad som händer när det sprids:

Vad, anser du, ska vara detsamma, oavsett var ESTHER placeras, och varför?

Vad skulle det vara okej att ändra om ESTHER antogs på en annan plats eller av en annan tjänst / vad som behövde ändras för att antas där? Förklara varför du tror det.

- Finns det saker som inte ska göras på en annan plats i landet eller världen och förklara varför?

- Baserat på din erfarenhet, vad skulle ditt råd vara om att sprida Esther till en annan plats eller verksamhet? Vad har fungerat bra och vad inte?

- Vad i själva ESTHER gör det enkelt eller svårt att genomföra någon annanstans.

- Organisatoriska överväganden som gör det enkelt eller svårt att göra någon annanstans? (t.ex. ledarskap och vision, kunskap och färdigheter, beredskap för förändring och innovation, dedikerad tid / resurser, utvärderingskapacitet etc.)?

- Tror du att det finns viktiga personer att involvera i att få "programmet" att fungera någon annanstans?

Appendix 1

- Vilka processer tror du skulle vara viktigt för att få ESTHER att fungera någon annanstans (t.ex. stöd för projektledning, kommunikation, användarnas input, beslutsfattande, utbildning och support, samarbete, feedback och uppföljning, etc.)?

Är det någon som vill sammanfatta del 2?

Finns det något annat som behöver kompletteras med just nu?

What is best for Esther? Facilitating co-production and improving care with a simple but challenging question

– a qualitative case study

This thesis examines the ESTHER initiative, a Swedish quality improvement project in health and social care with a strong patient/person focus, today globally recognized. ESTHER aims to bridge the gaps between care providers, promoting seamless collaboration, centered on persons' needs and promoting co-produced care improvements.

The thesis focuses on power dynamics and psychological safety in quality improvement, using two case studies including interviews, document analysis, and modelling. The results show how ESTHER shifted from a project to a mindset through embracing systems thinking and change psychology in multidisciplinary dialogues. Trust, simple rules, senior support, local coaching, continuous learning and co-production were crucial.

Further a "reflection-on-power" model was developed, displaying how power dynamics-resources, attitudes, perceptions - can influence co-produced outcomes. Sustainable co-produced improvement was built on mutual trust, power-sharing, and ongoing reflection. The shared vision, expressed through the simple question, "What is best for Esther?" guided collaboration, promoted co-production and ensured person-centered outcomes.



NICOLINE VACKERBERG is a senior quality improvement leader, coordinator of the ESTHER International Network and physiotherapist. Holding a master's degree in quality improvement and leadership, she combines academic teaching with practical leadership, coaching professionals and guiding collaborative ESTHER projects worldwide. Her work focuses on promoting collaboration between different caregivers to benefit persons with care needs. She is dedicated to strengthening care systems and ensuring that the voices of those in need of care, are at the heart of improvement efforts. Nicoline lives in Jönköping and is a proud mother of three children and grandmother to four grandchildren.

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