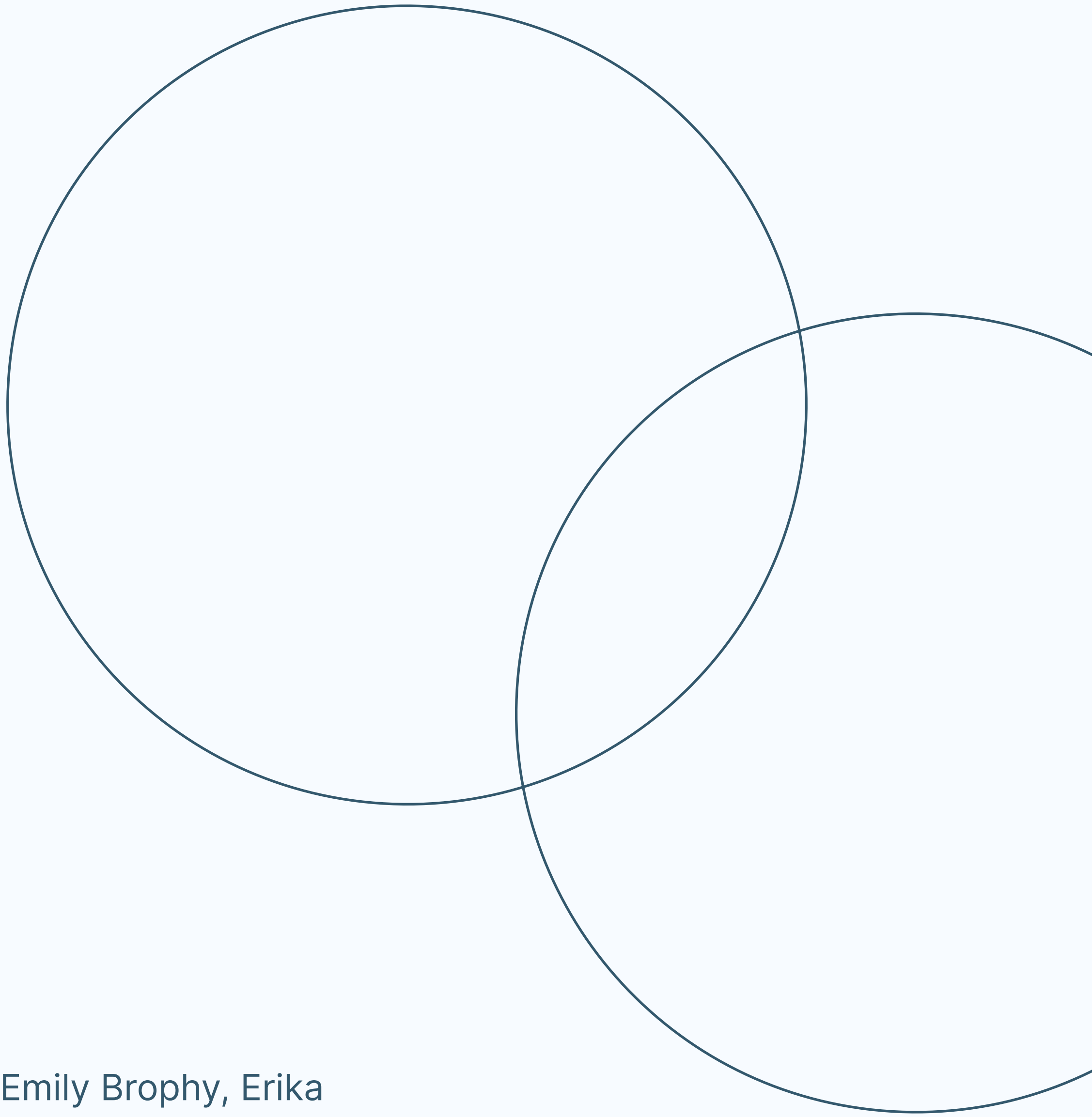
Enabling Change from Within

A Service Design Approach to Building Change Capabilities in Healthcare



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Abstract

This thesis explores how a service design approach can support the implementation and sustainment of change in complex healthcare settings. While many initiatives are introduced to improve healthcare systems, they often struggle to be embedded and sustained in practice. This project investigates how to address these challenges by focusing not only on solutions but also on building internal capabilities for implementing change.

The study is conducted at Rigshospitalet in collaboration with nurses from two cancer departments. Using a case as a situated context, the project engages with issues related to collaboration, responsibilities, and the patient pathway. Through a practice-based and iterative service design approach, including workshops, observations, and ongoing engagement, the study examines how change processes unfold in a real organisational context. Early findings reveal that previous initiatives have often remained at the level of intention, with limited implementation.

In response, the project shifts to enabling the nurses to take ownership of the process. Rather than positioning design as an external intervention, the approach focuses on distributing responsibility and supporting the nurses in developing, testing, and implementing their own solutions. This leads to both a tangible outcome, a patient-focused one-pager, and the development of a toolkit designed to support ongoing change efforts, including methods for facilitation, coordination, and implementation.

The findings suggest that service design can play a significant role in enabling change by fostering ownership, strengthening collaboration across organisational boundaries, and supporting the development of internal capabilities. However, the study reveals that it requires significant time, motivation, and willingness to navigate uncertainty. The thesis contributes to the understanding of service design not only as a problem-solving approach, but also as an approach that enables organisations to drive and sustain change from within.

Keywords: service design, co-creation, systemic change, capability building, implementation, healthcare

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01.

Introduction

This report presents a master’s thesis by Emily Brophy, Erika Strazio, and Lea Texmo Limstrand, completed from February to June 2026 as part of the Service Systems Design master's program at Aalborg University in Copenhagen. The thesis explores the intersection between *service design* and *change*. Change is a constant in daily life and becomes particularly prominent during periods of uncertainty at both organisational and societal levels (Alvesson & Sveningsson, 2025). Service designers act as agents of change by engaging with existing systems to improve, reshape, or disrupt established practices (Stickdorn et al., 2018). Although change is often viewed as positive, it also requires adaptation from individuals and organisations, making it challenging to implement (Lin et al., 2011; Stickdorn et al., 2018, p. 274).

Our aim and motivation for the thesis is therefore to examine how service design can facilitate change processes within complex, evolving systems, focusing specifically on the healthcare sector. Healthcare systems are vital to society and are characterised by high complexity, interdependencies, and a constant need for improvement (Braithwaite et al., 2017; Donetto et al., 2015; Halvorsrud et al., 2019). These features make healthcare an ideal context for investigating how change occurs in practice. To better contextualise and explore these issues, the thesis was conducted in collaboration with two departments at Rigshospitalet, providing a real-world case for analysis.

1.1 Learning Objectives

The thesis will demonstrate the attainment of the official learning objectives developed by Aalborg University, which entail the knowledge, skills, and competences students must acquire and master as service systems designers (Aalborg Universitet, 2023). Furthermore, we have formulated personal learning goals and areas of interest that we aspire to explore and achieve throughout this thesis:

- Investigate how service design methods and tools can support healthcare organisations in navigating complex change processes.
- Develop our skills in facilitating co-creation processes through interdisciplinary collaboration when navigating diverse expertise and perspectives.
- Contribute to the service design field by designing an adaptable solution that is scalable within complex systems and organisations.

These learning objectives are grounded in a broader reflection of what the thesis should represent. The ambition has been to develop a project that is meaningful in terms of its potential to create real human impact, particularly by addressing challenges experienced by patients and healthcare professionals. Furthermore, the thesis aims to be relevant in a future-oriented sense by engaging with challenges that are expected to become increasingly significant. It also aspires to contribute original insights to the field of service design, offering a perspective that adds to existing knowledge. At the same time, it has been important that the topic remains grounded in service design practice and its real-world implications.

1.2 Collaboration & Case

The thesis is conducted in collaboration with the Centre for Cancer and Organ Diseases at Rigshospitalet. This collaboration provides access to a complex hospital environment, allowing the project to engage with change in a situated context. Rigshospitalet is located in Copenhagen and is a highly specialised hospital with over 10.000 employees and 40 departments (Webgruppen på Rigshospitalet, 2026). The Centre for Cancer and Organ Diseases manages seven clinics specialising in oncology, urology, haematology, gastroenterology, nephrology, and endocrinology (Rigshospitalet, n.d.).

Within the centre, there is a department called the Unit for Healthcare Professional Collaboration, which supports the management and clinics in creating safer patient pathways and improving workflows by translating visions and complex problems into concrete actions and behavioural changes (Webgruppen på Rigshospitalet, 2024a). The unit consists of a service designer and an anthropologist, whom we reached out to when seeking a collaboration, as well as a quality coordinator from the centre. We had an initial meeting with the aforementioned to introduce ourselves and discuss our thesis interests and goals, as well as expectations for the collaboration. Following this, the next step was to find a relevant case, a task that was assigned to the representatives from Rigshospitalet.

1.2.1 THE CASE

The case received was developed by two departments within the Centre for Cancer and Organ Diseases: the department of Urological Surgery (URO) and the department of Cancer Treatment (ONC). The initiative started bottom-up by a few nurses from both departments, forming an interdisciplinary working group to improve patient pathways. They specifically wanted to focus on the transition between the two, as cancer patients get their surgery at URO before being transferred to ONC to begin follow-up care or the course of treatment, such as chemotherapy (see Figure 1).

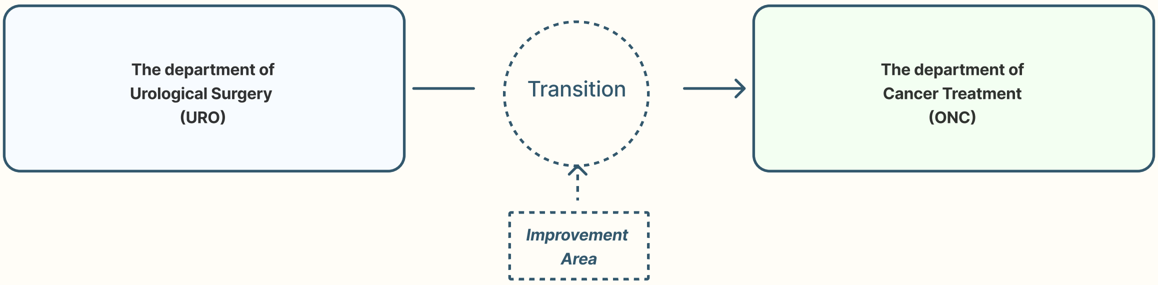

Figure 1: The transition between the two departments

The working group had already developed a descriptive case outlining the key elements (see Appendix B):

- **Background**
  - Lack of clarity in the patient pathway, for both patients and staff
  - Unclear division of roles and responsibilities during handover of care
  - Lack of coordination and communication between departments
- **Desired outcomes**
  - A clear and shared understanding of the patient pathway
  - Defined roles, responsibilities and contact points
  - Increased collaboration and coordination between the two departments
  - An improved patient experience during treatment
- **Target group**
  - Nurses in URO (42) and ONC (14)
  - Patients diagnosed with testicular cancer (URO: 2-3 operations per month; ONC: approximately 2 new patients per week)

In the case description, there is no defined patient group, because they see it as a general issue across different patient groups who transition between the two departments. However, in this project, they wanted to focus on testicular cancer patients as a starting point, as the pathway for this patient group is relatively simple compared to other types of cancer, with the goal of then applying the insights and outcomes to create a scalable solution applicable to other, more complex cancer pathways.

TESTICULAR CANCER

Testicular cancer is a type of cancer that occurs in the testicles. Commonly, it is younger men aged 25-35 who get the disease. In most cases, the diseased testicle is removed through surgery, after which the patients receive chemotherapy. The treatment for testicular cancer is very effective and is among the cancer types with the highest survival rates (Kræftens Bekæmpelse, 2024).

1.3 The Project Team

The project was carried out by a multidisciplinary team consisting of the thesis group, acting as service designers, and healthcare professionals from different departments. The professionals behind the case included a head nurse and a nurse from URO, as well as the head nurse and two nurses from ONC. Together, these participants formed the main project group. By involving people from the different departments, the project included both perspectives from the start. This also supported ongoing engagement and ownership of the work.

In addition to the core team, the project was supported by an internal service designer, anthropologist, and quality coordinator at the hospital. They contributed with guidance when needed, particularly in understanding the context and how service design could be applied within it. By supporting the project along the way, they could help ensure continuity after our departure. Figure 2 shows an overview of the project group and the surrounding actors.

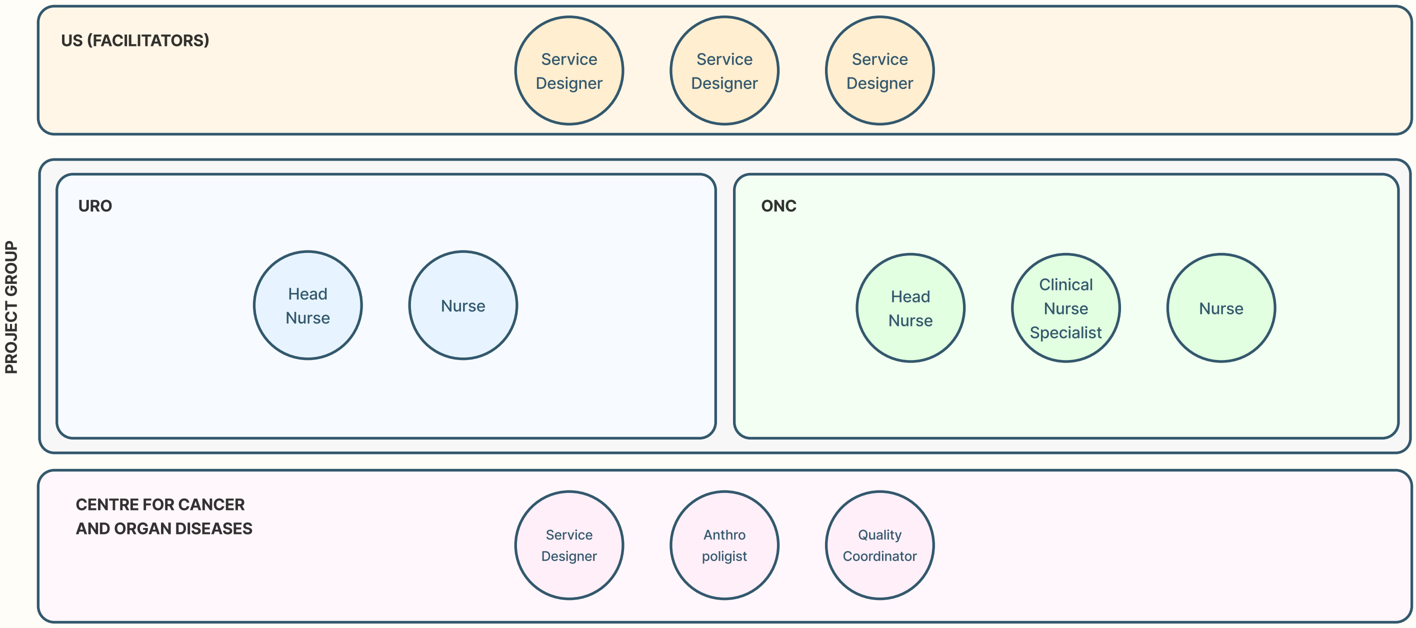

Figure 2: Project group and surrounding actors

In terms of the project group's constellation, we would act as project managers and facilitators. This involved taking responsibility for structuring and guiding the process, while actively engaging the project group in co-creation as they held valuable knowledge. Collaboration was maintained through bi-weekly check-ins to, among other things, share insights, receive feedback, provide guidance, and engage in small workshops. From the beginning, recurring one-hour check-ins were scheduled in everyone's calendar throughout the project period. Establishing these regular meetings early on was important to ensure consistent follow-up, especially given our experience working with the busy schedules of healthcare professionals.

We were physically present at the hospital throughout the project period. This made it easier to engage with staff and patients in a flexible way, without requiring extensive scheduling. Being present in the environment allowed for a closer observation of the everyday activities and practises. This helped get a better understanding of the system and context.

1.4 Focus Area

We find the case highly relevant to the topic of change, as it focuses on improving the transition between two departments. At a practical level, the case involves the transfer of information, responsibility and care related to patients. However, improving this transition requires changes to existing workflows, roles, and expectations, which would directly affect the two departments. We therefore apply the case to explore change processes in a healthcare context. The practical approach of doing so is described further in 03. Methodology.

The aim is to explore how change is perceived in practice and to investigate how we and service design approaches may facilitate and support change. Since these approaches are implemented within the project team, they naturally became the focus for exploring change, making them our focus group.

1.5 Reading Guide

The reading guide gives an overview of what the thesis and the following chapters will entail.

Chapter 2: Context
The chapter presents a review of relevant literature, which explores what change is and how change in organisations is needed. As the thesis centres on change within a healthcare setting, the literature critically explores the various challenges that can arise in hospitals. These include themes like system complexity, professional culture, capacity pressure, and ethical constraints. The chapter further outlines different aspects of service design and discusses how the approach can enable change. Lastly, the chapter examines existing projects and approaches to investigate how service design and changes have been applied in similar healthcare contexts.

Chapter 3: Methodology
In Chapter 3, the methodological framework of the thesis is presented. This entails a description of the Double Diamond model and its four phases (Discover, Define, Develop, Deliver), which we chose to apply to guide the exploration of the case we received. The chapter also introduces the thesis's theoretical perspective, which explains how the case will serve as a lens for examining how change is perceived and navigated in practice. This is supported by a visual model. The chapter concludes by explaining that exploring the thesis will provide two project outcomes: one for the specific case and another for the wider concept of change.

Chapter 4-7: Discover, Define, Develop, and Deliver
The four chapters will explore how change is perceived in practice through the case, as well as explore how service design approaches might facilitate and support change. In describing the process, the chapters adopt a reflective approach to cover the overall theme of change. Accordingly, the methods are presented chronologically, allowing them to collectively illustrate how processes and perspectives evolve over time. The first diamond (Discover and Define) serves as an explorative process, uncovering underlying issues and needs, and further defines the overall direction through the developed research question. The second diamond (Develop and Deliver) explores the latter through observations and facilitation, resulting in two project outcomes. The chapters include process descriptions, reflections on applied methods, and insights and outcomes derived from the various activities.

CHECK-INS

Throughout the report, there will be subchapters labelled as check-ins. The check-ins describe the bi-weekly meetings we had with the project group throughout the project. The check-ins were most often in person at the hospital, either at the Centre for Cancer and Organ Diseases or at ONC. During the project, the check-ins proved invaluable. They created a space for collaboration across departments. Further, they provided an opportunity for us to introduce different service design methods and tools and observe whether we succeeded in adapting them, as well as how the project group perceived and applied them. Lastly, they allowed for alignment on the project, validation of findings, and ongoing reflections throughout the project, which defined the next steps.

Chapter 8: Discussion
This chapter presents a discussion of the project in relation to the case and the research question. It contains critical reflections on the design process, our approach and identified limitations. The chapter further explores how the project has contributed to the development of enabling capabilities in practice, as well as the challenges associated with sustaining them over time. It also reflects on the overall impact of the work conducted. Finally, the chapter outlines key learning and suggests directions for future research.

Chapter 9: Conclusion
In chapter 9, the process is summarised by outlining how the process unfolded, how the case was approached, and what this led to. The chapter presents the main findings and key insights and concludes with the overall takeaways of the project.

02.

Context

In the following chapter, existing literature is reviewed to develop an understanding of change, particularly in hospitals, and to explore how it can be addressed through service design, both theoretically and in practice, drawing on existing case studies. The literature examines challenges of change at both organisational and staff levels.

The chapter is divided into the following sections:

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2.2 Challenges of Change in Hospitals 07
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2.4 Practical Applications in Healthcare 13
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2.1 Change in Organisations

According to the Cambridge Dictionary, change is *"the process or result of making something different or becoming different"* (Cambridge Dictionary, n.d-b.). Due to globalisation, societal and user expectations, and times of turbulence, organisations are often told to drive change or learn to adapt to change. However, change processes are often messy and disorganised, leading to unsuccessful change. Therefore, there is a need to understand what change is and what it requires, its identities, and the meanings and internal dynamics within the organisation (Alvesson & Sveningsson, 2025, pp. 3–4).

Existing organisational change literature has explored the factors that influence the success or failure of change initiatives within organisations. Key themes that are highlighted include readiness for change, organisational culture, leadership, resistance to change, and employee participation (Alvesson & Sveningsson, 2025, p. 5; Dalton & Gottlieb, 2003; Holt et al., 2010; Lehman et al., 2002; Weiner, 2009). Readiness for change refers to how individuals and organisations are prepared behaviourally, psychologically, and structurally to drive and support change (Dalton & Gottlieb, 2003; Lehman et al., 2002). Readiness for change can be described as both a state and a process that develops over time. It is common to view change mainly through its outcomes, comparing before and after an intervention. However, Alvesson and Sveningsson (2025) argue that this outcome-focused perspective overlooks what happens in between. They emphasise that micro-processes unfolding over time are essential to understanding change (Alvesson & Sveningsson, 2025, p. 5).

Holt et al. (2010) argue that readiness for change is closely related to the organisational culture and structure as well as leadership. Readiness depends on how well the organisation primes and motivates its employees, as well as on its technical capability. Therefore, there must be clear leadership and management support that emphasises the importance and value of change and creates an organisational infrastructure that supports it.

Readiness for change can be challenged by resistance to change, which is often due to established routines being disrupted, or it can stem from uncertainty, unclear expectations, and competing professional identities (Alvesson & Sveningsson, 2025, pp. 38–41; Evans & Britt, 2022). Alvesson & Sveningsson (2025) view change as a continuous process, which is important for overcoming implementation problems. By shifting away from large, episodic initiatives, change can develop gradually through ongoing learning, which often reduces resistance (Alvesson & Sveningsson, 2025, pp. 32–33).

While organisational change can be introduced through strategies, plans, and leadership decisions, the process perspective emphasises that change is shaped by the individuals who interpret it. Drawing on social constructionism, this view suggests that people do not respond to an objective, fixed reality. Instead, they create meaning through their own understanding of what the change involves (Alvesson & Sveningsson, 2025, p. 32). In that sense, change is shaped by everyday interpretations, not just from formal decisions.

2.2 Challenges of Change in Hospitals

The rapid development of technology, ever-changing patient expectations, and advances in knowledge and skills among healthcare professionals compel hospitals to continually improve and drive change (McKee et al., 2002). However, because the hospital is a unique, complex, and fragmented environment, facilitating change can be challenging (Fry, 2019). Given the context of the thesis, recognising and understanding the characteristics and challenges of driving change in a hospital environment is therefore important.

2.2.1 SYSTEM COMPLEXITY

Hospitals are complex due to their organisational structure, the many actors with various expertise and skills, and their interconnected parts (Halvorsrud et al., 2019).

Silo structure

As hospitals are organised into specialised departments with specific roles and responsibilities, this naturally divides the organisation into vertical "silos" with different hierarchical levels (Alves & Meneses, 2018). When knowledge, culture, and activity are separated in this way, it results in fragmented care (Mann, 2005). This fragmented organisational structure can lead to what Alves and Meneses (2018) describe as *silo-mentality*, in which departments focus on their own tasks rather than the organisation's broader goals. From a patient's point of view, it means the patient journey is also divided into silos and touchpoints, with departments focusing on isolated parts rather than the whole, leading to unsatisfying patient experiences (Fry, 2019). The complexity of the silo structure can create many bottlenecks and challenges for driving change. This mentality can increase competition between units, reduce willingness to share information, and create conflicts, all of which contribute to insufficient communication and collaboration. To confront these challenges, it requires a high level of cooperation and understanding across the different layers and hierarchy within the organisation (Alves & Meneses, 2018).

Multiple actors in an interconnected system
Achieving collective action is challenging because actors may perceive or prioritise initiatives differently, leading to resistance to change. Hospitals involve various actors, such as healthcare professionals, administrators, politicians, and charitable organisations, each with their own knowledge, skills, values, and work culture. They also have different goals, such as patient care, finances, or management. This diversity creates system complexity, making it hard to foster shared understanding and unified direction. Additionally, power varies among actors and departments, some are leaders, others are head nurses or nurses, resulting in power and decision-making being spread across and within departments rather than centralised in one place. Thus, implementing change requires negotiation and alignment across different hierarchies and silos (Denis et al., 2001).

Although hospitals are organised in silos and involve multiple actors, they remain part of an interconnected system. While the actors might stick to their own department, its ways of working and goals, the patient will often be transferred from one department to another. Therefore, if one action or change is implemented in one silo, it will inevitably influence others, including processes or patient pathways, and may have intended or unintended consequences in the system. This effect could make it difficult to implement change within a single department, as the wider impact should be considered (Braithwaite et al., 2017).

Regulatory Compliance
Hospitals are obliged to comply with national policies, regulations and laws, operating within a legal framework that adds an additional layer of complexity. These policies and regulations influence the system at several levels, including organisational structure, professional practices, and patient care (Braithwaite et al., 2017). Such interventions both shape the system, forcing hospitals to adapt, and limit hospitals' ability to drive change, since policies and laws constrain possibilities. An example is the *cancer package*, developed by the Danish authorities, which is a comprehensive, planned course with strict timeframes and pathways for diagnosing and treating cancer patients (Sundhedsstyrelsen, 2025). As departments involved in our case must follow regulations, it could limit the ability to change certain elements of the pathway when attempting to improve the patient experience.

2.2.2 PROFESSIONAL CULTURE

Healthcare is deeply shaped by a scientific, evidence-based culture that relies on research, data, and measurable outcomes (Jones, 2013, p. 17). This mindset not only influences clinical practice but also how to evaluate and justify change. Decision-making is therefore often based on quantitative data, such as surveys and efficiency metrics (Almqvist, 2019). This approach is crucial for patient safety, for example, when testing new drugs. However, it can become a barrier when implementing change. Organisational change is often experimental, gradual, and difficult to measure. In a professional culture that prioritises empirical evidence, important relational patterns may remain invisible (Jones, 2013, p. 73).

The professional culture at a hospital can also make employees resistant to change, partly due to a strong professional identity. Doctors and nurses are highly trained experts who operate within a high degree of autonomy. When change initiatives are introduced without meaningful personal involvement, these professionals may show lower engagement (Lin et al., 2011). Change in hospitals can therefore meet resistance as it directly affects the healthcare professionals and their everyday work. Research also shows that implementing change is often challenged by limited training and low interest among healthcare employees (Nilsen et al., 2016).

The strong sense of professional responsibility in hospitals also affects how failure is managed. Although failure can create important opportunities for learning and change, hospitals often struggle to benefit from them. Mistakes in healthcare can have serious consequences, which can create a strong fear of blame among staff. This fear is reinforced by a culture that encourages professionals to take personal responsibility and solve problems independently. Seeking help can be considered a weakness or as bothering colleagues who are already busy (Edmondson, 2004). This form of pressure exists on many levels within the system: patients feel anxious about their health, clinical staff worry about treatment outcomes, managers are under pressure despite having limited control, and politicians are held responsible for results they cannot influence (Durán & Wright, 2020, p. 186). These layers of anxiety create a cautious environment where speaking up feels risky. Building psychological safety and an open dialogue is therefore essential for learning, yet can be difficult to achieve through top-down management (Edmondson, 2004).

2.2.3 CAPACITY PRESSURE

Hospitals face significant challenges due to increasing pressure and workload. There is an ageing population with a growing need for care. Alongside this, health problems are becoming more complex and require expertise across multiple fields. At the same time, staff remain limited. The shortage of healthcare staff remains unresolved, as these roles are seen as less attractive and fewer young people choose this field for their future career (Pakarinen et al., 2023, p. 5). In Denmark, projections indicate a shortage of approximately 14,500 healthcare assistants by 2030. In 2021, this workforce was around 113,000 employees, highlighting the anticipated gap (Sundhedsstrukturkommissionen, 2023). These challenges taken together creates a reinforcing problem: staff shortages increase pressure on the system, and the heightened pressure makes the job less appealing.

For patients, this pressure results in reduced support and longer waiting times. Delays in discharging or transferring patients make it harder to create a flow (Pfannstiel et al., 2024, p. 526). This pressure is also visible outside hospitals, where a Danish study shows that approximately 90% of patients reported the importance of being able to address several health problems with their general practitioner. However, approximately 20% experiences that this is not possible (Sundhedsstrukturkommissionen, 2023). Together, rising patient demand and staff shortages put extra pressure on the system, leaving little time or capacity for engaging in change initiatives. At the same time, these challenges highlight the urgent need for change, as workforce shortages are expected to be one of the most critical issues in healthcare in the future (Pakarinen et al., 2023, p. 5).

2.2.4 ETHICAL CONSTRAINTS

Ethical considerations can also make change difficult at hospitals. Healthcare professionals are responsible for protecting patients' safety, privacy and rights. When new changes are introduced, they may worry that these responsibilities are at risk, which can lead to hesitation or resistance (Nilsen et al., 2016).

These ethical constraints also affect how designers can work with change in hospitals. Designers and researchers often face restricted access to users, such as patients and clinical staff, due to privacy rules, ethical approvals, and time pressures. Research and testing are, therefore, slow, as studies must often be carefully planned and approved by an ethics board before they can begin (Jones, 2013, p. 18). While these ethical considerations are necessary, they may reduce opportunities for iterative learning and experimentation, which are central to successful change processes (Alvesson & Sveningsson, 2025, pp. 38–41).

At an organisational level, change can be difficult in hospitals because it involves both cost and risk (Jones, 2013, p. 17). Hospitals have strong incentives to maintain stability, leaving little room to pause or experiment without consequences. Making change can feel like changing the wheels on a moving train, where everyday care must continue (Fry, 2019). This environment can limit designers' opportunities. However, hospitals also face a growing need for innovation and new ways of working. Because of this pressure, many organisations are becoming more open to creative and participatory design, despite the associated risks (Jones, 2013, p. 17).

2.3 Enabling Change through Service Design

Service design is closely linked to change, as its core aim is to reshape services to better meet people’s needs (Stickdorn et al., 2018, p. 13). Designers work by understanding complex situations, engaging with users and staff, and creating solutions that often require shifts in behaviour and practice (Lin et al., 2011). Given hospitals’ complexity and the demand for change, the application of service design theory and tools in the healthcare sector has become a rapidly growing field (Donetto et al., 2015).

SERVICE DESIGN

It is a human-centred, collaborative, interdisciplinary, iterative approach which uses research, prototyping, and a set of easily understood activities and visualization tools to create and orchestrate experiences that meet the needs of the business, the user, and other stakeholders (Stickdorn et al., 2018, p. 26).

2.3.1 HOLISTIC & SYSTEMIC DESIGN

Service design involves a systemic approach, which implies understanding the whole system around the service. Systemic design is a combination of systems thinking and design (Buchanan, 2019; van der Bijl-Brouwer & Malcolm, 2020). According to Buchanan (2019), *“a system is a relationship of parts that work together in an organized manner to accomplish a common purpose”*. The important part of systemic design is looking at the relationships between the system's parts rather than the isolated parts, because it is the interdependencies between the parts that shape the system’s behaviour and service experience, this supports a holistic approach (van der Bijl-Brouwer & Malcolm, 2020). Adopting this approach, therefore, views hospitals as interconnected systems, where the relationships between the departments and with patients are shaping the behaviours and outcomes of the system, for example, how patients are treated as well as how patients experience their treatment. Therefore, the challenges of change in hospitals should not be viewed in isolation, but rather handled by considering all the flows, processes, and actors within the system (Buchanan, 2019).

Another aspect that emphasises the need for a more systemic approach is the shift from the traditional disease-oriented model to a patient-centred approach. The key difference is that providers began paying more attention to patients’ needs and overall situation, rather than focusing solely on treating the condition, resulting in a more holistic health care approach (Robinson et al., 2008). In the context of the thesis, this also aligns with the Centre for Cancer and Organ Diseases’ strategy for patient-centred care (see next page). As patients transition between multiple departments and services, their experience can be shaped by coordination among departments and actors (Fry, 2019). This underscores the need to focus on their entire journey rather than isolated touchpoints when improving their pathway, which a service systems design approach can support (Buchanan, 2019).

CENTRE FOR CANCER AND ORGAN DISEASES STRATEGY

The Centre for Cancer and Organ Diseases strategy is called the *human-centred hospital,* which encompasses value-based healthcare, with core values including systematic patient involvement and maximising value for the patient. To succeed with the latter, there are three perspectives to focus on. First patient-experienced quality, second clinical quality, and third efficient resource utilisation. Focusing on all three dimensions is what they call value-based healthcare. However, a fourth perspective, staff well-being, is also included, as the centre believes that engaged and competent staff are a prerequisite for delivering high-quality treatments. As well as the importance of interdisciplinary collaboration, which is seen as a key component of delivering high-quality care and supporting teamwork (Webgruppen på Rigshospitalet, 2024b).

2.3.2 PARTICIPATION & CO-CREATION

Co-creation refers to creating value through joint participation rather than by a single actor. Co-creation has been shown to be an effective way of enabling change and reducing resistance to change. In service design, this idea is closely related to co-design, which describes the collaborative process where people from different backgrounds, often including those affected by the service, take part in shaping the service together (Sanders & Stappers, 2012, pp. 15–35). For designers to play a transformative role in an organisation, this means facilitating collaboration rather than directing outcomes. When users and staff are seen as co-designers, the process becomes more participatory, and their insights directly shape the solutions (Junginger & Sangiorgi, 2009).

Active participation and meaningful change require building trust and relationships within the organisation (Junginger & Sangiorgi, 2009). This is particularly important in a hospital setting, where professionals are often highly skilled experts with a high degree of autonomy (Lin et al., 2011). Designers can build trust through collaboration, transparency, sensitivity to organisational dynamics, and by bringing new perspectives that inspire people. By making underlying patterns visible, people often gain a new understanding of their organisation, both strengthening trust and sparking interest (Junginger & Sangiorgi, 2009). In hospital contexts, building trust also requires adapting to the language of the domain, rather than relying on design terminology (Jones, 2013, p. 7). Valuing the skills and knowledge of staff can strengthen professional pride and build engagement, while also supporting shared learning and interdisciplinary working, breaking down silos and friction between units (Alves & Meneses, 2018; Pakarinen et al., 2023, p. 6; Stickdorn et al., 2018, p. 24).

Additionally, active participation in successful change efforts requires building psychological safety. It is essential as it creates a foundation for developing new beliefs, behaviours and ways of working. Psychological safety enables learning from failures, as staff feel more comfortable speaking up about mistakes. To build this environment, employees need early support and guidance. It is important to clarify boundaries of what is acceptable and not, as unclear limits can create hesitation (Edmondson, 2004). Furthermore, listening to the employees who are hesitant or resistant is crucial, as their concerns are often legitimate. By establishing a psychologically safe environment, hospitals create stronger conditions for implementing change (Lin et al., 2011).

Meaningful change depends not on participation alone, but on involving stakeholders early and throughout the process (Stickdorn et al., 2018, p. 278). Early involvement allows employees to shape the initiative and builds a stronger sense of ownership. For change initiatives to succeed, they need to align with the values, norms and everyday realities of employees. When proposed changes reflect how staff work and what they care about, it is more likely to be accepted (Lin et al., 2011).

Leadership also plays an important role by creating a clear and motivating vision that communicates the urgency for change (Edmondson, 2004). When time is spent discussing existing challenges and why change is necessary, staff are more likely to connect these issues to their own work. This helps create a shared understanding of the vision (Lin et al., 2011). Co-creating this vision with employees further strengthens engagement. Designers can contribute by developing transformative insights that help shape a shared vision based on existing strengths and future potential, drawing on principles from positive psychology (Junginger & Sangiorgi, 2009). This could imply that once the need for change has been collectively acknowledged, hospitals could be better positioned to move forward with the change efforts.

Given the strong independence of healthcare professionals, change efforts benefit from a participatory design process (Lin et al., 2011). In practice, however, it is rarely possible to involve everyone directly, especially in a hospital setting where time pressure and workload are already high (Pakarinen et al., 2023, p. 5). Change initiatives, therefore, often rely on engaging smaller groups, who then can share experiences and insights with their own teams. To support this broader engagement and scaling, designers may also need to organise additional co-creation activities, beyond those strictly required for design output (Stickdorn et al., 2018, p. 278).

2.3.3 MAKING SERVICES VISIBLE

A principle in service design, according to Stickdorn et al. (2018, p. 26), is *real*, which encompasses that stakeholder needs should be researched in reality and ideas should be prototyped in reality. Furthermore, the intangible values in a service should be evidenced as a physical or digital reality. This means that when applying service design, it must be grounded in a real-world context. Evidencing builds trust, improves understanding of value, and strengthens the service experience (Stickdorn et al., 2018, p. 26).

As hospitals are organised in silos, resulting in fragmented care, services within the system often become invisible or intangible (Alves & Meneses, 2018; Mann, 2005). For example, in our case, this could lead to patients not being aware of all the systems and processes that happen ‘behind the scenes’ in their treatment journey, such as coordination and decision-making, and the staff are not aware of the patient processes, such as treatment plans and care in other departments. Therefore, there is a need to make the invisible elements visible to be able to drive change, which evidencing can support through visuals, communication or physical cues (Junginger & Sangiorgi, 2009; Stickdorn et al., 2018, pp. 25–27).

As mentioned earlier, decision-making in healthcare is also often based on quantitative data and measurable outcomes (Jones, 2013, p. 17), leaving out qualitative aspects such as experiences, emotions, and needs, which adds to the lack of visibility within the service. Service design, therefore, applies methods such as interviews and observations in real-life settings to understand what needs to be visible and what matters to users (Stickdorn et al., 2018, p. 26). By applying the principle of real in our case, stakeholders could better understand the system, its barriers, and problems, leading to increased transparency and trust and supporting better coordination between departments and implementation.

2.3.4 ITERATIVE LEARNING

Iteration is one of the main principles in service design. It refers to an ongoing process of working in cycles, where ideas are developed through small-scale experiments that are tested, evaluated and adjusted over time. Iteration embraces learning from failure and feedback. Iteration is used throughout the whole design process, in researching, prototyping and even implementation (Stickdorn et al., 2018, pp. 13–25). The approach is closely connected to change, by acknowledging that change does not happen in a fixed context, but in a reality that is continuously evolving (Alvesson & Sveningsson, 2025, p. 5).

Iteration can, however, be difficult for people to understand, as many are used to more linear approaches such as decide-plan-do (Stickdorn et al., 2018, p. 25). This is especially evident in the hospital setting, where staff are trained to rely on strong empirical evidence before taking action to ensure safety (Jones, 2013, p. 73). Given the ethical considerations healthcare professionals carry, approaches based on learning over time may seem inappropriate (Alvesson & Sveningsson, 2025, pp. 38–41). At the same time, iteration can function as a way to reduce risk in high-stakes hospital environments. By working in small, controlled steps, iteration can build a safer environment without putting patient safety at risk. Rather than requiring solutions to be right from the start, an iterative approach focuses on gradual improvement toward implementation. This lowers the stakes and makes decision-making easier (Stickdorn et al., 2018, p. 13).

A practical way to introduce an iterative mindset in organisations is through pilot projects. Pilot projects allow designers to start small, making it easier to spot hidden issues, learn how to approach problems, and identify future possibilities. In this way, a pilot project can act as a "seed" that grows into a larger organisational transformation. Through ongoing iteration and involvement, it can help build capabilities from within, supporting sustainable and lasting change (Junginger & Sangiorgi, 2009).

2.4 Practical Applications in Healthcare

To further understand the context we are designing within, we decided to explore existing projects and approaches that investigate how service design and change can be applied in healthcare. The purpose of exploring the cases was to build on existing knowledge. Despite the uniqueness of our thesis, the chosen projects share similarities and therefore provided useful insights for our further process.

2.4.1 IMPROVING PATIENT EXPERIENCE IN AN EMERGENCY DEPARTMENT

This project, described by Fry (2019), explored how service design can be used to improve the patient experience in a Norwegian emergency department. Through observations and interviews with patients and healthcare staff, the project identified that patients were often uncertain about what was happening, while staff lacked a clear understanding of the overall patient journey. Journey mapping was used to align staff around the problem, followed by co-creation sessions. The co-creation resulted in solutions such as brochures and digital screens explaining the stages of the patient journey, as well as a service blueprint clarifying staff responsibilities. The case focuses on improving an existing service, rather than changing the whole system. It shows that visualisation and co-creation can help alignment, but also that some solutions may not be implemented in practice due to constraints such as limited time and unpredictable working conditions (Fry, 2019).

2.4.2 IMPLEMENTING NEW NURSE PRACTICE AT HOSPITALS

This case, described by Lin et al. (2011), explored the implementation of an initiative called "Nurse Knowledge Exchange" at American hospitals. The main challenge was not designing the solution, but getting staff to adopt it after an initial top-down implementation approach failed and led to resistance and low ownership. The approach was redesigned using service design combined with change management. The nurses were involved early through observation, storytelling, and co-creation. Staff were also allowed to adopt the process to their own departments before full implementation, using minimum guidelines. The case represents service design used for implementation and adoption, rather than the design of the service itself. It shows a shift from a top-down approach to a participatory approach. The main insight is that participation supports long-term adoption, but requires significantly more time and effort from both designers and hospital stakeholders (Lin et al., 2011).

2.4.3 CHANGING CULTURE IN YOUTH MENTAL SERVICE

This project, described by Patrício et al. (2019), focuses on a youth mental clinic in Sweden. The main challenge was not a specific process but an institutional culture in which staff primarily interacted with young people in crisis situations. Through long-term co-creation involving youth, clinicians, parents, and teachers, participants explored new ways of working through storytelling and prototyping. This resulted in a digital service called "hurmårdu.nu" but also led to changes in how staff engaged with young people in everyday practice. This case represents service design as a tool for cultural and systemic change, where the goal is not to improve or implement a specific service, but to shift mindsets and relationships. It shows how co-creation can help build new practices that continue after the project ends, but also that this requires long-term facilitation and commitment (Patrício et al., 2019).

2.5 KEY TAKEAWAYS: CONTEXT

CHANGE IN ORGANISATIONS

○ Change does not only involve the outcome and should neither be seen as static or formal decisions. Change is rather about the process and the small things that happen over time.

○ Factors such as readiness for change, organisational culture, leadership, employee participation, and resistance to change influence the success or failure of change initiatives.

CHALLENGES OF CHANGE IN HOSPITALS

○ Hospitals are a unique and complex environment due to their silo structure, multiple actors, interconnected systems, and obligation to comply with policies and regulations, making it challenging to drive change within them.

○ As hospitals practice an evidence-based approach, it can be hard to drive change, since relational patterns and qualitative data are difficult to measure and therefore perceived as going against their quantitative research nature.

○ The pressure on hospitals due to an ageing population and a shortage of staff leaves little room for resources for driving change initiatives.

○ Ethical constraints, such as patient safety and rights, can restrict experimentation and processes that may facilitate change.

ENABLING CHANGE THROUGH SERVICE DESIGN

○ A systemic perspective enables change by viewing hospitals as interconnected systems, rather than fixing issues in isolation.

○ Co-design lets the people affected by the service actively shape it, so it fits their real needs and builds ownership.

○ Active participation in co-design requires trust and psychological safety so people feel comfortable sharing ideas, mistakes or concerns. This can be supported by adapting to stakeholders' language, valuing their knowledge, and visualising complex issues to make it easier to understand.

○ A shared understanding of why change is needed is essential before moving forward with initiatives. This can be done with a clear or co-created vision.

○ Iteration can reduce implementation risk by enabling continuous learning from feedback and can be applied through pilot projects.

PRACTICAL APPLICATIONS IN HEALTHCARE

○ Similar projects show that co-creation is effective for improving existing services, implementing new ones, and supporting cultural change.

○ The projects highlight common challenges in healthcare, including unpredictable workflows, limited time, and implementation difficulties.

03.

Methodology

In this chapter, the methodological framework of the thesis is presented. It entails a description of the Double Diamond model and its four phases and introduces the thesis's theoretical perspective, which explains how the case will serve as a lens for examining how change is perceived and navigated in practice.

The chapter is divided into the following sections:

3.1 The Design Process 16

3.2 The Theoretical Perspective 17

3.1 The Design Process

For the received design case, we chose to apply the *Double Diamond* model. Developed by the Design Council, the model outlines four phases of the design process: *Discover, Define, Develop,* and *Deliver*, visually represented as two diamonds. The Discover and Develop phases are characterised by divergent thinking, visually represented by the opening diamond, which involves exploration, broadening the scope, research, and data gathering. The Define and Deliver phases, in contrast, correspond to convergent thinking, involving data synthesis, identifying opportunity spaces, and narrowing down (see Figure 3). The Double Diamond model also emphasises iteration within each diamond, allowing the process and outcomes to be changed, improved, and refined to create the most suitable solution (Design Council, n.d.).

Each phase serves a distinct purpose. The goal of the Discover phase is to gather insights into services and their users, to better understand the context and those for whom these services are being designed. Furthermore, to explore possibilities, needs, or underlying issues. The data gathered in Discover is then clustered and analysed during the Define phase to identify key themes and opportunity spaces, shaping the direction for the second diamond. The third phase, Develop, centres on developing and testing ideas through ideation and prototypes, often including iterations. Lastly, in the Deliver phase, the concept is refined and finalised for implementation in the real world (Kochanowska et al., 2022; Design Council, n.d.).

Our decision to adopt the Double Diamond model was based on several reasons. Based on initial research, we were aware of potential barriers to forming a project group comprising nurses and service designers, given the different approaches and mindsets. To accommodate this, we found the Double Diamond appropriate, since the nurses had proposed a similar approach to the case. In the case description, they had suggested the following approach: *mapping the current system*, *analysis*, *development*, *evaluation and implementation* (see Appendix B). Since it aligns with the phases of the Double Diamond in some respects, we thought it might have been familiar to them and therefore could have reduced potential communication barriers. Furthermore, the Double Diamond model provides a clear visual framework that facilitates communication by making it easy to convey the current state of the project, the next steps and activities to the project group, and to support our decisions. Lastly, throughout our education and professional careers, we have frequently used the Double Diamond to guide our design processes, giving us the experience and confidence to apply it to the thesis.

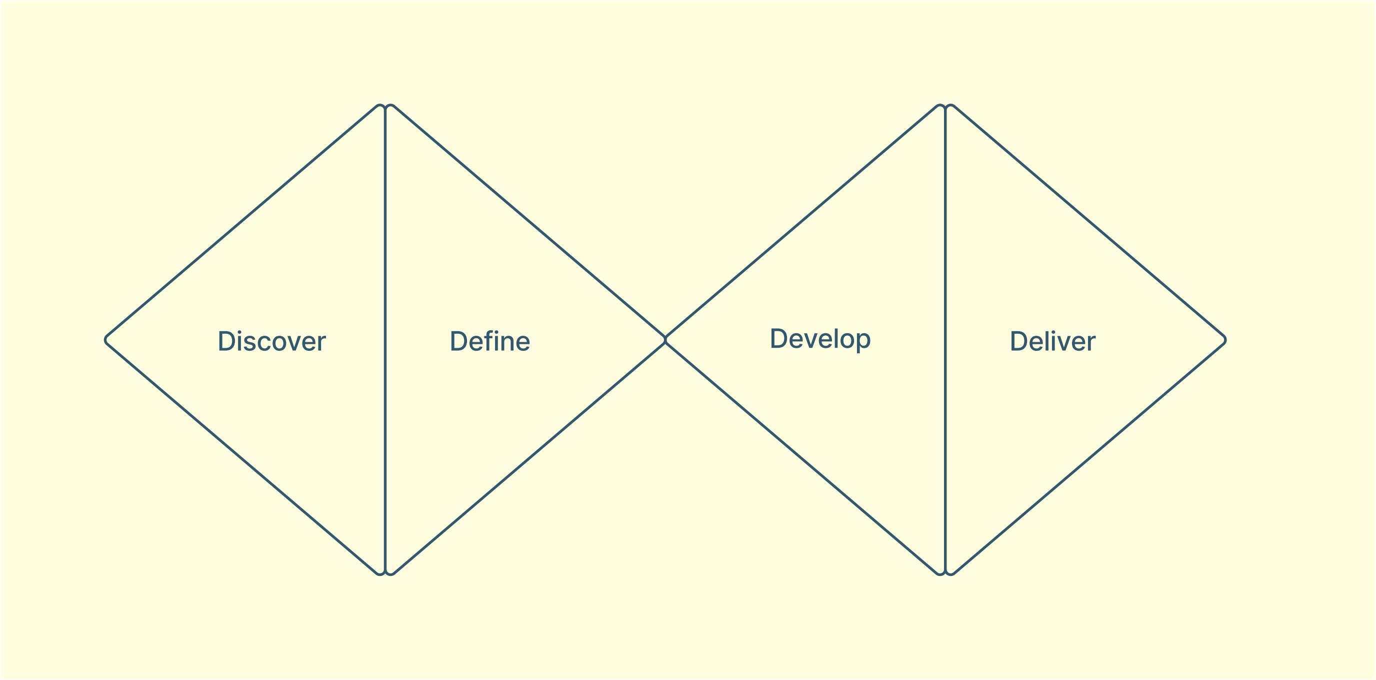


Figure 3: The Double Diamond – created by the British Design Council (n.d.)

3.2 The Theoretical Perspective

The design process of the case served as a lens to explore how change is perceived in practice. It also helps examine how service design approaches and our roles as designers can facilitate and support change. From this perspective, the Double Diamond is adapted to our project, visualised in Figure 4. As Kochanowska et al. (2022) note, the model is not meant to function as a fixed step-by-step guide, but rather as a point of reference that can be flexibly adjusted.

With the intention of understanding both the case and how change was perceived in practice, we approached the first diamond openly and exploratively. Drawing on existing knowledge (see 02. Context), the first diamond focused on understanding the case through several methods, gathering insights into the given situation. As previously described, since hospitals are complex systems (Durán & Wright, 2020, p. 6), it is necessary to allocate sufficient time in the first phase to understand and explore the system to ensure the solution's viability. According to Jones (2013, p. 18), small oversights or misunderstandings can lead to consequential errors, why designers are obligated to understand the underlying issues and systemic problems. Then the explorative work was synthesised, and key insights were defined both in relation to change and the case itself.

As the first diamond shaped the overall direction, the focus shifted in the second diamond. In these phases, the project group took a more active role in casework, while we as facilitators took a step back to observe and support them in driving change. Therefore, sufficient time was allocated to the last phase, Deliver. This shift is grounded in the mentioned literature, highlighting the need for stakeholders to drive solutions themselves, ensuring it fits the context's needs, and to build ownership (Lin et al., 2011). Ultimately, this approach helped us evaluate the service design methods used throughout the process and how different approaches may facilitate and support change. This resulted in two outcomes. One is a concrete solution to the case, developed by the nurses but driven by our insights. The other is a broader concept to help change efforts in the future, developed by us and based on the insights gathered throughout the project.

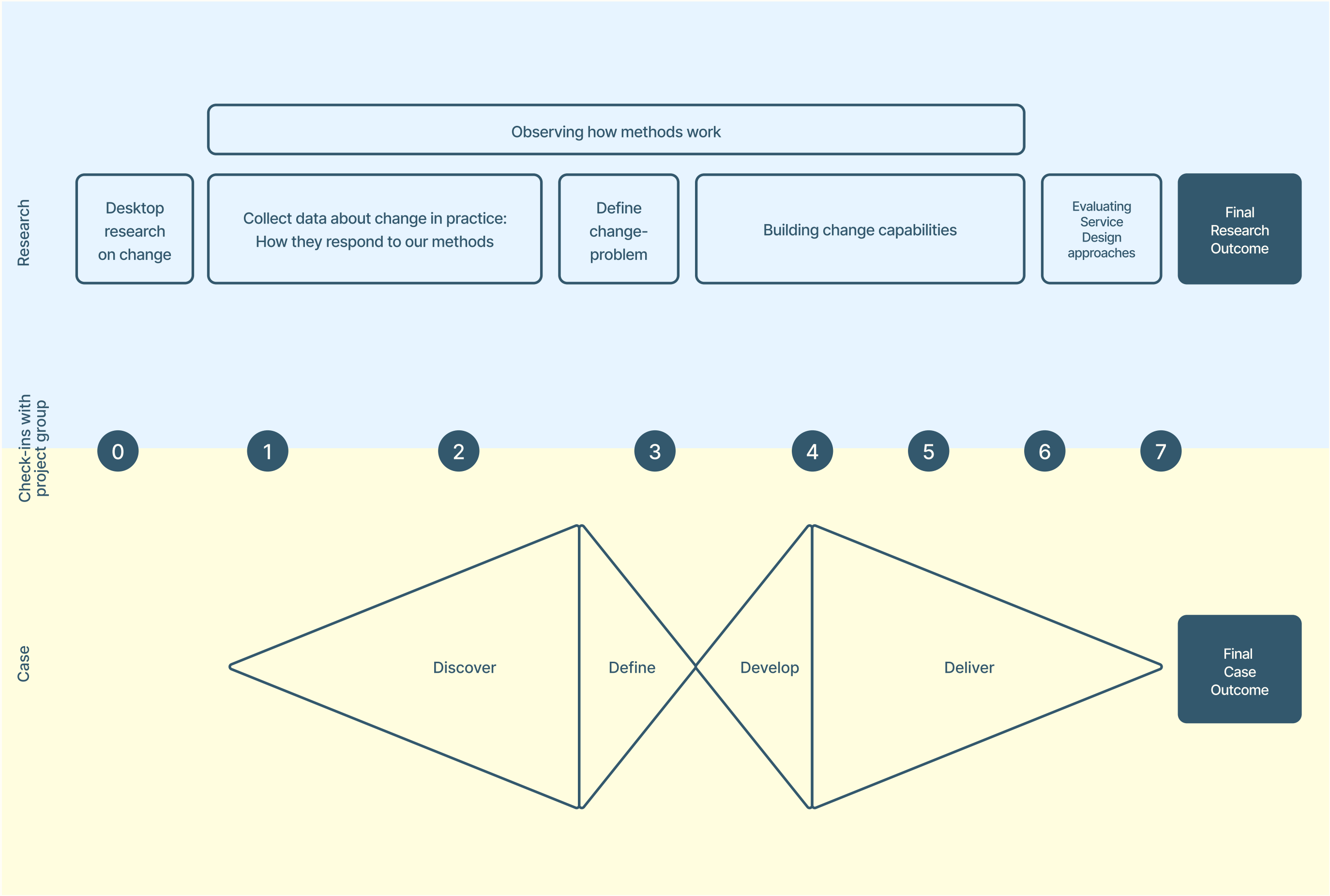


Figure 4: Our adaptation of the Double Diamond

04.

Discover

In this chapter, the context is explored through user research methods and check-ins to understand the underlying issues and needs of the patient pathway, as well as the collaboration and coordination between the departments. The user research methods include interviews, a survey, and a mapping activity. Additionally, several check-ins and attendance at a nurse seminar.

The chapter is divided into the following sections:

4.1 Check-in 0: An unsuccessful project kick-off ---- 19

4.2 Patient Survey ---- 20

4.3 Check-in 1: Making the implicit explicit ---- 23

4.4 Mapping the Patient Pathway ---- 25

4.5 Patient Interviews ---- 27

4.6 Check-in 2: Where insights shifted, and trust began ---- 30

4.7 Nurse seminar – From Ambition to Practice ---- 31

4.8 Pathway Coordinator Interview ---- 32

4.9 Key Takeaways: Discover ---- 35

4.1 CHECK-IN 0

An unsuccessful project kick-off

> **CONTEXT:**
> *Back in December, we had our first meeting with the project group. The purpose of that meeting was to agree on the collaboration, get introduced to the case, align expectations on project scope and timeline, and become familiar with one another. At this meeting, we agreed to meet again in January to officially kick off the project. Between the two meetings in December and January, we thoroughly reviewed the case and a green folder (see next page) and conducted initial desk research on testicular cancer patients. To explore the case, we wanted to roll out a survey to gain knowledge and a better understanding of the potential underlying issues of the patient experience, as reported by the nurses. We therefore prepared a draft for the survey and sent it to the project group before check-in 0. The survey will be described in 4.2. Patient Survey. The purpose of the meeting was, therefore, to revise and discuss the survey's content, to plan the survey's execution, and, more practically, to plan bi-weekly meeting dates.*

At the meeting, the nurses came well-prepared; they had all reviewed the survey draft and added comments. While reviewing the feedback and comments, we quickly realised we had misunderstood key information about the patient group and the case's focus area. While we had prepared the survey to gather knowledge of the patient pathway as a whole, the project group wanted to mainly focus on the waiting time between the two departments. Furthermore, we had misunderstood that it was only testicular cancer patients, leading to, we must admit, some quite embarrassing mistakes, such as adding a question about gender. This meant that the first draft of the survey was not applicable.

At the check-in, we also discussed the wording and formal aspects of the survey. It became clear that the project group practised a more evidence-based and scientific approach than we service designers do, since they did not find it sufficient. This led to extensive focus on how to describe in detail the survey's purpose, the GDPR rules, and how we would store the data. This was something we agreed to further elaborate upon in the next draft and, as one of the first steps in adapting to *their* world, as Jones (2013, p. 7) suggests, as a way to build trust.

These mistakes made us feel that we had lost their trust in our expertise and way of working, understandably. We identified several reasons why it had occurred: firstly, we had rushed the survey to ensure enough time for data collection, leading to fundamental errors. Secondly, we recognised that we had not thoroughly introduced them to our approach and ways of working as service designers. Principles such as co-creation, prototyping, and iteration were not introduced, leading to an expectation of a polished, finished first draft. Building on Junginger & Sangiorgi (2009) to build trust, we should have allocated time to explain that we wanted to create the survey collaboratively, combining our knowledge with their expertise, and then, through feedback, revise and iterate on it.

Since the survey was not applicable, we decided to end the meeting and agreed to make a second draft and get their feedback via written email. It turned into a long, back-and-forth correspondence, resulting in five iterations of the survey. With the final draft, the nurses began handing out the surveys, as agreed at check-in.

THE GREEN FOLDER

A folder containing a series of information materials and resources, informally referred to as “the green folder,” is distributed to patients at URO after surgery, prior to the waiting time. Its purpose is to provide patients with information and support during their course of treatment.

The green folder contains the following material:

1. A postcard linking to the MitForløb app, where patients can find informative videos and brief explanations about topics such as the operation and their patient pathway.
2. A business card with the pathway coordinator's contact information.
3. A printed document developed by Rigshospitalet (URO) with information about the post-operative period.
4. A brochure developed by Kræftens Bekæmpelse about testicular cancer.
5. A brochure developed by Kræftens Bekæmpelse about the rights of cancer patients and their next of kin.
6. An application form for financial support from Kræftens Bekæmpelse.

Throughout the project, we also identified additional informational materials distributed throughout the patient pathway, so the list may not be comprehensive. An overview of the materials collected is provided in Appendix C.

4.2 Patient Survey

As previously mentioned, we initiated the Discover phase with a survey to explore patients’ experiences of the testicular cancer pathway. This decision was grounded in the case description, which indicated that patients often lack clarity about the next steps. The survey was used to examine this claim by gathering firsthand patient perspectives. While we had established ongoing contact with the nurses, accessing patients presented both ethical and practical challenges, including their emotional and physical condition. A survey was therefore a pragmatic choice, as it allows for low-effort participation while allowing us to gather comparable data across patients (Bryman, 2012, p. 233; Creswell & Creswell, 2023, p. 137).

However, this approach also has clear limitations. The structured format of a survey limits depth and may not accurately capture how patients truly feel or behave (Bryman, 2012, pp. 178–179). This is particularly significant in a cancer context, where experiences are often complex and emotional (Wilke et al., 2025). Responses are further influenced by how questions are interpreted and formulated, which can introduce bias and reduce accuracy (Bryman, 2012, pp. 178–179). Despite this, we considered a survey as a relevant starting point, providing an initial indication of potential issues that could later be explored in depth.

4.2.1 SURVEY PREPARATION

In terms of sampling, the survey was planned to target all testicular cancer patients who arrived at the ONC department. This group was considered particularly relevant as they would have recently experienced the transition between the URO and ONC departments, providing fresh perspectives on the patient pathway. The distribution of the survey was planned to be facilitated by the nurses at ONC, as they already have established relationships with the patients and were a trusted channel for recruitment.

The project group opted for physical printed surveys to enhance response rates, as they could hand them out to patients while they received chemotherapy or during consultations. Distribution was planned to begin mid-January, with a four-week collection period to ensure sufficient data while allowing the project to progress.

We then planned to collect the surveys continuously to follow the progress of responses. Through several rounds of iteration with the project group, the final survey design was ready (see Appendix D). The survey was divided into three sections: demographic questions, waiting time, and information.

The first section included demographic questions about age, marital status, the highest completed level of education, and the hospital where the operation was performed. This information allowed us to evaluate whether the sample was representative of the typical patient group, particularly in terms of age and the hospital from which they arrived. The second section focused on how the patients experienced the waiting time between the departments. This period was of particular interest, as we had limited insight into patients' experience since they are not actively in contact with the hospital or any department at this point. The third section focused on the usage and quality of the information given. This aimed to explore how this information contributed to patients' understanding of their journey.

Most questions were closed and formatted as either multiple-choice or Likert-scale items, with only a few open-ended questions that allowed elaboration. This was chosen to more easily compare responses across patients and thereby identify patterns. Furthermore, it was important for us to make it quick and easy for patients to respond. To reduce burden and respondent fatigue, we created a simple response format to increase response rates and the completion of data forms (Bryman, 2012, pp. 231–244). Additionally, we saw the survey as a valuable entry point for recruiting participants for potential follow-up interviews. At the end of the survey, the respondents were given the opportunity to write down their contact information so we could reach them.

4.2.2 SURVEY OUTCOMES & INSIGHTS

The survey distribution proceeded smoothly over the four-week period. The nurses managed the process as they kept track of surveys handed out and informed us when surveys were ready for pickup. A total of 12 patients were approached, with all of them completing the survey, resulting in an *excellent* response rate (Bryman, 2012, p. 235). This indicates that the format and distribution approach were well-suited to the context. Involving the nurses early in this process contributed positively, fostering a sense of ownership (Stickdorn et al., 2018, p. 278).

Given the small sample size (see Appendix E), we decided to analyse the data by manually reviewing responses and identifying patterns across participants and the three themes. Based on these patterns, the patients were grouped into four categories reflecting the variations in patients' overall satisfaction with the testicular cancer pathway (see Figure 5).

Demographics: Deviations from the target group
Regarding demographics, nearly 50% of respondents were older than the average testicular cancer patient. Additionally, only four patients had their operations at Rigshospitalet, while the majority were operated at other hospitals. As care practices can vary across hospitals, this limits the relevance of the findings to the URO department at Rigshospitalet, with which we collaborated. Therefore, the majority of respondents differed from the average target group of the research, limiting overall representativeness and introducing potential selection bias (Smith & Noble, 2025). In hindsight, a longer data-collection period or a more thorough selection of respondents could have improved the representativeness. However, the sample was constrained by the project timeline. Moving forward, the data was therefore interpreted with caution and used to provide indications to guide further investigation, rather than as evidence.

Waiting time: Mixed experiences
Responses related to the waiting time indicated a mixed experience of the period. The majority selected the options 'Safe & Calm' and 'Aware of the next steps' when asked how they experienced the 14 days of waiting. None of the respondents was uncertain about the next steps. This suggests that patients generally felt informed during this phase. At the same time, the majority answered that time passed slowly and that they were mentally tired. Two participants explicitly reported "feeling scared". Overall, this points toward a complex experience where patients can feel informed and safe while still experiencing emotional strain. Most respondents felt satisfied with the patient information they received, describing it as clear and useful. A few patients noted that specific information was missing, however, this tended to relate to individual health conditions. Overall, the material was perceived as supportive in helping patients understand their situation.

Overall: Generally high satisfaction
Most patients were satisfied, felt well-informed, and safe during the waiting time. When grouping responses by overall satisfaction, the majority fell into the category where they felt their needs were met. At the other end, two patients indicated the need for additional mental support.

These findings differ from the initial case assumption that patients lack clarity in the pathway. This highlighted the need for further investigation, particularly to better understand the experiences of those patients who reported challenges, despite not representing the majority. To explore these nuances in depth, we saw qualitative interviews as the next step. However, to develop a focused interview guide, we needed to understand the details of the patient pathway.

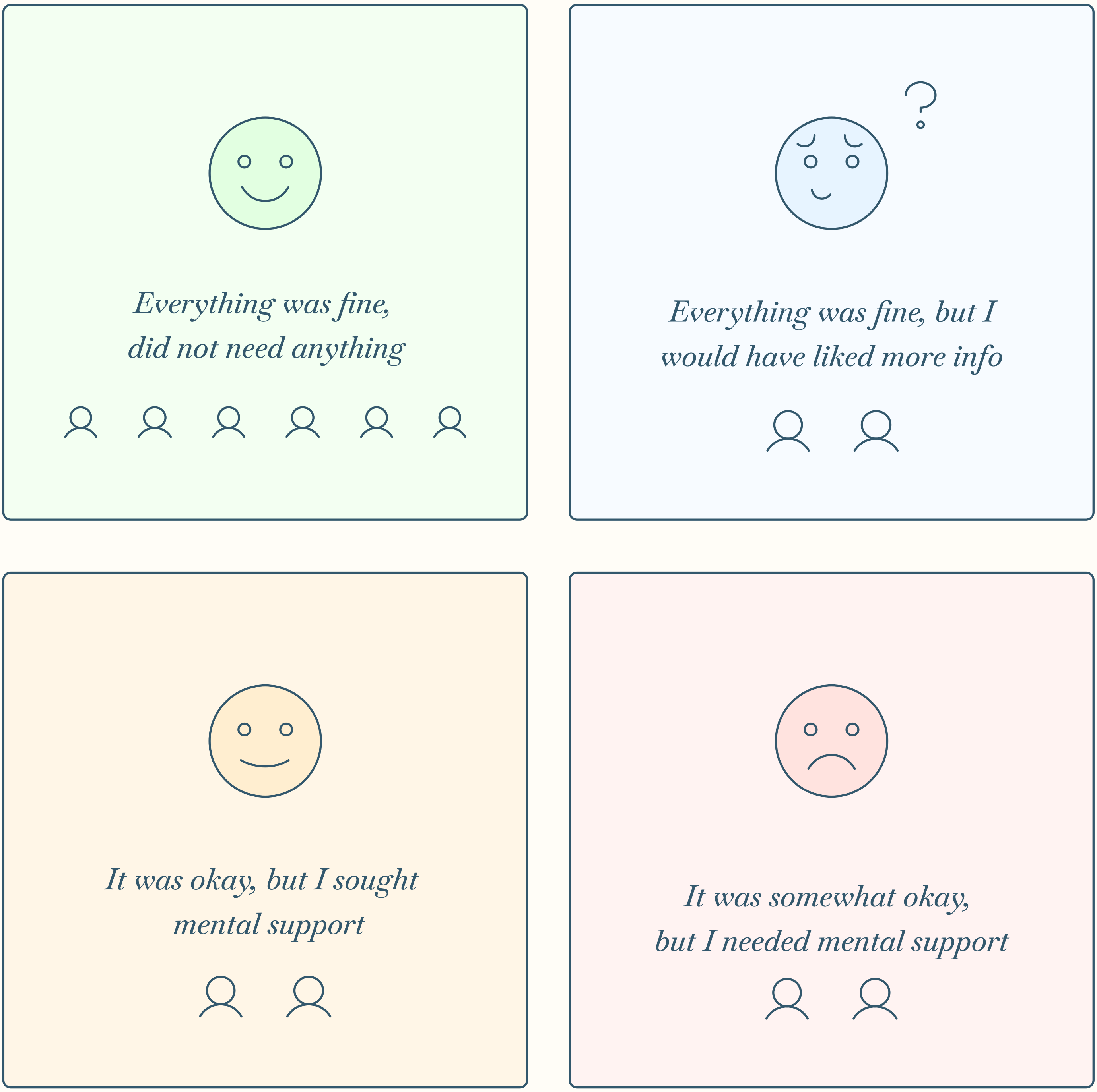


Figure 5: Patient survey analysis – the four categories

4.3 CHECK-IN 1

Making the implicit explicit

> **CONTEXT:**
> *Context: Although we had already done some preparatory and initial work on the case, preparing and handing out the survey, this check-in marked the beginning of the project, as it was the first time we met with the project group in person, and as the thesis semester had officially started, meaning we could dedicate more time and effort to the work. This also gave us more time to prepare our activities and avoid overlooking mistakes such as those that occurred in the patient survey. Learning from our misunderstandings, the purpose of this check-in was to introduce them to our service design approach, clarify our academic lens on the project to ensure transparent and ethical conduct, and to understand the patient pathway in more detail through a co-mapping exercise.*

We started the meeting by explaining three principles in service design: holistic, co-creative, and iteration (Figure 6). This was intended to clarify our approach and address potential points of friction that can arise when applying design thinking's core principles, such as iteration and tolerance for ambiguity, in a healthcare context (Milne et al., 2023). Furthermore, we wanted to emphasise that our knowledge of the healthcare system might sometimes appear limited, and therefore, it is important that we co-create to ensure the solution meets the needs of the users (Junginger & Sangiorgi, 2009). Since trust is one of the most essential relationship factors influencing behaviours within the healthcare system, as noted by Bedenik et al. (2024), we also decided to present previous projects we conducted in a similar context to demonstrate our experience working in hospitals. The project group were receptive and interested in hearing about our approach and projects, and with no further questions, it was the first step in establishing a common language.

We continued by presenting our take on the case and our thesis focus area, as it included observing the project group and how they perceived and applied the interventions and tools they received. As Bryman (2012, p. 138) emphasises, participants should be informed about the nature of the research, how data will be collected and stored, and given the opportunity to refuse or withdraw at any stage. Therefore, we handed out consent forms (see Appendix F), which are increasingly used in research (Bryman, 2012, pp. 138–140), explaining how we would store the data and asking for permission to take pictures and record quotations to document our process. The project group read them through and all consented, expressing strong interest in having a broader area of research. They mentioned it aligned with their desire for insights and outcomes that extend beyond the specific case, creating a scalable concept.

For the check-in, we prepared a co-mapping activity inspired by the service blueprint to gain further insights into the patient pathway and the stakeholders involved. Furthermore, it was also to foster discussions between the departments, with the purpose of creating a better overview of responsibilities and roles, as they, according to the case description, lacked this. The details and further reflections of the co-mapping activity will be elaborated on in the following chapter.

We decided to end the check-in with a reflective exercise, asking them individually to share one thing they were looking forward to and one thing they were worried about, to ensure transparency, which, according to Junginger & Sangiorgi (2009), can help build trust. A comment that stayed with us was the concern that the data collection might not be sufficiently theoretical or representative, indicating that our approach lacked sufficient theoretical grounding in the survey design. Furthermore, it emphasised the need to thoroughly explain our intent and approach to every method introduced in the future. Through this exercise, we realised that the check-ins were valuable not only as opportunities for feedback and activities, but also as a shared space for the two departments to meet and exchange perspectives on the project. The check-ins also left room for more informal discussion, with the nurses talking about their everyday tasks and procedures, slowly getting to know each other's worlds.

Figure 6: Us presenting service design principles at check-in 1

4.4 Mapping the Patient Pathway

As mentioned in check-in 1, we had prepared a co-mapping activity to address the three points listed in the case background: lack of clarity in the patient pathway among patients and staff, unclear division of roles and responsibilities during handover of care, and lack of coordination and communication between departments. Morelli and Tollestrup (2007) argue that it is necessary to understand the context of intervention and how it can be shaped. This involves understanding what kinds of actions take place between actors. Representation techniques, which are tools or methods that visually or verbally communicate systems and processes, can be applied to explore the context designers are intervening within.

We decided to draw inspiration from the service blueprint, a detailed diagram that maps the service, including both customers and the organisation's actions. Compared to a user journey, a service blueprint incorporates both customer actions, frontstage actions, and backstage actions, which gives a comprehensive understanding of the processes of the system. Front- and backstage actions refer to employee actions that are either visible to the customer or not. Lastly, support processes and physical evidence that the customer interacts with (Ruiz et al., 2014; Stickdorn et al., 2018, p. 53).

4.4.1 CO-MAPPING PREPARATION

As Aguirre-Ulloa and Paulsen (2017) argue, public services are shifting from designing *for* people to designing *with* people, the design process must therefore be accessible and inclusive for non-designers. Furthermore, it is necessary to adapt tools and methods to the context to make them easier to understand and engage with for the project group (Jones, 2013, p. 7). We simplified the blueprint by distinguishing only between patient actions and healthcare staff actions.

As our knowledge of treatment pathways and medical terminology was limited, we were unsure of certain elements and aware of the possibility of discrepancies compared to Rigshospitalet's workflows. The aim was therefore to first lower the barriers and reduce the time required by preparing a first draft before the check-in. Then we could later on co-create the blueprint with the project group, with them validating and finalising the draft, as they could contribute with their knowledge and experiences, which is essential when co-creating services (Stickdorn et al., 2018, p. 125).

Our draft was informed by two sources: a draft overview of the patient pathway created by one of the nurses in the project group (see Appendix G) and desk research on the Cancer Package for Testicular Cancer (Sundhedsstyrelsen, 2016). The draft ended up consisting of two main sections. The patient's actions at the top and the involved stakeholders' actions at the bottom (see Appendix H). The stakeholders included the general practitioner and the different departments patients interact with throughout the pathway, including URO and ONC. During the research, we noticed that patients engage with a range of digital and physical communication and information channels, including e-Boks, phone calls, and the green folder. However, instead of adding a physical evidence layer, we prepared small icons of the different channels, which could be added within the different stakeholders. In practical terms, we printed a base layer showing the two main sections, while the actions and communication touchpoints were added on top, making it easy to move items around and add or remove them as needed. We also added blank pieces that they could fill out when specific elements were missing.

4.4.2 MAPPING OUTCOMES & INSIGHTS

We were excited to introduce the mapping activity and observe how they received it, as it was the first time we introduced a visual service design tool. After explaining the purpose and expected output, the nurses stood up and gathered around the table, signalling engagement and excitement (see Figure 7). The group quickly began moving pieces around and interacting with the material themselves. We also noticed that the visual materials sparked interesting discussions between the two departments, as co-creation of the blueprint revealed a limited understanding of the actions in each department. Several episodes occurred where one department said, *"No, we actually do this"*, while the other department said, *"Really? We did not know that"*. Emphasising the lack of clarity in the patient pathway and poor communication between them, which can be a result of a silo-structured organisation (Alves & Meneses, 2018). During the exercise, we observed that there was no clear hierarchy among the departments or between nurses and head nurses, creating a balanced dynamic and collaborative efforts. This contrasts with some literature, which indicates that working across silos and hierarchies can increase complexity because of the difficulties in establishing shared understanding or equal decision-making power (Denis et al., 2001).

Having a draft as a starting point allowed us to use the time more effectively, focusing on validating our understanding of the pathway while also leaving room for discussion. While the project group were in charge of finalising the blueprint, we would occasionally ask them either to elaborate or prompt to specify certain actions. The outcome of the co-mapping activity was a finalised visualisation of the patient pathway, developed with input from the project group (see Figure 8). As shown in the final blueprint, patients interact with multiple departments and stakeholders, often within a short period.

The activity proved beneficial for several reasons. It served as a facilitator for the two departments in gaining a better understanding of the whole pathway and in sharing experiences and insights, which seem valuable for the project, as it created common ground. From our perspective, it also enlightened us as we better understood the patient pathway, which later informed the patient interviews. Lastly, we found the adaptation of the blueprint successful, as the project group understood the tool and showed strong engagement.

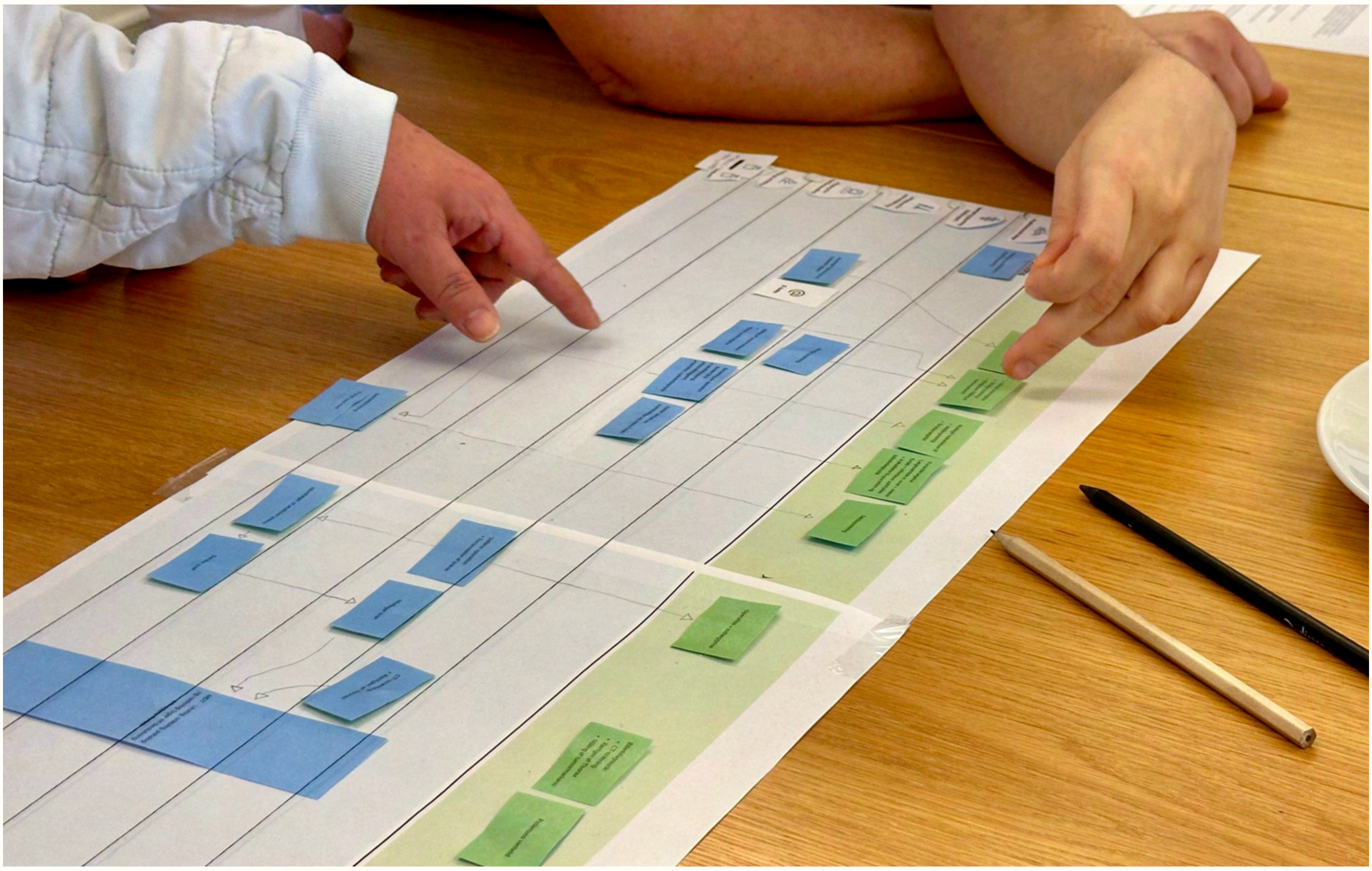


Figure 7: Project group interacting with the service blueprint

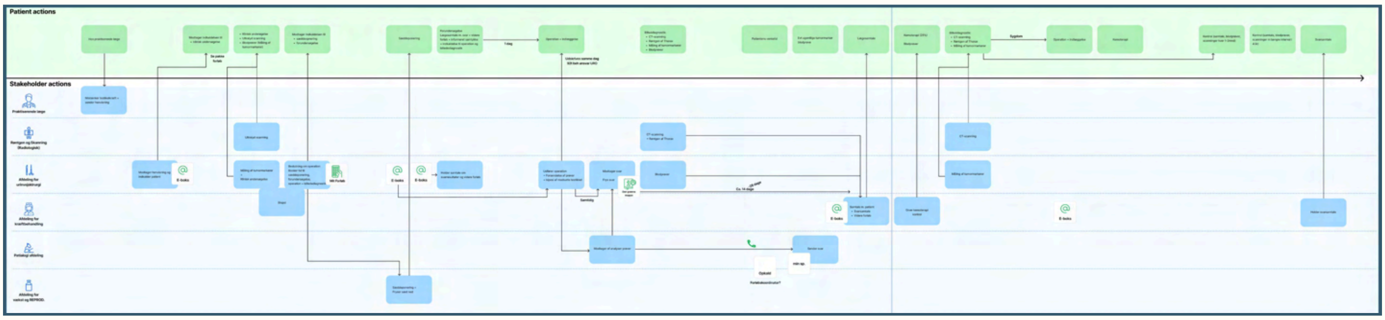


Figure 8: A digitalised result of the mapping activity – the patient pathway (see Appendix I)

4.5 Patient Interviews

While the data from the survey indicated that most patients felt safe and satisfied with the testicular cancer pathway, this contrasted with the initial case assumption that patients lacked clarity. This contrast required further investigation. In addition, the survey identified a smaller group of patients who reported challenges, which required a deeper understanding. We therefore chose to conduct interviews, as their qualitative nature allows for an in-depth exploration of patients' lived experiences, emotions, perceptions, and needs throughout the course of treatment (Bryman, 2012, pp. 468–499).

4.5.1 INTERVIEW PREPARATION

To recruit participants for the interviews, we used the survey which included an option to provide their contact information to further elaborate on their answers. We considered this an appropriate approach, as it allowed patients to volunteer. Eight out of twelve respondents agreed to be contacted. We reached out to all of them through text message, explaining the purpose and asking about their availability within the following weeks (see Appendix J). Furthermore, participants were given the choice to decide on a time and location that suited them, including meeting at Rigshospitalet, their home, or another convenient place. The aim was to create a safe and comfortable setting for participation.

As the interviews were intended to explore themes identified in the survey, we chose to conduct semi-structured interviews. This format ensures coverage of certain areas with predetermined questions while still allowing participants to elaborate and share their experiences through open-ended questions. This also allows for changing the order of the questions and asking follow-up questions if relevant insights emerge (Bryman, 2012, pp. 470–487).

We were responsible for developing the interview guide with the aim of receiving feedback from the project group. To support their understanding, we shared a draft interview guide supported with comments explaining the purpose of each section and intended outcomes. This proved to be an effective way of involving the project group in our process and minimising misunderstandings. As a result, they only provided minor feedback on how the patient touchpoints were described, leading to a finalised interview guide (see Appendix K).

The first part of the interview guide consisted of describing the project and its purpose to the patients and obtaining their consent (see Appendix F). Following an introductory part to get the patient to introduce themselves, as a soft start to getting to know each other. The next part was diving into the information material. Since they had already answered questions about it in the survey, it was important for us not to repeat the questions but to ask them to elaborate on their answers, meaning that we also tailored each interview to each patient based on their survey answers.

In the last part of the interview guide, we asked the patients to discuss which areas of life had been significant during the waiting period and to associate them with emotions. Given the sensitive topic, patients' experiences may include tacit knowledge, making it difficult for them to communicate verbally what they felt at the time (Sanders & Stappers, 2012; Wilke et al., 2025). We therefore prepared visual props in the form of printed cards, as they can expand vocabulary and encourage patients to express their feelings, by making it more tangible (Sanders & Stappers, 2012, p. 21). The cards consisted of a graphical element together with either an emotion or an area of life (see Figure 9 and Appendix L). In this way, a patient could, for example, combine the emotion *Anxiety* with the area of *Relationships*.

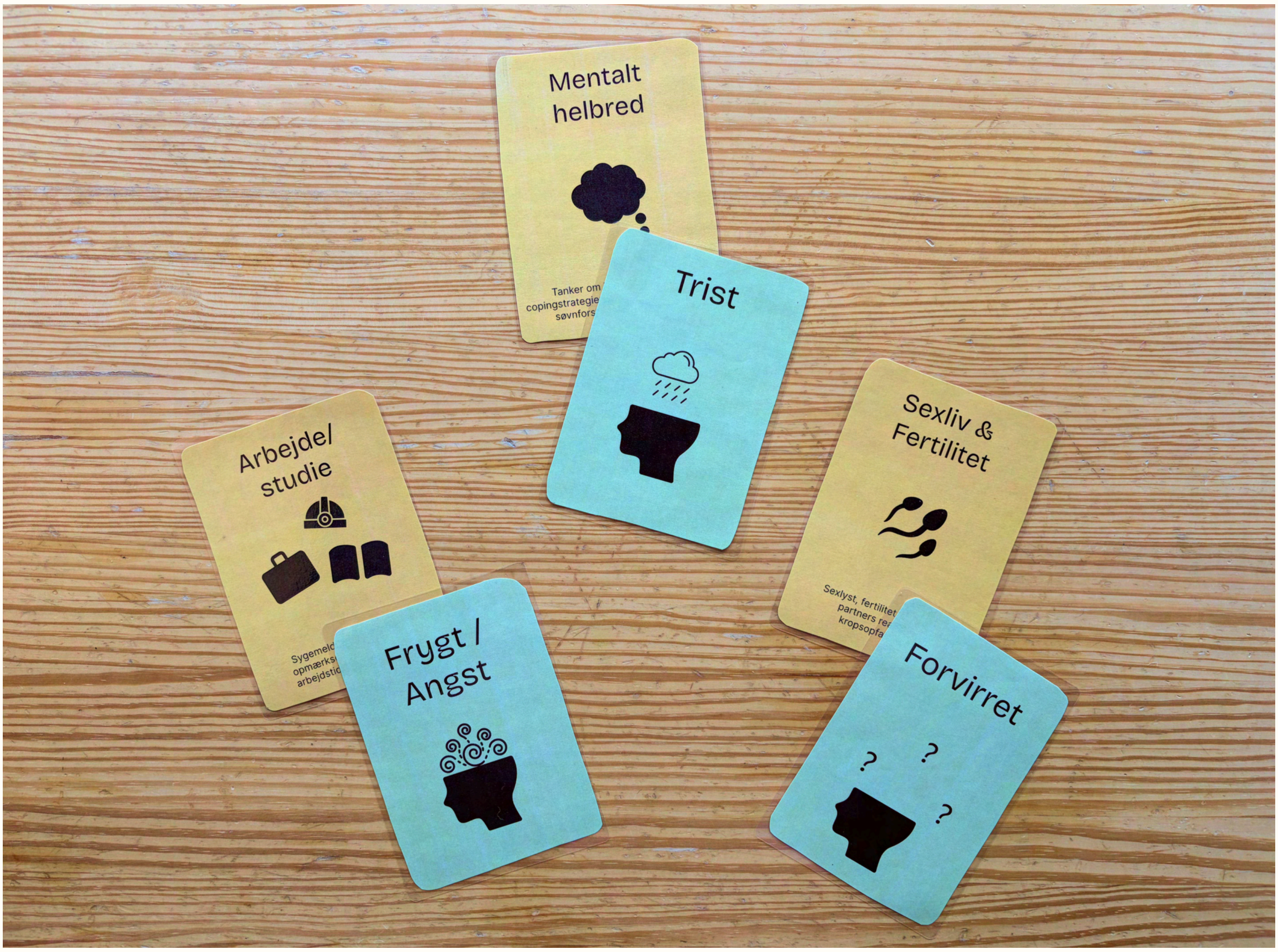


Figure 9: Examples of emotion and life area cards – applied in patient interviews

DEPARTMENT OBSERVATION

Before conducting the interviews, we wanted to understand the environment we were designing within, and therefore, we chose to observe both departments, URO and ONC. Our observational research was inspired by the Service Safari tool, which helps designers experience the service and its interactions from a user's perspective (Service Design Tools, n.d.). However, the service safari required a clear protocol for observation, which we did not follow, so we only used some elements of the tool and adapted it to our project. We focused on both observing the physical elements and the environment and atmosphere. To document our findings, we took field notes (see Appendix M), which are brief notes of what was observed (Bryman, 2012, pp. 270–287). This activity provided us with a deeper understanding of the pathway, particularly highlighting the significant physical distance between the departments, which are located on opposite sides of the hospital and on different levels. It also enabled us to empathise more with patients, as we gained insights into the environments they navigate, including the specific rooms and settings that shape their experience.

4.5.2 INTERVIEW OUTCOMES & INSIGHTS

We were able to conduct interviews with three testicular cancer patients in total. Only one of the participants fell into the average age group, while the other two were older, and only one had undergone surgery at Rigshospitalet. Although the sample was limited, the variations in their survey answers were considered valuable, providing different perspectives on the patient pathway. One interview was conducted at the hospital, while the other two took place in their private homes. Each interview lasted approximately one hour.

The interviews were conducted and allowed the patients to elaborate on the survey responses. They also described the waiting time more in depth, often connecting to broader aspects of their lives and emotions. The visual cards supported this process, particularly in helping them to express emotions, as they acted as a facilitator for further reflection and elaboration. One of us conducted the interview while another took notes. The interviews were also audio-recorded, allowing us to be present in sensitive contexts.

To analyse the interviews, all recordings were transcribed (see Appendix N). We then reviewed the transcriptions and highlighted key quotes. Based on these, we wrote down central insights from each participant's experience. In addition, each patient pathway was visualised as a timeline to map their journey and better understand how their experiences unfolded over time (see Appendix O).

Information: Trusted, but inconsistently communicated

Overall, the interviews confirmed that all the patients felt safe during the waiting time, largely due to their trust and appreciation for the healthcare staff. One interviewee mentioned: *"I felt safe, and I know we have a fantastic healthcare system. I feel that all the professionals have been really good and taken me really seriously"*. He selected the cards *Safe and Confident* with the card *Support & Community*.

At the same time, the interviews revealed inconsistencies in how information was communicated, particularly by doctors. While written information was generally perceived as clear and helpful, some patients described negative experiences related to how their pathway and survival rate were explained. Some doctors had focused on the worst-case scenarios, with patients matching the visual cards *Fear/anxiety* with the *Future*.

Patient pathway: Unclear transitions between professionals

Patients also highlighted a lack of coordination and communication across health professionals. Some participants had been transferred between nurses and doctors without clear explanations of the next steps, leading to confusion and unanswered questions, matching cards as *Confused* with *Course of treatment*. A patient quoted: *"I felt a bit like a tossed ball. I think it could have been made smoother. Yes, maybe there could be fewer shifts"*. This suggested that it was not necessarily caused by missing information, but by how transitions and responsibilities were communicated to him.

Overall: Limited need for improvement

The interviews largely validated the survey findings, while also adding important nuance. For example, the person who expressed the most negative responses in the survey described a more balanced experience during the interview, emphasising that although the period was difficult, he was satisfied with his care. When asked about potential improvements, all participants pointed to only minor issues, related to individual encounters, such as how information was communicated by specific doctors. However, the patients described these issues as difficult to address and expressed a limited need for improvements in general. These findings made us rethink the initial case from the patient's perspective, as their experiences suggested a more nuanced and positive reality than first assumed.

4.6 CHECK-IN 2

Where insights shifted, and trust began

> **CONTEXT:**
> *Since the previous check-in, we had completed the patient surveys, observations at two clinics, and the first patient interview. The purpose of the check-in was therefore to share the insights collected so far. The data so far had shown general patient satisfaction; the check-in was also intended to explore deeper how and why the case originally unfolded, whether any relevant data or experiences were missing, and whether the challenge could be situated at the staff level.*

When the results were presented, the nurses immediately nuanced the findings. They noted that the survey respondents were not fully representative, as many were older than the typical patient population and had undergone surgery at other hospitals. Although the overall feedback from both the survey and the interview was positive, the nurses tended to focus on the few critical comments that had emerged, rather than the overall results. They dwelled on small details, for example, a specific patient need. However, this highlighted that the nurses are paying attention to the patients and their well-being, supporting the strategy of patient-centred care (Webgruppen på Rigshospitalet, 2024b). Despite the focus on critical aspects, they expressed strong engagement and appreciation for having concrete data reflecting patient perspectives.

As the discussion shifted towards the origins of the case, new and unexpected insights emerged. The initiative to improve the transition between two departments was not grounded in patient data, but in a nurse's observation of a lack of connection between departments. They described how the doctors communicated across departments, while nurses had no contact with one another. This created a sense of responsibility and discomfort when transferring patients without knowing who would receive them or how it would be followed up. The nurses explained that this lack of communication often resulted in uncertainty when patients asked questions, leading to responses such as *"We do not know, ask the other department"*. They wanted more openness and connection across departments and emphasised that this concern was shared more broadly among staff, not only within the project group. This also highlighted a strong desire for connection among the nurses.

Toward the end of the meeting, the nurses revealed that attempts to improve collaboration between departments had been ongoing for several years, without lasting success. Previous initiatives, such as workshops, focused on envisioning an ideal future hospital. However, they described it as disconnected from reality, such as the physical separation between departments. These efforts had not generated visible results, and communication about the next steps gradually faded. This indicated barriers connected to change initiation and implementation.

After the check-in, the nurses invited us to attend a nursing seminar the following day at the Centre for Cancer and Organ Diseases, with the aim of creating a shared understanding of the strategy and presenting ongoing projects. Efforts were made to ensure we gained access, signalling openness to continuing the collaboration beyond the scheduled project activities and marking an early shift in the relationship between the nurses and us, namely, developing trust.

4.7 Nurse seminar – From Ambition to Practice

The nurse seminar was a half-day event for nurses across the seven cancer departments at the hospital, as well as several leaders. The theme for the seminar was “Strategies in interaction – From ambition to practice”, with the stated aim to create a shared understanding across departments of the strategies and how they are unfolded in practice. The program consisted of eleven presentations by nurses on ongoing projects aimed at improving care delivery. This was followed by two presentations from leaders addressing strategic priorities and future directions.

One of the nurses shared the agenda with us the day before and informed us that our project would be presented as part of the program. This event felt significant as the seminar closely aligned with the focus of our project and offered an opportunity to gain a broader understanding of nurses across departments, as well as insights into how leaders communicated and worked with strategy in practice. We were also curious to see how the nurses chose to present the project publicly, what they emphasised, and how they interpreted its purpose. Attending the seminar was therefore both a learning opportunity and a way to show support and interest in the nurse’s work.

The nurse presentations showed a wide range of ongoing initiatives by motivated and engaged nurses, spanning from tools to support difficult patient conversations to empowering female cancer patients experiencing hair loss. Many of these projects appeared to be driven by the nurses themselves, indicating a strong internal motivation for improvement. At the same time, a few collaborated with other professional teams, such as design or strategy. The presentations also highlighted potential challenges related to capacity and competence. Several projects seemed to require skills beyond those nurses are typically trained for, showing a need for support from other fields, such as service design.

4.7.1 PRESENTING OUR PROJECT

When the nurses from the project group presented our project, it provided us with additional insights. They explained how the project had unfolded and introduced both the design team and the field of service design (see Figure 10). The presentation included pictures of us, and we were publicly acknowledged and thanked for our involvement. This moment stood out as a visible expression of appreciation and trust toward us as the design team. Their presentation confirmed that we were aligned on how the patient data were interpreted. Notably, however, the presentation did not touch upon the challenges experienced by the nurses themselves, which had been central in the previous check-in discussion. Toward the end of the presentation, the nurses mentioned that they had already started to brainstorm potential improvements to the patient pathway, including ideas such as follow-up phone calls or additional written information. This was the first time that we became aware that solutions had already been discussed, signalling a tendency to move quickly toward solutions before unpacking the underlying problem. According to Dorst (2011), this is a tendency in traditional problem solving, whereas design thinking involves framing and reframing the problem to understand the underlying issues before moving into a solution-focused space.

4.7.2 LEADERS TALKING ABOUT THE STRATEGY

Lastly, leaders from the cancer department shared their strategy (see Centre for Cancer and Organ Diseases strategy in 2.3.1). They highlighted the significance of having a unified strategic direction to tackle the rising complexity in healthcare, such as evolving patient needs and increased demand for multidisciplinary teamwork. This shared vision is crucial for motivating employees to lead change (Edmondson, 2004). During the presentation, the leaders paused and asked the audience to raise their hands if they were familiar with the strategy for the cancer department. Around 40% of the room raised their hand, a result that did not seem to surprise the presenters. This moment was used to further express the role of strategy as a shared direction, rather than directly forming patient interactions. The presentation emphasised that strategy provides a common language, vision and foundation for reflection and dialogue across departments. They explicitly highlighted the importance of openly addressing uncertainty, arguing that avoiding these conversations risks losing direction over time.

Figure 10: Nurses presenting our project at the nurse seminar

Although attending the nurse seminar was not initially part of the planned project activities, it proved highly insightful and shaped our understanding of the culture within the cancer departments. At the same time, it raised questions about visibility, impact and sustainability as many of these initiatives were unknown to other nurses and us. This validated the lack of coordination and communication between the departments, which was one of the addressed issues that formed the case. Differences in engagement were also noticeable as presenters were highly committed to their own projects, while general engagement in others' initiatives seemed lower. This raised questions about whether this was due to tiredness and focus or cultural dynamics around ownership and competitiveness.

4.8 Pathway Coordinator Interview

During the mapping workshop, the nurses introduced us to the role of a pathway coordinator whom cancer patients could contact during the waiting period. Through desk research, we learned that the coordinator was a part of the "Unit for Coherent Patient Care" at the cancer department, which aims to support safe and coherent patient transitions. The coordinator's role includes supporting patients and relatives throughout the cancer pathway and facilitating collaboration across departments (Webgruppen på Rigshospitalet, 2025). We therefore found it highly relevant to interview the coordinator. The coordinator's position seemed to hold a unique overview of the overall transition process, by being in between patients, nurses and departments. We saw the coordinator as a key actor to help us connect the insights we had gathered so far and nuance our findings. The interview was therefore conducted to gain a more holistic understanding of the system and to further explore our emerging assumption of the problem lying at the staff level.

4.8.1 COORDINATOR INTERVIEW PREPARATION

We contacted the coordinator through email and scheduled a one-hour in-person interview. We chose to conduct a semi-structured interview revolving around four main themes: the coordinator's role, experiences with patients, collaboration with staff, and finally, a discussion around our findings and the coordinators' reflections on them. Although we had already gained an overview of their role through desk research, we wanted them to describe their responsibilities in their own words. This was to ensure that we had the right understanding of what them does, but also to have a point of reference when moving further in the conversation. We intentionally planned questions about patients and staff before introducing our findings. This allowed the coordinator to speak openly about their experiences without being influenced by our interpretations. By first understanding their perspective, we were better positioned to later present our findings and ask more targeted follow-up questions. This structure helped us explore if they experience aligned with, challenged or expanded the insights we had gathered so far.

4.8.2 COORDINATOR INTERVIEW OUTCOME & INSIGHTS

The interview was conducted in a meeting room at the hospital, with one of us acting as the interviewer and the coordinator as the interview participant. Prior to the interview, the coordinator signed a consent form allowing us to record and further use and share the findings (see Appendix F). As the interview was conducted by a single interviewer, it was audio-recorded to ensure accurate capture of the coordinator's experiences and reflections and to remain fully engaged. Following the interview, the audio recording was transcribed and analysed by highlighting key themes and insights (see Appendix N).

The coordinator's role: A buffer, rather than a bridge
By asking them about the role, we quickly realised that the role was primarily administrative, rather than facilitating collaboration. They use most of their time working with cancer care packages, ensuring that patients remain on the right track within the system and that maximum waiting time policies are followed. Contact with patients, relatives and external partners takes place through incoming phone calls and often involves clarifying processes or referring people to the right professionals. Additionally, despite being a part of the "Unit for Coherent Patient Care", there is no ongoing collaboration or contact between the different professional roles within the unit. These findings contrasted with our expectations based on desk research and the unit's name. Rather than functioning as an active driver for coherence across departments, the coordinator's role seemed more like a buffer service, compensating for the gaps from other services, as described by de Götzen (2025). They provide support when confusion arises, ensure the following rules, and direct inquiries rather than facilitating system change.

The patient experience: Caught between two departments
The coordinator described a strong sense of empathy toward patients with testicular cancer and demonstrated extensive knowledge about the clinical and emotional aspects of their journey. Surprisingly, patients with testicular cancer are the group that most frequently contacts them compared to other cancer types. They assumed that this may be because the nurses include their contact information in the green folder, which the patients receive. In practice, this results in approximately one incoming call every two weeks. It is usually the patients themselves calling, rather than relatives. They perceived them as generally resourceful, although they emphasised that it can be difficult to interpret patients through phone conversations alone. A large part of these phone calls involves listening to patients, allowing them to express frustration and concerns and providing emotional support.

Many of these calls relate to post-operative concerns, such as wound healing and physical limitations. The coordinator noted that them is not authorised to provide medical advice on these issues and therefore refers patients back to URO where they were operated. In contrast, questions related to ONC could sometimes be answered more directly, as they had previously worked there as a nurse. However, they emphasised the importance of caution and often chose to refer inquiries to ensure correct information and protect patient safety.

Another recurring theme is waiting times, particularly after surgery, when patients are waiting to be transferred to ONC for further treatment. Patients often express concern and frustration about why results or next steps take time. In these situations, the coordinator mainly explains the reasons behind the waiting periods and tries to reassure the patients. The coordinator highlighted that the period after surgery can be challenging for patients as they often feel like they have nowhere to belong in the system. They summarised this experience by stating:

> *"For many patients, this period is deeply frustrating. Having finished in one department and not yet received by another, they experience being in between two chairs, unsure where to direct their questions"*

While they expressed understanding of patients' frustration, they did not see possibilities for change and described the overall patient pathway as relatively well-functioning. This was also due to regulations of the cancer package, mentioned in 2.2.1 System Complexity.

Staff collaboration: Shared intentions, silos in practice

The interview revealed that the coordinator has limited contact with nurses and staff in other departments. While staff may occasionally reach out to them in specific situations to ask questions, the contact is not part of a systemic collaboration. The coordinator expressed a wish for closer and more consistent collaboration but described the current ways of working as siloed, leading to fragmented distribution of responsibilities and cases (Alves & Meneses, 2018).

They explained that although departments operate separately, patients move across them, often without clear coordination. Over the years, several initiatives have tried to address this challenge. The coordinator has previously been in different collaboration groups with the intention of improving coherence and strengthening patient pathways. While they described these initiatives as well-intended, they emphasised that they did not lead to concrete changes in practice. They noted that these efforts had faded out over time due to a lack of prioritisation and time, which corresponded with what the nurses had described in check-in 2.

Our case: Addressing silos with patients in mind

When we presented the insights we had gathered to the coordinator, they recognised the challenges we had identified, particularly the lack of collaboration across departments. At the same time, they encouraged us not to underestimate patients. Although patients with testicular cancer are often perceived as resourceful and adaptable, they emphasised that a cancer diagnosis still has a significant emotional impact, regardless of outcome. According to the coordinator, many patients do not openly express their emotional struggles, which makes it difficult to identify those who need additional support.

In relation to potential solutions, the coordinator expressed a clear desire to take a more active role in the project. They stated that they would like to work more closely with departments and showed a willingness to allocate time to the project, addressing an initial concern we had regarding their availability. This highlighted a gap between the potential of their role and how it is currently utilised within the system.

4.9 KEY TAKEAWAYS: DISCOVER

- Check-ins emphasised the distinctions between mindsets and approaches, specifically the evidence-based and service design perspectives.
- The mapping activity resulted in a shared understanding of the patient pathway.
- Observation of the mapping activity and insights from the patient interviews pointed towards a lack of coordination and collaboration between the departments, both from a patient and nurse perspective.
- Patient interviews and surveys further revealed that patients were generally satisfied with the clarity of the cancer pathway.
- Activities revealed a highly engaged and motivated project group, taking on an active role, among other things, in handing surveys out.
- Trust was slowly built throughout the Discover phase through check-ins and the nurse seminar.
- The nurse seminar revealed several ongoing projects initiated by nurses.
- The pathway coordinator turned out to have a crucial role in the patient pathway; however, not living up to its full potential.

05.

Define

In the Define chapter, all insights gathered and observations made in Discover are analysed and clustered in a data synthesis session to identify key themes and opportunity spaces for further research, thereby forming the research question.

The chapter is divided into the following sections:

5.1 Data Synthesis 37

5.2 Research Question 41

5.3 Check-in 3: Aligning on a new direction 42

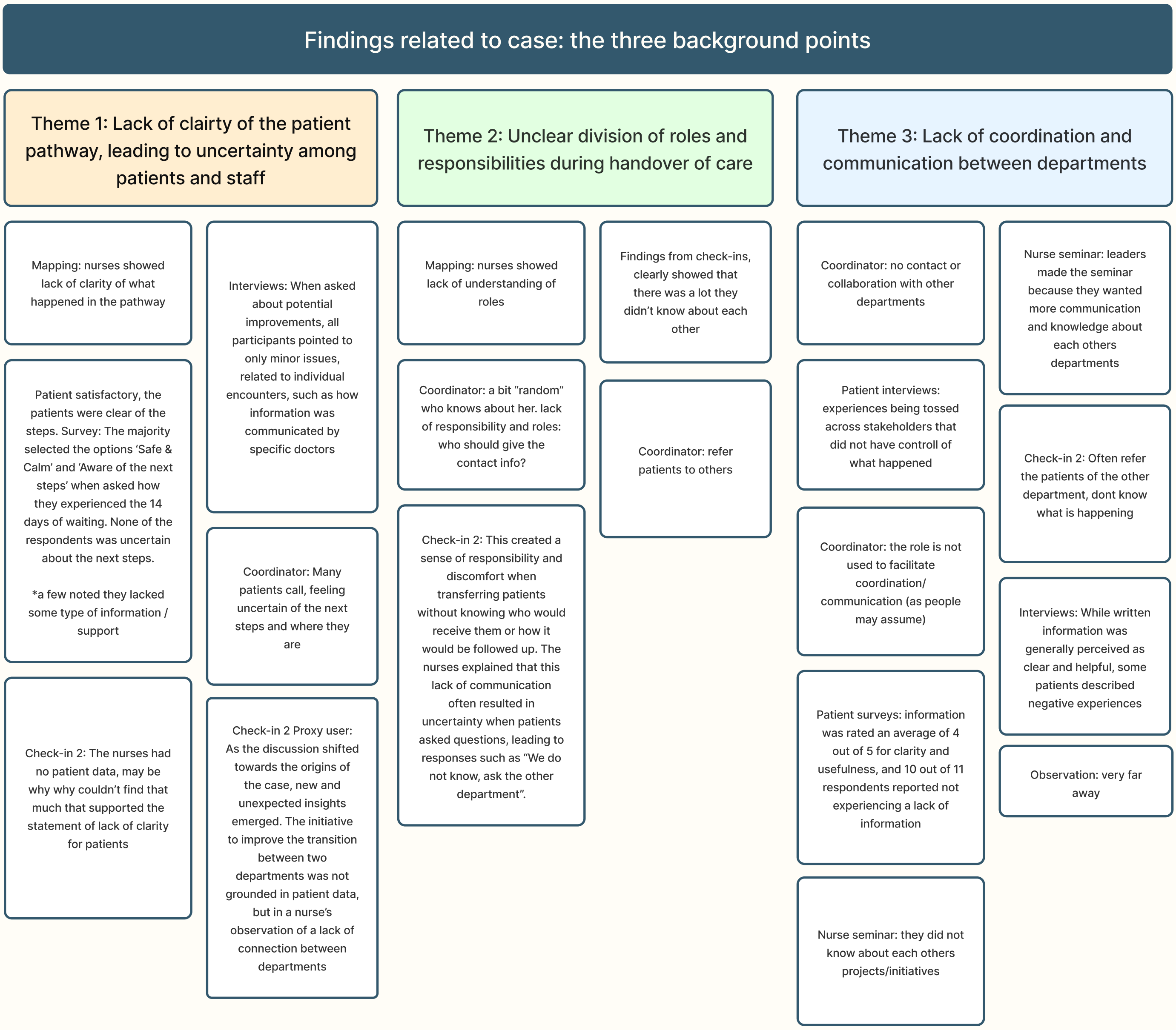
5.4 Key Takeaways: Define 43

5.1 Data Synthesis

After collecting and analysing the data in the Discover phase, we conducted an internal data synthesis session with the goal of analysing and clustering the data to identify key themes and opportunity spaces. We individually noted down interesting elements while maintaining an organised colour-coding system to trace each point back to its source. This was inspired by the *Research Wall* method, which provides an overview of all data and the different data types (Stickdorn et al., 2018, p. 110). Since the case was used as a lens to explore change, we aimed to have a dual perspective in the synthesis, distinguishing between insights related to the case itself and insights into the conditions for change. While analytically separated, these perspectives are closely interconnected as the case reveals and shapes conditions for change.

5.1.1 THE CASE

Throughout the Discover phase, we gathered insights into the context by exploring the case to identify underlying issues, needs, and opportunities. While sharing the interesting elements we had noted down, we clustered them into three themes related to the original case background (see Figure 11). This allowed us to examine whether the initial assumptions that initiated the case were reflected in the data.



Findings related to case: the three background points

Theme 1: Lack of clairty of the patient pathway, leading to uncertainty among patients and staff

Mapping: nurses showed lack of clarity of what happened in the pathway

Patient satisfactory, the patients were clear of the steps. Survey: The majority selected the options 'Safe & Calm' and 'Aware of the next steps' when asked how they experienced the 14 days of waiting. None of the respondents was uncertain about the next steps.

*a few noted they lacked some type of information / support

Check-in 2: The nurses had no patient data, may be why why couldn't find that much that supported the statement of lack of clarity for patients

Interviews: When asked about potential improvements, all participants pointed to only minor issues, related to individual encounters, such as how information was communicated by specific doctors

Coordinator: Many patients call, feeling uncertain of the next steps and where they are

Check-in 2 Proxy user: As the discussion shifted towards the origins of the case, new and unexpected insights emerged. The initiative to improve the transition between two departments was not grounded in patient data, but in a nurse's observation of a lack of connection between departments

Theme 2: Unclear division of roles and responsibilities during handover of care

Mapping: nurses showed lack of understanding of roles

Coordinator: a bit "random" who knows about her. lack of responsibility and roles: who should give the contact info?

Check-in 2: This created a sense of responsibility and discomfort when transferring patients without knowing who would receive them or how it would be followed up. The nurses explained that this lack of communication often resulted in uncertainty when patients asked questions, leading to responses such as "We do not know, ask the other department".

Findings from check-ins, clearly showed that there was a lot they didn't know about each other

Coordinator: refer patients to others

Theme 3: Lack of coordination and communication between departments

Coordinator: no contact or collaboration with other departments

Patient interviews: experiences being tossed across stakeholders that did not have controll of what happened

Coordinator: the role is not used to facilitate coordination/ communication (as people may assume)

Patient surveys: information was rated an average of 4 out of 5 for clarity and usefulness, and 10 out of 11 respondents reported not experiencing a lack of information

Nurse seminar: they did not know about each others projects/initiatives

Nurse seminar: leaders made the seminar because they wanted more communication and knowledge about each others departments

Check-in 2: Often refer the patients of the other department, dont know what is happening

Interviews: While written information was generally perceived as clear and helpful, some patients described negative experiences

Observation: very far away

Figure 11: Clustered insights related to the case

Theme 1: Lack of clarity of the patient pathway, among patients and staff
The analysis revealed that the nurses tended to have less clarity about certain aspects of the patient pathway than the patients did. The mapping exercise revealed that nurses had limited knowledge of what patients were going through in the other department, highlighting gaps in the shared understanding of the overall pathway. In contrast, surveys and interviews revealed that patients generally reported feeling safe and aware of the next steps, though a few lacked specific types of information and support. Through an exploration of the case's origins, it became clear in check-in 2 that the case had been initiated based on assumptions rather than patient data, which can explain the high patient satisfaction. To explore this further, we developed a visualisation of two possible explanations (see Figure 12). First, the high quality of individuals' work may compensate for organisational challenges by resolving them before they reach the patient. Second, the relatively streamlined pathway for testicular cancer patients, with only a single transition between departments, may make it easier to maintain clarity. However, the coordinator interview provided knowledge that testicular patients often call with questions about waiting time and next steps, suggesting that the surveys and interviews might not have fully captured everything, possibly due to limited representativeness. Overall, the findings showed a misalignment between how patients experienced the pathway and how the nurses understand it.

Theme 2: Unclear division of roles and responsibilities during handover of care
The data gathered showed that roles and responsibilities are not clearly defined across departments. Both the several check-ins and the mapping exercise revealed an unclear division of responsibility for different tasks along the pathway. The previous check-in revealed that nurses were often unable to answer patients' questions, instead referring them to other departments. Furthermore, insights from the coordinator interview validated this, as it appeared somewhat random which types of patients received her contact information, depending on individual staff actions. In addition, the coordinator primarily redirected patients rather than addressing their questions directly, making her role unclear to both patients and the relevant departments. Overall, the findings indicate a lack of ownership in patient handover and unclear roles during the waiting time, resulting in fragmented responsibility across the pathway.

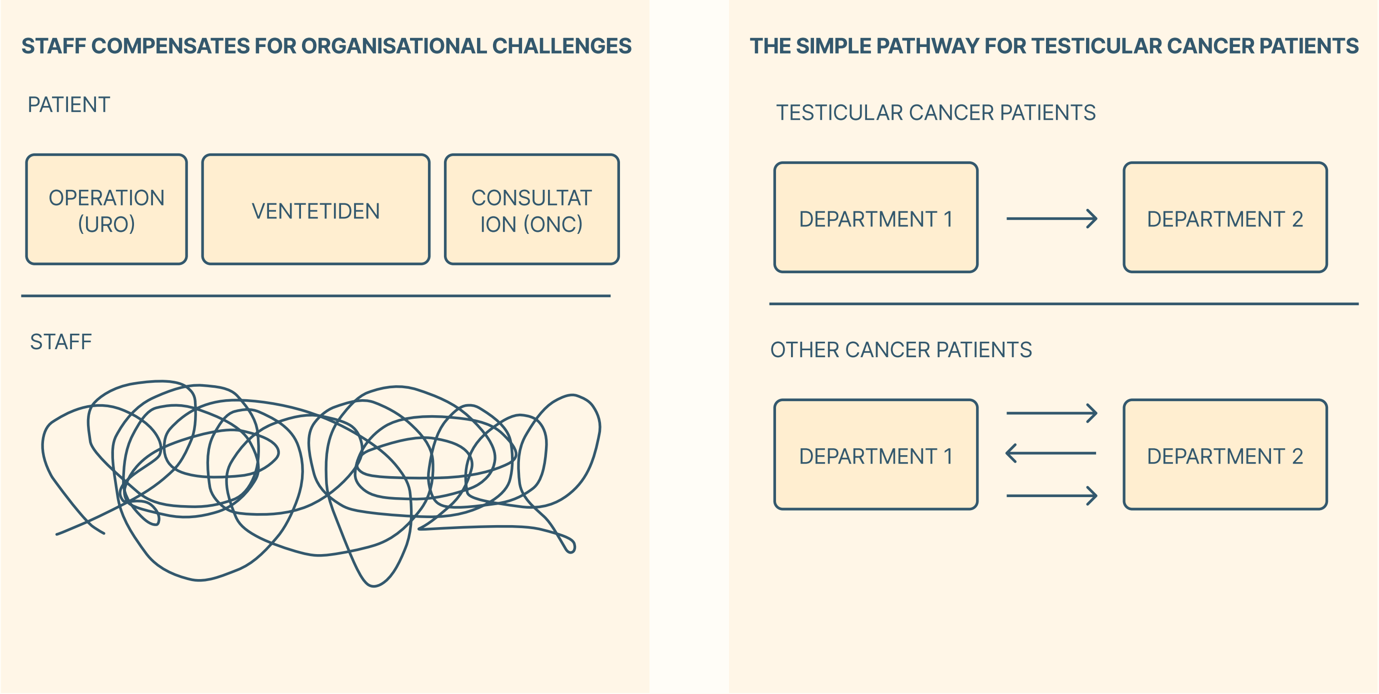


Figure 12: Two possible explanations of high patient satisfaction

Theme 3: Lack of coordination and communication between departments
The data clustering revealed a clear gap in coordination and communication between the departments. Patient interviews revealed gaps in communication between staff, as some felt tossed around between different staff, without being informed that it would happen. The need for better communication was further emphasised by the leaders, who had organised the nurse seminar to strengthen the understanding across departments. During the seminar, we observed multiple ongoing initiatives, but with limited awareness and coordination between them, potentially leading to parallel efforts. Insights from the coordinator interview also revealed that her role was not actively used to support coordination and that she had little to no contact with other departments. Observation further highlighted a significant physical distance between URO and ONC, which explains the limited interaction. The lack of communication is illustrated in Figure 13, which shows how the departments operate as separate units with distinct services. The coordinator role is intended to connect them, but remains disconnected. This leaves the patient as the main link between departments, despite not being prepared or intended to manage this role. Overall, the findings indicated a context with limited communication and coordination.

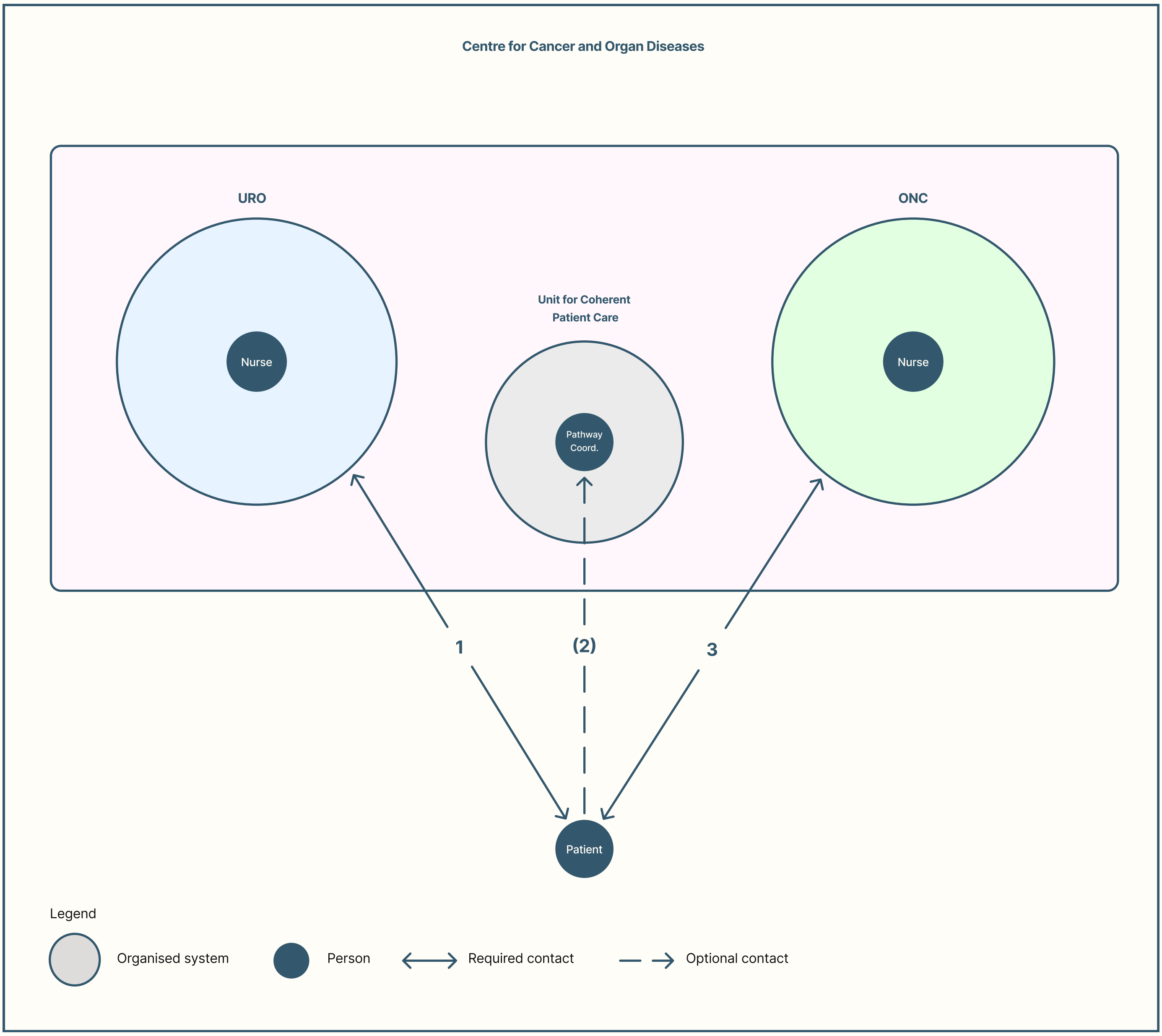


Figure 13: Map visualising fragmented communication across departments

5.1.2 THE FOCUS AREA

In addition to understanding the case itself, a second layer of analysis focused on the context through a change-oriented lens. The analysis, therefore, consists of our observations and interactions with the nurses, including discussions in check-ins and the activities we prepared and participated in. The analysis focuses on existing conditions that support change and barriers that limit the ability to create change.

Existing drivers and facilitators of change

Our observations indicated several existing drivers and facilitators of change within the context. The case itself was initiated by the nurses, demonstrating a strong sense of ownership, initiative, and engagement. The engagement had been evident throughout the process so far, as the nurses actively contributed to activities such as the survey and mapping exercise. Through their contribution, they consistently showed high motivation and interest in participating, as well as excitement for the project and its ongoing outcomes. They also invited and involved us in their world, such as inviting us to the nurse seminar, which reflected openness and a willingness to collaborate. Check-ins and the coordinator interview revealed that previous efforts have been made to improve, among other projects, collaboration, but without success, suggesting that there are both drivers and facilitators of change among the nurses and departments. The seminar further highlighted a wide range of initiatives across departments, as well as the leadership's ambition to foster a culture that supports change through shared language, collaboration and openness. This was reinforced by the strong desire among the project group and the coordinator for stronger connections across departments. Together, these findings show an environment characterised by high motivation, engagement and an existing foundation for enabling change.

Barriers to enabling change

While it was clear that there is a foundation for enabling change, the insights also revealed several barriers that limit its ability. Early check-ins revealed difficulties within our project group, adapting to one another’s approaches and language. The different expectations between a structured, evidence-based method and a more exploratory design approach led to misaligned expectations and less effective collaboration. Additionally, previous initiatives to improve collaboration did not seem to sustain, often falling flat due to time constraints and unclear responsibilities, reflecting broader barriers to translating ideas into implementation. Observations from the nurse seminar further suggested a lack of tools and support to carry out change efforts. As well as the uneven engagement across initiatives, this indicated that efforts were not fully collective. This was further emphasised in the seminar, which revealed limited awareness of the overall strategy, suggesting a lack of shared direction. In addition, when the nurses publicly presented our project, it revealed that they had already moved to thinking about solutions without exploring the area of problems. This was further evident in their presentation, which focused solely on patient issues rather than the underlying staff dynamics we had collaboratively uncovered. Overall, the findings indicate a lack of supporting structures to implement and sustain change efforts.

5.2 Research Question

The clustering of insights resulting in several themes contributed to a broader understanding of the case related to patients and nurses, and second, to the observed drivers and barriers to change. Our initial focus areas were, through the exploration of the case, how change is perceived in practice and how service design approaches may facilitate and support change. The analysis of insights revealed an existing foundation for both driving and facilitating change, grounded in high engagement and proactivity. However, barriers such as a lack of collective drive, tools and methods, and resources pose greater challenges, since ideas rarely reach the implementation phase, leading to no changes. Therefore, we see that nurses do not lack the motivation, but rather the capabilities to drive change.

Given the close relationship between service design and change processes, and its potential to address implementation challenges (Stickdorn et al., 2018, pp. 271–278), we found it relevant to explore how a service design approach can support the development of such capabilities. Strengthening internal capabilities can enable more sustainable change and better prepare the hospital departments to address challenges beyond this current project (Bailey, 2012). This leads to the following research question:

> How can a service design approach enable nurses in cancer departments to develop internal capabilities for implementing and sustaining change?

Rather than asking what should be improved, the question focus on how the system itself becomes capable of improving. This moves the focus from solutions to conditions. Capabilities mean the ability to do something (Cambridge Dictionary, nd.-a). In this context, internal capabilities go beyond individual competence and rather refer to a collective ability of the nurses to translate intentions into sustained practice. This is critical because without such capabilities, change initiatives risk remaining temporary efforts.

Addressing this research question aims to contribute on multiple levels. First, our primary objective is to explore how a service design approach can enable nurses to develop internal capabilities for implementing and sustaining change over time. To address this, our approach involves the project group taking a more active role in casework, while we act as facilitators who observe, support, and guide them in driving change. By shifting the ownership of the case, the approach also seeks to address key challenges identified in the case, particularly related to collaboration and unclear responsibility. Through this active involvement, the nurses will address patient-related issues while also strengthening the collaboration between departments. Ultimately, this creates an impact on multiple levels while contributing to answering the research question.

5.3 CHECK-IN 3

Aligning on a new direction

> **CONTEXT:**
> *At this point in the process, we had completed our analysis and synthesis of the collected data and identified a direction: tackling implementation issues. It was now time to share our analysis with the project group. The purpose was both to inform them and to verify whether they could relate to our observations, and to propose the narrowed-down direction. The meeting was supported by visual slides to clearly communicate the key findings.*

Presenting the findings on the patients and staff was approached with some caution. While staff-related challenges had been discussed previously, earlier check-ins showed that the nurses often returned to a patient focus, despite data showing high patient satisfaction. This suggested a strong patient-focused mindset, where focus on continuous improvement made it less natural to recognise when things worked well. It was therefore important to clearly communicate and reinforce what the patient data showed. To address this, we deliberately emphasised positive patient feedback; several comments revolved around patients appreciating the nurses' work. A comment, referring to a nurse, was: *"She was calm, kind and reassuring. It made a big difference that we met her"*. This helped emphasise the quality of care being delivered and created a shared understanding of the data, before moving on to staff-related challenges. Taking time to highlight these positive aspects seemed to reduce defensiveness, aligning with research that emphasises recognising and validating professional contributions to foster motivation and create a more open dialogue (Amabile & Kramer, 2012).

The overall reaction to the findings was positive. We noticed that critical concerns about their work as nurses appeared to lessen. They recognised and agreed with our explanations for the high patient satisfaction and acknowledged that the relatively simple patient pathway could contribute to the observed positive outcomes. Several nurses also reflected that the challenges may lie more in internal collaboration. The findings clearly resonated with their own experiences and signalled to engage with the issue. Notably, they seemed to naturally mention examples of implementation challenges, even before we introduced it as a topic. This reassured us that the direction was not only accepted, but internally recognised.

We then presented our intended direction and how we planned to proceed from that point onward. We emphasised that our focus would be on them and the collaboration between departments, with particular attention to strengthening their ability to implement initiatives. The reactions were positive and enthusiastic, and the project group highlighted that we had identified a very relevant issue. This marked an important moment of validation and alignment before moving forward.

5.4 KEY TAKEAWAYS: DEFINE

- There is a misalignment between how patients experience the pathway and how the nurses understand it.
- Roles and responsibilities in patient handover are unclear, leading to a fragmented pathway.
- There is a clear lack of communication and coordination across departments.
- At the same time, the environment shows high motivation, engagement and an existing foundation for enabling change.
- However, there is a lack of supporting structures to implement and sustain change efforts.
- Based on these insights, we created the following research question: *How can a service design approach enable nurses in cancer departments to develop internal capabilities for implementing and sustaining change?*
- The research question aims to contribute on multiple levels by addressing both implementation challenges and the case-specific issues.
- The check-in showed that we were all aligned on the findings and the direction within the project group.

06.

Develop

As the research question was framed in the Define phase, ideas are generated and explored in this chapter to solve case-related issues. Further, the chapter explores how a service design approach can enable nurses to develop internal capabilities by applying several service design tools in an ideation workshop to observe their perception and use.

The chapter is divided into the following sections:

6.1 Ideation Workshop 45

6.2 Development of the One-Pager 51

6.3 Key Takeaways: Develop 53

6.1 Ideation Workshop

To kick off the Develop phase, we planned an ideation workshop with the purpose of generating ideas to improve collaboration among staff in the two departments. This decision was based on the analysis in the Define phase, which revealed overall high patient satisfaction and identified room for improvement in collaboration between the two departments. This was not to shift focus away from the patients; rather, we saw that increasing collaboration could enhance the patient experience of the pathway. Additionally, we saw the ideation workshop as an opportunity to introduce the project group to several ideation and implementation methods and provide hands-on experience in applying them, which could increase confidence in engaging and initiating similar processes in the future (Bailey, 2012). Furthermore, it offered a space for us to observe how they perceived the methods in practice, with the aim of applying them to build capabilities.

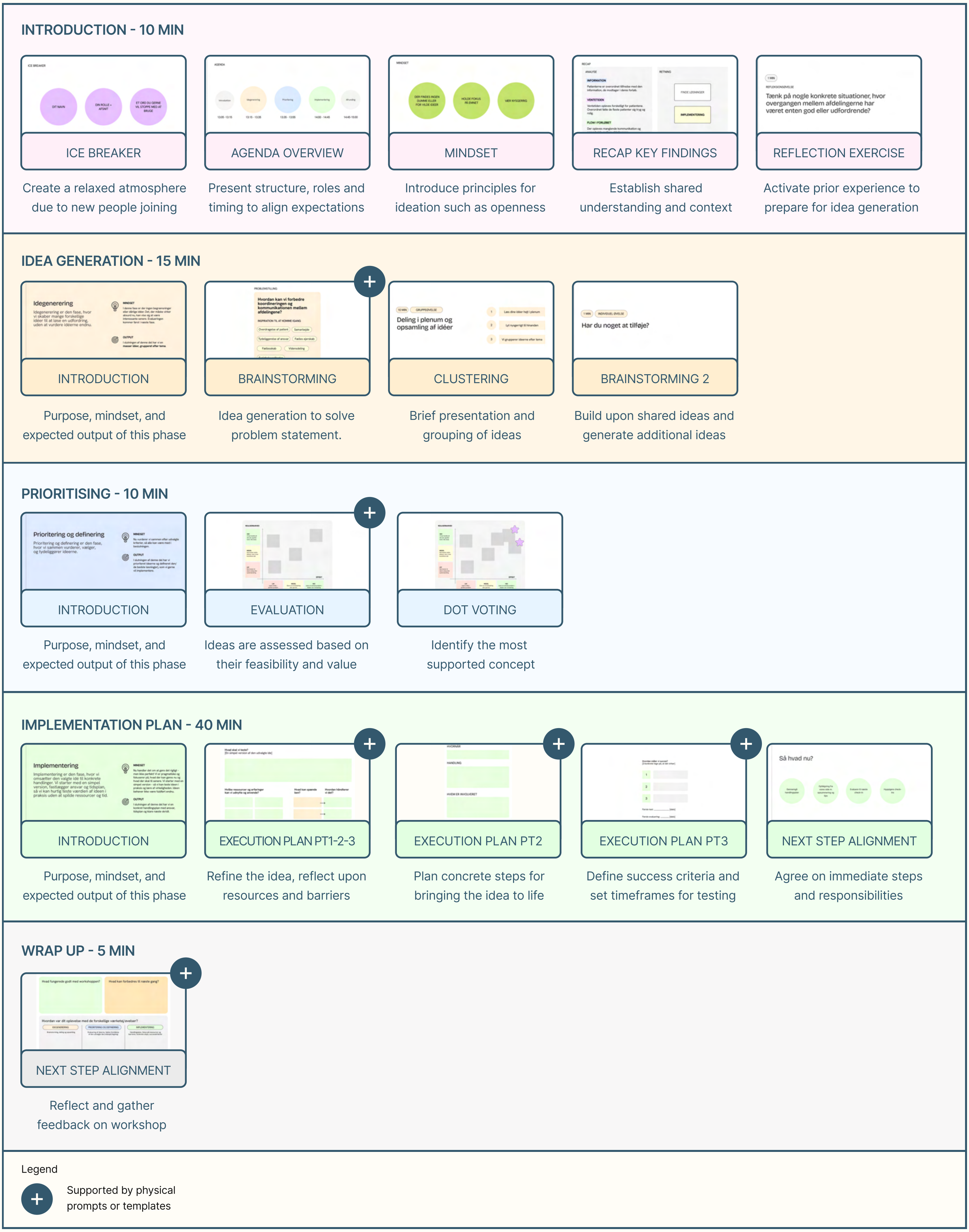
6.1.1 PREPARATION

To prepare for the workshop, we only invited nurses, as the focus was on enhancing the collaboration between them. While the project group had demonstrated a high level of engagement, including additional nurses allowed for a broader understanding of how nurses outside the group might participate in such a process, which is why we asked them to invite more nurses. Furthermore, we saw it as a way to support implementation by building a sense of ownership around potential solutions. The pathway coordinator was also invited, as she had an external perspective of the two departments. Additionally, it could strengthen the connection and relationship between the departments and the coordinator. The workshop was carefully planned to ensure relevance and feasibility for the project group. Based on feedback from the previous check-in, the duration was set to two hours. This was enough time to cover the planned activities while remaining realistic within the nurses' work schedules. The ideation workshop revolved around the following problem statement:

How might we improve the coordination and communication between the departments?

As previous findings indicated, the barriers to driving change were not a lack of ideas, but rather difficulties in developing and implementing them. We therefore planned to dedicate the first half of the workshop to a traditional ideation workshop, including brainstorming, clustering ideas, evaluating ideas, and selecting ideas (Stickdorn et al., 2018, p. 158). And the other half on reflecting and planning on how these ideas could progress in practice, focusing on testing and implementation. In this way, the workshop was designed as a "rapid" real-life simulation in which participants moved from insight to idea generation and then to initial planning for implementation. We intentionally planned to be facilitators, rather than co-designers, in the workshop. While co-design can contribute to idea development and new perspectives (Sanders & Stappers, 2012, pp. 15–35), taking a facilitative role felt more appropriate.

Following the initial planning, a draft agenda was shared with the project group and the service designer and anthropologist within the department one week in advance. By inviting feedback on the agenda, we ensured the workshop was relevant and gave participants an opportunity to begin reflecting on ideas in advance, based on the problem statement. The project group did not suggest any changes. The service designer and anthropologist, drawing on prior experience with similar workshops at Rigshospitalet, provided several suggestions. They recommended reducing the time spent on the introduction, clarifying the expected output for each exercise, and focusing on developing a single idea rather than multiple. They also shared a concrete list of questions to ask the participants, to support the development of a realistic implementation plan. Based on this input, the workshop plan was refined, resulting in the final structure with supporting materials (see Figure 14).



INTRODUCTION - 10 MIN

ICE BREAKER
Create a relaxed atmosphere due to new people joining

AGENDA OVERVIEW
Present structure, roles and timing to align expectations

MINDSET
Introduce principles for ideation such as openness

RECAP KEY FINDINGS
Establish shared understanding and context

REFLECTION EXERCISE
Activate prior experience to prepare for idea generation

IDEA GENERATION - 15 MIN

INTRODUCTION
Purpose, mindset, and expected output of this phase

BRAINSTORMING +
Idea generation to solve problem statement.

CLUSTERING
Brief presentation and grouping of ideas

BRAINSTORMING 2
Build upon shared ideas and generate additional ideas

PRIORITISING - 10 MIN

INTRODUCTION
Purpose, mindset, and expected output of this phase

EVALUATION +
Ideas are assessed based on their feasibility and value

DOT VOTING
Identify the most supported concept

IMPLEMENTATION PLAN - 40 MIN

INTRODUCTION
Purpose, mindset, and expected output of this phase

EXECUTION PLAN PT1-2-3 +
Refine the idea, reflect upon resources and barriers

EXECUTION PLAN PT2 +
Plan concrete steps for bringing the idea to life

EXECUTION PLAN PT3 +
Define success criteria and set timeframes for testing

NEXT STEP ALIGNMENT
Agree on immediate steps and responsibilities

WRAP UP - 5 MIN

NEXT STEP ALIGNMENT +
Reflect and gather feedback on workshop

Legend

+ Supported by physical prompts or templates

Figure 14: Ideation workshop structure describing the activities

6.1.2 CONDUCT OF WORKSHOP & RESULTS

The workshop was conducted in a large meeting room at the hospital. Two of us acted as facilitators, while the third served as the notetaker to support documentation. All members of the project group attended, along with one additional nurse, who later became part of the project group. The limited number of additional participants was due to constraints related to time and capacity within the departments. The pathway coordinator, who had initially accepted, was unfortunately unable to attend due to a last-minute scheduling conflict. In total, six participants attended the workshop: three from URO and three from ONC.

Idea development: aligned thinking & persistent patient focus

At the first brainstorming activity, the nurses generated around 4-7 ideas per person; many of these ideas overlapped and clustered around similar themes. Notably, the majority of ideas focused on improving the patient pathway, rather than addressing collaboration between staff, which was the intended focus of the workshop. The ideas primarily revolved around three areas: improving IT systems (e.g. new functions to communicate patient needs, patient initiatives, shared information material), and increased coordination between departments (e.g. physical tours across departments). During voting, all participants selected similar ideas and ultimately decided to pursue *shared patient material* (see Figure 15). This strong patient focus was unexpected, as earlier discussions had led to a shared decision to focus on staff-related challenges, based on the limited clarity of patient problems. This raised questions about whether we communicated the problem framing clearly enough or whether existing mental models and habits influenced the direction of idea development. Furthermore, it validated their tendency to move to solutions without including the data gathered.

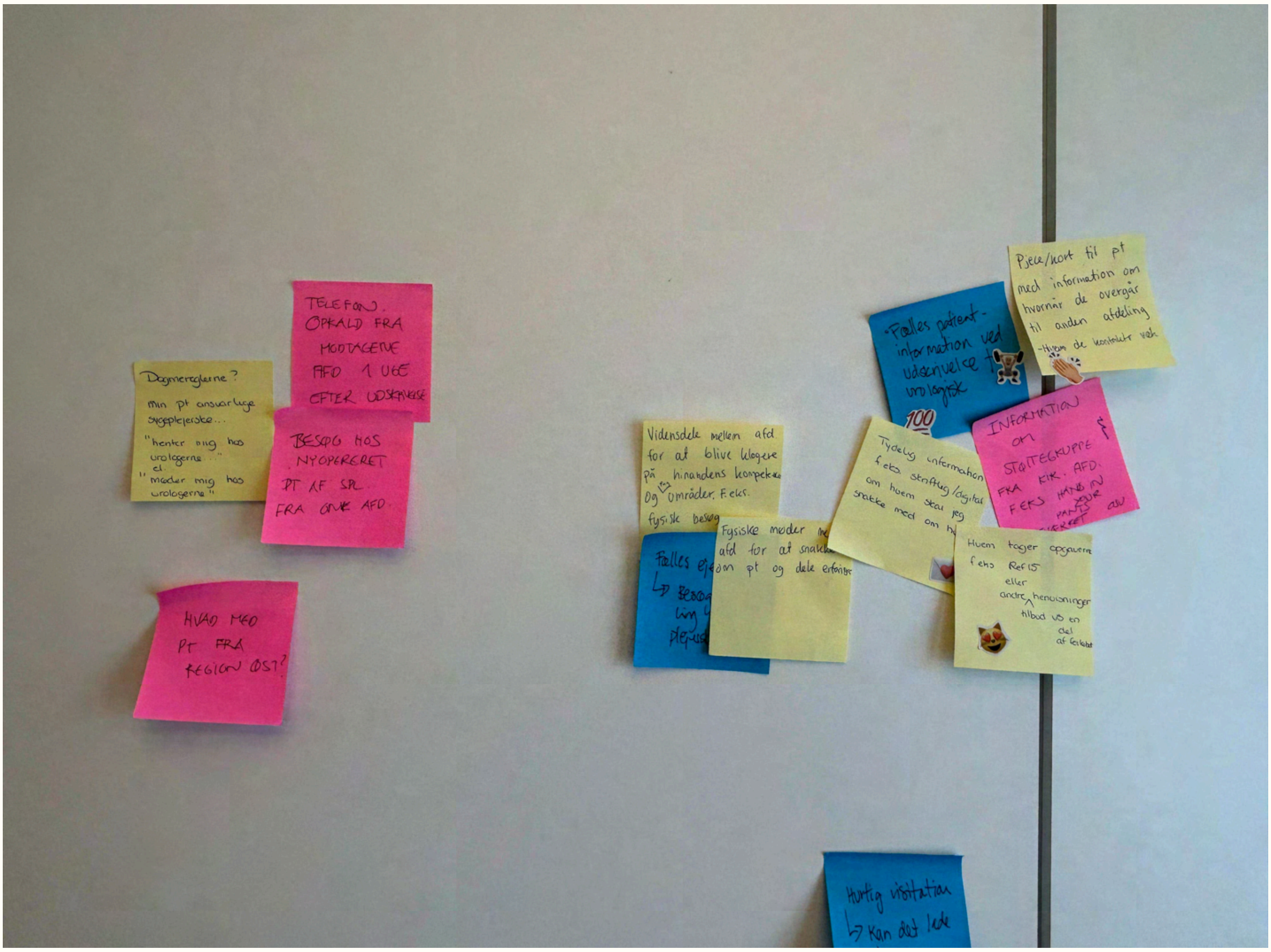


Figure 15: Result of Dot Voting session during ideation workshop

Break: the turning point of intervening or letting it unfold

Following the voting session, the short break provided an opportunity for us to reflect on the direction of the workshop and decide how to proceed. We had to quickly assess whether to adjust the course or continue as planned.

On one hand, it was clear that the selected idea was not aligned with the insights from earlier data gathering, showing that challenges pointed towards staff rather than patients. From this perspective, intervening could help steer the process back toward our original focus. On the other hand, doing so risked disrupting the sense of ownership and the natural progression of the workshop, which was a central intention.

We ultimately decided to let the nurses continue developing their chosen idea. Although this meant moving away from the original focus, we considered the process itself as valuable. By continuing with the selected idea, it also gave us the opportunity to observe how they collaborated and developed an idea in practice, which remained relevant for understanding how change initiatives can be carried forward.

Implementation: pushing toward actions

As the workshop moved toward implementation focus, the nurses aligned on the chosen idea: developing a one-page document containing key information for patients. The idea was partly inspired by examples from other departments where similar formats had been successfully received. The project group focused largely on the content of the one-pager, rather than working with the implementation templates we had developed, leading to the conversation remaining at a conceptual level. To move forward, we intervened more actively by asking the specific questions from the templates and filling them out together, which helped them progress (see Figure 16).

Figure 16: Us intervening to drive progress during the ideation workshop

When having to decide on a simple version of the idea, they found it difficult to decide on what to write and were hesitant to make a simple version. This reflected a tendency for striving toward perfection and wanting fully developed solutions before taking action. As one participant noted, *"We are used to thinking everything through in detail beforehand"*. To address this, we emphasised the importance of testing early and developing a simple version of the idea before moving on. Further elaborating on rapid prototyping and the value of small pilot tests, which is about testing a solution quickly, learning from it, and then adapting, without wasting too many resources (Junginger & Sangiorgi, 2009; Stickdorn et al., 2018, p. 13). We challenged them to create a first prototype within a week. Another participant reflected, *"We often want to have everything in place at once, but we need to adopt a mindset where we can take one step at a time"*. This highlighted an emerging awareness around the need to shift toward a more iterative approach in the development of ideas.

Following this shift, the nurses began to engage more concretely with the planning process (see Figure 17). They collaboratively defined next steps, assigned roles, and made success criteria, including a patient survey to evaluate the solution. They also coordinated by aligning on specific dates for testing and follow-up. Notably, they increasingly took initiative and ownership of the implementation process, independently delegating tasks and driving the planning forward. To ensure a shared understanding and alignment, we documented the plan and shared it with the participants via mail after the workshop.

We agreed that the responsibility of developing the solution for the patients rested on the nurses, as a way to embed the methods and tools in their everyday practice. However, we would be available at any point to provide support if needed. According to Morelli et al. (2021, p. 64), doing so not only helps develop capabilities but also sustains them. Since value is only produced when users participate in or use services, designers must create the conditions for users to create value (Morelli et al., 2021, p. 45). Therefore, we agreed to later discuss testing tips and perspectives, as well as providing them with an evaluation scheme, when the one-pager had been finalised.

Figure 17: One of the nurses taking the lead of filling out the template in the ideation workshop

Wrap up: positively stepping outside the comfort zone
To wrap up the workshop, we were curious about how the workshop was received by the project group, asking them to fill out the reflection template (see Figure 18). Their responses revealed that the implementation focus had made the strongest impression, with several nurses highlighting that it was both challenging and eye-opening.

One nurse reflected, *"Everyone wants to be a part of the project, but no one wants to be the project".* This points to a common barrier in their context: a general willingness to be involved, but hesitation when it comes to ownership and responsibility of implementation. Ownership is further elaborated upon by Amabile and Kramer (2012), highlighting that when individuals are satisfied with their own work, their co-workers, and their organisation, they become more creative and proactive. In contrast, if the staff have individual or unclear goals and conflicting priorities, they become frustrated and demotivated.

Participants expressed both discomfort and appreciation when encouraged to develop and test a simple version of their idea within a short timeframe. One participant stated, *"It feels a bit rushed. I prefer to spend more time developing something before moving forward"*. However, the same participant added, *"It's good that we are being pushed, it never happens that something happens within a week!".* This highlighted a recognition that external pressure can help move initiatives forward by creating the right conditions and succeeding in adapting the tool and methods to the context (Morelli et al., 2021, p. 45; van der Bijl-Brouwer, 2022).

Another nurse emphasised the balance between speed and quality, *"We also need to be professional and deliver something well-developed for the patients; it is a balance".* This reflects an underlying concern about maintaining professional standards, particularly in healthcare, where accuracy is critical (Nilsen et al., 2016). We acknowledged this concern and emphasised the importance of adapting testing approaches to the context, for example, clearly communicating that it is a prototype. The workshop concluded with one participant remarking, *"This is a whole new world"*. This suggests that the workshop not only introduced new tools but also challenged and expanded existing mindsets.

Hvad fungerede godt med workshoppen?

Hvad kan forbedres til næste gang?

Hvordan var dit oplevelse med de forskellige værktøj/øvelser?

IDEGENERERING	PRIORITERING OG DEFINERING	IMPLEMENTERING
Brainstorming, deling og opsamling	Evaluering af ideerne, fælles forståelse af den udvalgte ide (rollespil/tegning)	Handlingsplan, fokus på ressourcer og barrierer, konkrete steps, successkriterier

Figure 18: Reflection template used during the ideation workshop

6.1.3 REFLECTING UPON THE WORKSHOP

After the workshop, we reflected upon the outcome. The workshop provided valuable insights into group dynamics and practical challenges with moving from ideas to implementation in real life.

Overall, the participants were highly engaged and positive throughout the workshop, including the additional nurse who participated. The level of engagement was consistent with the observations of our previous meetings. While the group dynamics remained relatively stable, a notable shift occurred during the implementation exercises. Here, one of the nurses from the ONC department took a more dominant role, actively guiding the discussion and contributing to decision-making. We saw this as a positive development, as successful implementation often relies on individuals or change agents to take initiative (Alvesson & Sveningsson, 2025, pp. 120–128; Lunenburg, 2010).

We also identified several areas of improvement for the workshop. We included multiple activities within a limited timeframe, which appeared overwhelming for the participants. It required continuous facilitation to ensure progression, suggesting that the plan may have been too ambitious. Furthermore, the project group sometimes struggled to engage with the materials, often going back to discussion rather than completing the task. This could indicate that the purpose of the tools and materials was not always clearly explained. This highlighted the importance of aligning tools with the context, working practices, and familiarity (Jones, 2013, p. 7).

The role of us as facilitators was also a key point of reflection. Throughout the workshop, our role gradually shifted from facilitating to directing, particularly in guiding them toward concrete planning. As this proved to be effective, it suggests that earlier intervention could have been beneficial to influence the overall direction of the workshop. However, even if the workshop did not unfold as planned, we consider the overall outcome as valuable. While the initial plan was to develop concrete solutions to improve collaboration between departments, the process itself became a form of collaboration. This also opened an opportunity to follow the development further, using it as a case to observe and support how initiatives are implemented.

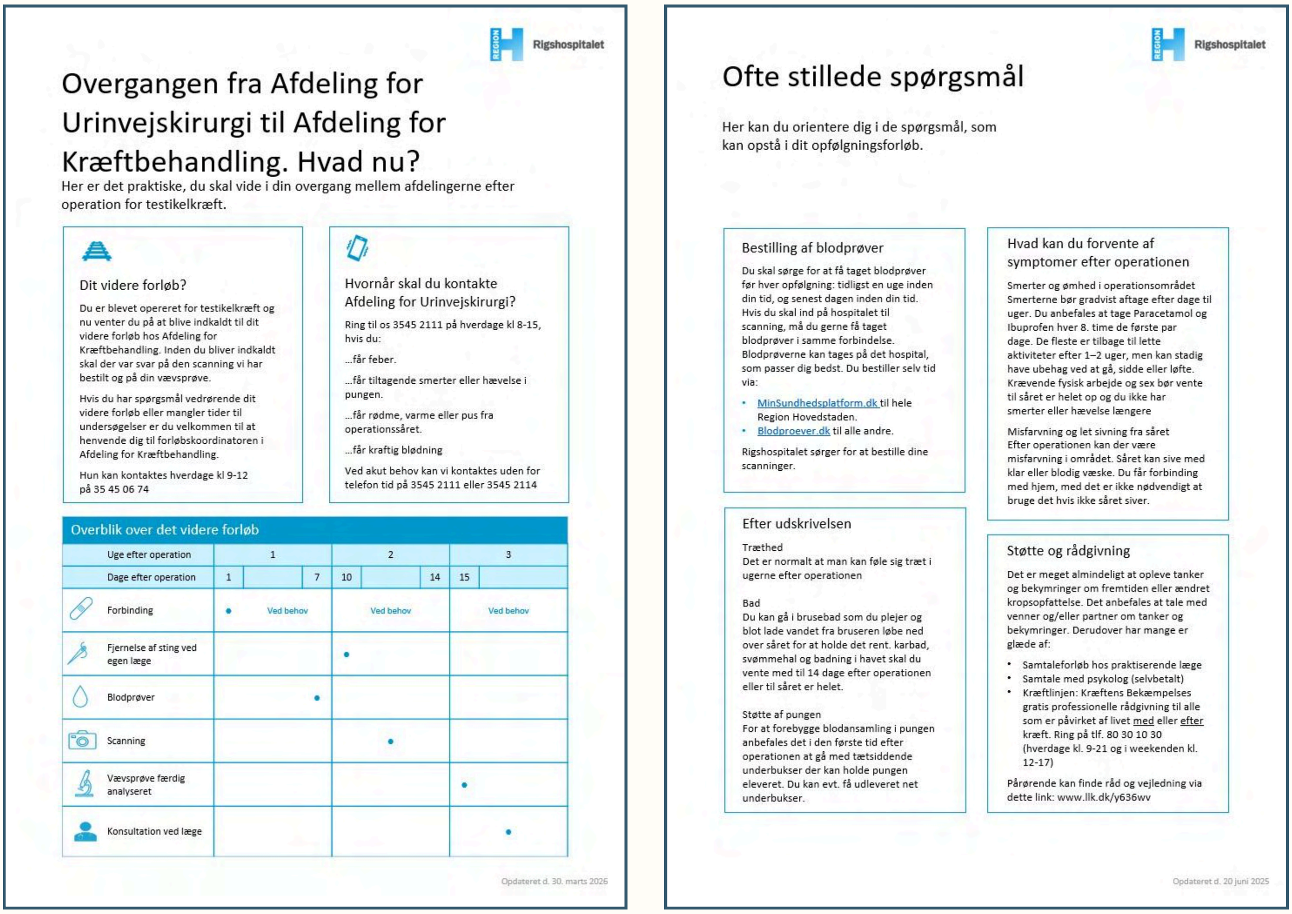
Overall, the workshop highlighted both challenges and the potential of developing capabilities for implementation and sustaining change. It demonstrated that while participants are motivated and able to generate ideas, additional support is needed to translate these ideas into concrete, achievable actions. At the same time, it showed that hands-on experience and facilitation can contribute to shifting mindsets and building confidence in working more iteratively.

6.2 Development of the One-Pager

Following the ideation workshop, the nurses quickly began to develop the one-pager. The aim was to create a simple A4 document containing essential information for patients after surgery, potentially waiting to get further treatment and transitioning to a new department. Although previous findings indicated high patient satisfaction with the information material given, the nurses saw an opportunity to make some aspects clearer. The content was therefore based on their own experience and recurring questions, and those received by the coordinator. This included post-operative guidance of what the patient can and cannot do, what to expect in the journey ahead, and who to contact if needed. The main intent was to replace the green folder that the patients receive to simplify the information and make important aspects more accessible.

The development was primarily driven by two nurses, one from each department, including the nurse who joined the project following the workshop. Initial work was done collaboratively at the hospital, followed by email exchanges to involve the project group and us.

Within one week, they had produced a first draft on their own, consisting of the one-pager and a digital survey to collect patient feedback (see Appendix P). The nurses considered the draft ready for testing and had identified additional nurses who could hand them out to patients. It was URO who would be in charge of delivering the one-pagers, since the patients needed to receive them before the waiting time. The first version of the one-pager is shown in Figure 19.



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Uge efter operation	1			2			3	
Dage efter operation	1		7	10		14	15	
Forbinding	●	Ved behov			Ved behov			Ved behov
Fjernelse af sting ved egen læge				●				
Blodprøver			●					
Scanning					●			
Vævsprøve færdig analyseret							●	
Konsultation ved læge								●

Opdateret d. 30. marts 2026

Rigshospitalet

Ofte stillede spørgsmål

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Efter udskrivelsen

Træthed
Det er normalt at man kan føle sig træt i ugerne efter operationen

Bad
Du kan gå i brusebad som du plejer og blot lade vandet fra bruseren løbe ned over såret for at holde det rent. karbad, svømmehal og badning i havet skal du vente med til 14 dage efter operationen eller til såret er helet.

Støtte af pungen
For at forebygge blodansamling i pungen anbefales det i den første tid efter operationen at gå med tætsiddende underbukser der kan holde pungen eleveret. Du kan evt. få udleveret net underbukser.

Hvad kan du forvente af symptomer efter operationen

Smerter og ømhed i operationsområdet
Smerterne bør gradvist aftage efter dage til uger. Du anbefales at tage Paracetamol og Ibuprofen hver 8. time de første par dage. De fleste er tilbage til lette aktiviteter efter 1–2 uger, men kan stadig have ubehag ved at gå, sidde eller løfte. Krævende fysisk arbejde og sex bør vente til såret er helet op og du ikke har smerter eller hævelse længere

Misfarvning og let sivning fra såret
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Opdateret d. 20 juni 2025

Figure 19: First version of the one-pager developed by the project group

6.2.1 EVALUATING THE DEVELOPMENT OF THE ONE-PAGER

According to Schön & Bennett (1996), it is important to reflect-on-action, meaning reflecting on post activities, to then transform the experiences into learning, informing future practices. Upon completion of the first version of the one-pager, we found it relevant to collect feedback on the process, to understand if the execution plan from the workshop proved effective, as well as to hear how the nurses experienced taking a primary role and gather information on possible enablers and barriers in the process. This has been conducted in both oral and written form through a reflection sheet, collecting a total of three perspectives across URO and ONC. The sheet included questions as what had worked well, if there had been any challenges, if there had been any surprises, and lastly, if there was something they were proud of.

In terms of what had worked well, one quoted: *"It worked well because it was a joint task across the two departments"*, elaborating further, mentioning they were now a team. Another quoted *"That one was in charge of a first draft, so there was a template when we met up"*, meaning it made it easier to have a starting point to work on together. In terms of challenges, one mentioned *"Getting used to delivering something unfinished"*, another mentioned *"What to call us in the survey"*, which highlighted a shift, since they had previously divided themselves into URO and ONC, to now viewing themselves as *us*. This pointed as a positive step in the direction of addressing the silo-mentality of hospital (Alves & Meneses, 2018), as well as one of the case's desired outcomes: increased collaboration and coordination between the two departments.

Additionally, the project group mentioned time as a challenge, since they were worried about not making it on time. However, reflecting on this, it also surprised them. They were surprised by how quickly they executed the one-pager. By prioritising and planning it well, they found time for it. Lastly, when asked what they were proud of, they all mentioned the visual look and format of the one-pager, giving credit to one another. They also mentioned that it was nice that the head nurses gave them time to prioritise it and entrusted them with being in charge, emphasising the importance of having leaders support employees' work (Bailey, 2012).

6.3 KEY TAKEAWAYS: DEVELOP

○ The ideation workshop gave us the opportunity to apply several service design tools and to observe how the nurses would perceive them.

○ The nurses had a natural tendency to move from staff focus to quickly shifting to a patient focus.

○ The nurses showed high engagement in applying the tools, resulting in many ideas developed.

○ The workshop introduced several new mindsets, such as testing unfinished prototypes, which challenged the nurses, however, they enjoyed being challenged.

○ The nurses began to take ownership of the process, highlighting engagement and collaboration across the two departments.

○ The first draft of the one-pager was made.

07.

Deliver

The Deliver chapter elaborates on the process of testing the one-pager and producing its several iterations, leading to a finalised version. Further, the entire project and process are evaluated to inform a final deliverable for the nurses, which aims to support future efforts to implement and sustain change.

The chapter is divided into the following sections:

7.1 The Approach to Testing 55
7.2 The Final One-pager 62
7.3 Scaling 63
7.4 Evaluation Survey of the Process 63
7.5 Final Deliverable 66
7.6 Check-in 7: The handover 74
7.7 Key Takeaways: Deliver 75

7.1 The Approach to Testing

As the project group was about to approach the next phase of the process, namely testing, it was relevant to equip them with the right knowledge and tools to approach it and build capabilities in that regard. After careful consideration of different approaches and methods of testing, we selected the adapted the model presented by Stickdorn et al. (2018, p. 214), which focuses on testing *value*, *look and feel*, *feasibility*, and *integration*. For each perspective, the model provides a series of questions to be investigated through testing.

During the Ideation workshop (6.1 Ideation Workshop), we had noticed that the nurses had concurrent doubts on different aspects of the one-pager, including its format, content, and value. By focusing on one perspective at the time, we aimed at making the testing phase more accessible to the project group, as well as ensuring a holistic approach that addressed all the key perspectives. The plan was therefore to tackle one aspect at the time during the following weeks (see Figure 20), by introducing the selected perspective, planning and conducting the testing activity, and reflecting together on success and challenges using a reflection template (see Figure 21). On top of regular check-ins, we emphasised the possibility of contacting us in case of doubts or problems, in order not to leave the project group alone in the process.

To ensure understanding of the above, we prepared introductory slides to the importance of testing and to the different perspectives. In particular, we contextualised the testing questions from the model, making them relevant to the case (see Figure 22). Aware of the limited number of new patients coming in on a weekly base, we also presented alternative ways of gathering feedback, such as testing with former patients or colleagues.

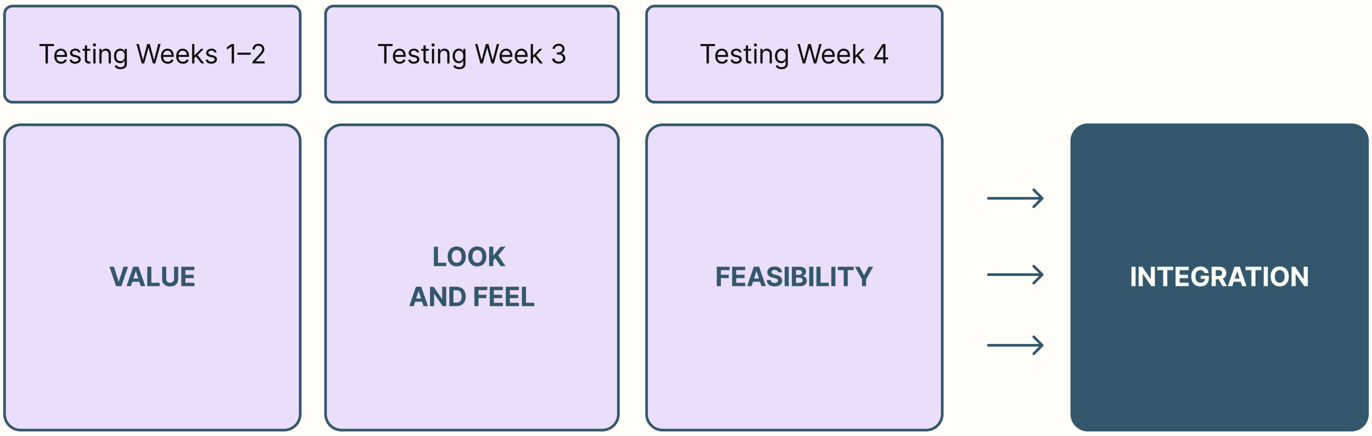
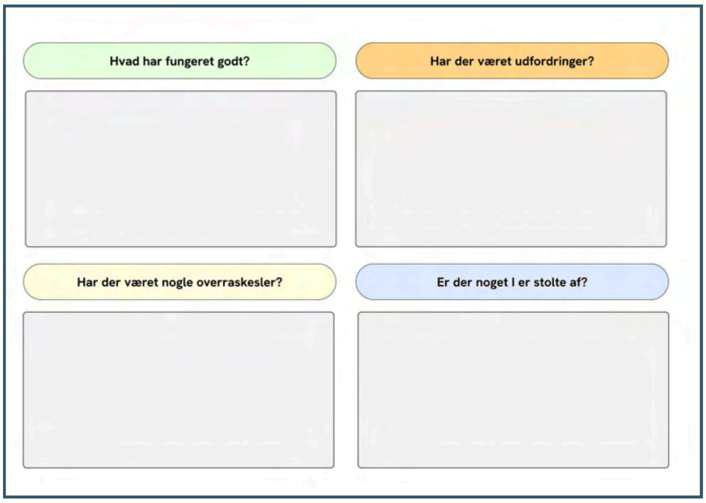


Figure 20: Test plan inspired by Stickdorn et al. (2018, p. 214)


Hvad har fungeret godt?

Har der været udfordringer?

Har der været nogle overraskesler?

Er der noget I er stolte af?

Figure 21: Reflection template used after each testing phase

VALUE

The testing should provide answers to the following:

- What needs should the one-pager meet?
- What information will make the experience more secure, clear and meaningful?
- How much should the one-pager contain?
- What information should the one-pager contain to be useful?

LOOK AND FEEL

The testing should provide answers to the following:

- What should the one-pager look like so it feels calm, clear, and trustworthy?
- What tone and visual style are appropriate for the topic of waiting time after surgery?
- How can we make the content short, simple and clear?
- What format should the one-pager have? (Physical, online, visual, text)
- In what order should the information be presented?

FEASIBILITY

The testing should provide answers to the following:

- How does the one-pager fit into the current patient pathway before and after surgery?
- Who should provide or refer to it so that it is used in practice?
- How can it support existing touchpoints without creating extra work?
- How do we ensure that the content complements what the patient already receives from the hospital, department or outpatient clinic?

INTEGRATION

What is the overall patient experience when we bring together value, feasibility, look and feel, and integration?

Figure 22: Adapted questions for the respective testing phases

DISCLAIMER: Each of the following check-ins introduces a new testing perspective, which the project group then had 1–2 weeks to test, until the next check-in. For the reader's sake, we have, however, included both the test plan and the results in the respective check-ins to avoid confusion. This means that there was a time gap between the introduction to the testing focus and the discussion of the results and evaluation of the process.

7.1.1 CHECK-IN 4

Value

Check-in 4 marked the first check-in focused on testing. Therefore, we provided the general introduction to the selected testing model, as well as an overall plan on how to proceed across the different phases. In line with the intention to focus on one aspect at a time, we then took a closer look at testing perspective *value*. Starting with testing the value has been defined as “often a great starting point”, as for example building a good look and feel without verifying its value might result in waste of resources (Stickdorn et al., 2018, p. 213).

As mentioned in 6.2 Development of the One-Pager, the project group had created a survey to collect patient feedback. This was self-initiated by the nurses after discussing during the workshop what a successful one-pager would include. As the questions presented in the one-pager feedback survey largely aligned with the ones we had prepared for testing the value, we agreed to use it for the purpose.

Results of testing the value
During the testing period, one patient had completed the survey and provided positive feedback. While the result was positive, the response rate was still low. Prior to the check-in, the nurses had already discussed ways to increase the number of responses. This made the meeting feel more like a shared discussion with distributed ownership, in which the nurses had already taken the initiative to address a problem, reducing our need to intervene. We saw this shift as positive, since it showed their ability to apply the capabilities we had introduced.

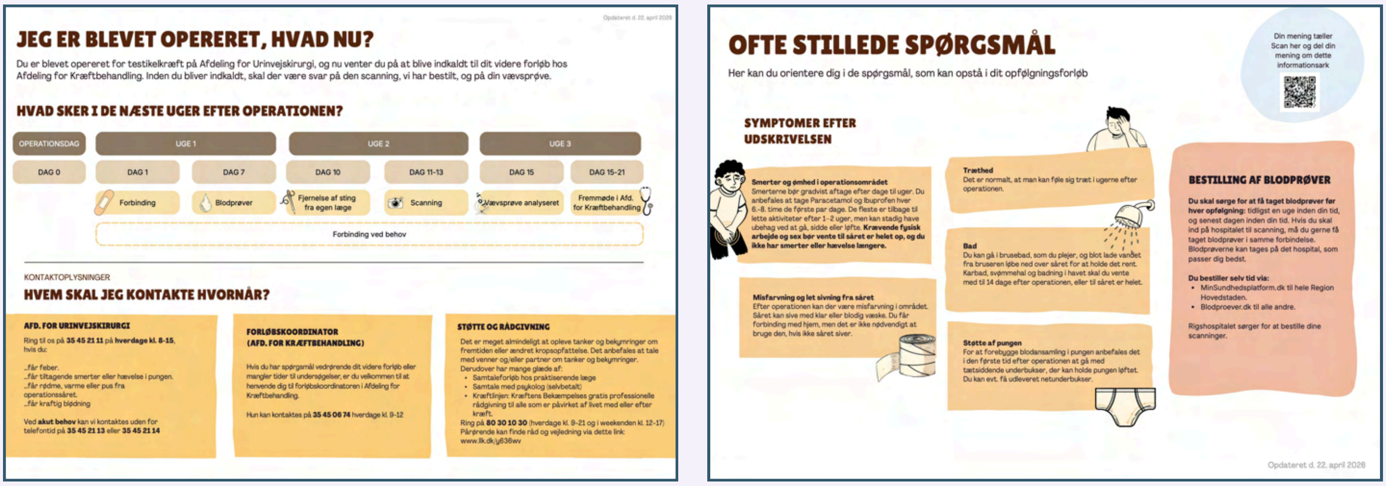
The reflection template supported discussion on the process. One point that emerged was colleagues' interest in and curiosity about the project. On top of that, the nurses expressed pride in the one-pager creating value internally, but, of course, they were unaware whether it had done so for the patients, as survey response rates were still low. We therefore agreed to leave the survey open, test it with colleagues, and make follow-up calls to the patients who had received it.

7.1.2 CHECK-IN 5

Look and Feel

Check-in 5 focused on testing the look and feel of the one-pager. Aware that the value had not been fully tested, we chose to proceed in parallel with testing the look and feel while gathering further feedback. Although this can be considered risky, the positive feedback from colleagues, as well as the single patient response, indicated a positive direction. On top of that, given the relatively low use of resources, the risk associated with the idea failing was low. Lastly, the strict timeframe required us to move further to ensure we tested the different perspectives before the end of the project.

To test the look and feel, prior to the check-in we designed another version of the one-pager that differed significantly from the original (see Figure 23). The new version was intended to present a more organic look and feel, with differences in tone of voice, visual language, and the distribution of information. By testing two different versions, we aimed to gather feedback on which tone of voice and type of communication could better support patients. The nurses' response to the second version was positive. They appreciated being challenged and one quoted "*we had actually expected that you would make a version*". They were a bit sceptical of the colours and the missing logo, emphasising that it would not be appropriate to deliver to the patients, as it lacked professionalism. We agreed on this and emphasised our intent to only test this on colleagues or previous patients. To support the collection of feedback, we handed out an evaluation scheme for them to use while testing the two versions, including criteria such as clarity, credibility, professionalism, and readability (see Appendix Q).



Opdateret d. 22. april 2026

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HVAD SKER I DE NÆSTE UGER EFTER OPERATIONEN?

OPERATIONSDAG	UGE 1		UGE 2		UGE 3	
DAG 0	DAG 1	DAG 7	DAG 10	DAG 11-13	DAG 15	DAG 15-21
	Forbinding	Blodprøver	Fjernelse af sting fra egen læge	Scanning	Vævsprøve analyseret	Fremmøde i Afd. for Kræftbehandling
	Forbinding ved behov					

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Træthed
Det er normalt, at man kan føle sig træt i ugerne efter operationen.

Bad
Du kan gå i brusebad, som du plejer, og blot lade vandet fra bruseren løbe ned over såret for at holde det rent. Karbad, svømmehal og badning i havet skal du vente med til 14 dage efter operationen, eller til såret er helet.

Støtte af pungen
For at forebygge blodansamling i pungen anbefales det i den første tid efter operationen at gå med tætsiddende underbukser, der kan holde pungen løftet. Du kan evt. få udleveret netunderbukser.

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Figure 23: Alternative version to the one-pager developed by us

Results of testing the look and feel

The project group took the opportunity of a regular meeting with colleagues to test the look and feel, and asked participants to fill out the evaluation scheme that we had provided. In total, they received eight completed evaluation schemes (see Appendix Q), which showed that the template worked well as a tool for collecting input from the participants. It also proved useful for transferring the feedback to us, as we were not present during the feedback collection, and for documenting the responses for later review. We therefore considered it a relevant and effective tool.

The staff who had been testing the two versions indicated a preference for the second version, although they noted that it should be adapted to Rigshospitalet's colours and recommended minor changes. We therefore agreed to update the visuals to match Rigshospitalet's guidelines and send them an editable version, allowing the project group to take responsibility for adjusting the content based on feedback and to practice the iterative nature of a service design process. Although the project group collected a good number of responses, we missed the patient perspective on this topic. In hindsight, we could have emphasised further the need for collecting feedback from previous patients.

7.1.2 CHECK-IN 6

Feasibility

To test the feasibility of the one-pager, it was necessary to evaluate questions such as who should provide or refer to it for practical use, and how it can support existing touchpoints without adding extra work. We therefore focused on mapping with the project group the use of the one-pager across the patient pathway to create a clear reference point for future use regarding roles and responsibilities. This also aligned with the desired outcome of the case, namely, defined roles, responsibilities and contact points as well as a clear and shared understanding of the pathway.

The purpose was for the project group to take ownership of all processes required for the one-pager and to continue the work going forward. To support this, we prepared a mapping template based on insights gathered over the last two test weeks and from the first mapping of the patient pathway. We structured the template around three time frames: one-time processes that must be in place before the patient pathway begins, actions that occur during the patient pathway, and ongoing feedback and improvement processes to support future refinement of the one-pager. We also mapped the additional information provided during the pathway to avoid overlap or information gaps.

Results of testing the feasibility

The project group reacted well to the mapping exercise and was quick to take responsibility for the different touchpoints, leading to a clear distribution of who was in charge of what, with URO mainly in charge of preparing and distributing the one-pager and ONC taking the lead on checking feedback on the one-pager survey, suggesting changes, and aligning with URO to implement edits. They also agreed to have a monthly check-in during the next couple of months. This workflow allows for continuous learning and iteration. The final mapping is shown in Figure 24.

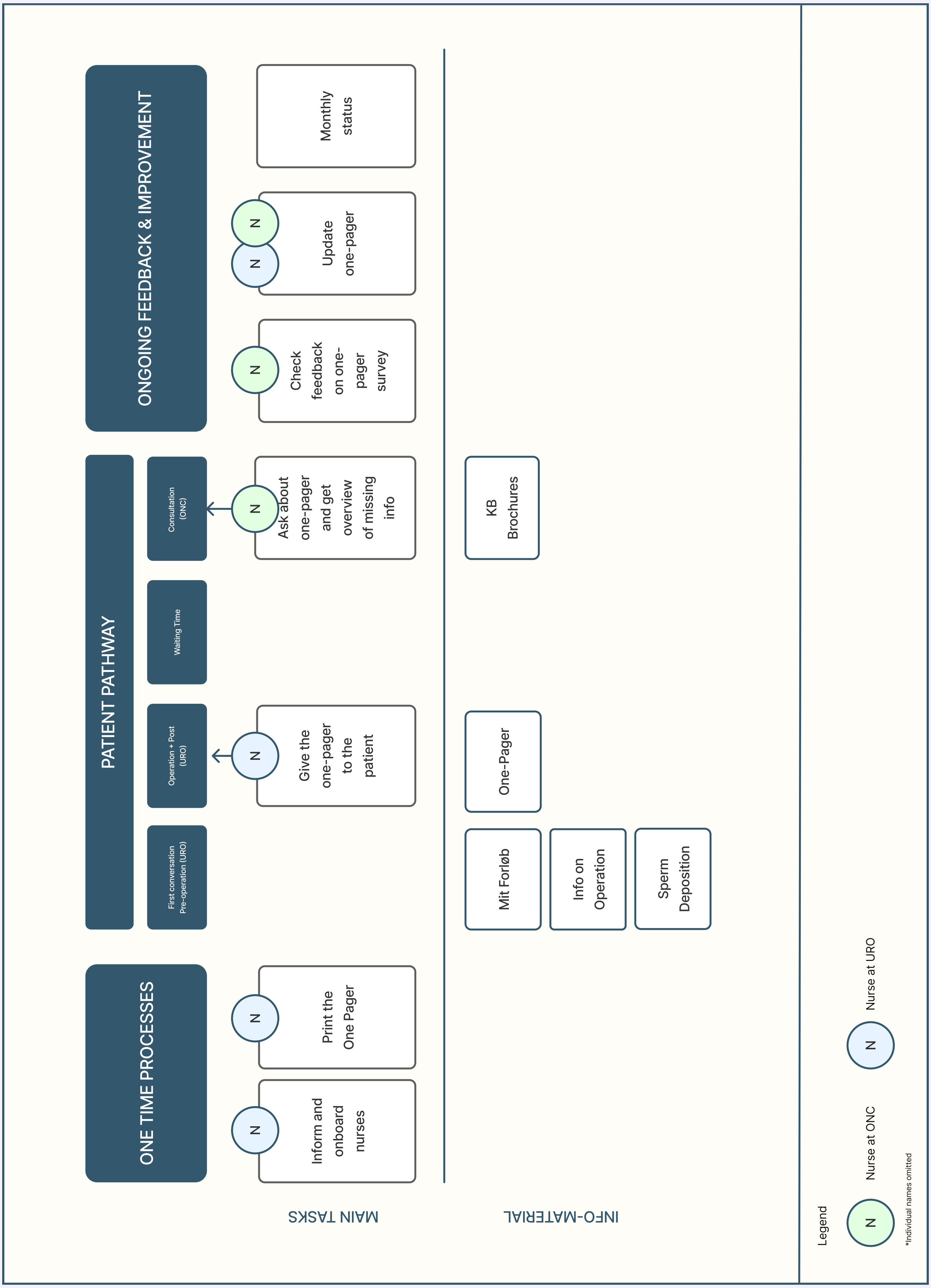

Figure 24: Finalised mapping of main responsibilities and information materials

7.2 The Final One-pager

As agreed during check-in 5, the project group was responsible for refining the content in the new editable version of the one-pager. As we discussed *integration*, we prompted questions about how the one-pager would work across the departments when including tests of value, look and feel, and feasibility. Therefore, we asked them to keep all three in mind when producing the final one-pager. We agreed with the project group to keep the survey, which tested value, open to continue gathering feedback and refining accordingly. Taking all the collected data into account resulted in the final version of the one-pager (see Figure 25), successfully handed out to the patients. With the one-pager being handed out in the URO department, it suggests that the solution had moved toward implementation.

What observed and discussed during the meeting highlighted general satisfaction with all the work done. In particular, the nurses mentioned that they had shared all the data with the departments. Reflecting further, they also enjoyed being challenged by both other versions and new tools, since it forced them to think thoroughly about their practices and what they took for granted. The meeting ended on a positive note, with one of them quoting:

> *"This project has given us some tools for how we can facilitate things going forward."*

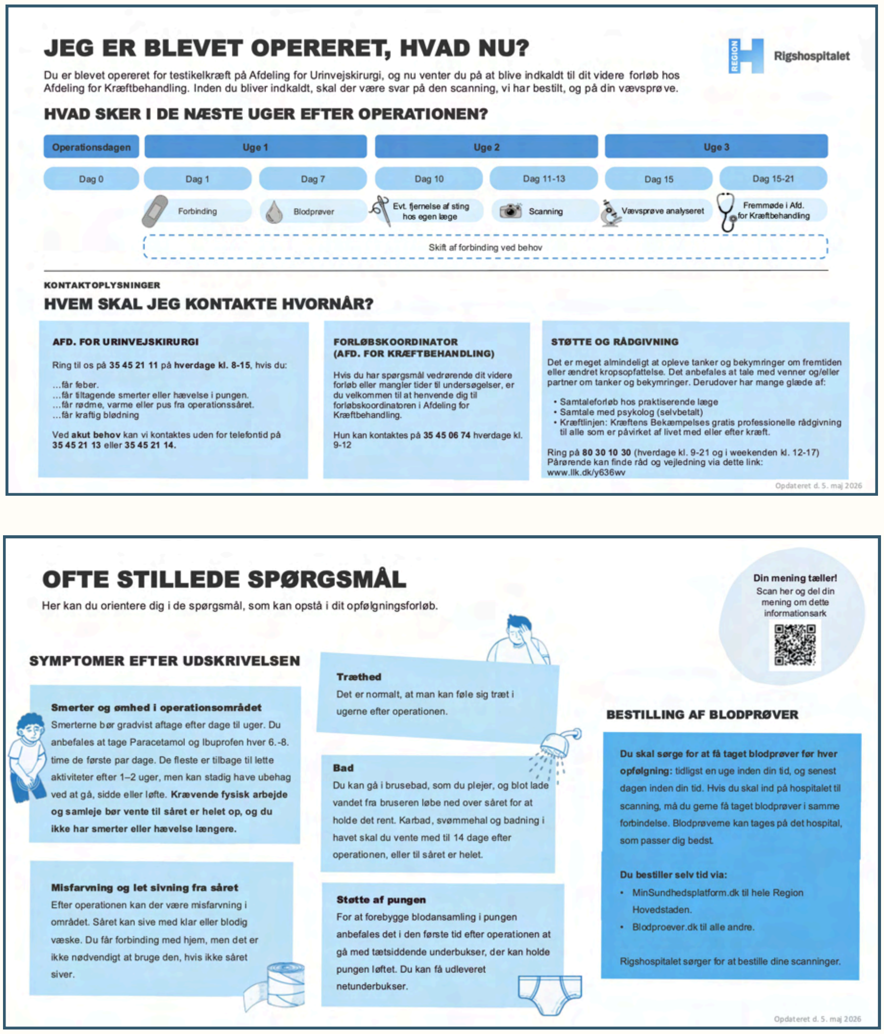

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Figure 25: Final version of the one-pager developed by the project group

7.3 Scaling

From the beginning of the project, the focus was intended to be only on the testicular cancer patient pathway, due to its simpler journey. However, the overarching goal was to adapt the solution and capabilities built throughout the process to other patient types and even other hospitals. As we had entered the Deliver phase, we wanted to discuss scaling types with the project group to ensure they had the right tools and capabilities for scaling after our collaboration. According to Moore et al. (2015), there are three types of scaling when organisations want to create social change. The three types are scaling up, scaling out and scaling deep. Scaling up involves changing rules, policies, and laws, and is therefore out of scope in this context. However, by implementing the one-pager in their everyday practice and aligning on distribution, this may represent a first step to scaling up.

Scaling out is about replication and increasing the number of people, employees, and organisations impacted by the solution (Moore et al., 2015). Scaling out is therefore closely related to the project's context, since the project group saw the opportunity to implement the one-pager in other hospitals that transfer patients to Rigshospitalet, as well as across other cancer patient groups. We discussed with the project group how they would approach replicating the one-pager in other hospitals. One of the head nurses explained an upcoming conference, including the other regional hospitals within the urology department, and said she planned to introduce the one-pager as a first step toward implementing it. One of the nurses interrupted and said, "*That's a good idea; then we just must change the phone number.*" Another nurse mentioned being part of a network group across the Centre for Cancer and Organ Diseases that worked on patient transitions, where her mission was to make the one-pager a default format for all patient types. These thoughts and actions showed a strong motivation on their part to succeed in scaling by applying tools and approaches learned throughout the project.

Lastly, scaling deep focuses on changing values, relationships, and behaviours to shift culture over time (Moore et al., 2015). Scaling deep relates to our research question, as through the project, we have sought to enable nurses to build capabilities to implement and sustain change in the future. To succeed with that, the nurses will need to incorporate the processes, tools and methods into their daily work life. Over time, this can lead to a shift in behaviours, changes in relationships and cultural values, for example, being comfortable to test unfinished ideas. As we wanted them to succeed in scaling deep over time, we conducted a survey. The aim was to help them reflect on and evaluate the process and the tools used, to identify what had been valuable to them and what had not, and inform a final deliverable that could support future efforts. Further information will be presented in the following section.

7.4 Evaluation Survey of the Process

To enlighten the final deliverable, we conducted a survey to gather quantitative insights from the project group, which had them reflect and evaluate the process. This was both in terms of listing barriers and supporting factors such as structural elements, information provided and tools applied. Lastly, we included an overall assessment of the process and their take on how well equipped they felt for the future. It gave us concrete insights and feedback on what we had done well, what we could have done differently, and what had worked well. The feedback was valuable and gave us an indication of what the deliverable should include.

Based on the survey responses (see Figure 26/ Appendix R), we had an oral discussion with the project group to elaborate on certain elements that surprised or intrigued us. The ideation workshop scored highest in terms of the structural elements that were supportive of the project. They added further comments, such as it helps when there is a facilitator, simple tools that guide the activities, making it tangible, and knowing what the output should be helps us understand how to approach the activity.

However, practical support and test tools had scored lower than other tools. They had lacked some support in testing tools and methods, highlighting that we, as facilitators, may have stepped back too soon and not guided them well enough. This was specifically related to the testing of the two versions of the one-pager conducted with colleagues, as they were in doubt about which questions they should ask to get further insights, as well as some practical questions on the evaluation scheme we had prepared. This also indicated that a future evaluation scheme should include more guided elements.

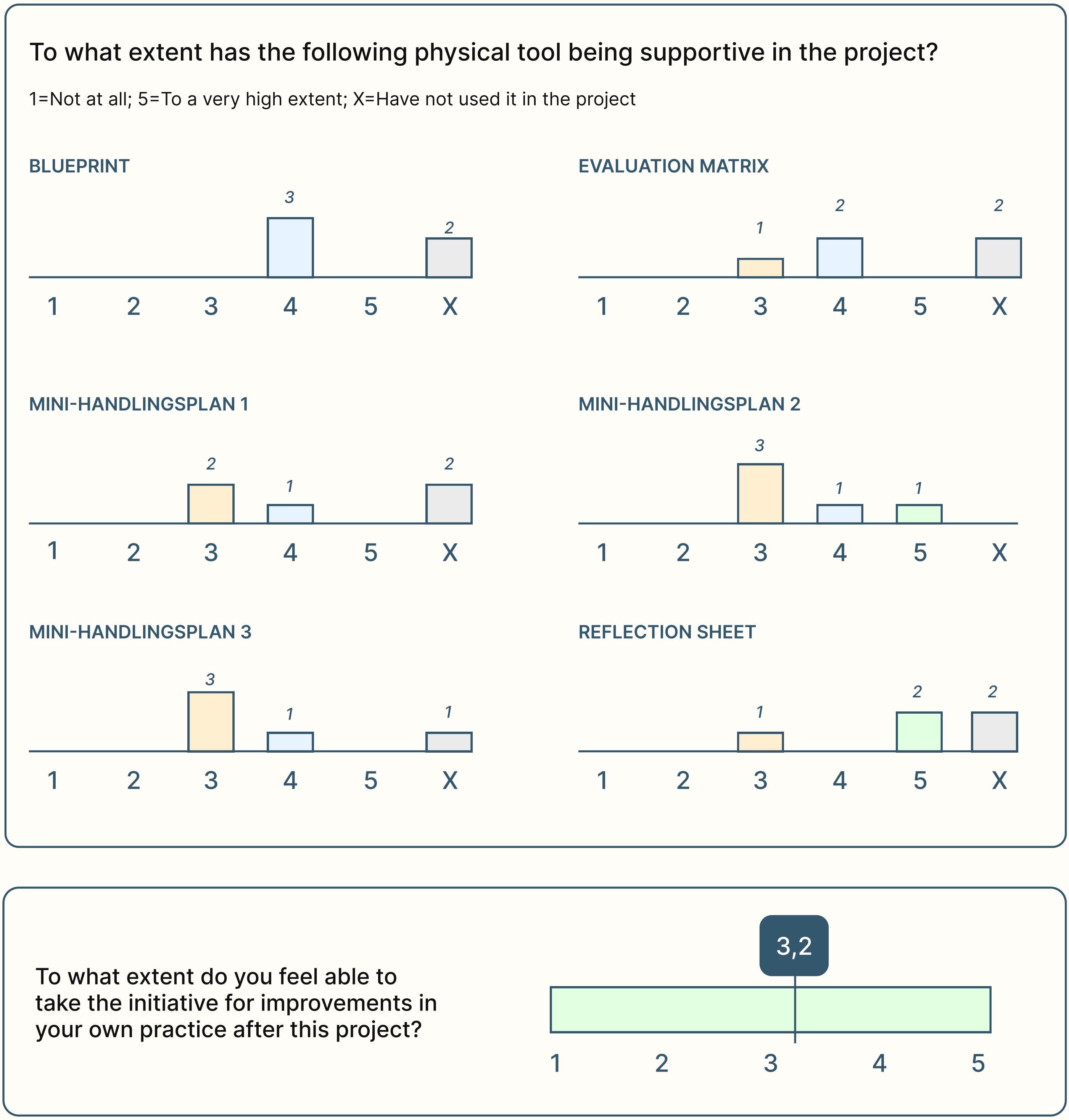


Figure 26: Partial survey results – physical tools and preparedness for future projects

The blueprint was one of the tools that had scored highest; we were curious to get them to elaborate on this. They elaborated this with it being a relatively simple tool to quickly get an overview of the pathway across the departments, giving insight into how much the patients go through. They also enjoyed the physical element of being able to move actions and stakeholders back and forth. It created a shared understanding across the departments.

As seen in Figure 26, when asked how capable they felt of being able to take initiative and drive similar projects in the future, the average result was 3.2. Their reply revolved around the fact that the actual ability to take initiative had not changed due to the project. However, the tools and methods had given them some capabilities to drive the process, and it had been invaluable to have us guide and facilitate the process.

The survey and further elaborations highlighted that most of the tools given and applied throughout the project were understandable, easy to apply, and added value to the process. However, it also highlighted that some of the tools could be improved in terms of including more guidance or clearly communicating the output. Furthermore, throughout the whole project, we had observed how the project group had perceived the tools in practice, what had worked well, and what had not.

We asked the project group how they would feel most supported post-project to continue applying the capabilities learned and implement change in the future. They mentioned an ideal solution would be to be given all the tools and templates we had applied throughout the project in the form of a physical toolkit, with descriptions including purpose and intended outcomes, so they would not forget how to apply them. They explicitly mentioned they wanted it to include all the required supplies, making it accessible and ready to use in their everyday work. The toolkit is presented in the following section.

7.5 Final Deliverable

The final deliverable developed for the nurses is a toolkit that aims to support the application of the gained capabilities, including step-by-step guidance to collaboratively implement new ideas. The templates used during the process have been further refined for the toolkit based on the previous evaluation meeting with the project group. We added particular attention to providing additional guidance and supporting templates for testing, as it was the one that highlighted the most challenges. Additionally, we incorporated feedback indicating that having a facilitator was effective by adding some additional tools to ensure distributed responsibility to drive progress.

The toolkit encompasses tools that have proven effective in guiding the project group to understand challenges, explore opportunities, and develop and implement ideas in a complex healthcare context. Specifically, we included the following activities and tools:

1. Mapping of the patient journey, supported by the blueprint template
2. Brainstorming session
3. Prioritisation of ideas, supported by an evaluation matrix
4. Execution plan, supported by templates to support idea definition, identification of resources and barriers, as well as the definition of concrete steps towards testing
5. Testing guidelines, supported by evaluation schemes to fill-out to ease the process of gathering feedback on ideas
6. Reflection activity, supported by reflection sheets

The above is intended to be used either as a whole or in selected parts, depending on the context, with the freedom to adapt the tools and templates to specific needs. Iteration is further emphasised, as the toolkit encourages continuous revisiting and application of the tools.

The toolkit is developed in a physical format and consists of the following elements:

- Information manual: guidelines on the toolkit as a whole and on the different activities, including their purpose, the required mindset, expected results, estimated time, required materials, and detailed step-by-step instructions;
- Printed Templates: supporting templates for the different activities;
- Materials: supporting materials, including post-its, pens, dot-voting stickers, a timer, and Blu-Tack;
- Role Badges: Badges indicating the role of people during the activities (facilitator, helper, or participant), as well as the main tasks of each.
- A space to share inspirational thoughts or quotes after the use of the toolkit.

A picture of the physical toolkit is presented in Figure 27. Figure 28 represents an overview of all the elements included in the toolkit, while Figure 29-32 highlight the main elements. Lastly, the full toolkit instructions and templates can be seen in Appendix S-X.

Although the toolkit stems from a request of the project group, we see potential in it being used and serving the needs of other projects and nurses. Therefore, when creating it, we focused on making the activities clear to those who approach the activities for the first time, providing detailed instructions and all the necessary materials in the box.

Figure 27: The physical toolkit

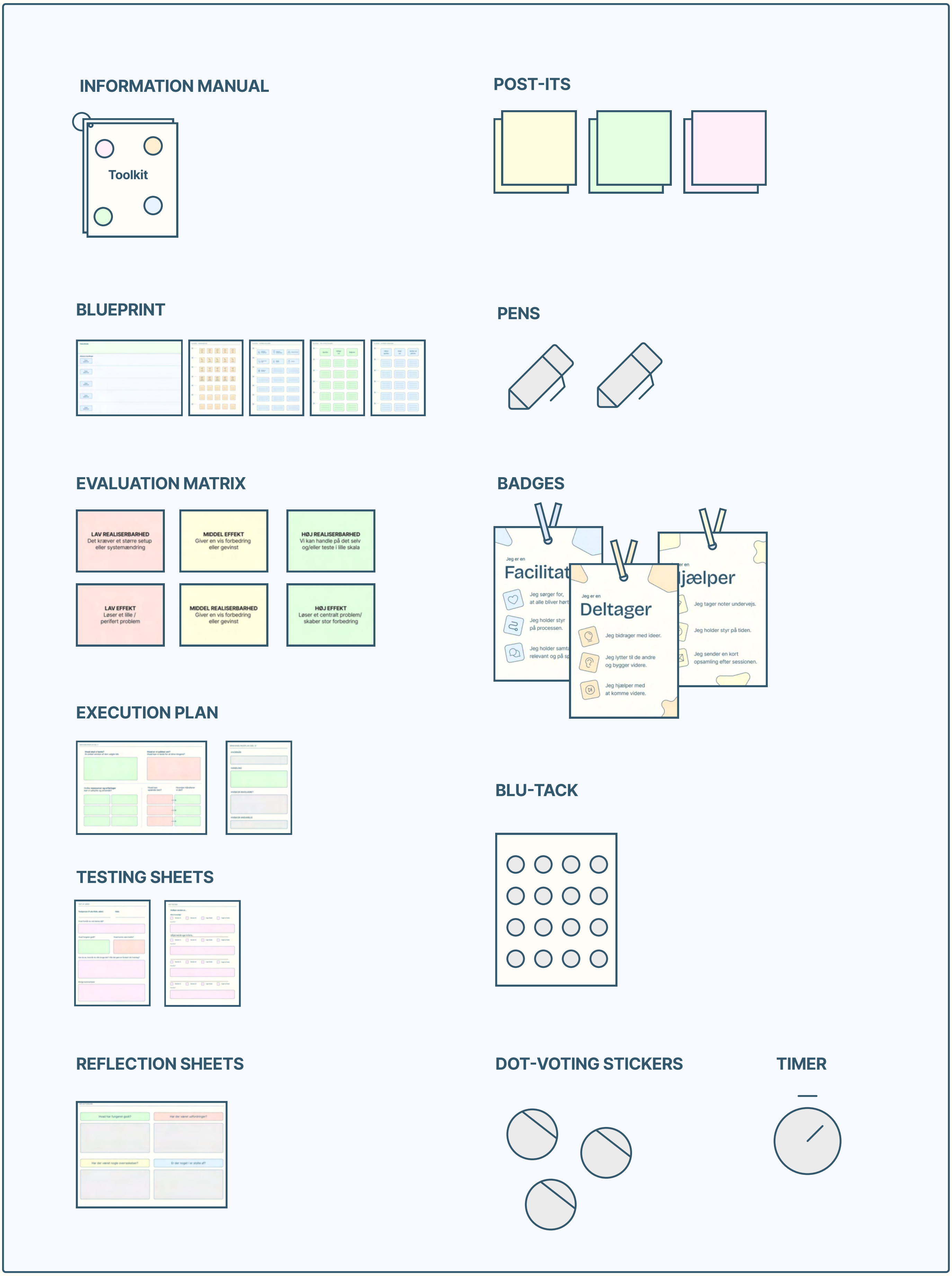


Figure 28: Overview of the toolkit elements

INTRODUCTION PAGES FROM INSTRUCTION MANUAL

TOOLKIT

Sammen på tværs

Værktøjer, der hjælper jer med at udvikle, afprøve og justere løsninger sammen.

"Lidt forskel gør en stor forskel"

OM TOOLKITTET

Dette toolkit er udviklet som en del af projektet *Patientforløb på tværs af Afdeling for Urinvejskirurgi* (2113) *og Afdeling for Kræftbehandling* (4222) på Rigshospitalet i samarbejde med specialestuderende i service design fra Aalborg Universitet med fokus på at skabe mere sammenhæng, tryghed og klarhed i patientforløb på tværs.

Toolkittet samler de værktøjer, som gennem projektet har understøttet arbejdet med at forstå udfordringer, udforske muligheder og udvikle idéer, der kan omsættes til praksis i en kompleks sundhedsfaglig hverdag. Målet er, at værktøjerne også kan inspirere andre til at tage små skridt, afprøve idéer tidligt og skabe større forandringer gennem tæt samarbejde og løbende læring.

En særlig tak til projektgruppen, de involverede medarbejdere fra de to afdelinger og Center for Kræft og Organsygdomme for deres engagement, åbenhed og værdifulde bidrag undervejs. Deres villighed til at afprøve værktøjerne i praksis samt dele konkrete erfaringer og feedback har været afgørende for at forme og kvalificere toolkittet.

Udviklet og designet af:
Emily Brophy, Lea Texmo Limstrand og Erika Strazio.

Første udgave, trykt i maj 2026.

1

r:

POST-ITS

KUGLEPENNE

BADGES

ELEFANTSNOT

KLISTERMÆRKER

TIMER

at bruge toolkittet

dforsk

t værktøj har sin egen korte
ktion, som guider jer igennem
ssen, men vær ikke bange for at
e den til jeres egen kontekst.
øjerne er skabt til at understøtte
forskellige typer processer, men
gerer bedst, når de bruges med
litet og tilpasses den kontekst, de

så selv definere rammerne for
rkshop, for eksempel hvor lang
ruge, og hvilke skabeloner der
st mening.

lt naturligt at begynde et sted,
age senere og justere
. Værktøjerne er tænkt som
kan udvikles iterativt.

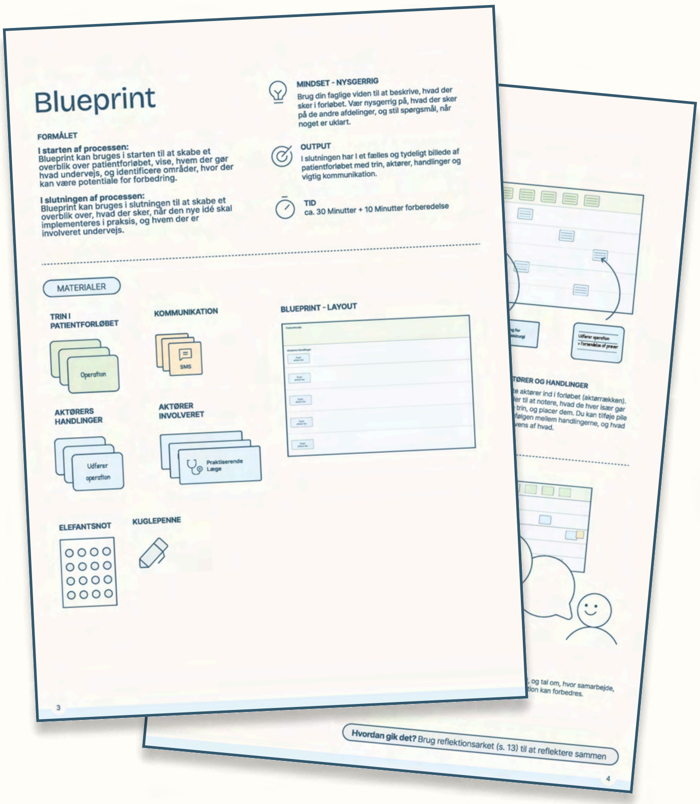
3

Reflektér

Efter processen anbefaler vi at bruge reflektionsarket (s. 13) til at samle op på det, der fungerede godt, det, der var udfordrende, og det, I tager med jer videre. Tag et øjeblik til at reflektere, og del gerne jeres tanker med hinanden.

2

BLUEPRINT



Blueprint

MINDSET - NYSGERRIG
Brug din faglige viden til at beskrive, hvad der sker i forløbet. Vær nysgerrig på, hvad der sker på de andre afdelinger, og stil spørgsmål, når noget er uklart.

FORMÅLET

I starten af processen:
Blueprint kan bruges i starten til at skabe et overblik over patientforløbet, vise, hvem der gør hvad undervejs, og identificere områder, hvor der kan være potentiale for forbedring.

I slutningen af processen:
Blueprint kan bruges i slutningen til at skabe et overblik over, hvad der sker, når den nye idé skal implementeres i praksis, og hvem der er involveret undervejs.

OUTPUT
I slutningen har I et fælles og tydeligt billede af patientforløbet med trin, aktører, handlinger og vigtig kommunikation.

TID
ca. 30 Minutter + 10 Minutter forberedelse

MATERIALER

3

TØRER OG HANDLINGER
e aktører ind i forløbet (aktørrækken).
er til at notere, hvad de hver især gør
trin, og placer dem. Du kan tilføje pile
følgen mellem handlingerne, og hvad
vens af hvad.

, og tal om, hvor samarbejde,
tion kan forbedres.

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

4

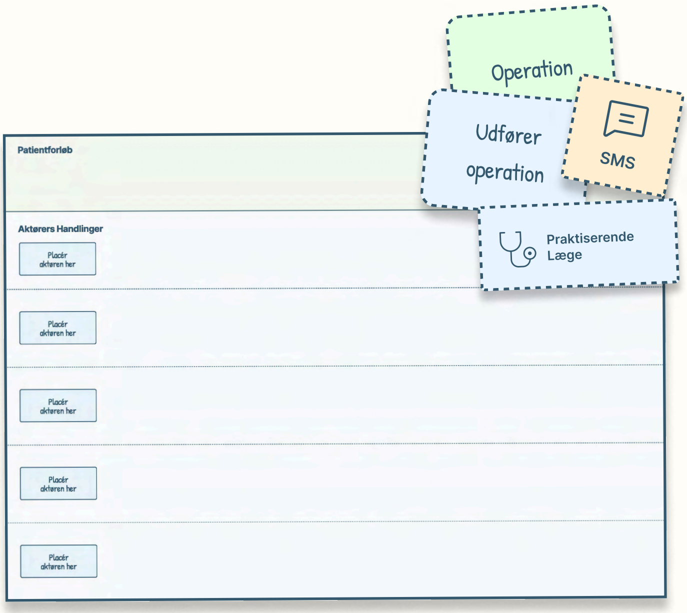
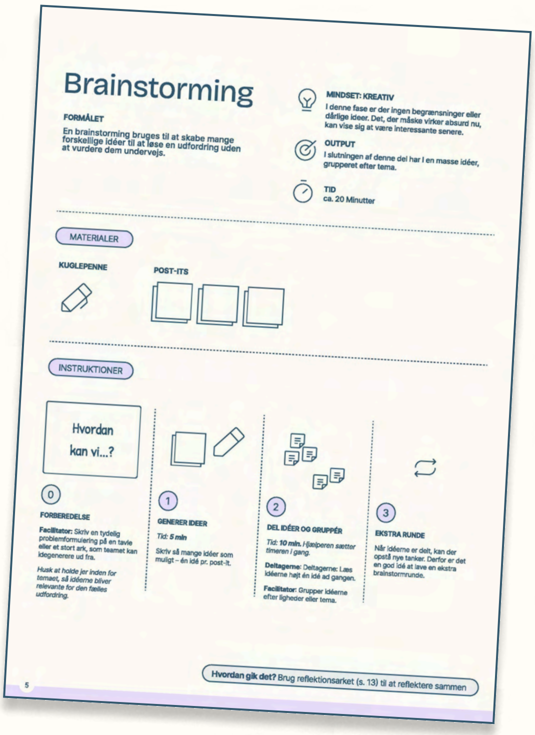


Figure 29: Instructions, activities, and tools inside the toolkit – part 1

BRAINSTORMING



Brainstorming

FORMÅLET

En brainstorming bruges til at skabe mange forskellige idéer til at løse en udfordring uden at vurdere dem undervejs.

MINDSET: KREATIV

I denne fase er der ingen begrænsninger eller dårlige ideer. Det, der måske virker absurd nu, kan vise sig at være interessante senere.

OUTPUT

I slutningen af denne del har I en masse idéer, grupperet efter tema.

TID

ca. 20 Minutter

MATERIALER

KUGLEPENNE

POST-ITS

INSTRUKTIONER

Hvordan kan vi...?

0

FORBEREDELSE

Facilitator: Skriv en tydelig problemformulering på en tavle eller et stort ark, som teamet kan idegenerere ud fra.

Husk at holde jer inden for temaet, så idéerne bliver relevante for den fælles udfordring.

1

GENERER IDEER

Tid: ***5 min***

Skriv så mange idéer som muligt – én idé pr. post-it.

2

DEL IDÉER OG GRUPPÉR

Tid: ***10 min.*** *Hjælperen sætter timeren i gang.*

Deltagerne: Deltagerne: Læs idéerne højt én idé ad gangen.

Facilitator: Grupper idéerne efter ligheder eller tema.

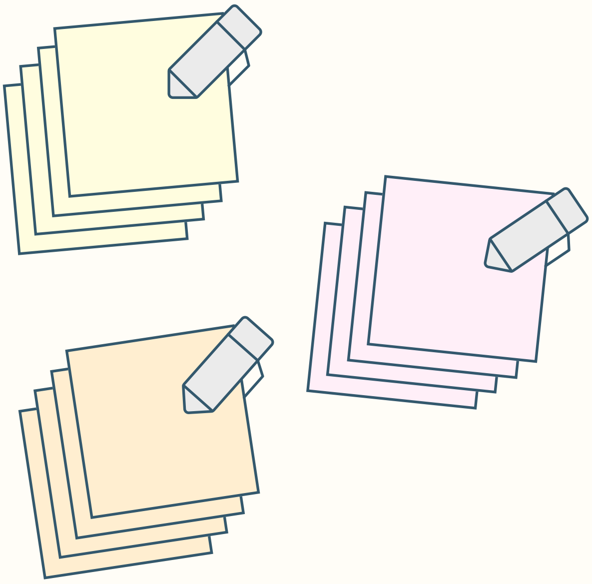
3

EKSTRA RUNDE

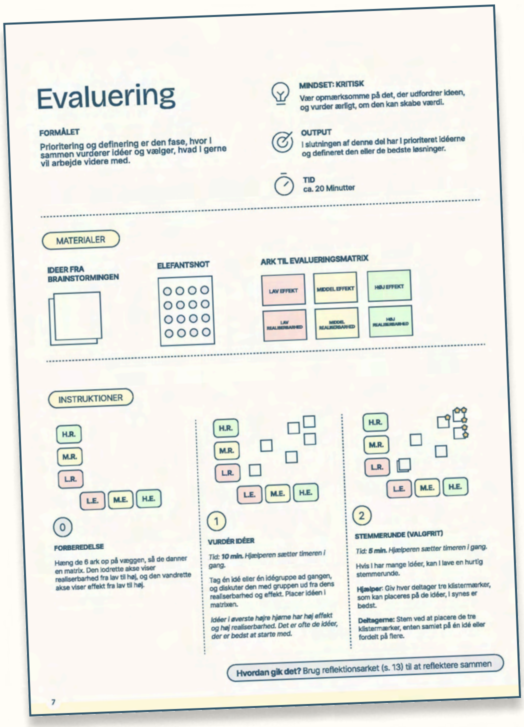
Når idéerne er delt, kan der opstå nye tanker. Derfor er det en god idé at lave en ekstra brainstormrunde.

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

5



EVALUATION OF IDEAS



Evaluering

FORMÅLET

Prioritering og definering er den fase, hvor I sammen vurderer idéer og vælger, hvad I gerne vil arbejde videre med.

MINDSET: KRITISK

Vær opmærksomme på det, der udfordrer ideen, og vurder ærligt, om den kan skabe værdi.

OUTPUT

I slutningen af denne del har I prioriteret idéerne og defineret den eller de bedste løsninger.

TID

ca. 20 Minutter

MATERIALER

IDEER FRA BRAINSTORMINGEN

ELEFANTSNOT

ARK TIL EVALUERINGSMATRIX

LAV EFFEKT
MIDDEL EFFEKT
HØJ EFFEKT
LAV REALISERBARHED
MIDDEL REALISERBARHED
HØJ REALISERBARHED

INSTRUKTIONER

H.R.
M.R.
L.R.
L.E. M.E. H.E.

0

FORBEREDELSE

Hæng de 6 ark op på væggen, så de danner en matrix. Den lodrette akse viser realiserbarhed fra lav til høj, og den vandrette akse viser effekt fra lav til høj.

1

VURDÉR IDÉER

Tid: ***10 min.*** *Hjælperen sætter timeren i gang.*

Tag én idé eller én idégruppe ad gangen, og diskuter den med gruppen ud fra dens realiserbarhed og effekt. Placer idéen i matrixen.

Idéer i øverste højre hjørne har høj effekt og høj realiserbarhed. Det er ofte de idéer, der er bedst at starte med.

2

STEMMERUNDE (VALGFRIT)

Tid: ***5 min.*** *Hjælperen sætter timeren i gang.*

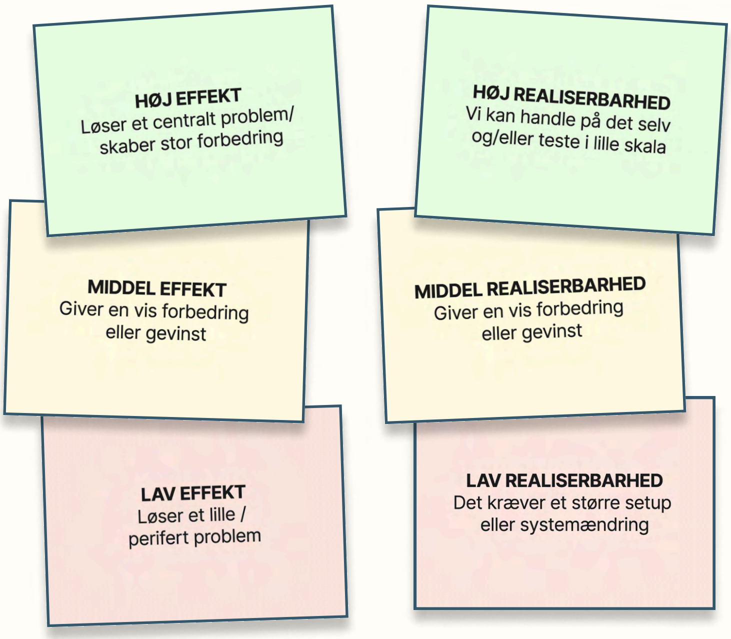
Hvis I har mange idéer, kan I lave en hurtig stemmerunde.

Hjælper: Giv hver deltager tre klistermærker, som kan placeres på de idéer, I synes er bedst.

Deltagerne: Stem ved at placere de tre klistermærker, enten samlet på én idé eller fordelt på flere.

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

7



HØJ EFFEKT
Løser et centralt problem/ skaber stor forbedring

HØJ REALISERBARHED
Vi kan handle på det selv og/eller teste i lille skala

MIDDEL EFFEKT
Giver en vis forbedring eller gevinst

MIDDEL REALISERBARHED
Giver en vis forbedring eller gevinst

LAV EFFEKT
Løser et lille / perifert problem

LAV REALISERBARHED
Det kræver et større setup eller systemændring

Figure 30: Instructions, activities, and tools inside the toolkit – part 2

EXECUTION PLAN

Handlingsplan

FORMÅLET

En minihandlingsplan hjælper med at omsætte den valgte idé til konkrete handlinger. Vi starter med at formulere en simpel version af idéen og fastlægger ansvar og tidsplan, så vi hurtigt kan teste værdien af idéen i praksis uden at spilde ressourcer og tid.

MINDSET: PRAGMATISK
Nu handler det om at gøre det rigtigt, men ikke perfekt! I skal være pragmatiske og fokusere på, hvad der kan gøres nu og hvad der skal til senere.

OUTPUT
I slutningen af denne del har I en konkret handlingsplan med ansvar, tidsplan og tydelige næste skridt.

TID
ca. 50 Minutter

MATERIALER

HANDLINGSPLANSARK (DEL 1)

HANDLINGSPLANSARK (DEL 2)

KUGLEPENNE

INSTRUKTIONER

Facilitator: Led gruppens samtale gennem de forskellige felter, og sørg for at holde samtalen på sporet.
Deltagerne: Bidrag med jeres perspektiver undervejs.
Hjælper: Udfyld felterne løbende, og hold øje med tiden.

DEL 1 - IDEDEFINERING

① **DEFINÉR IDÉEN**
Tid: ***10 min.*** *Hjælperen sætter timeren i gang.*
Skab en fælles forståelse af den valgte idé i Evalueringsøvelsen, og gør den så enkel som muligt, så den kan testes hurtigt. Venstre kolonne bruges til at notere en simpel version af den valgte idé. Højre kolonne bruges til at skrive det, I stadig er usikre på, som noget der kunne testes.

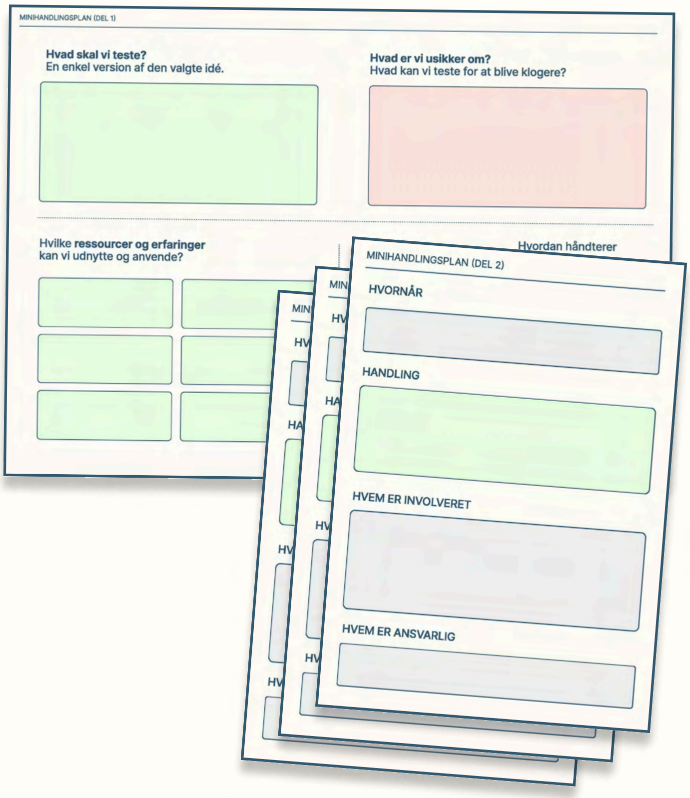
② **RESSOURCER**
Tid: ***10 min.*** *Hjælperen sætter timeren i gang.*
Afklar, hvilke ressourcer der allerede er til rådighed, og om der allerede findes lignende løsninger, I kan bygge videre på.

③ **BARRIERER**
Tid: ***10 min.*** *Hjælperen sætter timeren i gang.*
Identificér, hvad der kan spænde ben for idéen, og hvordan det kan håndteres.

9

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

10



MINIHANDLINGSPLAN (DEL 1)

Hvad skal vi teste?
En enkel version af den valgte idé.

Hvad er vi usikker om?
Hvad kan vi teste for at blive klogere?

Hvilke **ressourcer og erfaringer**
kan vi udnytte og anvende?

Hvordan håndterer

MINIHANDLINGSPLAN (DEL 2)

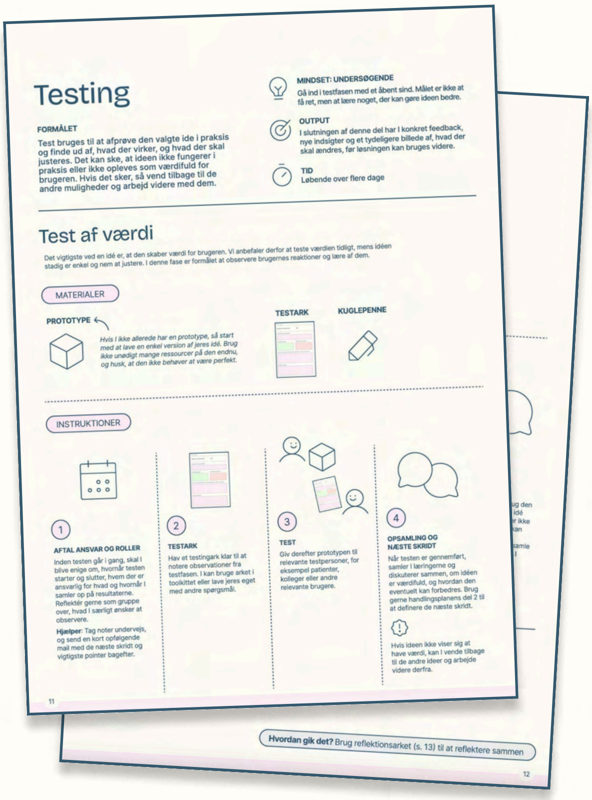
HVORNÅR

HANDLING

HVEM ER INVOLVERET

HVEM ER ANSVARLIG

TESTING



Testing

FORMÅLET

Test bruges til at afprøve den valgte ide i praksis og finde ud af, hvad der virker, og hvad der skal justeres. Det kan ske, at ideen ikke fungerer i praksis eller ikke opleves som værdifuld for brugeren. Hvis det sker, så vend tilbage til de andre muligheder og arbejd videre med dem.

MINDSET: UNDERSØGENDE
Gå ind i testfasen med et åbent sind. Målet er ikke at få ret, men at lære noget, der kan gøre ideen bedre.

OUTPUT
I slutningen af denne del har I konkret feedback, nye indsigter og et tydeligere billede af, hvad der skal ændres, før løsningen kan bruges videre.

TID
Løbende over flere dage

Test af værdi

Det vigtigste ved en idé er, at den skaber værdi for brugeren. Vi anbefaler derfor at teste værdien tidligt, mens idéen stadig er enkel og nem at justere. I denne fase er formålet at observere brugernes reaktioner og lære af dem.

MATERIALER

PROTOTYPE

Hvis I ikke allerede har en prototype, så start med at lave en enkel version af jeres idé. Brug ikke unødigt mange ressourcer på den endnu, og husk, at den ikke behøver at være perfekt.

TESTARK

KUGLEPENNE

INSTRUKTIONER

① **AFTAL ANSVAR OG ROLLER**
Inden testen går i gang, skal I blive enige om, hvornår testen starter og slutter, hvem der er ansvarlig for hvad og hvornår I samler op på resultaterne. Reflektér gerne som gruppe over, hvad I særligt ønsker at observere.
Hjælper: Tag noter undervejs, og send en kort opfølgende mail med de næste skridt og vigtigste pointer bagefter.

② **TESTARK**
Hav et testingark klar til at notere observationer fra testfasen. I kan bruge arket i toolkittet eller lave jeres eget med andre spørgsmål.

③ **TEST**
Giv derefter prototypen til relevante testpersoner, for eksempel patienter, kolleger eller andre relevante brugere.

④ **OPSAMLING OG NÆSTE SKRIDT**
Når testen er gennemført, samler I læringerne og diskuterer sammen, om idéen er værdifuld, og hvordan den eventuelt kan forbedres. Brug gerne handlingsplanens del 2 til at definere de næste skridt.

Hvis ideen ikke viser sig at have værdi, kan I vende tilbage til de andre ideer og arbejde videre derfra.

11

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

12

TEST AF VÆRDI

Testperson (F.eks Rolle, alder)

Dato

Hvad forstår du ved denne idé?

Hvad fungerer godt?

Hvad kunne være bedre?

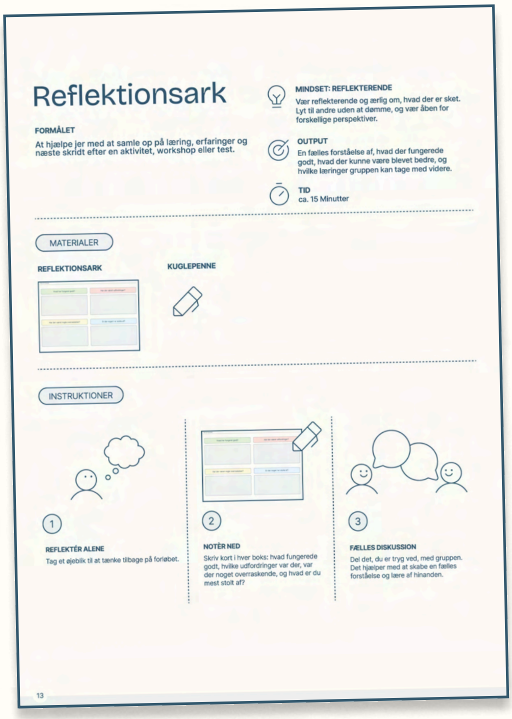
Kan du se, hvornår du ville bruge det? Ville det gøre en forskel i din hverdag?

Øvrige kommentarer

Ingen af dem

Figure 31: Instructions, activities, and tools inside the toolkit – part 3

REFLECTION ACTIVITY



Reflektionsark

FORMÅLET

At hjælpe jer med at samle op på læring, erfaringer og næste skridt efter en aktivitet, workshop eller test.

MINDSET: REFLEKTERENDE

Vær reflekterende og ærlig om, hvad der er sket. Lyt til andre uden at dømme, og vær åben for forskellige perspektiver.

OUTPUT

En fælles forståelse af, hvad der fungerede godt, hvad der kunne være blevet bedre, og hvilke læringer gruppen kan tage med videre.

TID

ca. 15 Minutter

MATERIALER

REFLEKTIONSARK

KUGLEPENNE

INSTRUKTIONER

① REFLEKTÉR ALENE

Tag et øjeblik til at tænke tilbage på forløbet.

② NOTÈR NED

Skriv kort i hver boks: hvad fungerede godt, hvilke udfordringer var der, var der noget overraskende, og hvad er du mest stolt af?

③ FÆLLES DISKUSSION

Del det, du er tryg ved, med gruppen. Det hjælper med at skabe en fælles forståelse og lære af hinanden.

13

REFLEKTIONSARK

Hvad har fungeret godt?

Har der været udfordringer?

Har der været nogle overraskelser?

Er der noget I er stolte af?

INSPIRATIONAL BOARD

Del en tanke, som kan inspirere andre

Lidt forskel gør en stor forskel

Det kunne lade sig gøre!

BADGES

Jeg er en

Facilitator

Jeg sørger for, at alle bliver hørt.

Jeg holder styr på processen.

Jeg holder samtalen relevant og på spo

Jeg er en

Hjælper

Jeg tager noter undervejs.

Jeg holder styr på tiden.

Jeg sender en kort opsamling efter sessionen.

Jeg er en

Deltager

Jeg bidrager med ideer.

Jeg lytter til de andre og bygger videre.

Jeg hjælper med at komme videre.

Figure 32: Instructions, activities, and tools inside the toolkit – part 4

7.6 CHECK-IN 7

The handover

> **CONTEXT:**
>
> *The purpose of the last check-in was to present the project group with the toolkit. Originally, we had planned to meet in person, but due to some last-minute cancellations and one nurse being online, the check-in ended up being online.*

Two nurses attended the handover, one from URO and one from ONC. We shared our screen and took them through the information manual and the tool templates. Lastly, we also showed them the physical box, including all the materials. Despite the limitations of online meetings, such as not being able to experience the toolkit first-hand, the nurses seemed very excited about the deliverable. One of the nurses commented that, despite not usually being a visual person, she really appreciated all the visual work, as it made it easy to understand and communicated it in a nice way. Further elaborating, it really fitted the process type. The other nurse said she really liked it all being physical, especially the badges, so you could be reminded of the role you had, and the specific task allocated to it during the session. They also mentioned that it seemed very intuitive and compared it to a game: when you know the ‘rules’, it is easy to play. On top of that, they both made positive comments on the box, including all the materials.

Since the meeting was online, it was not possible to hand over the toolkit in person. As a result, one of the nurses asked if we could send it digitally as soon as possible, since she wanted to present it at a development seminar across several departments. The other nurse nearly interrupted and said, “*I would like to borrow it mid-June*”. Both comments showed high engagement in applying the toolkit, both to spread awareness and use it for upcoming projects, slowly adapting it to their everyday work routines. When we mentioned that for now, we had only made one box, and therefore, they would have to share it, they said, “*Well then, we have an excuse to see each other more often, and work together in the future*”. This validated that the project had also facilitated closer connections and improved collaboration. The meeting therefore ended on a positive note, and upon further reflection, we felt we had succeeded in balancing service design tools with adaptation to their context.

Moreover, to ensure the toolkit’s use, we strategically planned a handover with the internal service designer and anthropologist at the Centre for Cancer and Organ Diseases. In this way we could include them in our process, to ensure an adaption and usage of the toolkit after our departure. We additionally planned a celebration at the hospital with everyone involved in the project, to celebrate all the good work, effort, learnings and outcomes. This was not only to show appreciation toward the involved ones. It was also a strategic decision, as building capabilities requires learning from failures and successes; in the latter, it is especially important to celebrate to sustain the drive for change (Amabile & Kramer, 2012).

when you know the ‘rules’, it is easy to play

7.7 KEY TAKEAWAYS: DELIVER

- In the Deliver phase, there was a shift in the check-ins, making our role as facilitators more invisible, as they took more ownership, resulting in shared discussions.
- Testing the different aspects of the one-pager helped the project group practice iterations and understand its value.
- Through mapping the process of the one-pager, it became clear that the nurses were willing to take responsibility for the various touchpoints to ensure the one-pager's implementation was feasible.
- We observed a shift in the nurses’ mindset, as they took risks in handing out an unfinished one-pager, which contrasted with previous worries.
- The final one-pager was made.
- Through the evaluation of the process, we gained insights into what had worked well and what had lacked throughout the project, informing our final deliverable for the nurses.
- The final deliverable included an information manual with guidelines on how to apply the selected tools, as well as templates and materials for the chosen tools.

08.

Discussion

In this chapter, the project will be discussed in relation to the case and the research question. It will critically reflect on the process and the applied approach, and examine how internal capabilities have been enabled in practice and how they may be sustained. Furthermore, the chapter outlines key learnings and presents suggestions for future research.

The chapter is divided into the following sections:

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8.1 Approaching the Case

The initial phase of the project was intentionally open and exploratory. The case addressed three background reasons and four desired outcomes, addressing both patient and staff-related issues. Rather than defining a narrow problem from the outset, we wanted to understand the broader context of the case: the hospital system, the transition between clinics, and the multiple actors involved.

8.1.1 THE COMPLEXITY OF SYSTEMS AND ITS BOUNDARIES

Our approach was informed by systemic design thinking, seeking not to view it as isolated parts but rather as flows and processes that include all relevant actors (Buchanan, 2019). We therefore explored the interdependent relationships among patients, nurses, support departments, organisational structures, and cultural dynamics. This perspective led us to explore both specific touchpoints, such as the green folder, and the less visible layers of coordination, responsibility, and dynamics within the system, for example, in interactions during check-ins. Being present at the hospital throughout the project further deepened understanding of the context.

However, the ambition for a holistic understanding quickly revealed its limitations. As the process unfolded, it became increasingly clear that fully understanding such a complex system was neither feasible nor desirable within the scope of the project. With both focusing on patient and staff-related issues, it was ambitious to further investigate the surrounding actors, for example, the leaders of the two departments. This raises questions such as: what does it mean to understand a system, and are we as designers obligated to understand the whole system?

Service design aims to holistically shape a service by understanding the needs of all the relevant stakeholders across the entire organisation (Stickdorn et al., 2018, pp. 25–26). However, while a systems thinking approach provides insight into the complexities and interdependencies in a system, it does not inherently reveal which parts of the system should be prioritised. As a consequence, the focus of the design process is shaped by those interpreting the system, ultimately influencing the outcome (Buchanan, 2019).

Reflecting on the project, we recognise that our interpretations also shaped how the problem was shaped and approached. In hindsight, this revealed some limitations in how we defined the boundaries of the case. It could have been beneficial to allocate more time to understanding the emergence of the case. By doing so, we would have become aware that the case regarding the patient issues was based on assumptions rather than existing patient data. Additionally, we might have gained insights into earlier initiatives to solve the case issues, allowing us to build on existing knowledge and value created. This could have influenced the time spent on the Discover phase, which aims to explore underlying issues. At the same time, these insights emerged during the process, indicating that our approach was effective. These insights therefore still provide a valuable learning in approaching similar cases by focusing on the case's origins before moving to extensive research methods.

8.1.2 THE LACK OF PATIENT PERSPECTIVES

When exploring the patient's case-related issues, it became evident to allocate more time to understand the case's emergence. Through the conduct of patient surveys and interviews, we expected to identify challenges in the transition between URO and ONC. The expectations were based on the staff's description of potential issues. Contrary to our expectations, the findings indicated a relatively high level of satisfaction. On a practical level, we questioned whether our methods had been sufficient or whether additional research might have uncovered less visible challenges. More importantly, it challenged a deeper assumption about the role of design. What if change is not needed? And to what extent are we constructing problems on behalf of others, when the service may already be working well enough for those who directly experience them?

Both our process and the nurse's mindset reflected a tendency to look for problems, for example, patients lacking sufficient information during their waiting time. However, through the process, it became evident that there lies great value in also acknowledging what works well and the existing values, such as the information they already have. This made us reconsider how we approached the system. Rather than viewing it mainly as something to be fixed, we started paying more attention to existing value within it. Recognising what works was not a passive observation but an active design decision that shaped whether and how we chose to intervene. For example, by understanding what worked well with the green folder, we were able to leverage these insights to inform the final one-pager.

Despite indications of high patient satisfaction in our data, we still agreed to move further with a patient-focused solution. Given the potential consequences of overlooking patient challenges, we made an ethically grounded choice not to conclude that no issues existed. This decision was grounded in our acknowledgement that the sample was not necessarily representing the average testicular cancer patient. Furthermore, the pathway coordinator revealed some challenges the patients are facing, making us recognise that aspects of the patient pathway still needed improvement. This enabled us to shift our focus to enabling capabilities, positioning the nurses as key actors in continuing to address patient needs.

At the same time, the patient perspectives were only partially integrated into the development process. While we focused on introducing the methods and how to apply them, we were not responsible for recruiting patients to test the one-pager. During the ideation workshop, where the one-pager idea was developed, patients were not involved as the session originally focused on staff issues. Throughout the project, we had emphasised the need for co-creation, further highlighting the importance of including those affected by the service (Sanders & Stappers, 2012, pp. 15–35). However, a limited number of patients tested the value of the one-pager. Therefore, it can be argued that we failed to help the nurses co-create the one-pager with the patients.

This highlights a constrain in our approach: while stepping back and focusing on building capabilities, it reduced our ability to actively engage and ensure the inclusion of patient perspectives. However, rather than representing a failure, it can be understood as a broader learning process. This project can be understood as a pilot, where the experiences gained by the project group provide a foundation for more informed approaches in future initiatives.

8.2 Review of the Research Question

The explorative process revealed repeated attempts over time to address challenges within the case, yet with limited success. This suggests that the challenges were less related to willingness or initiative to drive change, and more about the capabilities required to implement and sustain it. This brings us back to the research question: *How can a service design approach enable nurses in cancer departments to develop internal capabilities for implementing and sustaining change?*

8.2.1 ESTABLISHING THE CONDITIONS FOR REAL CHANGE

A natural starting point is to consider why previous initiatives had not been sustained, in order to understand which capabilities may have been lacking. Based on discussions with nurses and coordinators, several constraints emerged, including limited time, unclear responsibility, competing priorities, and challenges related to feasibility. Initiatives were often perceived as too extensive, while responsibility for driving them forward remained diffuse, leading to a lack of follow-through. While these insights pointed toward structural challenges, they were primarily based on participants' perspectives, and a deeper exploration of the underlying causes was not pursued.

Instead, we decided to focus on guiding and facilitating the process aimed at achieving implementation within the project timeframe. This approach allowed us to observe what supported or hindered the integration of new practices in real time. This choice reframed of our roles as designers. Rather than directly solving all identified challenges, our contribution became enabling those within the system to address them over time.

At first glance, such recurring challenges may suggest that capability building should primarily be addressed at the level of hospital leadership or formal organisational structures. However, this raises a more fundamental question of responsibility: who ultimately drives and sustains change in everyday clinical practice? Nurses operate within structural constraints, carrying significant responsibility for prioritising clinical tasks, which, combined with high workloads and limited time, may restrict their capacity to engage with improvement efforts (Fry, 2019; Lin et al., 2011; Pakarinen et al., 2023, p. 5). From this perspective, and considering that the previous initiatives were limited by time, it may seem counterintuitive to focus on enabling nurses themselves to drive change, while we, as designers, deliberately stepped back.

However, change literature and similar initiatives emphasise that sustainable change cannot be introduced solely from the outside; it must be continuously shaped, adapted and embedded by those enacting it in practice (Alvesson & Sveningsson, 2025, p. 32; Junginger & Sangiorgi, 2009; Lin et al., 2011; Patrício et al., 2019). In this sense, and as reflected in our experience of shifting responsibility, nurses should not be seen as recipients of change, but active carriers of it.

This creates a tension where the system, in this case, depends on nurses to sustain change, yet does not always provide the conditions necessary for them to do so. This questions whether capability building should be understood as an additional task, or as something that must be embedded within existing practices. In this project, one distinguishing factor compared to previous initiatives was the explicit allocation of time within nurses' existing working hours from the outset, alongside a clear distribution of responsibility. This suggests that engaging in change processes requires dedicated time, not as an add-on, but as an integrated part of everyday practice. At the same time, it highlights that while internal ownership is essential, it may require structure and support, particularly in the early stages.

Taken together, this underscores that change is not something that should be introduced from the outside, but as something that must be developed and sustained from within (Alvesson & Sveningsson, 2025, p. 32; Junginger & Sangiorgi, 2009; Lin et al., 2011; Patrício et al., 2019), shaping how responsibility and capability-building are approached in practice.

8.2.2 ENABLING CAPABILITIES IN PRACTICE

By enabling nurses as active carriers of the change process, it became visible in practice how the nurses increasingly took initiative and responsibility. During the ideation workshop, the nurses took ownership of the project by collaboratively planning how to develop and test the one-pager. Similarly, when feedback from initial testing was limited, nurses independently discussed how to increase response rates and identified patients for follow-up. These instances indicate a gradual shift in responsibility, from designers facilitating the process to the nurses actively taking ownership themselves. More importantly, it demonstrated that the nurses began collaborating across departments without our involvement.

The ideation workshop also marked an important step toward enabling capabilities related to experimentation and iteration. Initially, this approach proved challenging as the nurses were used to developing fully finished solutions before testing. Introducing the idea of testing early and working with unfinished concepts required a shift in mindset. Through continuous explanation and facilitation, we were able to clarify the rationale behind this approach, which appeared to increase their willingness to engage with it. This was reflected in their ability to develop a testable version of the one-pager within a few days, something they themselves noted had not occurred in previous projects. One nurse highlighted this when evaluating the project, by stating that *"being pressured to test an unfinished product"* had been the most valuable learning. While this suggests that new ways of working were beginning to take hold, it also indicates that such capabilities did not emerge independently but required continuous prompting and guidance.

Similarly, the structure of the last check-ins was designed to support capability-building. While these sessions included brief introductions to practices such as testing and scaling, the primary focus was on prompting the nurses with questions that required them to reflect and take action between meetings. In this sense, tools and methods were not introduced as outputs, but as inspiration to guide and support their work in practice. However, this approach revealed limitations. In hindsight, we might have stepped too far back when introducing some of the tools. When evaluating the overall process, nurses revealed that the steps in the testing phase were unclear and lacked our support, leaving them uncertain how to approach the process and ensure sufficient feedback. This may have contributed to the limited feedback on the value of the one-pager, as more guidance from our side could have strengthened the outcomes. This suggests that while responsibility can be shifted, it needs sufficient support to be effective. In this case, the tools were rather adopted, which, according to Dorst (2015), means that when techniques and methods are applied in a field, without substantial changes.

Taken together, these observations and feedback from nurses suggest that capabilities were enabled not only through the introduction of the tools, but through how responsibility, time and action were structured. Nurses were given space to act independently, while facilitation was used to guide and support the process. This approach contributed to moments of ownership, cross-departmental collaboration, and progress, ultimately resulting in the development and implementation of the one-pager.

8.2.3 SUSTAINING CAPABILITIES AND CHANGE

While we argue that we enabled the nurses to develop internal capabilities to implement change within the case context, we question whether these capabilities can be sustained, embedded in their everyday practice, and scaled across departments.

These questions feed further into a discussion if service design lacks implementation strategies, which can prevent service concepts from moving beyond the design stage. Service implementation does not simply involve handing over a finished design; it requires organisational change and adaptation and should be viewed as a continuous process, emphasising the need for continuous observations (Alvesson & Sveningsson, 2025, pp. 32–33; Overkamp & Holmlid, 2016; Stickdorn et al., 2018, p. 33). Acknowledging our limited timeframe, we strategically developed a toolkit aimed at supporting and continuing capability-building after our involvement. The toolkit was based on the tools the nurses themselves found valuable, and was designed to be accessible, with clear guidelines and facilitation role cards to support independent use. In this sense, it aimed to strengthen both the application of the methods and the nurses' ability to drive and facilitate change processes. However, as this outcome emerged during the project, insufficient time was allocated to test the toolkit without our involvement. While individual elements were applied throughout the process, the toolkit itself was primarily evaluated through initial feedback rather than sustained use. This limits our ability to measure its long-term impact.

Furthermore, we question whether we have made a change in the system. Existing literature describes change as a process of making something different or becoming different over time (Alvesson & Sveningsson, 2025, p. 5), shaped by dynamic system interactions that influence each other and are unpredictable (Buchanan, 2019; van der Bijl-Brouwer & Malcolm, 2020). This makes it, according to Morelli et al. (2021, p.87), hard to measure the effect of change. As capability-building and interventions often lead to shifts in mindset or new ways of collaborating, they could rather be measured through qualitative insights, such as observations of practices and the collection of perspectives and insights from included actors. However, this would require more time. Therefore, to support continuity, we collaborated with internal service designers at Rigshospitalet, who planned to take over the responsibility of the toolkit. This was a strategic decision, creating potential for ongoing adaptation and scaling, allowing the initiative to extend beyond our involvement.

Ultimately, we have attempted to develop internal capabilities to create long lasting change. According to van der Bijl-Brouwer (2022), service design cannot control change; it can, however, enable positive change, which can act as a leverage point for broader systemic change. Further elaborating, service designers should create space for change to emerge by designing conditions and infrastructure that foster it and by providing employees with space to build capabilities and take ownership (van der Bijl-Brouwer, 2022). Therefore, it can be argued that through the project, we created the conditions for the nurses to develop capabilities to further implement and sustain change. This is further strengthened by the overall evaluation of the process, quoting a nurse, *"The project with you has been invaluable, giving us the tool and courage to proceed".*

8.3 Our Learnings

The Master's in Service Systems Design holds that *"change can only be achieved through a deep understanding of the complex systems that services operate in"* (Aalborg Universitet, n.d.). By immersing ourselves in the system and collaborating with Rigshospitalet, we expanded our perspectives and our own capabilities as service designers. Referring back to our personal learning goals, the project has allowed us to not only to investigate which methods and tools that can support hospitals in navigating complex change processes, but also how. Through check-ins, feedback and reflections, we became aware of how to adapt the methods and tools to their context, enabling them to develop internal capabilities.

This further developed our skills in the co-creation process, when navigating diverse expertise and different mindsets, which both challenged us, but also revealed that experience from earlier projects could be applied. Since the project led to a toolkit, with the aim of sustaining capabilities to further implement change, we would argue that we have created an adaptable solution that can be scaled out to other complex systems and organisations. Ultimately, the collaboration with Rigshospitalet enabled us to create meaningful change, creating value for both patients and healthcare professionals.

Our learnings, reflections and insights can further be translated into some practice-based considerations for supporting change and building internal capabilities in healthcare in the future:

BEFORE STARTING THE PROCESS:

1. **Engage the right people early:** Involve a diverse group of stakeholders from the beginning, including motivated professionals, potential change agents and internal designers if available. Early engagement builds ownership and ensures different perspectives are considered from the beginning.

2. **Align on the need and readiness for change:** Make sure there is a shared understanding that change is needed and openly address concerns early. Acknowledge that change requires time and effort.

3. **Create shared understanding of the project:** Ensure that all participants understand the background, purpose, scope, possibilities and limitations of the project. Misaligned expectations early on can create friction later in the process.

4. **Agree on practical ways of working:** Clarify communication channels (e.g. email, Teams, physical meetings) and align on roles and how collaboration will take place. Set up time in people's calendars early, while keeping it realistic and flexible, and communicate that it's not expected to participate in every session.

5. **Plan access to patients early:** When involving patients, organise access as soon as possible. Collaborating with nurses or other staff who have already established relationships can make recruitment more feasible and ethical.

DURING THE PROCESS:

6. **Adapt to context, do not simply apply methods:** Service design approaches need to be adapted to the healthcare setting. Take time to understand each other's perspectives, build shared language, and find common ground. Respect the high-stakes nature of healthcare, while also gently challenging existing practices.

7. **Be patient with the process and with resistance:** Service design may feel unfamiliar or abstract to healthcare professionals. Resistance or confusion is not necessarily a barrier, but a part of the process. Allow time for building trust and understanding.

8. **Stay flexible and expect change:** Plans will shift, often on short notice. Build flexibility into the process and be prepared with simpler alternatives or backup approaches.

9. **Make insights visible and discussable:** Present data and insights in clear, tangible ways. Create space and time for stakeholders to question, interpret, and challenge findings together. This supports shared understanding and ownership.

10. **Highlight what already works:** Healthcare professionals operate under high pressure. Actively recognising and valuing what works well can strengthen motivation and create a better foundation for change.

11 **Co-create solutions, not just ideas:** Develop and plan solutions together with stakeholders. This strengthens relevance, feasibility, and ownership, increasing the likelihood that changes will be sustained.

12 **Gradually transfer ownership:** Over time, let go of control and shift responsibility for the work to internal actors, such as healthcare professionals or internal designers. Plan for what happens after the project ends to ensure continuity.

AFTER THE PROCESS:

13 **Reflect together on the process:** create space for collective reflection on what worked, what did not, and what could be done in the future. This supports learning beyond the project itself.

14 **Acknowledge the effort and celebrate progress:** Recognise the contribution of everyone involved. Even small steps can require significant effort in a healthcare context, and celebrating progress helps reinforce engagement and confidence.

8.4 Future Research

While this project has generated valuable insights and a nuanced understanding of building internal capabilities, it has also revealed limitations and areas that remain unexplored to implement and sustain change. This creates opportunities for future research to further develop and strengthen the field. Several areas emerged throughout the study, where a selection is highlighted below.

Change initiatives take time and require ongoing observation to ensure their success. As this project was conducted within a limited timeframe, following similar initiatives over the years could provide a deeper understanding of how change is sustained in practice, and how internal capabilities develop, stabilise or fade over time.

There is also a potential to further investigate specific service design tools and approaches. Testing and comparing specific methods, could provide greater clarity on which approaches are the most effective in supporting capability building.

Another relevant area is to focus more on those who are less motivated or more resistant to change. This project was characterised by high engagement, but future research could explore how different levels of motivation and group dynamics affect the ability to implement and sustain change.

The role of leadership could also be further explored. While this study mainly focused on head nurses and nurses, further research could investigate how leaders, organisations, and policy shape the conditions for change and how they can support or hinder the development of internal capabilities.

Additionally, further research could explore the role of technology in supporting change processes. While this project mainly focused on relational and physical approaches, future research could explore how digital tools and infrastructures enable or constrain the implementation of new practices.

Finally, it would be relevant to investigate whether these approaches are specific to healthcare or if similar patterns can be found in other sectors. This could help clarify the extent to which our findings depend on context and how service design can contribute to capability building across different fields.

09.

Conclusion

This project was conducted in close collaboration with five nurses from two cancer departments at Rigshospitalet, with the aim of understanding how change is experienced in everyday clinical practice. In a healthcare context characterised by complexity, high workload, and interdependent systems, the ability to initiate and sustain change is both critical and challenging (Braithwaite et al., 2017; Halvorsrud et al., 2019; Pakarinen et al., 2023, p. 5). Through this lens, our aim was to explore the potential role of service design in enabling and supporting sustainable change processes.

Through an in-depth case study focusing on the transition between the two departments, we uncovered a critical paradox. While the nurses demonstrated a high degree of engagement, initiative, and willingness to improve their work practices, these efforts rarely translated into implemented change. Our findings indicate that the challenge was not rooted in a lack of motivation, but rather limited access to shared structures and practical tools to move ideas from concept to execution. In this sense, the primary barrier to change lied in the capability rather than the intent.

Accordingly, the project focused on strengthening nurses' internal capabilities to navigate and sustain change processes independently. By positioning the nurses as active drivers of the project, being responsible for ideation, planning, testing and implementation, while we acted as facilitators, the process itself strengthened their ability to drive change. Practices such as iteration, testing, mapping and scaling were introduced and embedded through action. This participatory approach not only resulted in a concrete improvement of collaboration across departments, but also fostered a stronger sense of ownership and confidence among nurses to lead future initiatives.

Importantly, the impact of the project extends beyond the immediate case. Through ongoing experimentation with service design methods, a tangible toolkit was developed to support the nurses in carrying these practices forward in their everyday work. In doing so, the project contributes to building internal capabilities for change, reducing reliance on external facilitation.

Overall, this study demonstrates that in healthcare, meaningful and lasting change should not only be introduced from the outside but be developed and sustained by those working within the system. Service design, in this sense, is not only a profession, but a mindset and an approach that can, and should be, adopted by healthcare professionals themselves. It is ultimately the people operating in the everyday realities of a service who determine whether change takes hold (Alvesson & Sveningsson, 2025, pp. 32–33). By equipping them with the tools, structures, and confidence to shape their own practices, small, consistent actions over time can create the foundation for deeper, systemic change.

10.
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11.
Appendix

Appendix A: AI Declaration

GENERATIVE AI TECHNOLOGY USED FOR THE REPORT:

Grammarly, PerplexityAI, Copilot

Description of how generative AI has been used:

The AI tools mentioned above have been used to enhance grammar and sentence structure in the report to improve its flow and clarity.

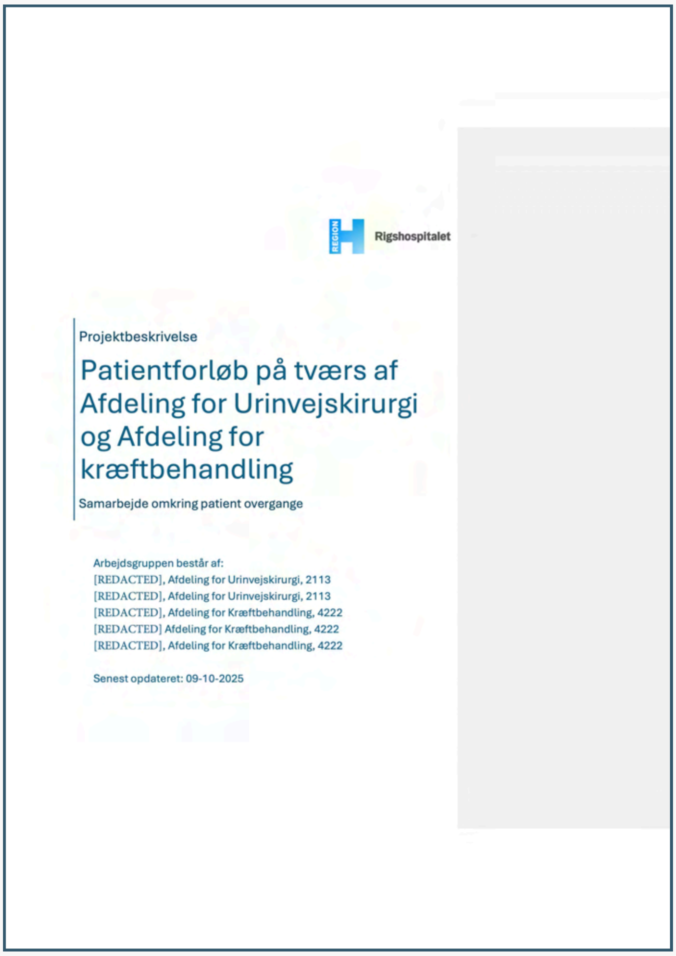
GENERATIVE AI TECHNOLOGY USED DURING THE PROCESS

Grammarly, Perplexity AI, Chat GPT, Copilot

Description of how generative AI has been used:

The AI tools mentioned above have been used during the process as a support to the development of materials for the case, including presentations, printed materials, and the final delivery. In particular, their use has supported the translation from English to Danish and viceversa as well as as a brainstorming support.

Appendix B: Project Description (Anonymised)



Rigshospitalet

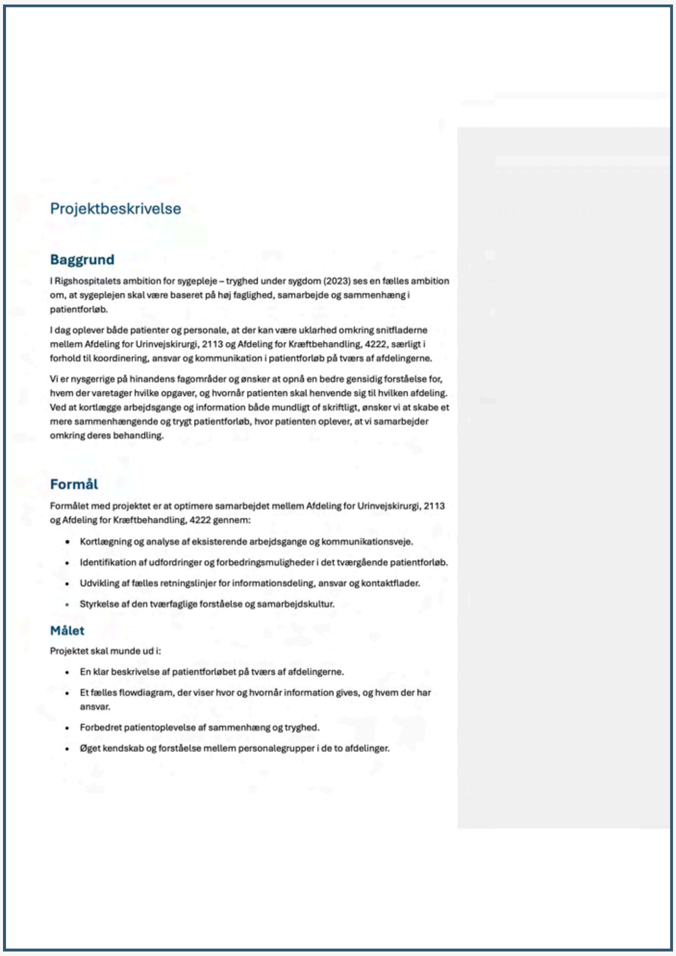
Projektbeskrivelse

Patientforløb på tværs af Afdeling for Urinvejskirurgi og Afdeling for kræftbehandling

Samarbejde omkring patient overgange

Arbejdsgruppen består af:
[REDACTED], Afdeling for Urinvejskirurgi, 2113
[REDACTED], Afdeling for Urinvejskirurgi, 2113
[REDACTED], Afdeling for Kræftbehandling, 4222
[REDACTED] Afdeling for Kræftbehandling, 4222
[REDACTED], Afdeling for Kræftbehandling, 4222

Senest opdateret: 09-10-2025



Projektbeskrivelse

Baggrund

I Rigshospitalets ambition for sygepleje – tryghed under sygdom (2023) ses en fælles ambition om, at sygeplejen skal være baseret på høj faglighed, samarbejde og sammenhæng i patientforløb.

I dag oplever både patienter og personale, at der kan være uklarhed omkring snitfladerne mellem Afdeling for Urinvejskirurgi, 2113 og Afdeling for Kræftbehandling, 4222, særligt i forhold til koordinering, ansvar og kommunikation i patientforløb på tværs af afdelingerne.

Vi er nysgerrige på hinandens fagområder og ønsker at opnå en bedre gensidig forståelse for, hvem der varetager hvilke opgaver, og hvornår patienten skal henvende sig til hvilken afdeling. Ved at kortlægge arbejdsgange og information både mundligt of skriftligt, ønsker vi at skabe et mere sammenhængende og trygt patientforløb, hvor patienten oplever, at vi samarbejder omkring deres behandling.

Formål

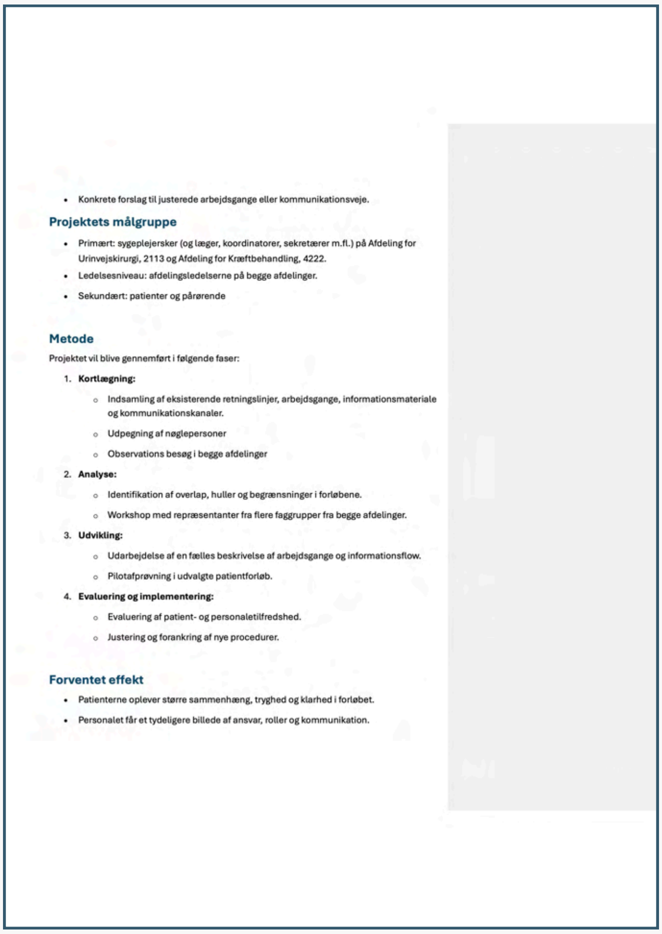
Formålet med projektet er at optimere samarbejdet mellem Afdeling for Urinvejskirurgi, 2113 og Afdeling for Kræftbehandling, 4222 gennem:

- Kortlægning og analyse af eksisterende arbejdsgange og kommunikationsveje.
- Identifikation af udfordringer og forbedringsmuligheder i det tværgående patientforløb.
- Udvikling af fælles retningslinjer for informationsdeling, ansvar og kontaktflader.
- Styrkelse af den tværfaglige forståelse og samarbejdskultur.

Målet

Projektet skal munde ud i:

- En klar beskrivelse af patientforløbet på tværs af afdelingerne.
- Et fælles flowdiagram, der viser hvor og hvornår information gives, og hvem der har ansvar.
- Forbedret patientoplevelse af sammenhæng og tryghed.
- Øget kendskab og forståelse mellem personalegrupper i de to afdelinger.



- Konkrete forslag til justerede arbejdsgange eller kommunikationsveje.

Projektets målgruppe

- Primært: sygeplejersker (og læger, koordinatorer, sekretærer m.fl.) på Afdeling for Urinvejskirurgi, 2113 og Afdeling for Kræftbehandling, 4222.
- Ledelsesniveau: afdelingsledelserne på begge afdelinger.
- Sekundært: patienter og pårørende

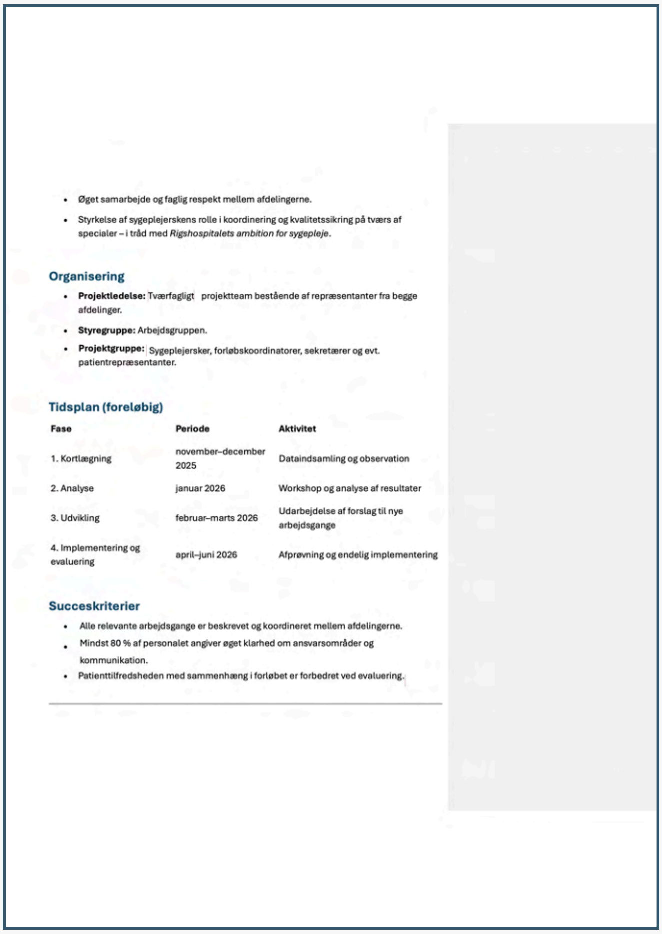
Metode

Projektet vil blive gennemført i følgende faser:

1. **Kortlægning:**
    - Indsamling af eksisterende retningslinjer, arbejdsgange, informationsmateriale og kommunikationskanaler.
    - Udpegning af nøglepersoner
    - Observations besøg i begge afdelinger
2. **Analyse:**
    - Identifikation af overlap, huller og begrænsninger i forløbene.
    - Workshop med repræsentanter fra flere faggrupper fra begge afdelinger.
3. **Udvikling:**
    - Udarbejdelse af en fælles beskrivelse af arbejdsgange og informationsflow.
    - Pilotafprøvning i udvalgte patientforløb.
4. **Evaluering og implementering:**
    - Evaluering af patient- og personaletilfredshed.
    - Justering og forankring af nye procedurer.

Forventet effekt

- Patienterne oplever større sammenhæng, tryghed og klarhed i forløbet.
- Personalet får et tydeligere billede af ansvar, roller og kommunikation.



- Øget samarbejde og faglig respekt mellem afdelingerne.
- Styrkelse af sygeplejerskens rolle i koordinering og kvalitetssikring på tværs af specialer – i tråd med *Rigshospitalets ambition for sygepleje*.

Organisering

- **Projektledelse:** Tværfagligt projektteam bestående af repræsentanter fra begge afdelinger.
- **Styregruppe:** Arbejdsgruppen.
- **Projektgruppe:** Sygeplejersker, forløbskoordinatorer, sekretærer og evt. patientrepræsentanter.

Tidsplan (foreløbig)

Fase	Periode	Aktivitet
1. Kortlægning	november–december 2025	Dataindsamling og observation
2. Analyse	januar 2026	Workshop og analyse af resultater
3. Udvikling	februar–marts 2026	Udarbejdelse af forslag til nye arbejdsgange
4. Implementering og evaluering	april–juni 2026	Afprøvning og endelig implementering

Succeskriterier

- Alle relevante arbejdsgange er beskrevet og koordineret mellem afdelingerne.
- Mindst 80 % af personalet angiver øget klarhed om ansvarsområder og kommunikation.
- Patienttilfredsheden med sammenhæng i forløbet er forbedret ved evaluering.

Forankring

Projektets resultater og anbefalinger forankres i begge afdelinger og implementeres i gældende instrukser og patientforløbsbeskrivelser.

Appendix C: Overview of info materials collected

							The Green Folder					
	Preparation to the operation	Guide for hair removal	Pathway Coordinator	Patient advisor	Welcome to the department...	Operation: Before & During	Flyer to MitForløb	Business Card	KB Brochure 1 "Your Rights"	KB Brochure 2 "Testicular Cancer"	Operation: After	KB Financial Support
Receiver	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients
Author	Rigshospitalet	Rigshospitalet	Rigshospitalet	Rigshospitalet	Rigshospitalet	Rigshospitalet	Rigshospitalet	Rigshospitalet	Kræftens Bekæmpelse	Kræftens Bekæmpelse	Rigshospitalet	Kræftens Bekæmpelse
Content	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients	Patients
When and where does it get delivered	Preliminary examination - URO	Preliminary examination - URO	Preliminary examination - URO	Preliminary examination - URO	Preliminary examination - URO	-	After Operation - URO	After Operation - URO	After Operation - URO	After Operation - URO	After Operation - URO	After Operation - URO
												

Appendix D: Final Survey Design

Evaluering af ventetiden for testikelkræftpatienter

Formål og samtykke

Formålet med dette spørgeskema er at indsamle viden om, hvordan du har oplevet overgangen mellem Afdeling for Urinvejskirurgi og Afdeling for kræftbehandling. Dine svar vil blive brugt til at forbedre kvaliteten af forløbet for fremtidige patienter. Undersøgelsen er udarbejdet af kandidatstuderende i Service Systems Design i samarbejde med Rigshospitalet. Dine svar er anonyme og behandles i overensstemmelse med gældende regler for persondata (GDPR). Resultater fra undersøgelsen kan eventuelt indgå i videnskabelige publikationer. Det er frivilligt at deltage, og du kan til enhver tid vælge ikke at besvare specifikke spørgsmål.

Hvis du har spørgsmål, er du velkommen til at kontakte os på mail:
Emily Brophy: **emily.brophy@regionh.dk,** Erika Strazio: **estraz24@student.aau.dk,**
Lea Texmo Limstrand: **llimst24@student.aau.dk**

A. Demografiske spørgsmål

1. **Hvor gammel er du?**

    ☐ 18–20
    ☐ 20-22
    ☐ 21-23
    ☐ 24-26
    ☐ 27-29
    ☐ 30-33
    ☐ 34–39
    ☐ 40-49
    ☐ 50–59
    ☐ 60 eller derover

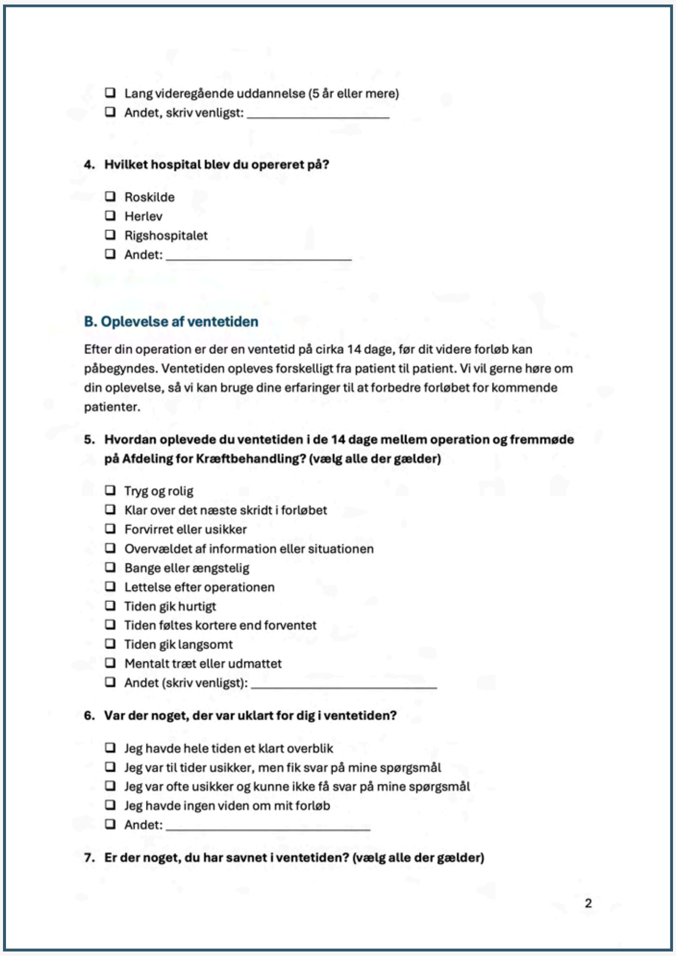
2. **Hvad er din civilstand?**

    ☐ Gift/partner
    ☐ Skilt/separeret
    ☐ Single
    ☐ Andet: ______________________

3. **Hvad er din højeste fuldførte uddannelse?**

    ☐ Grundskole (folkeskole el. tilsvarende)
    ☐ Gymnasial uddannelse (STX, HF, HHX, HTX el. tilsvarende)
    ☐ Erhvervsuddannelse
    ☐ Kort videregående uddannelse (under 2 år)
    ☐ Mellemlang videregående uddannelse (2–4 år)

1



    ☐ Lang videregående uddannelse (5 år eller mere)
    ☐ Andet, skriv venligst: ____________________

4. **Hvilket hospital blev du opereret på?**

    ☐ Roskilde
    ☐ Herlev
    ☐ Rigshospitalet
    ☐ Andet: ______________________

B. Oplevelse af ventetiden

Efter din operation er der en ventetid på cirka 14 dage, før dit videre forløb kan påbegyndes. Ventetiden opleves forskelligt fra patient til patient. Vi vil gerne høre om din oplevelse, så vi kan bruge dine erfaringer til at forbedre forløbet for kommende patienter.

5. **Hvordan oplevede du ventetiden i de 14 dage mellem operation og fremmøde på Afdeling for Kræftbehandling? (vælg alle der gælder)**

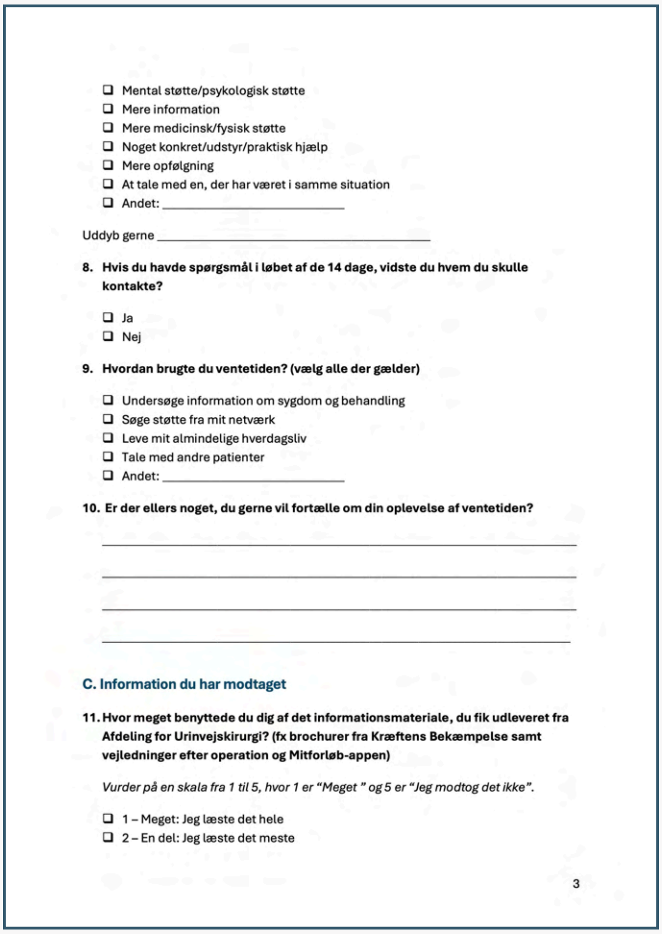
    ☐ Tryg og rolig
    ☐ Klar over det næste skridt i forløbet
    ☐ Forvirret eller usikker
    ☐ Overvældet af information eller situationen
    ☐ Bange eller ængstelig
    ☐ Lettelse efter operationen
    ☐ Tiden gik hurtigt
    ☐ Tiden føltes kortere end forventet
    ☐ Tiden gik langsomt
    ☐ Mentalt træt eller udmattet
    ☐ Andet (skriv venligst): ______________________

6. **Var der noget, der var uklart for dig i ventetiden?**

    ☐ Jeg havde hele tiden et klart overblik
    ☐ Jeg var til tider usikker, men fik svar på mine spørgsmål
    ☐ Jeg var ofte usikker og kunne ikke få svar på mine spørgsmål
    ☐ Jeg havde ingen viden om mit forløb
    ☐ Andet: ______________________

7. **Er der noget, du har savnet i ventetiden? (vælg alle der gælder)**

2



- ☐ Mental støtte/psykologisk støtte
- ☐ Mere information
- ☐ Mere medicinsk/fysisk støtte
- ☐ Noget konkret/udstyr/praktisk hjælp
- ☐ Mere opfølgning
- ☐ At tale med en, der har været i samme situation
- ☐ Andet: ____________________________

Uddyb gerne ____

8. Hvis du havde spørgsmål i løbet af de 14 dage, vidste du hvem du skulle kontakte?

- ☐ Ja
- ☐ Nej

9. Hvordan brugte du ventetiden? (vælg alle der gælder)

- ☐ Undersøge information om sygdom og behandling
- ☐ Søge støtte fra mit netværk
- ☐ Leve mit almindelige hverdagsliv
- ☐ Tale med andre patienter
- ☐ Andet: ____________________________

10. Er der ellers noget, du gerne vil fortælle om din oplevelse af ventetiden?

____

____

____

____

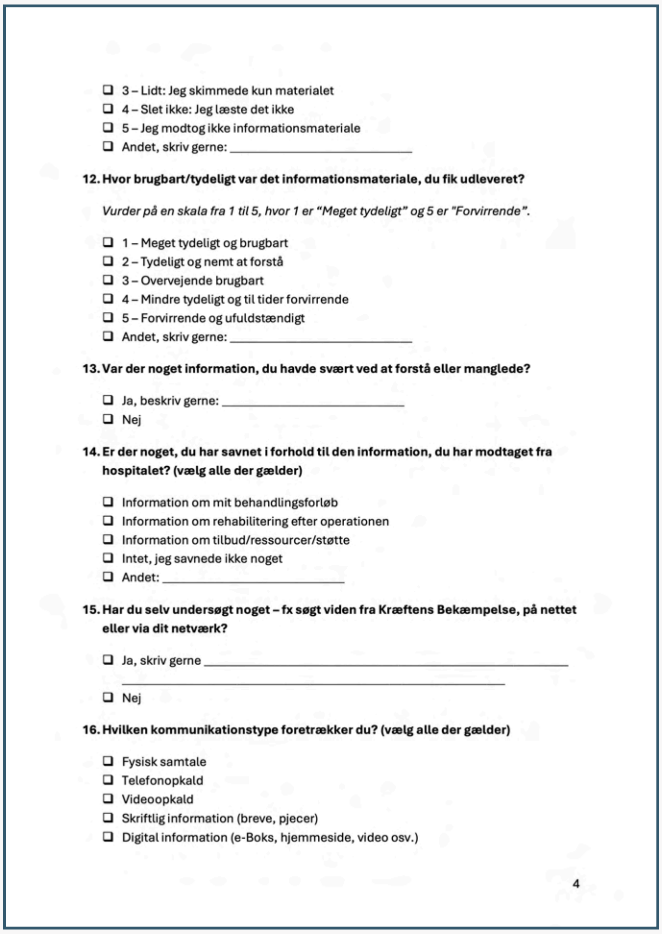
C. Information du har modtaget

11. Hvor meget benyttede du dig af det informationsmateriale, du fik udleveret fra Afdeling for Urinvejskirurgi? (fx brochurer fra Kræftens Bekæmpelse samt vejledninger efter operation og Mitforløb-appen)

Vurder på en skala fra 1 til 5, hvor 1 er "Meget " og 5 er "Jeg modtog det ikke".

- ☐ 1 – Meget: Jeg læste det hele
- ☐ 2 – En del: Jeg læste det meste

3



- ☐ 3 – Lidt: Jeg skimmede kun materialet
- ☐ 4 – Slet ikke: Jeg læste det ikke
- ☐ 5 – Jeg modtog ikke informationsmateriale
- ☐ Andet, skriv gerne: ____________________________

12. Hvor brugbart/tydeligt var det informationsmateriale, du fik udleveret?

Vurder på en skala fra 1 til 5, hvor 1 er "Meget tydeligt" og 5 er "Forvirrende".

- ☐ 1 – Meget tydeligt og brugbart
- ☐ 2 – Tydeligt og nemt at forstå
- ☐ 3 – Overvejende brugbart
- ☐ 4 – Mindre tydeligt og til tider forvirrende
- ☐ 5 – Forvirrende og ufuldstændigt
- ☐ Andet, skriv gerne: ____________________________

13. Var der noget information, du havde svært ved at forstå eller manglede?

- ☐ Ja, beskriv gerne: ____________________________
- ☐ Nej

14. Er der noget, du har savnet i forhold til den information, du har modtaget fra hospitalet? (vælg alle der gælder)

- ☐ Information om mit behandlingsforløb
- ☐ Information om rehabilitering efter operationen
- ☐ Information om tilbud/ressourcer/støtte
- ☐ Intet, jeg savnede ikke noget
- ☐ Andet: ____________________________

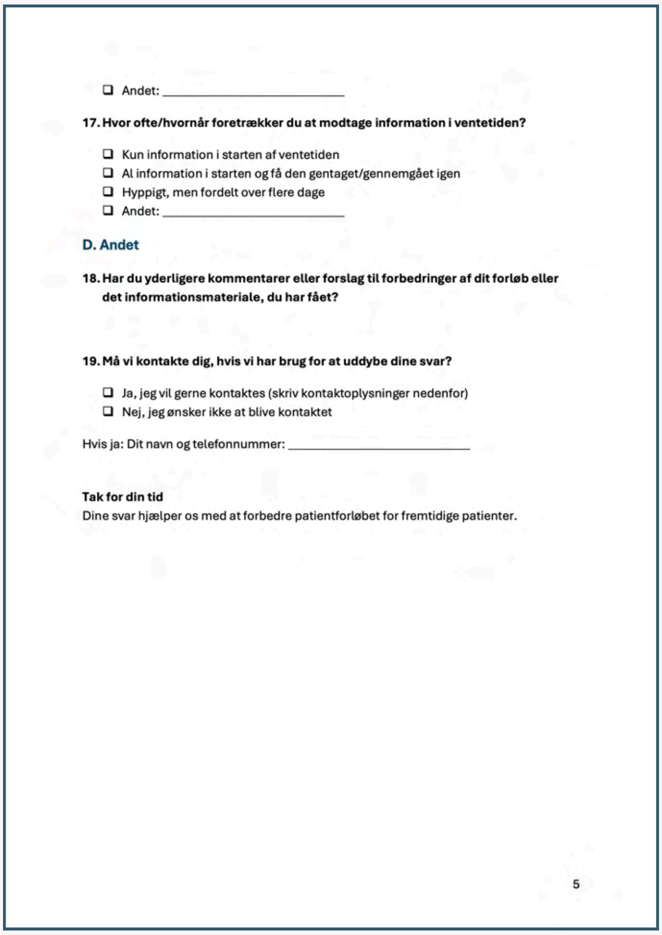
15. Har du selv undersøgt noget – fx søgt viden fra Kræftens Bekæmpelse, på nettet eller via dit netværk?

- ☐ Ja, skriv gerne ____
  ____
- ☐ Nej

16. Hvilken kommunikationstype foretrækker du? (vælg alle der gælder)

- ☐ Fysisk samtale
- ☐ Telefonopkald
- ☐ Videoopkald
- ☐ Skriftlig information (breve, pjecer)
- ☐ Digital information (e-Boks, hjemmeside, video osv.)

4



- ☐ Andet: ____________________________

17. Hvor ofte/hvornår foretrækker du at modtage information i ventetiden?

- ☐ Kun information i starten af ventetiden
- ☐ Al information i starten og få den gentaget/gennemgået igen
- ☐ Hyppigt, men fordelt over flere dage
- ☐ Andet: ____________________________

D. Andet

18. Har du yderligere kommentarer eller forslag til forbedringer af dit forløb eller det informationsmateriale, du har fået?

19. Må vi kontakte dig, hvis vi har brug for at uddybe dine svar?

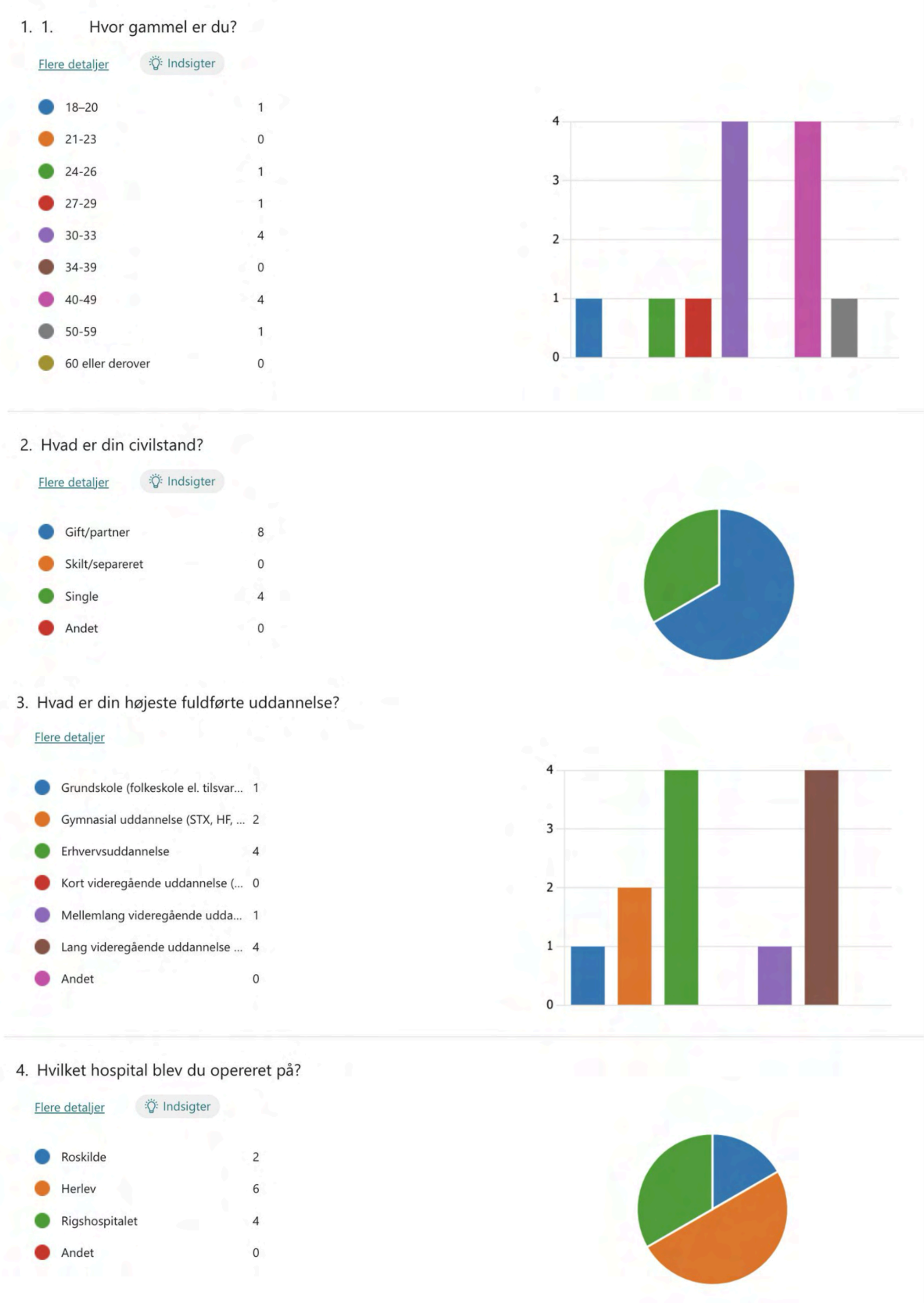
- ☐ Ja, jeg vil gerne kontaktes (skriv kontaktoplysninger nedenfor)
- ☐ Nej, jeg ønsker ikke at blive kontaktet

Hvis ja: Dit navn og telefonnummer: ____________________________

Tak for din tid
Dine svar hjælper os med at forbedre patientforløbet for fremtidige patienter.

5

Appendix E: Survey Results



1. 1. Hvor gammel er du?

●	18–20	1
●	21-23	0
●	24-26	1
●	27-29	1
●	30-33	4
●	34-39	0
●	40-49	4
●	50-59	1
●	60 eller derover	0

2. Hvad er din civilstand?

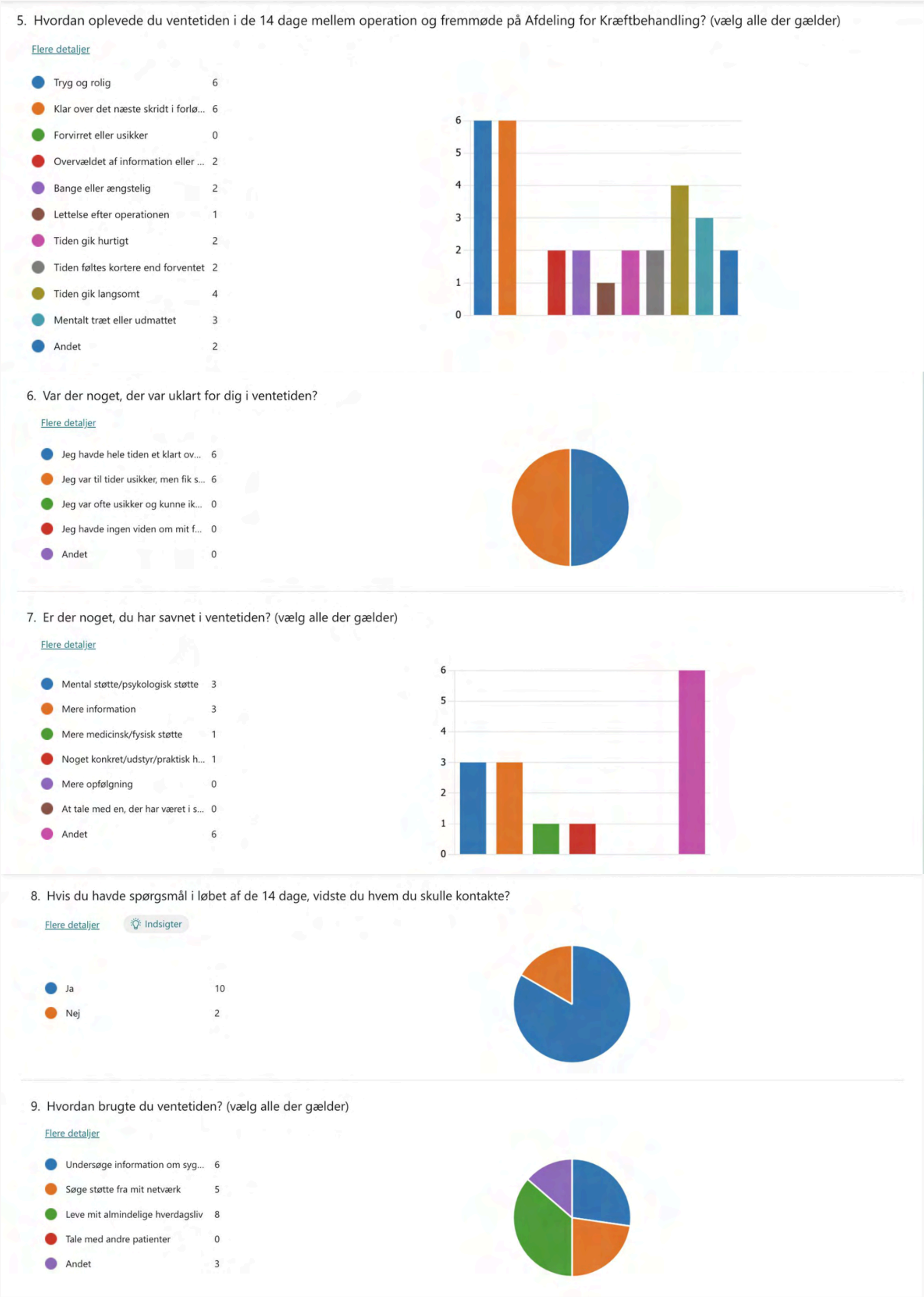
●	Gift/partner	8
●	Skilt/separeret	0
●	Single	4
●	Andet	0

3. Hvad er din højeste fuldførte uddannelse?

●	Grundskole (folkeskole el. tilsvar...	1
●	Gymnasial uddannelse (STX, HF, ...	2
●	Erhvervsuddannelse	4
●	Kort videregående uddannelse (...	0
●	Mellemlang videregående udda...	1
●	Lang videregående uddannelse ...	4
●	Andet	0

4. Hvilket hospital blev du opereret på?

●	Roskilde	2
●	Herlev	6
●	Rigshospitalet	4
●	Andet	0



5. Hvordan oplevede du ventetiden i de 14 dage mellem operation og fremmøde på Afdeling for Kræftbehandling? (vælg alle der gælder)

Flere detaljer

● Tryg og rolig	6
● Klar over det næste skridt i forlø...	6
● Forvirret eller usikker	0
● Overvældet af information eller ...	2
● Bange eller ængstelig	2
● Lettelse efter operationen	1
● Tiden gik hurtigt	2
● Tiden føltes kortere end forventet	2
● Tiden gik langsomt	4
● Mentalt træt eller udmattet	3
● Andet	2

6. Var der noget, der var uklart for dig i ventetiden?

Flere detaljer

● Jeg havde hele tiden et klart ov...	6
● Jeg var til tider usikker, men fik s...	6
● Jeg var ofte usikker og kunne ik...	0
● Jeg havde ingen viden om mit f...	0
● Andet	0

7. Er der noget, du har savnet i ventetiden? (vælg alle der gælder)

Flere detaljer

● Mental støtte/psykologisk støtte	3
● Mere information	3
● Mere medicinsk/fysisk støtte	1
● Noget konkret/udstyr/praktisk h...	1
● Mere opfølgning	0
● At tale med en, der har været i s...	0
● Andet	6

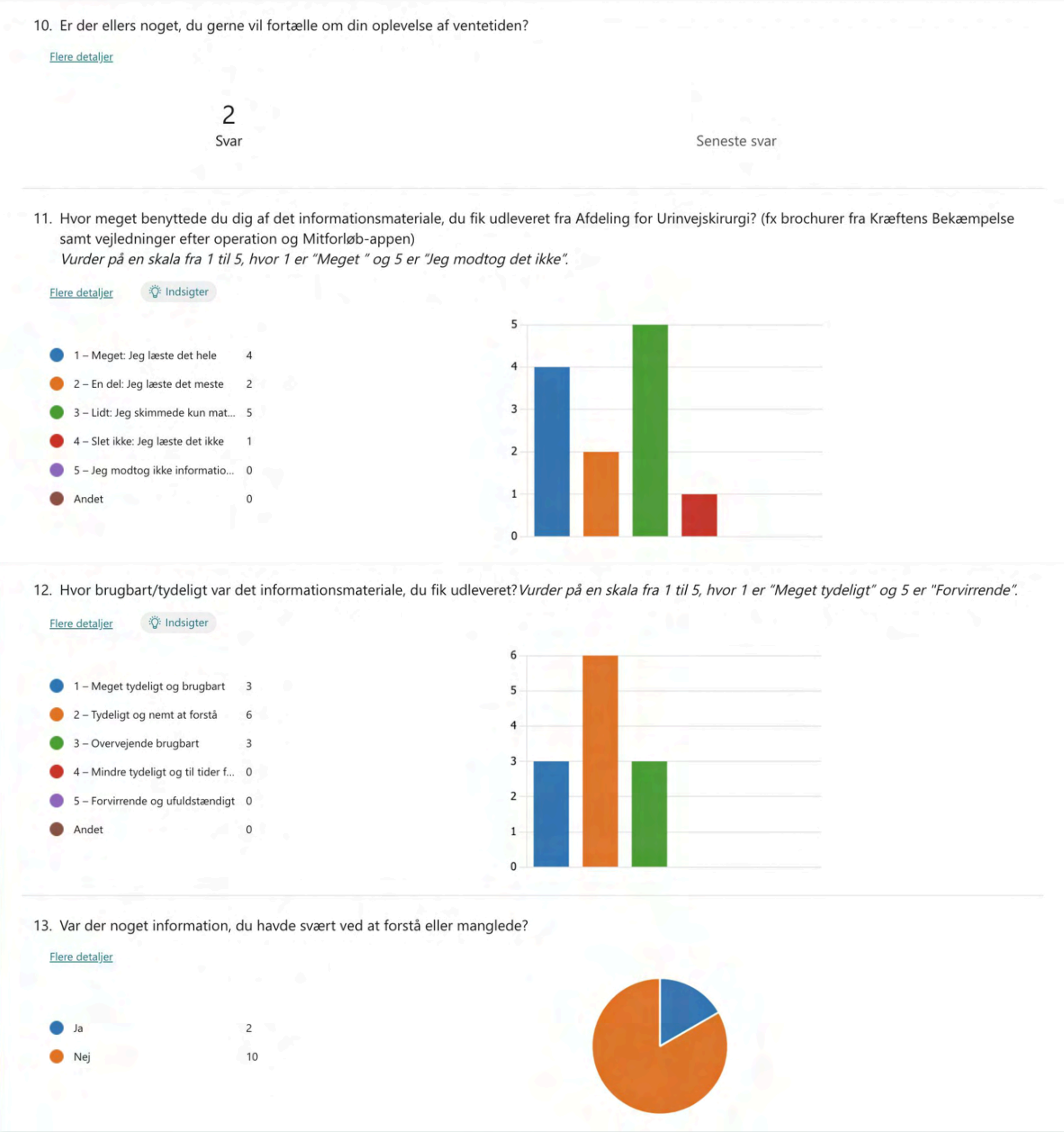
8. Hvis du havde spørgsmål i løbet af de 14 dage, vidste du hvem du skulle kontakte?

● Ja	10
● Nej	2

9. Hvordan brugte du ventetiden? (vælg alle der gælder)

Flere detaljer

● Undersøge information om syg...	6
● Søge støtte fra mit netværk	5
● Leve mit almindelige hverdagsliv	8
● Tale med andre patienter	0
● Andet	3



10. Er der ellers noget, du gerne vil fortælle om din oplevelse af ventetiden?

Flere detaljer

2
Svar

Seneste svar

11. Hvor meget benyttede du dig af det informationsmateriale, du fik udleveret fra Afdeling for Urinvejskirurgi? (fx brochurer fra Kræftens Bekæmpelse samt vejledninger efter operation og Mitforløb-appen)
Vurder på en skala fra 1 til 5, hvor 1 er "Meget " og 5 er "Jeg modtog det ikke".

Flere detaljer · Indsigter

● 1 – Meget: Jeg læste det hele	4
● 2 – En del: Jeg læste det meste	2
● 3 – Lidt: Jeg skimmede kun mat...	5
● 4 – Slet ikke: Jeg læste det ikke	1
● 5 – Jeg modtog ikke informatio...	0
● Andet	0

12. Hvor brugbart/tydeligt var det informationsmateriale, du fik udleveret? *Vurder på en skala fra 1 til 5, hvor 1 er "Meget tydeligt" og 5 er "Forvirrende".*

Flere detaljer · Indsigter

● 1 – Meget tydeligt og brugbart	3
● 2 – Tydeligt og nemt at forstå	6
● 3 – Overvejende brugbart	3
● 4 – Mindre tydeligt og til tider f...	0
● 5 – Forvirrende og ufuldstændigt	0
● Andet	0

13. Var der noget information, du havde svært ved at forstå eller manglede?

Flere detaljer

● Ja	2
● Nej	10

14. Hvis 'JA' beskriv gerne

Flere detaljer

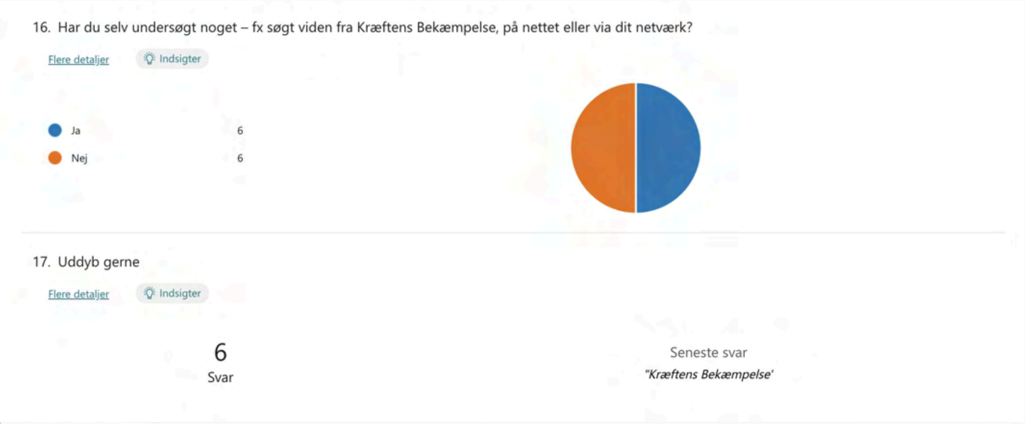
2
Svar

Seneste svar

15. Er der noget, du har savnet i forhold til den information, du har modtaget fra hospitalet? (vælg alle der gælder)

Flere detaljer

● Information om mit behandling...	1
● Information om rehabilitering ef...	4
● Information om tilbud/ressourc...	3
● Intet, jeg savnede ikke noget	6
● Andet	1



16. Har du selv undersøgt noget – fx søgt viden fra Kræftens Bekæmpelse, på nettet eller via dit netværk?

● Ja	6
● Nej	6

17. Uddyb gerne

6
Svar

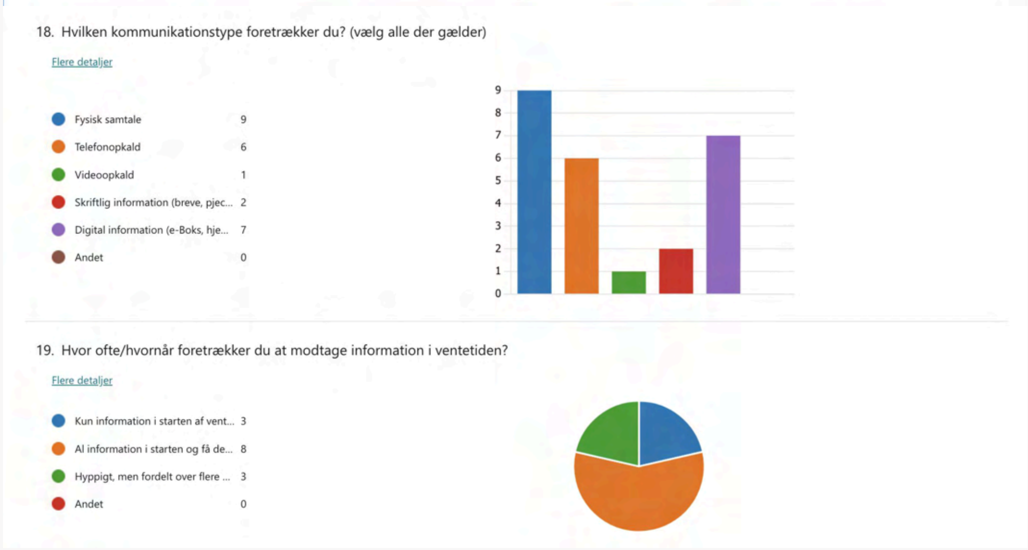
Seneste svar
"Kræftens Bekæmpelse"

17. Uddyb gerne

6
Svar

Seneste svar
"Kræftens Bekæmpelse"

1 respondenter (**17**%) svarede **netværk primært** på dette spørgsmål.



18. Hvilken kommunikationstype foretrækker du? (vælg alle der gælder)

● Fysisk samtale	9
● Telefonopkald	6
● Videoopkald	1
● Skriftlig information (breve, pjec...	2
● Digital information (e-Boks, hje...	7
● Andet	0

19. Hvor ofte/hvornår foretrækker du at modtage information i ventetiden?

● Kun information i starten af vent...	3
● Al information i starten og få de...	8
● Hyppigt, men fordelt over flere ...	3
● Andet	0

20. Har du yderligere kommentarer eller forslag til forbedringer af dit forløb eller det informationsmateriale, du har fået?

2
Svar

Seneste svar

21. Må vi kontakte dig, hvis vi har brug for at uddybe dine svar?

● Ja, jeg vil gerne kontaktes (skriv ...	8
● Nej, jeg ønsker ikke at blive kon...	4

Appendix F: Example of consent form

Oplysningstekst

SÅDAN BEHANDLER VI DINE DATA

VI ER DATAANSVARLIGE

Emily Brophy: emily.brophy@regionh.dk, Erika Strazio: estraz24@student.aau.dk,
Lea Texmo Limstrand: llimst24@student.aau.dk

FORMÅLET MED AT BEHANDLE DINE OPLYSNINGER

Projektet har til formål at undersøge, hvordan patientoplevelsen i overgangen mellem Afdeling for Urinvejskirurgi og Afdeling for Kræftbehandling kan styrkes, og hvordan service design-metoder kan understøtte patienter, personale og andre sundhedsaktører i at navigere i forandringer i komplekse hospitalsmiljøer. Disse oplysninger bruges til at udvikle servicesystemer og servicekoncepter samt til at dokumentere projektet i specialerapport, præsentationer og relaterede materialer.

VI BEHANDLER DISSE PERSONOPLYSNINGER

Almindelige personoplysninger, jf. databeskyttelsesforordningens art. 6, stk. 1, litra a.
Følgende almindelige personoplysninger behandles om dig:

- Rolle
- Billeder, hvor du kan indgå (visuelle data fra observationer, interviews, workshops)
- Citater og udsagn fra interviews/samtaler (anonymiseret tekstdata)

De indsamles fra: interviews, samtaler, observationer og workshops i forbindelse med projektet.

SÅDAN OPBEVARER VI DINE OPLYSNINGER

Vi opbevarer dine personoplysninger, så længe det er nødvendigt i forhold til formålet med at indhente dit samtykke og i henhold til gældende lovgivning. Herefter sletter vi dine personoplysninger.

DINE RETTIGHEDER

Når vi behandler dine personoplysninger, har du ifølge databeskyttelsesforordningen flere rettigheder. Det betyder bl.a., at du har ret til sletning og dataportabilitet, og i visse tilfælde har du ret til indsigt, berigtigelse, begrænsning og til at gøre indsigelse mod vores behandling af de omfattede personoplysninger.

Du har altid mulighed for at trække dit samtykke tilbage. Vær dog opmærksom på, at du ikke kan trække dit samtykke tilbage med tilbagevirkende kraft.

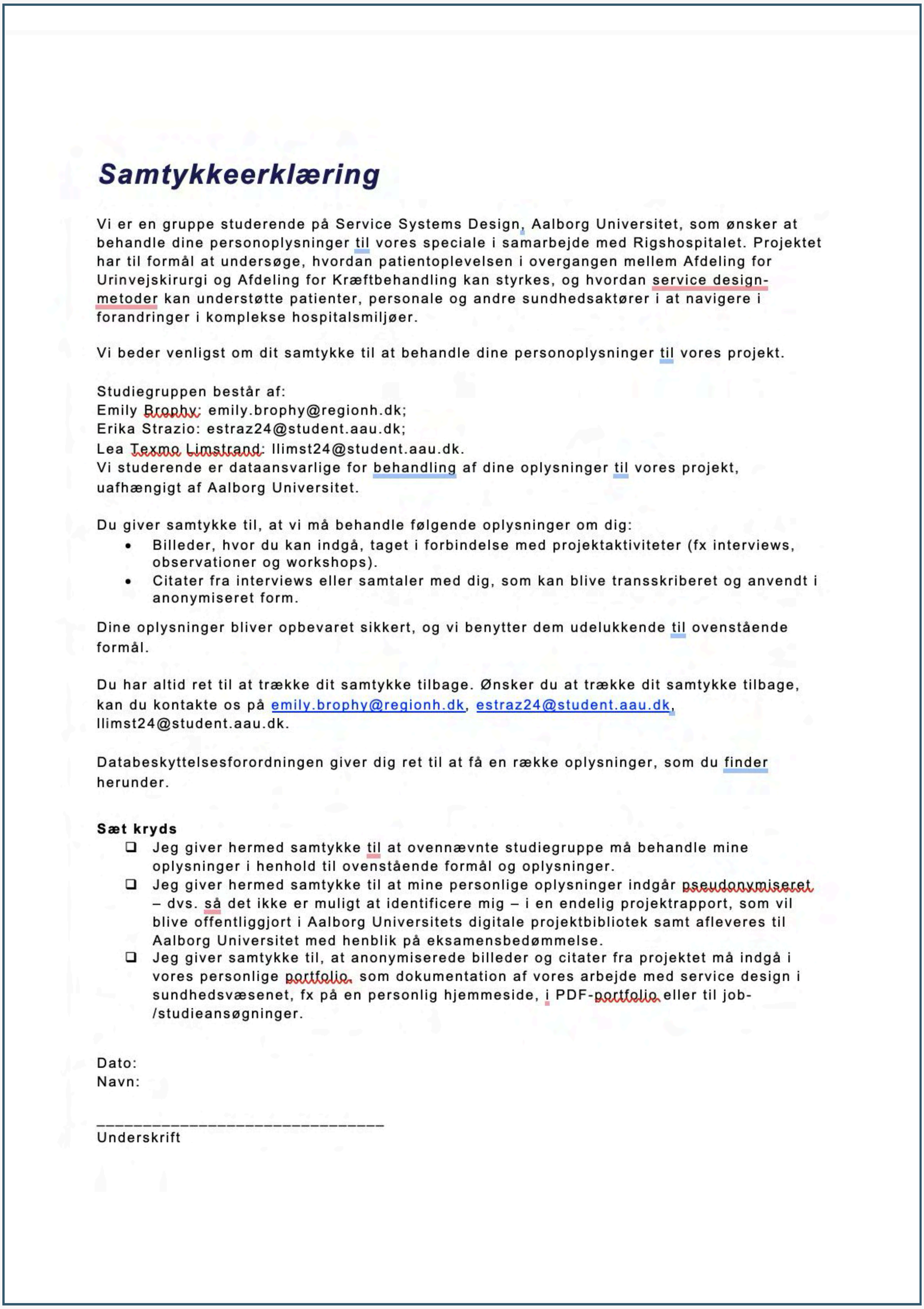
Læs mere om dine rettigheder her på Datatilsynets hjemmeside: https://www.datatilsynet.dk/hvad-siger-reglerne/vejledning/de-registreredes-rettigheder-

VIL DU KLAGE?

Du er altid velkommen til at kontakte os med spørgsmål. Hvis du mener, at vi ikke behandler dine oplysninger efter reglerne, så kontakt os gerne.

Du har også altid mulighed for at klage til Datatilsynet på dt@datatilsynet.dk.

Vi opfordrer dig dog til at kontakte os først, da vi vil gøre, hvad vi kan, for at imødekomme din klage.



Samtykkeerklæring

Vi er en gruppe studerende på Service Systems Design, Aalborg Universitet, som ønsker at behandle dine personoplysninger til vores speciale i samarbejde med Rigshospitalet. Projektet har til formål at undersøge, hvordan patientoplevelsen i overgangen mellem Afdeling for Urinvejskirurgi og Afdeling for Kræftbehandling kan styrkes, og hvordan service design-metoder kan understøtte patienter, personale og andre sundhedsaktører i at navigere i forandringer i komplekse hospitalsmiljøer.

Vi beder venligst om dit samtykke til at behandle dine personoplysninger til vores projekt.

Studiegruppen består af:
Emily Brophy: emily.brophy@regionh.dk;
Erika Strazio: estraz24@student.aau.dk;
Lea Texmo Limstrand: llimst24@student.aau.dk.
Vi studerende er dataansvarlige for behandling af dine oplysninger til vores projekt, uafhængigt af Aalborg Universitet.

Du giver samtykke til, at vi må behandle følgende oplysninger om dig:

- Billeder, hvor du kan indgå, taget i forbindelse med projektaktiviteter (fx interviews, observationer og workshops).
- Citater fra interviews eller samtaler med dig, som kan blive transskriberet og anvendt i anonymiseret form.

Dine oplysninger bliver opbevaret sikkert, og vi benytter dem udelukkende til ovenstående formål.

Du har altid ret til at trække dit samtykke tilbage. Ønsker du at trække dit samtykke tilbage, kan du kontakte os på emily.brophy@regionh.dk, estraz24@student.aau.dk, llimst24@student.aau.dk.

Databeskyttelsesforordningen giver dig ret til at få en række oplysninger, som du finder herunder.

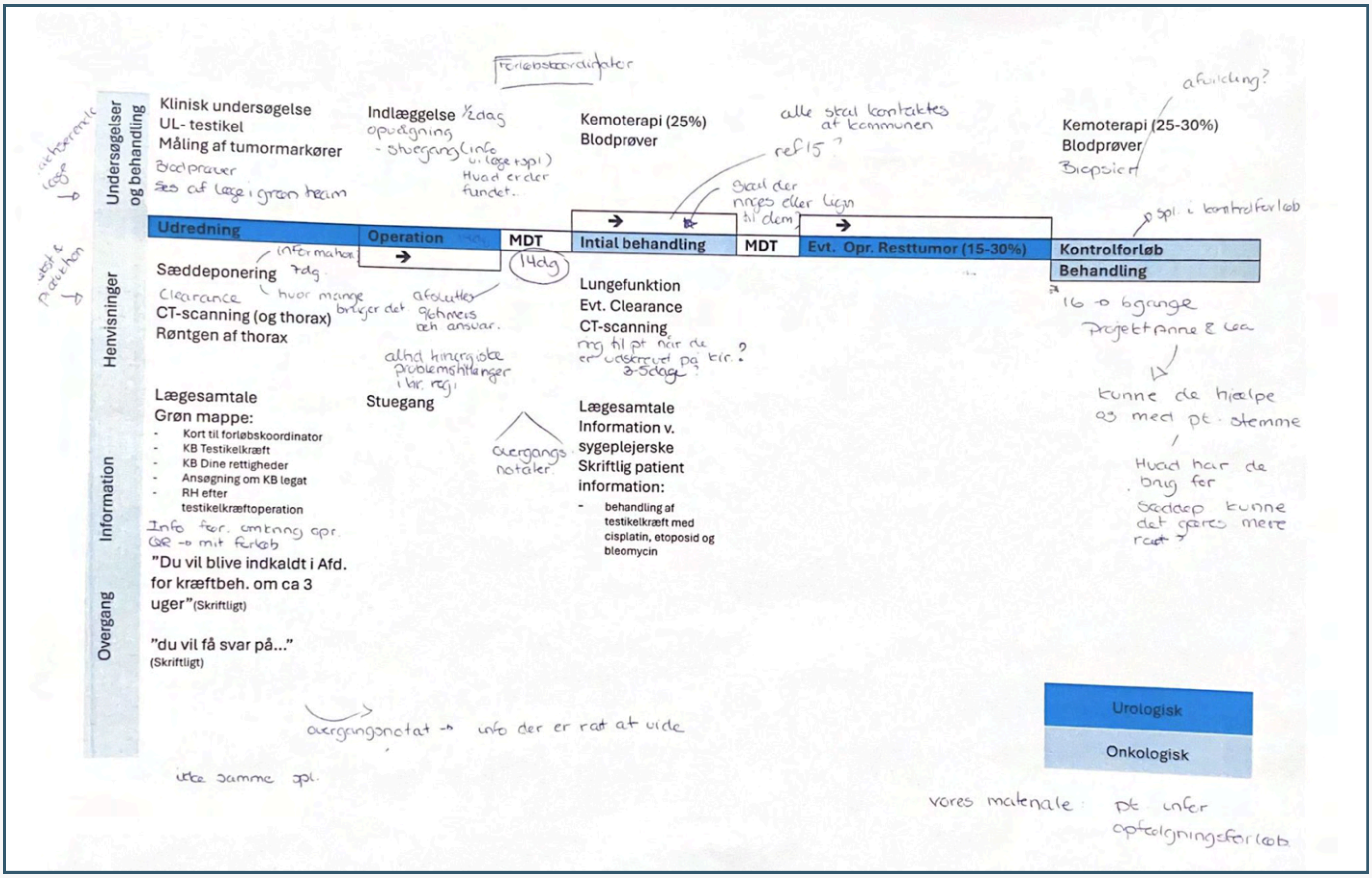
Sæt kryds

- ☐ Jeg giver hermed samtykke til at ovennævnte studiegruppe må behandle mine oplysninger i henhold til ovenstående formål og oplysninger.
- ☐ Jeg giver hermed samtykke til at mine personlige oplysninger indgår pseudonymiseret – dvs. så det ikke er muligt at identificere mig – i en endelig projektrapport, som vil blive offentliggjort i Aalborg Universitets digitale projektbibliotek samt afleveres til Aalborg Universitet med henblik på eksamensbedømmelse.
- ☐ Jeg giver samtykke til, at anonymiserede billeder og citater fra projektet må indgå i vores personlige portfolio, som dokumentation af vores arbejde med service design i sundhedsvæsenet, fx på en personlig hjemmeside, i PDF-portfolio eller til job-/studieansøgninger.

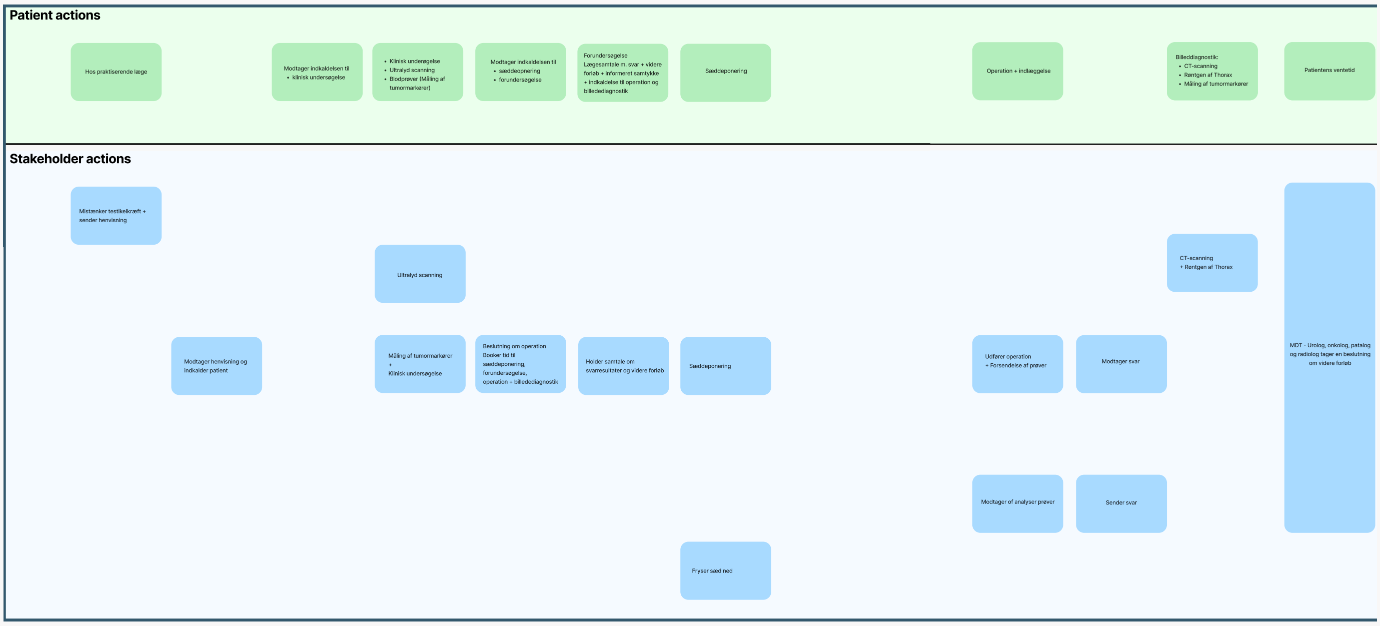
Dato:
Navn:

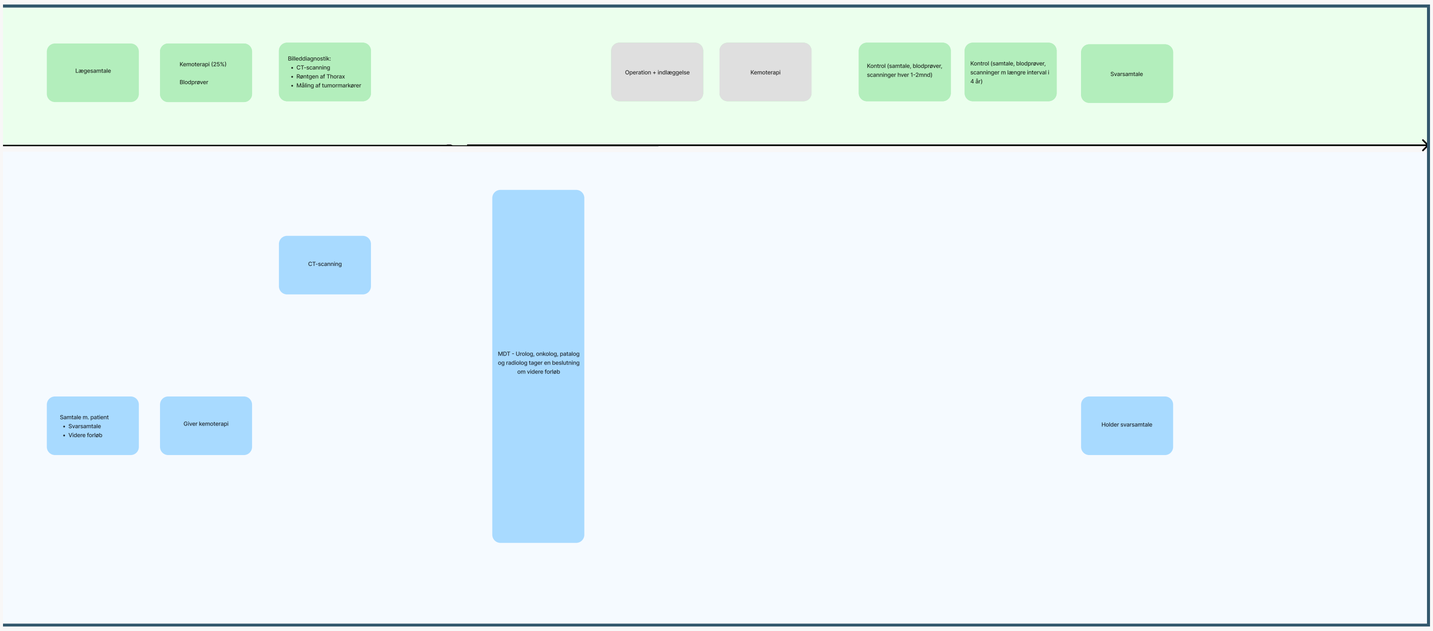
____
Underskrift

Appendix G: Draft of Patient Pathway

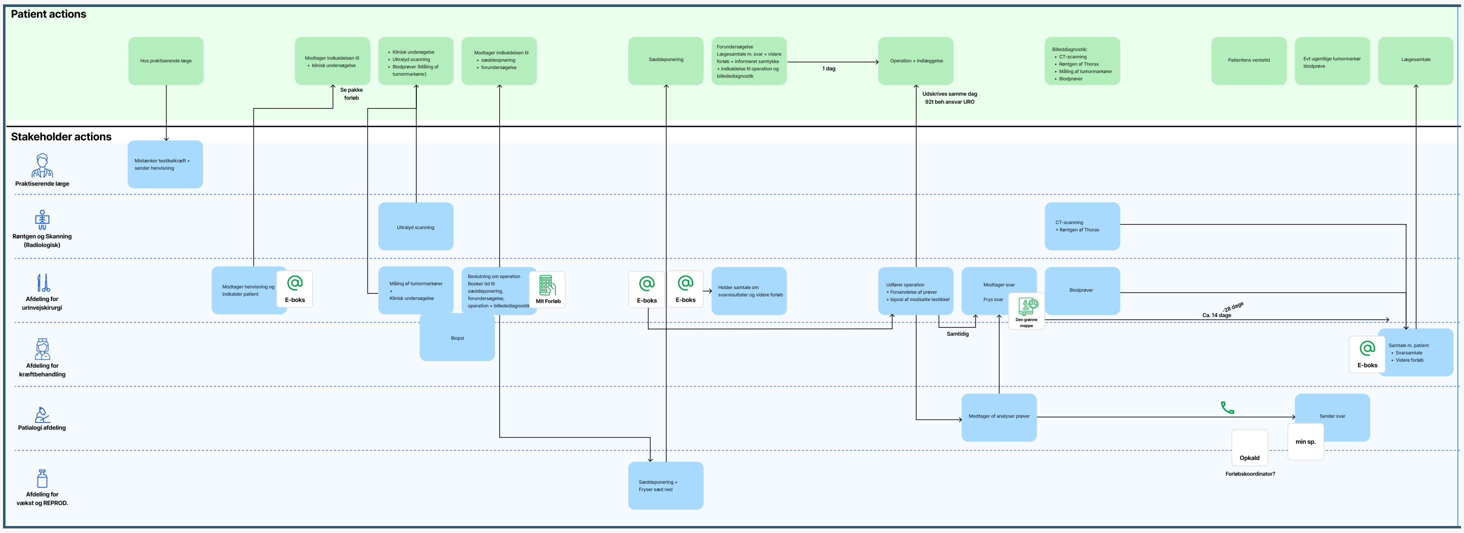


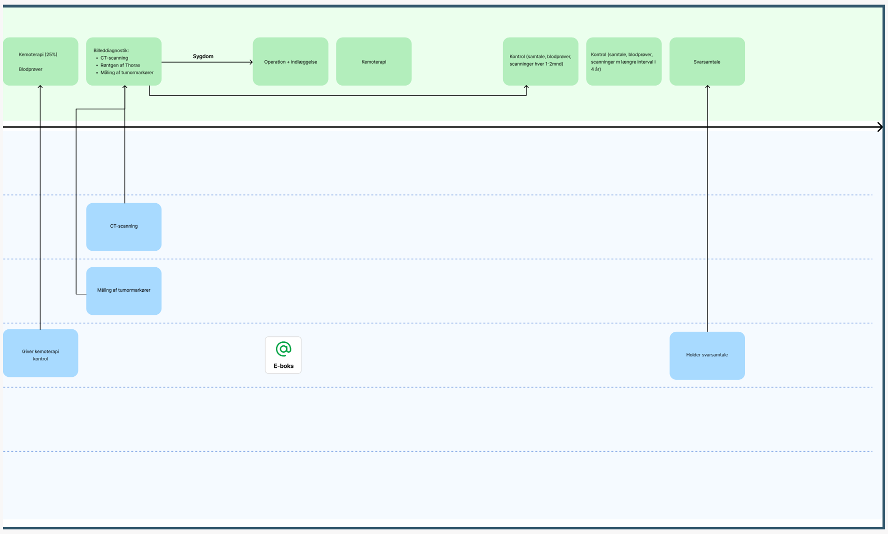
Appendix H: First Draft of Patient Mapping





Appendix I: Finalised visualisation of patient pathway





Appendix J: Example of Invitation to Interview

Lidt information om interviewet

Dato: [REDACTED]

Det er Emily, der interviewer dig, og Lea, der tager noter og observerer.

Emily 🇩🇰

Lea 🇳🇴

Formål

Vi er tre servicedesignstuderende fra Aalborg Universitet: Emily, Erika og Lea. I forbindelse med vores speciale samarbejder vi med to klinikker på Rigshospitalet – Afdeling for Urinvejskirurgi og Afdeling for Kræftbehandling.

Projektet undersøger patientforløbet for personer med testikelkræft med særligt fokus på overgangen mellem de to afdelinger og ventetiden på ca. 2-3 uger, som ofte opleves i denne fase.

Formålet er at forbedre patientforløbet. Derfor er dit perspektiv meget vigtigt for os, og vi vil gerne høre om dine oplevelser, tanker og følelser undervejs. Der findes ingen rigtige eller forkerte svar, og du behøver kun at dele det, du selv føler dig tryg ved.

Forberedelse

Interviewet kræver ingen forberedelse, men du må gerne overveje, hvordan overgangen mellem afdelingen for operationen og Afdeling for Kræftbehandling opleves, og hvordan du havde det i perioden.

Vi stiller konkrete spørgsmål og taler om de temaer, livsområder og følelser, der fyldte for dig, med hjælp fra nogle visuelle kort vi medbringer.

Du er meget velkommen til at skrive, hvis du har spørgsmål.

Vi ser frem til at møde dig 😊

AALBORG UNIVERSITET

REGION H Rigshospitalet

Appendix K: Final Interview Guide

Patient – Interviewguide

Format: Semistruktureret interview med et generativt toolkit
Varighed: 1 time
Sted: Efter aftale m. patient
Roller: Interviewer (Emily) + Skribent (Lea eller Erika)
Materialer: Samtykkeerklæring + Den enkelte patients spørgeskema + Forløbstidslinje + Den grønne mappe + toolkit

Formål & Baggrund

Vi er tre servicedesignstuderende fra Aalborg Universitet: Emily, Erika og Lea. Vi er i gang med vores speciale, som vi udarbejder i samarbejde med to klinikker på Rigshospitalet – Afdeling for Urinvejskirurgi og Afdeling for Kræftbehandling. I projektet undersøger vi patientforløbet for personer med testikelkræft, med særligt fokus på overgangen mellem de to klinikker og den ventetid på cirka 2–3 uger, som ofte opstår i denne fase.

Vi har fokus på dit perspektiv, og derfor vil vi meget gerne høre om dine oplevelser som patient – særligt hvordan du har oplevet overgangen, og hvilke tanker og følelser der har fyldt undervejs. Dine oplevelser er vigtige for os, og der findes ingen rigtige eller forkerte svar.

Interviewet bygger videre på det spørgeskema, du tidligere har udfyldt. Undervejs vil vi derfor bede dig om at uddybe nogle af dine svar og knytte dem til de følelser og temaer, der har været vigtige for dig. Interviewet er åbent og fleksibelt, og du bestemmer selv, hvad du har lyst til at gå i dybden med.

Vi er opmærksomme på, at dette er et følsomt emne, så du skal vide, at du kun behøver at dele det, du selv føler dig tryg ved. Vi kan til enhver tid holde pause, springe spørgsmål over eller stoppe samtalen helt.

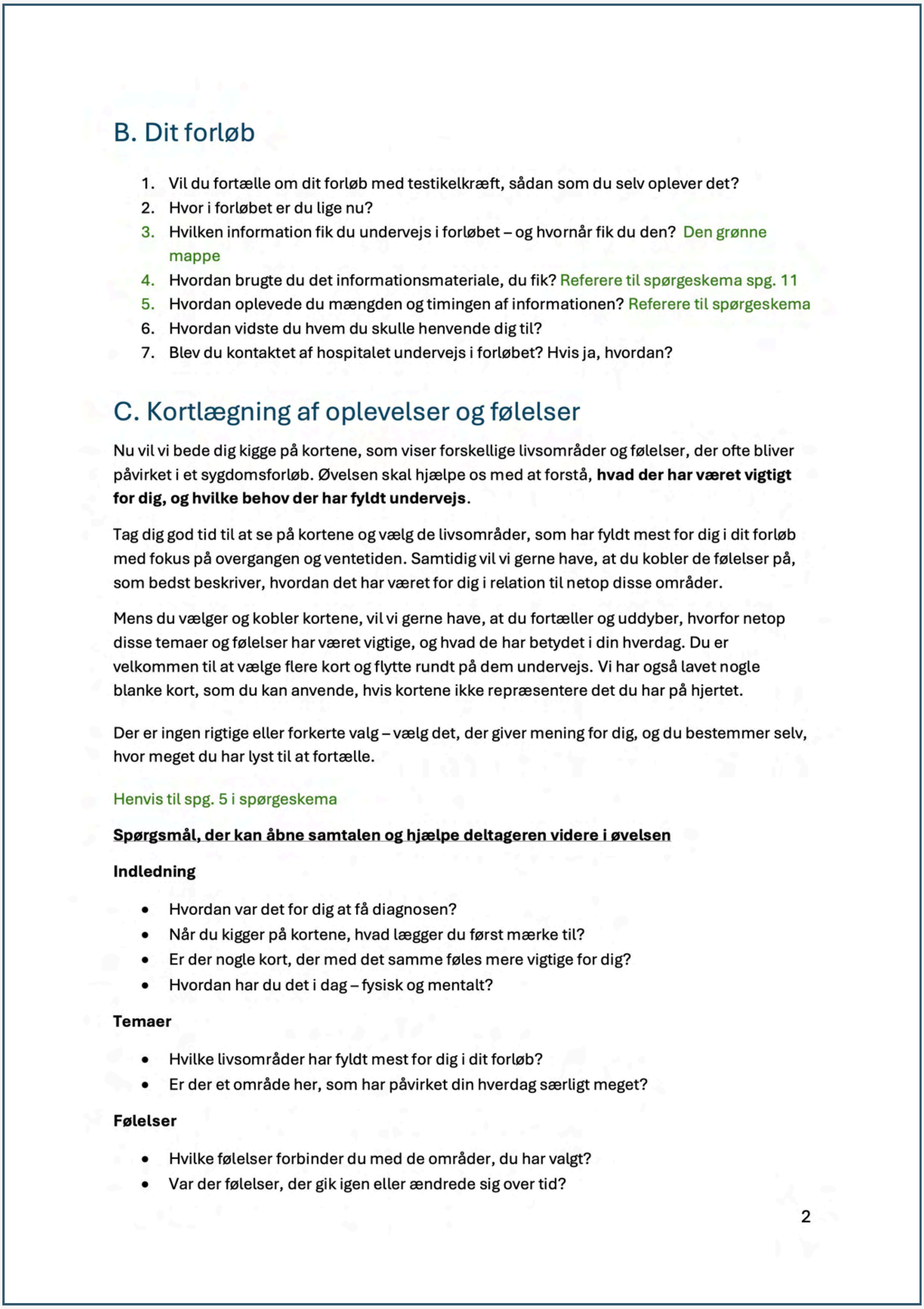
Til din orientering vil du være anonymiseret i vores projekt, og dit navn vil ikke fremgå nogen steder. Inden vi går i gang med interviewet, vil vi gerne høre, om det er okay for dig, at vi optager samtalen. Hverken dit navn eller dit ansigt vil blive brugt eller fremgå nogen steder.

Vi vil bede dig om at udfylde denne samtykkeerklæring. På forhånd tak.

Har du nogen spørgsmål, før vi begynder?

A. Baggrund og kontekst

1. Vil du fortælle lidt om dig selv og din hverdag?
2. Hvordan så din hverdag ud, før du blev syg?
3. Har du tidligere haft kræft eller anden alvorlig sygdom?
    a. Oplever du, at dine egne eller andres erfaringer har haft betydning for, hvordan du har oplevet dit forløb?



B. Dit forløb

1. Vil du fortælle om dit forløb med testikelkræft, sådan som du selv oplever det?
2. Hvor i forløbet er du lige nu?
3. Hvilken information fik du undervejs i forløbet – og hvornår fik du den? Den grønne mappe
4. Hvordan brugte du det informationsmateriale, du fik? Referere til spørgeskema spg. 11
5. Hvordan oplevede du mængden og timingen af informationen? Referere til spørgeskema
6. Hvordan vidste du hvem du skulle henvende dig til?
7. Blev du kontaktet af hospitalet undervejs i forløbet? Hvis ja, hvordan?

C. Kortlægning af oplevelser og følelser

Nu vil vi bede dig kigge på kortene, som viser forskellige livsområder og følelser, der ofte bliver påvirket i et sygdomsforløb. Øvelsen skal hjælpe os med at forstå, **hvad der har været vigtigt for dig, og hvilke behov der har fyldt undervejs**.

Tag dig god tid til at se på kortene og vælg de livsområder, som har fyldt mest for dig i dit forløb med fokus på overgangen og ventetiden. Samtidig vil vi gerne have, at du kobler de følelser på, som bedst beskriver, hvordan det har været for dig i relation til netop disse områder.

Mens du vælger og kobler kortene, vil vi gerne have, at du fortæller og uddyber, hvorfor netop disse temaer og følelser har været vigtige, og hvad de har betydet i din hverdag. Du er velkommen til at vælge flere kort og flytte rundt på dem undervejs. Vi har også lavet nogle blanke kort, som du kan anvende, hvis kortene ikke repræsentere det du har på hjertet.

Der er ingen rigtige eller forkerte valg – vælg det, der giver mening for dig, og du bestemmer selv, hvor meget du har lyst til at fortælle.

Henvis til spg. 5 i spørgeskema

Spørgsmål, der kan åbne samtalen og hjælpe deltageren videre i øvelsen

Indledning

- Hvordan var det for dig at få diagnosen?
- Når du kigger på kortene, hvad lægger du først mærke til?
- Er der nogle kort, der med det samme føles mere vigtige for dig?
- Hvordan har du det i dag – fysisk og mentalt?

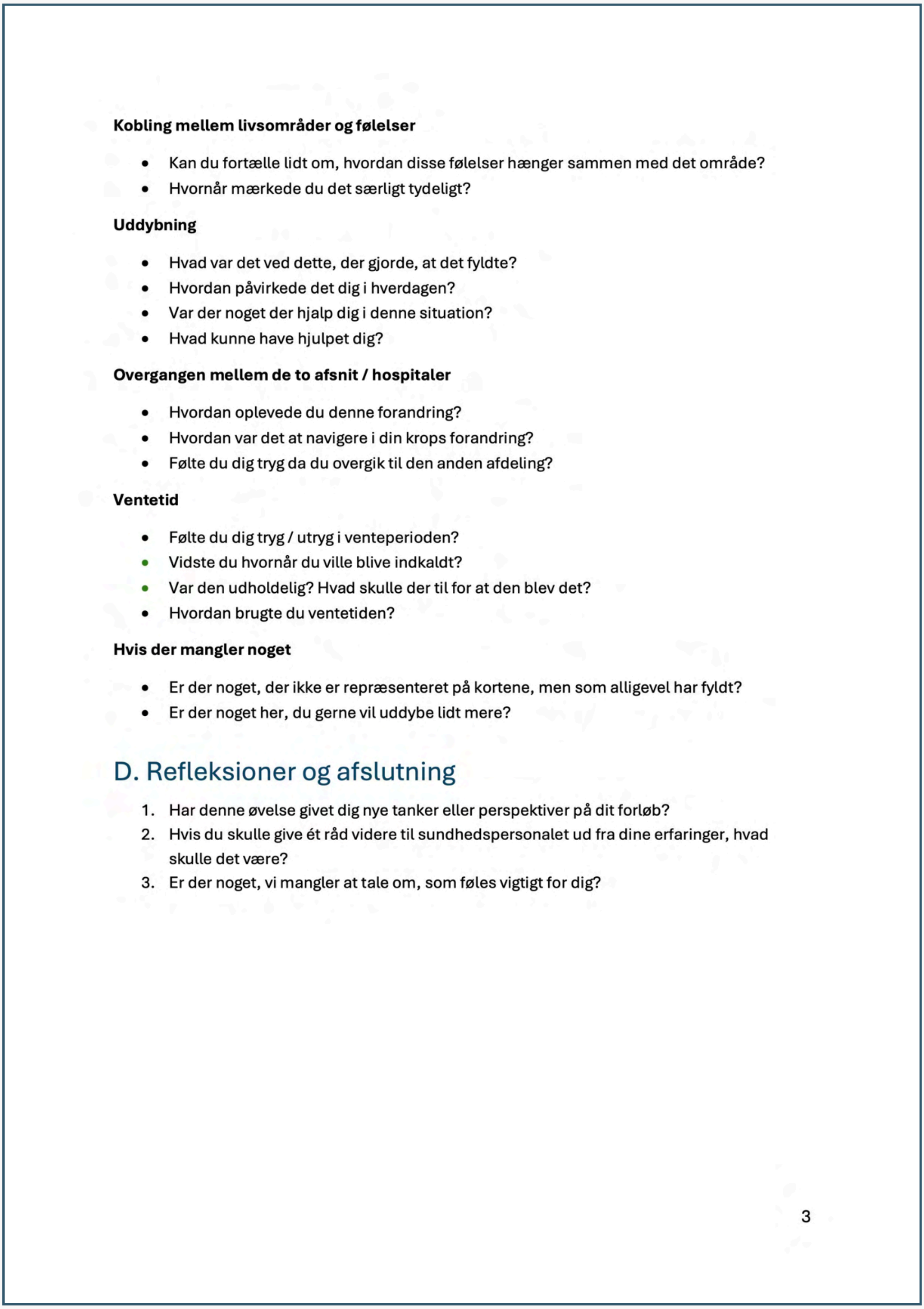
Temaer

- Hvilke livsområder har fyldt mest for dig i dit forløb?
- Er der et område her, som har påvirket din hverdag særligt meget?

Følelser

- Hvilke følelser forbinder du med de områder, du har valgt?
- Var der følelser, der gik igen eller ændrede sig over tid?

2



Kobling mellem livsområder og følelser

- Kan du fortælle lidt om, hvordan disse følelser hænger sammen med det område?
- Hvornår mærkede du det særligt tydeligt?

Uddybning

- Hvad var det ved dette, der gjorde, at det fyldte?
- Hvordan påvirkede det dig i hverdagen?
- Var der noget der hjalp dig i denne situation?
- Hvad kunne have hjulpet dig?

Overgangen mellem de to afsnit / hospitaler

- Hvordan oplevede du denne forandring?
- Hvordan var det at navigere i din krops forandring?
- Følte du dig tryg da du overgik til den anden afdeling?

Ventetid

- Følte du dig tryg / utryg i venteperioden?
- Vidste du hvornår du ville blive indkaldt?
- Var den udholdelig? Hvad skulle der til for at den blev det?
- Hvordan brugte du ventetiden?

Hvis der mangler noget

- Er der noget, der ikke er repræsenteret på kortene, men som alligevel har fyldt?
- Er der noget her, du gerne vil uddybe lidt mere?

D. Refleksioner og afslutning

1. Har denne øvelse givet dig nye tanker eller perspektiver på dit forløb?
2. Hvis du skulle give ét råd videre til sundhedspersonalet ud fra dine erfaringer, hvad skulle det være?
3. Er der noget, vi mangler at tale om, som føles vigtigt for dig?

Appendix L: Printed Cards


Nysgerrig


Glad


Selvsikker


Skamfuld

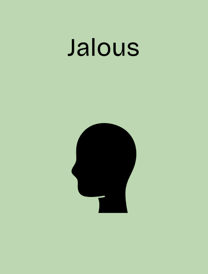

Frygt /
Angst


Skyldig


Lettet


Vred


Trist

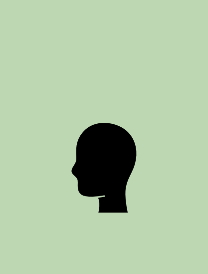

Jalous


Støttet


Afsky


Forvirret


Tryg




Fritids-
aktiviteter

Rejse, fysisk aktivitet, mad,
natur, musik


Mentalt
helbred

Tanker om livet, tankemylder
copingstrategier, koncentrationsbesvær,
søvnforstyrrelser, ensomhed


Fysisk
helbred

Smerter, ændret appetit, tjek af
symptomer, bivirkninger, søvn,
kropsforandringer


Relationer

Samtale med partner, venner,
familien, naboer, informere familien,
reaktioner


Sexliv &
Fertilitet

Sexlyst, fertilitet, intimitet,
partners reaktion,
kropsopfattelse


Behandling
& Forløb

Kontakt med hospital, ventetid,
overblik, skift i personale


Selvtillid

Maskulinitet, udseende,
kontroltab, føle sig anderledes,
styrke, tro på sig selv


Fremtid

Tilbagefald, arvelighed, overlevelse,
livsændringer, sat på pause

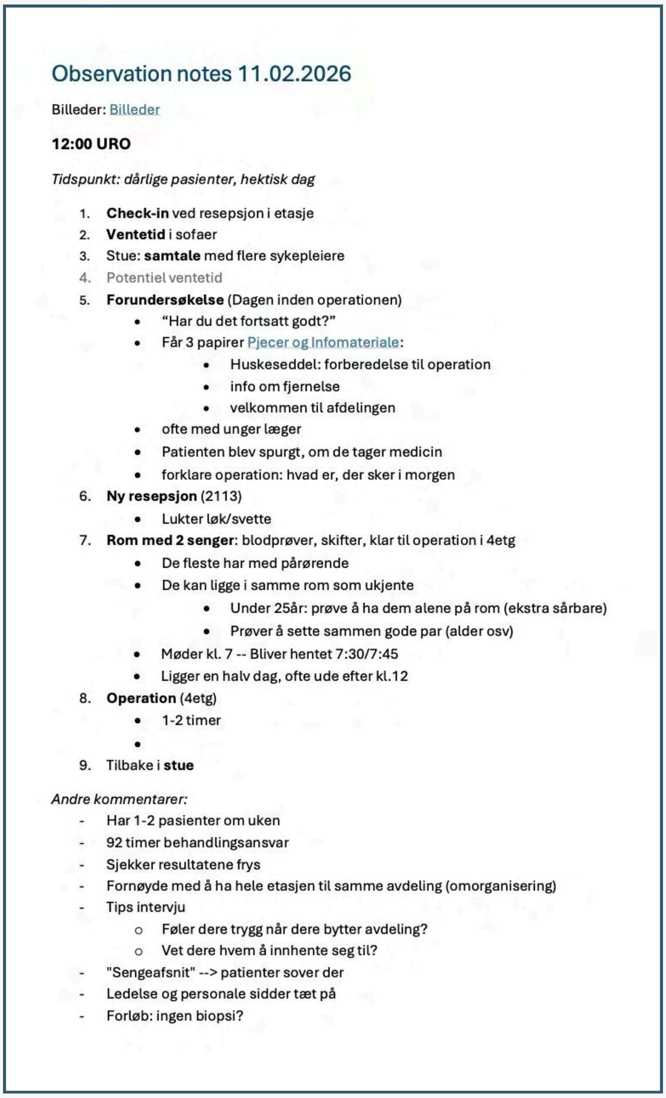

Arbejde/
studie

Sygemelding, produktivitet,
opmærksomhed fra kolleger,
arbejdstider, hjemmearbejde


Støtte og
fælleskab

Støttegrupper, Kræftens bekæmpelse,
sociale medier, ligemænd

Appendix M: Field Notes from Observation



Observation notes 11.02.2026

Billeder: Billeder

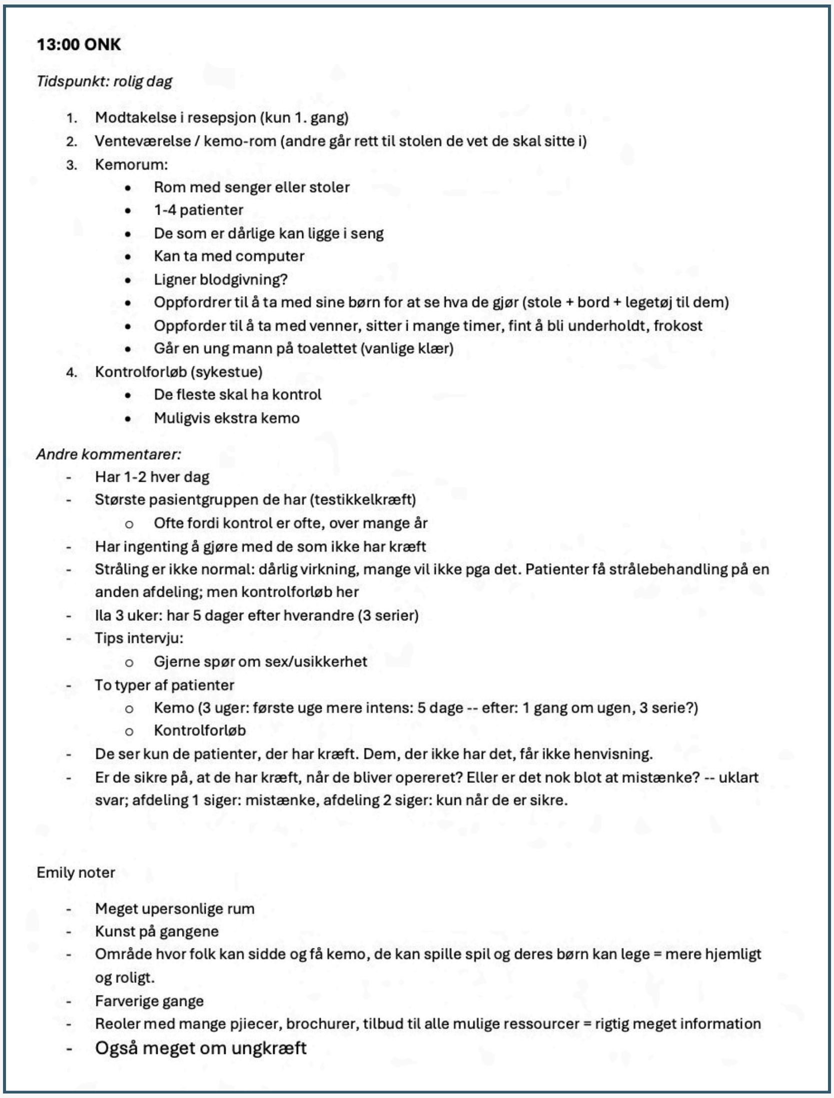
12:00 URO

Tidspunkt: dårlige pasienter, hektisk dag

1. **Check-in** ved resepsjon i etasje
2. **Ventetid** i sofaer
3. Stue: **samtale** med flere sykepleiere
4. Potentiel ventetid
5. **Forundersøkelse** (Dagen inden operationen)
   - "Har du det fortsatt godt?"
   - Får 3 papirer Pjecer og Infomateriale:
     - Huskeseddel: forberedelse til operation
     - info om fjernelse
     - velkommen til afdelingen
   - ofte med unger læger
   - Patienten blev spurgt, om de tager medicin
   - forklare operation: hvad er, der sker i morgen
6. **Ny resepsjon** (2113)
   - Lukter løk/svette
7. **Rom med 2 senger**: blodprøver, skifter, klar til operation i 4etg
   - De fleste har med pårørende
   - De kan ligge i samme rom som ukjente
     - Under 25år: prøve å ha dem alene på rom (ekstra sårbare)
     - Prøver å sette sammen gode par (alder osv)
   - Møder kl. 7 -- Bliver hentet 7:30/7:45
   - Ligger en halv dag, ofte ude efter kl.12
8. **Operation** (4etg)
   - 1-2 timer
   -
9. Tilbake i **stue**

Andre kommentarer:

- Har 1-2 pasienter om uken
- 92 timer behandlingsansvar
- Sjekker resultatene frys
- Fornøyde med å ha hele etasjen til samme avdeling (omorganisering)
- Tips intervju
  - Føler dere trygg når dere bytter avdeling?
  - Vet dere hvem å innhente seg til?
- "Sengeafsnit" --> patienter sover der
- Ledelse og personale sidder tæt på
- Forløb: ingen biopsi?



13:00 ONK

Tidspunkt: rolig dag

1. Modtakelse i resepsjon (kun 1. gang)
2. Venteværelse / kemo-rom (andre går rett til stolen de vet de skal sitte i)
3. Kemorum:
   - Rom med senger eller stoler
   - 1-4 patienter
   - De som er dårlige kan ligge i seng
   - Kan ta med computer
   - Ligner blodgivning?
   - Oppfordrer til å ta med sine børn for at se hva de gjør (stole + bord + legetøj til dem)
   - Oppforder til å ta med venner, sitter i mange timer, fint å bli underholdt, frokost
   - Går en ung mann på toalettet (vanlige klær)
4. Kontrolforløb (sykestue)
   - De fleste skal ha kontrol
   - Muligvis ekstra kemo

Andre kommentarer:

- Har 1-2 hver dag
- Største pasientgruppen de har (testikkelkræft)
  - Ofte fordi kontrol er ofte, over mange år
- Har ingenting å gjøre med de som ikke har kræft
- Stråling er ikke normal: dårlig virkning, mange vil ikke pga det. Patienter få strålebehandling på en anden afdeling; men kontrolforløb her
- Ila 3 uker: har 5 dager efter hverandre (3 serier)
- Tips intervju:
  - Gjerne spør om sex/usikkerhet
- To typer af patienter
  - Kemo (3 uger: første uge mere intens: 5 dage -- efter: 1 gang om ugen, 3 serie?)
  - Kontrolforløb
- De ser kun de patienter, der har kræft. Dem, der ikke har det, får ikke henvisning.
- Er de sikre på, at de har kræft, når de bliver opereret? Eller er det nok blot at mistænke? -- uklart svar; afdeling 1 siger: mistænke, afdeling 2 siger: kun når de er sikre.

Emily noter

- Meget upersonlige rum
- Kunst på gangene
- Område hvor folk kan sidde og få kemo, de kan spille spil og deres børn kan lege = mere hjemligt og roligt.
- Farverige gange
- Reoler med mange pjiecer, brochurer, tilbud til alle mulige ressourcer = rigtig meget information
- Også meget om ungkræft

Appendix N: Interview transcripts

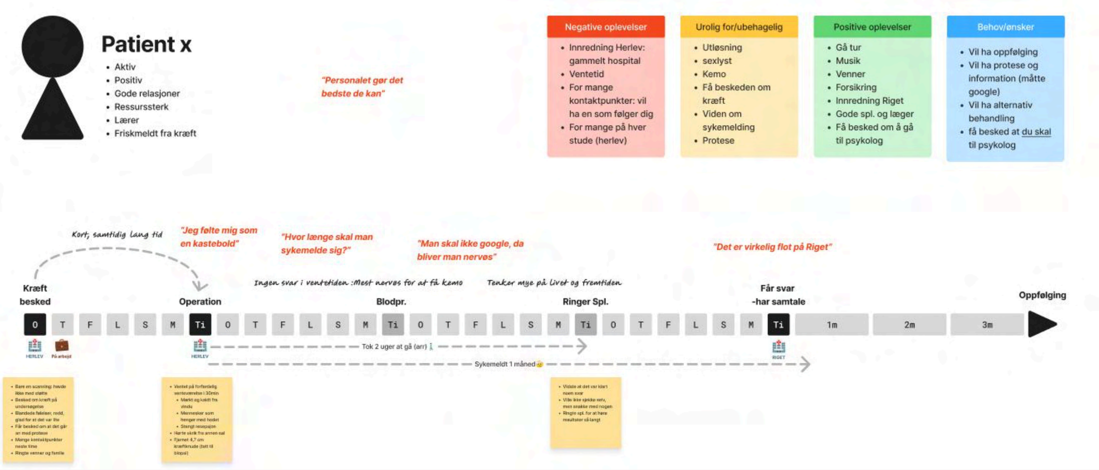
All interview transcripts are securely stored in a restricted-access folder on Microsoft Teams (SharePoint) to ensure confidentiality and prevent unauthorised distribution. Access to these materials is granted only with the consent of the respective participant. Interested parties may contact the authors to request access.

LINK: Transcripts

CONTENT:

- 1_Patient_Interview_Transcript
- 2_Patient_Interview_Transcript
- 3_Patient_Interview_Transcript
- 4_Coordinator_Interview_Transcript

Appendix O: Visual Timelines of Patient Journeys



Patient x

- Aktiv
- Positiv
- Gode relasjoner
- Ressurssterk
- Lærer
- Friskmeldt fra kræft

"Personalet gør det bedste de kan"

Negative oplevelser

- Innredning Herlev: gammelt hospital
- Ventetid
- For mange kontaktpunkter: vil ha en som følger dig
- For mange på hver stude (herlev)

Urolig for/ubehagelig

- Utløsning
- sexlyst
- Kemo
- Få beskeden om kræft
- Viden om sykemelding
- Protese

Positive oplevelser

- Gå tur
- Musik
- Venner
- Forsikring
- Innredning Riget
- Gode spl. og læger
- Få besked om å gå til psykolog

Behov/ønsker

- Vil ha oppfølging
- Vil ha protese og information (måtte google)
- Vil ha alternativ behandling
- få besked at du skal til psykolog

Kort, samtidig lang tid

"Jeg følte mig som en kastebold"

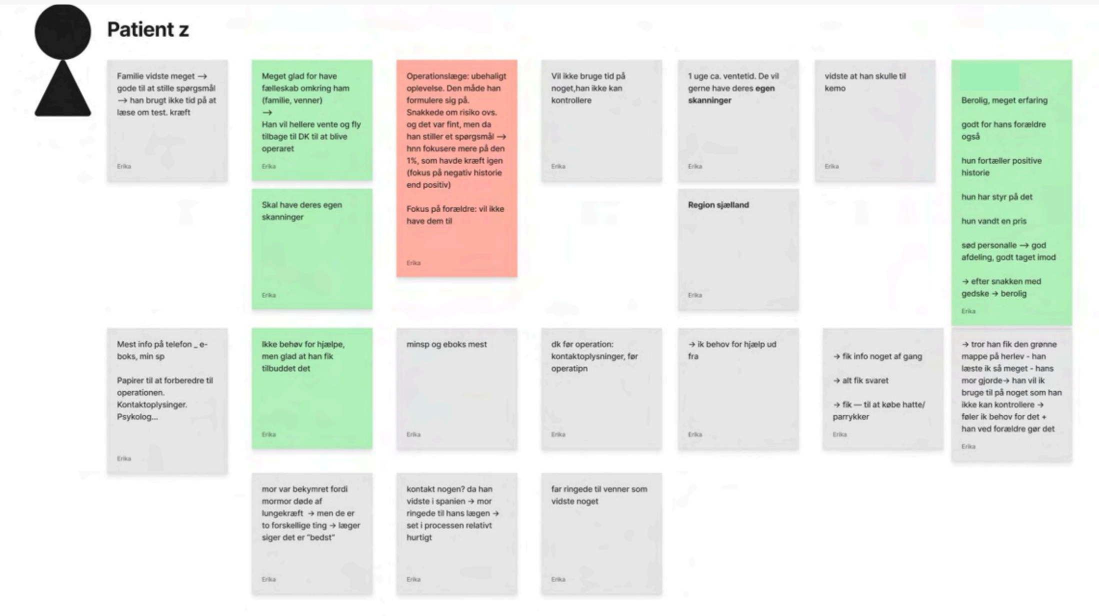
"Hvor længe skal man sykemelde sig?"

"Man skal ikke google, da bliver man nervøs"

"Det er virkelig flot på Riget"

Ingen svar i ventetiden :Mest nervøs for at få kemo

Tenker mye på livet og fremtiden



Patient z

Familie vidste meget → gode til at stille spørgsmål → han brugt ikke tid på at læse om test. kræft

Erika

Meget glad for have fælleskab omkring ham (familie, venner)
→
Han vil hellere vente og fly tilbage til DK til at blive operaret

Erika

Skal have deres egen skanninger

Erika

Operationslæge: ubehaligt oplevelse. Den måde han formulere sig på. Snakkede om risiko ovs. og det var fint, men da han stiller et spørgsmål → hnn fokusere mere på den 1%, som havde kræft igen (fokus på negativ historie end positiv)

Fokus på forældre: vil ikke have dem til

Erika

Vil ikke bruge tid på noget,han ikke kan kontrollere

Erika

1 uge ca. ventetid. De vil gerne have deres **egen skanninger**

Erika

Region sjælland

Erika

vidste at han skulle til kemo

Erika

Berolig, meget erfaring

godt for hans forældre også

hun fortæller positive historie

hun har styr på det

hun vandt en pris

sød personalle → god afdeling, godt taget imod

→ efter snakken med gedske → berolig

Erika

Mest info på telefon _ e-boks, min sp

Papirer til at forberedre til operationen. Kontaktoplysinger. Psykolog...

Erika

Ikke behøv for hjælpe, men glad at han fik tilbuddet det

Erika

minsp og eboks mest

Erika

dk før operation: kontaktoplysninger, før operatipn

Erika

→ ik behov for hjælp ud fra

Erika

→ fik info noget af gang

→ alt fik svaret

→ fik — til at købe hatte/ parrykker

Erika

→ tror han fik den grønne mappe på herlev - han læste ik så meget - hans mor gjorde→ han vil ik bruge til på noget som han ikke kan kontrollere → føler ik behov for det + han ved forældre gør det

Erika

mor var bekymret fordi mormor døde af lungekræft → men de er to forskellige ting → læger siger det er "bedst"

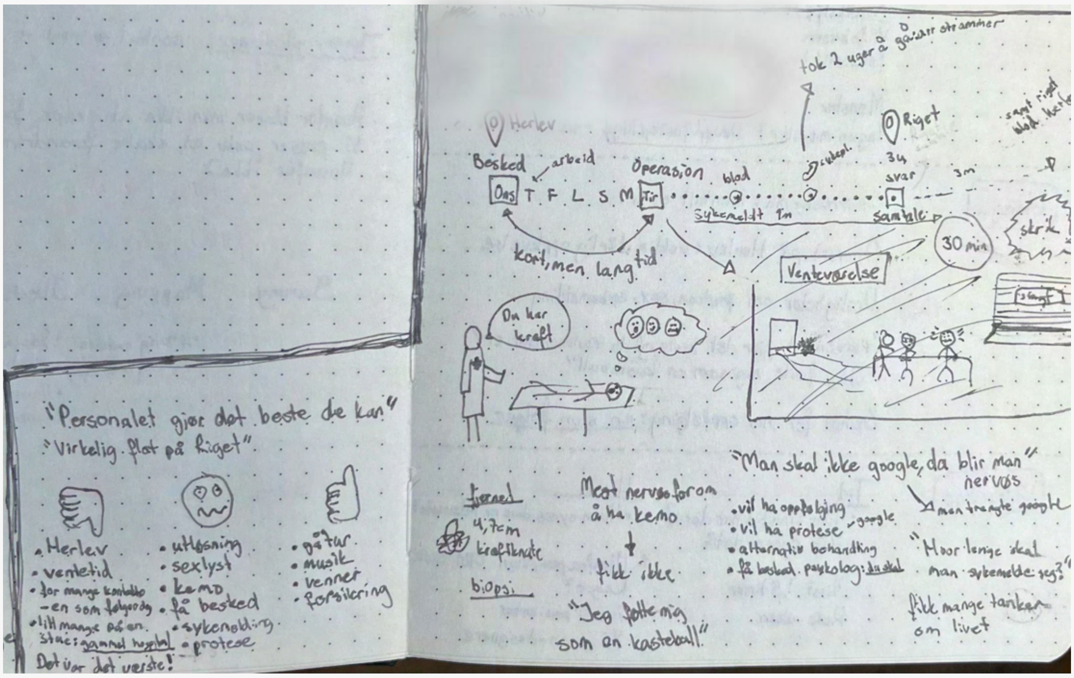
Erika

kontakt nogen? da han vidste i spanien → mor ringede til hans lægen → set i processen relativt hurtigt

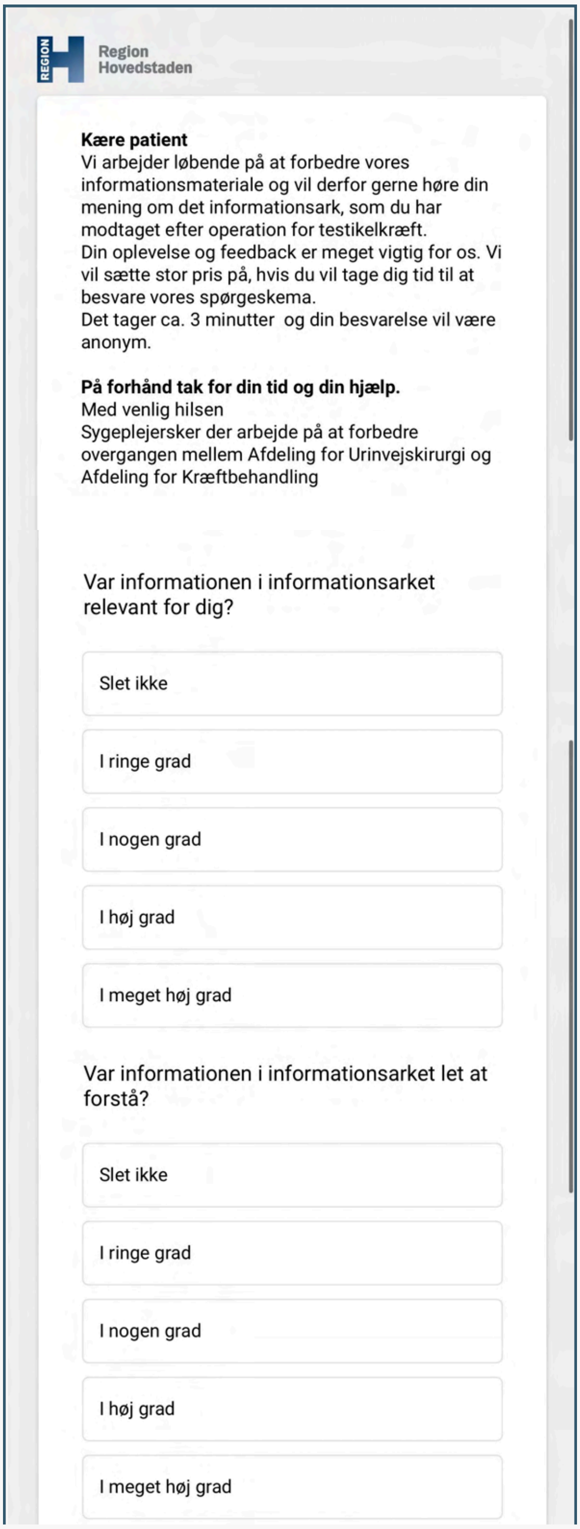
Erika

far ringede til venner som vidste noget

Erika



Appendix P: One-pager survey



Region Hovedstaden

Kære patient
Vi arbejder løbende på at forbedre vores informationsmateriale og vil derfor gerne høre din mening om det informationsark, som du har modtaget efter operation for testikelkræft.
Din oplevelse og feedback er meget vigtig for os. Vi vil sætte stor pris på, hvis du vil tage dig tid til at besvare vores spørgeskema.
Det tager ca. 3 minutter og din besvarelse vil være anonym.

På forhånd tak for din tid og din hjælp.
Med venlig hilsen
Sygeplejersker der arbejde på at forbedre overgangen mellem Afdeling for Urinvejskirurgi og Afdeling for Kræftbehandling

Var informationen i informationsarket relevant for dig?

- Slet ikke
- I ringe grad
- I nogen grad
- I høj grad
- I meget høj grad

Var informationen i informationsarket let at forstå?

- Slet ikke
- I ringe grad
- I nogen grad
- I høj grad
- I meget høj grad

Indeholder informationsarket for meget information?

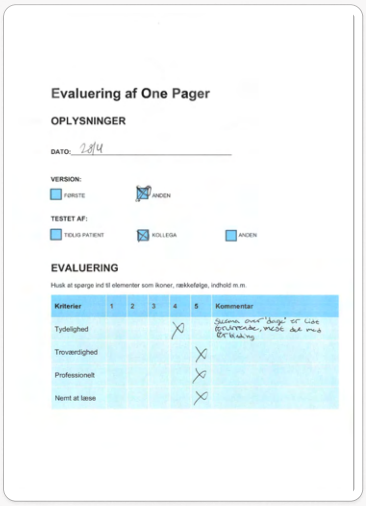
- Slet ikke
- I ringe grad
- I nogen grad
- I høj grad
- I meget høj grad

Er der nogen specifikke emner eller områder, vi bør inkludere i informationsarket?

- Nej
- Ja

Har du yderligere kommentarer eller forslag til forbedringer af informationsarket?

Appendix Q: Feedback from Look and Feel Testing



Evaluering af One Pager

OPLYSNINGER

DATO: 28/4

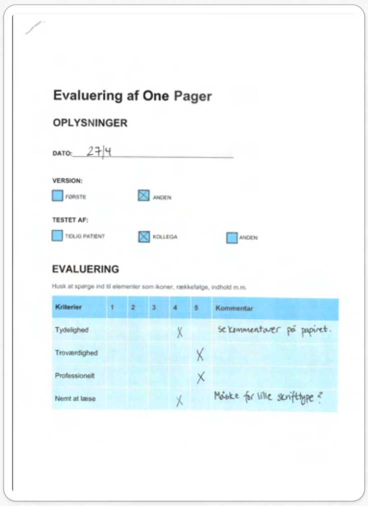
VERSION:
☐ FØRSTE ☒ ANDEN

TESTET AF:
☐ TIDLIG PATIENT ☒ KOLLEGA ☐ ANDEN

EVALUERING

Husk at spørge ind til elementer som ikoner, rækkefølge, indhold m.m.

Kriterier	1	2	3	4	5	Kommentar
Tydelighed				X		Skema over 'dage' er lidt forvirrende, mest det med forbinding
Troværdighed					X	
Professionelt					X	
Nemt at læse					X	



Evaluering af One Pager

OPLYSNINGER

DATO: 27/4

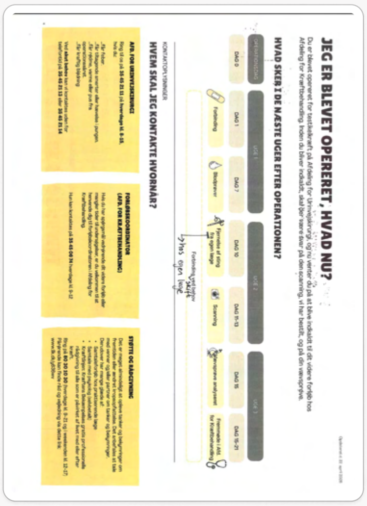
VERSION:
☐ FØRSTE ☒ ANDEN

TESTET AF:
☐ TIDLIG PATIENT ☒ KOLLEGA ☐ ANDEN

EVALUERING

Husk at spørge ind til elementer som ikoner, rækkefølge, indhold m.m.

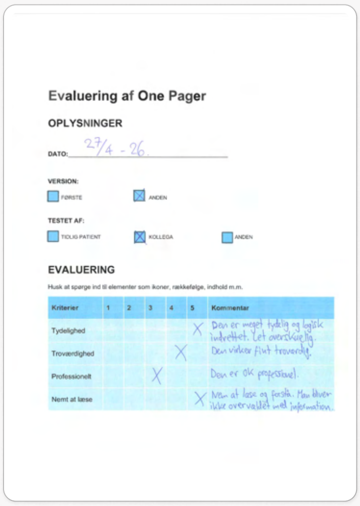
Kriterier	1	2	3	4	5	Kommentar
Tydelighed				X		Se kommentarer på papiret.
Troværdighed					X	
Professionelt					X	
Nemt at læse				X		Måske for lille skrifttype?



JEG ER BLEVET OPERERET, HVAD NU?

HVAD SKER I DE NÆSTE UGER EFTER OPERATIONEN?

HVEM SKAL JEG KONTAKTE HVORNÅR?



Evaluering af One Pager

OPLYSNINGER

DATO: 27/4 - 26.

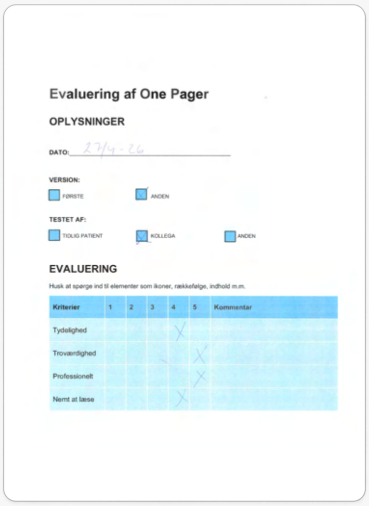
VERSION:
☐ FØRSTE ☒ ANDEN

TESTET AF:
☐ TIDLIG PATIENT ☒ KOLLEGA ☐ ANDEN

EVALUERING

Husk at spørge ind til elementer som ikoner, rækkefølge, indhold m.m.

Kriterier	1	2	3	4	5	Kommentar
Tydelighed					X	Den er meget tydelig og logisk indrettet. Let overskuelig.
Troværdighed				X		Den virker flot troværdig.
Professionelt			X			Den er OK professionel.
Nemt at læse					X	Nem at læse og forstå. Man bliver ikke overvældet med information.



Evaluering af One Pager

OPLYSNINGER

DATO: 27/4 - 26

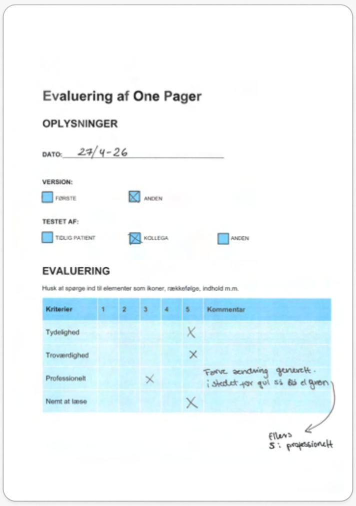
VERSION:
☐ FØRSTE ☒ ANDEN

TESTET AF:
☐ TIDLIG PATIENT ☒ KOLLEGA ☐ ANDEN

EVALUERING

Husk at spørge ind til elementer som ikoner, rækkefølge, indhold m.m.

Kriterier	1	2	3	4	5	Kommentar
Tydelighed				X		
Troværdighed					X	
Professionelt					X	
Nemt at læse				X		



Evaluering af One Pager

OPLYSNINGER

DATO: 27/4-26

VERSION:
☐ FØRSTE ☒ ANDEN

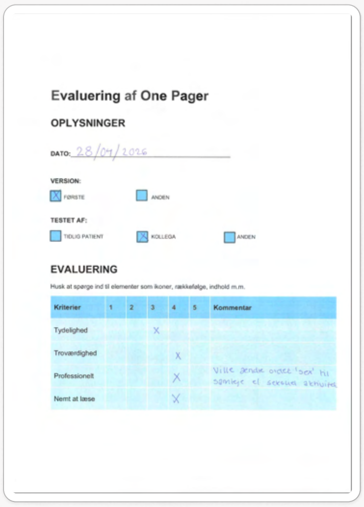
TESTET AF:
☐ TIDLIG PATIENT ☒ KOLLEGA ☐ ANDEN

EVALUERING

Husk at spørge ind til elementer som ikoner, rækkefølge, indhold m.m.

Kriterier	1	2	3	4	5	Kommentar
Tydelighed					X	
Troværdighed					X	
Professionelt			X			Farve ændring generelt. i stedet for gul så blå el grøn
Nemt at læse					X	

Ellers
5: professionelt



Evaluering af One Pager

OPLYSNINGER

DATO: 28/04/2026

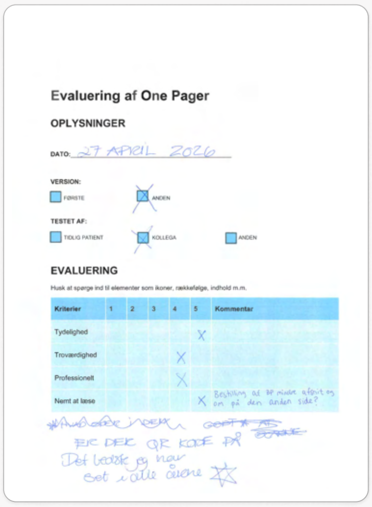
VERSION:
☒ FØRSTE ☐ ANDEN

TESTET AF:
☐ TIDLIG PATIENT ☒ KOLLEGA ☐ ANDEN

EVALUERING

Husk at spørge ind til elementer som ikoner, rækkefølge, indhold m.m.

Kriterier	1	2	3	4	5	Kommentar
Tydelighed			X			
Troværdighed				X		
Professionelt				X		Ville ændre ordet 'sex' til samleje el seksuel aktivitet
Nemt at læse				X		



Evaluering af One Pager

OPLYSNINGER

DATO: 27 APRIL 2026

VERSION:
☐ FØRSTE ☒ ANDEN

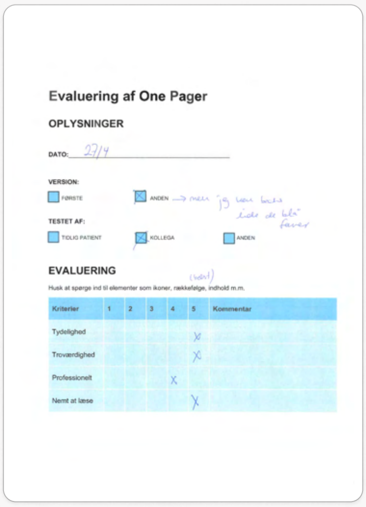
TESTET AF:
☐ TIDLIG PATIENT ☒ KOLLEGA ☐ ANDEN

EVALUERING

Husk at spørge ind til elementer som ikoner, rækkefølge, indhold m.m.

Kriterier	1	2	3	4	5	Kommentar
Tydelighed					X	
Troværdighed				X		
Professionelt				X		
Nemt at læse					X	Bestilling af BP mindre afsnit og om på den anden side?

~~#Anvendelse index~~ ~~godt at~~ ~~samle~~
ER DER QR KODE PÅ
Det bedste jeg har
set i alle årene



Evaluering af One Pager

OPLYSNINGER

DATO: 27/4

VERSION:
☐ FØRSTE ☒ ANDEN → men 'jeg kan bedre lide de blå' farver

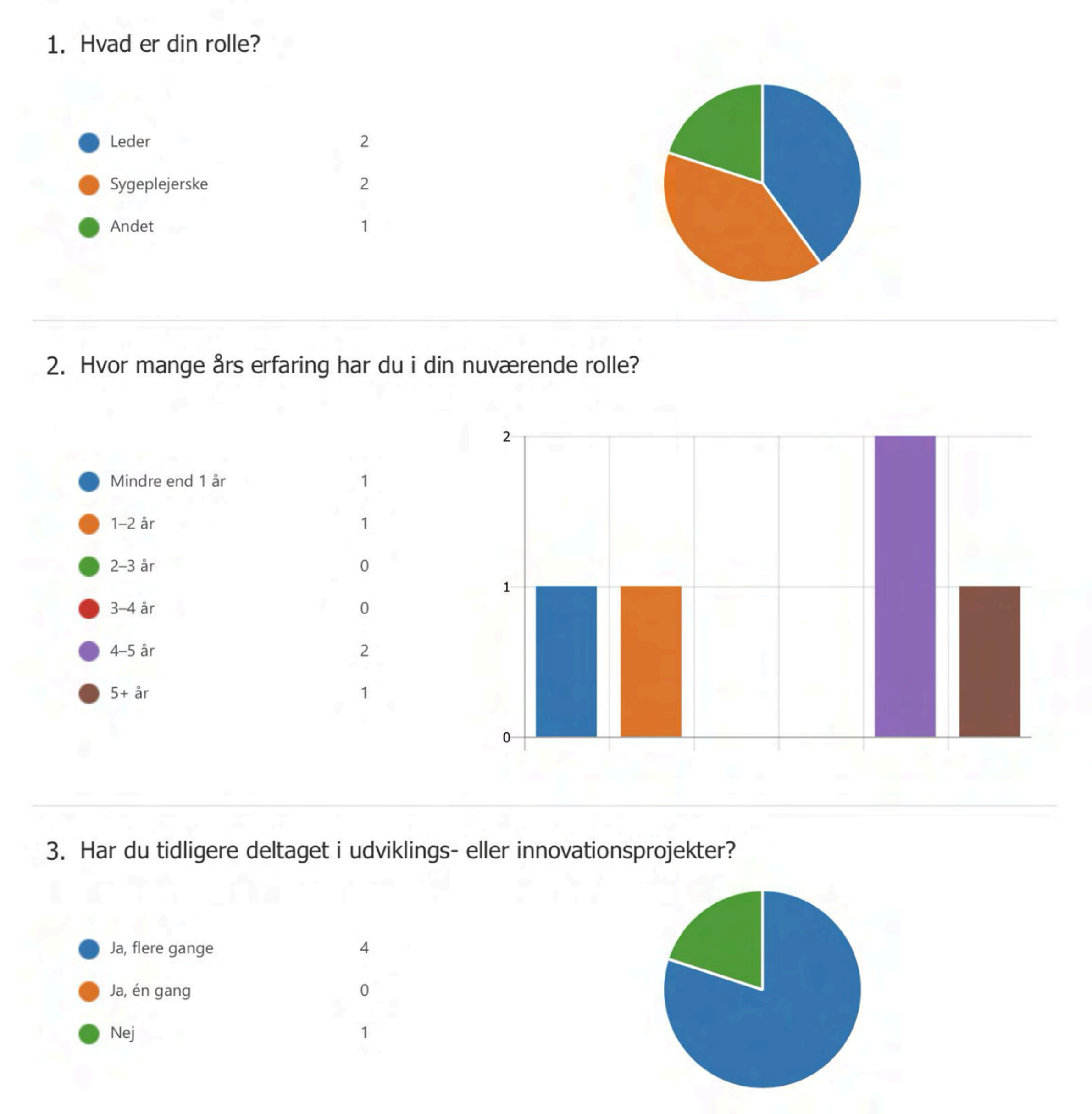
TESTET AF:
☐ TIDLIG PATIENT ☒ KOLLEGA ☐ ANDEN

EVALUERING

Husk at spørge ind til elementer som ikoner, rækkefølge, (tekst) indhold m.m.

Kriterier	1	2	3	4	5	Kommentar
Tydelighed					X	
Troværdighed					X	
Professionelt				X		
Nemt at læse					X	

Appendix R: Evaluation of process – survey results



1. Hvad er din rolle?

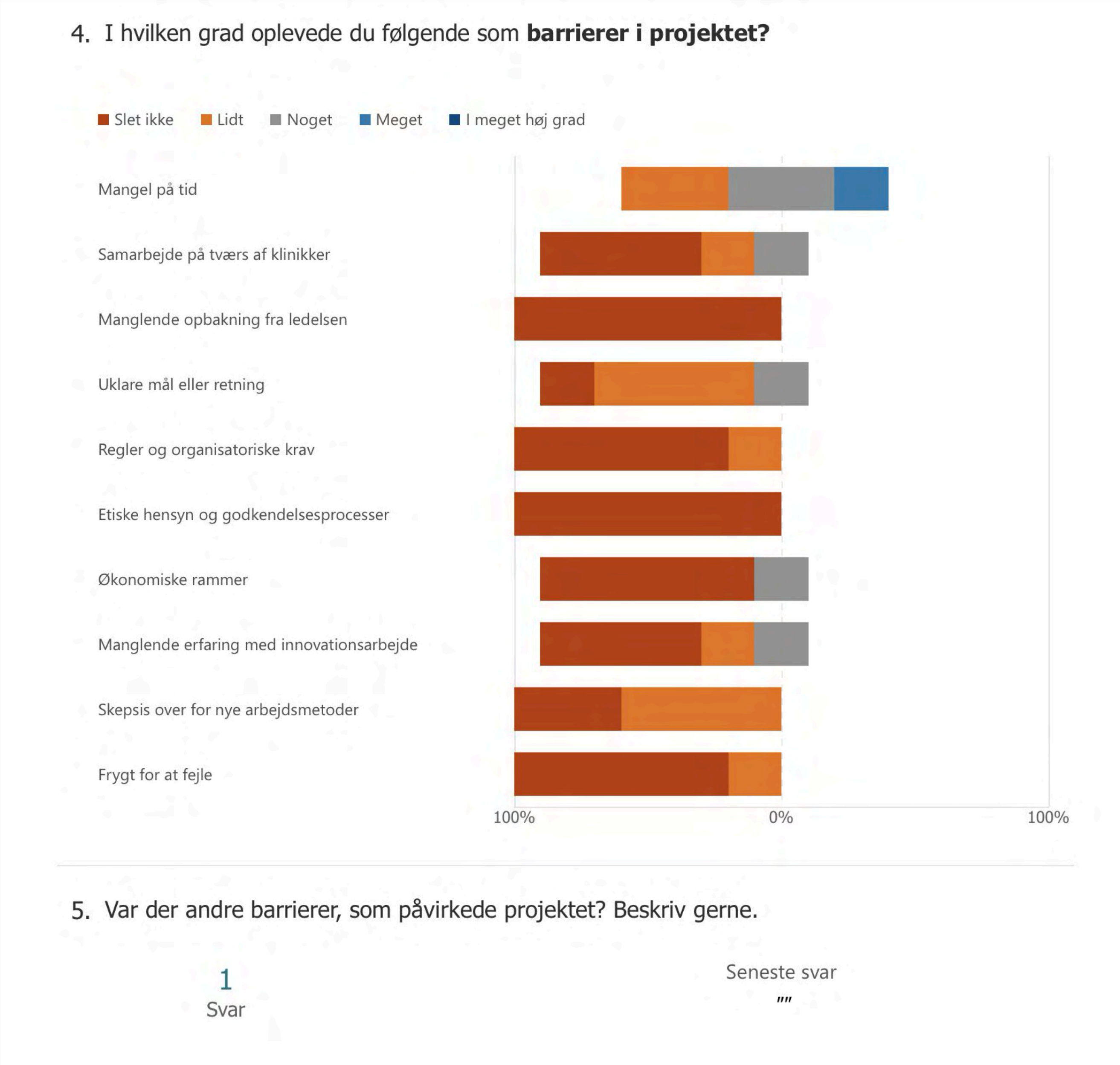
● Leder	2
● Sygeplejerske	2
● Andet	1

2. Hvor mange års erfaring har du i din nuværende rolle?

● Mindre end 1 år	1
● 1–2 år	1
● 2–3 år	0
● 3–4 år	0
● 4–5 år	2
● 5+ år	1

3. Har du tidligere deltaget i udviklings- eller innovationsprojekter?

● Ja, flere gange	4
● Ja, én gang	0
● Nej	1

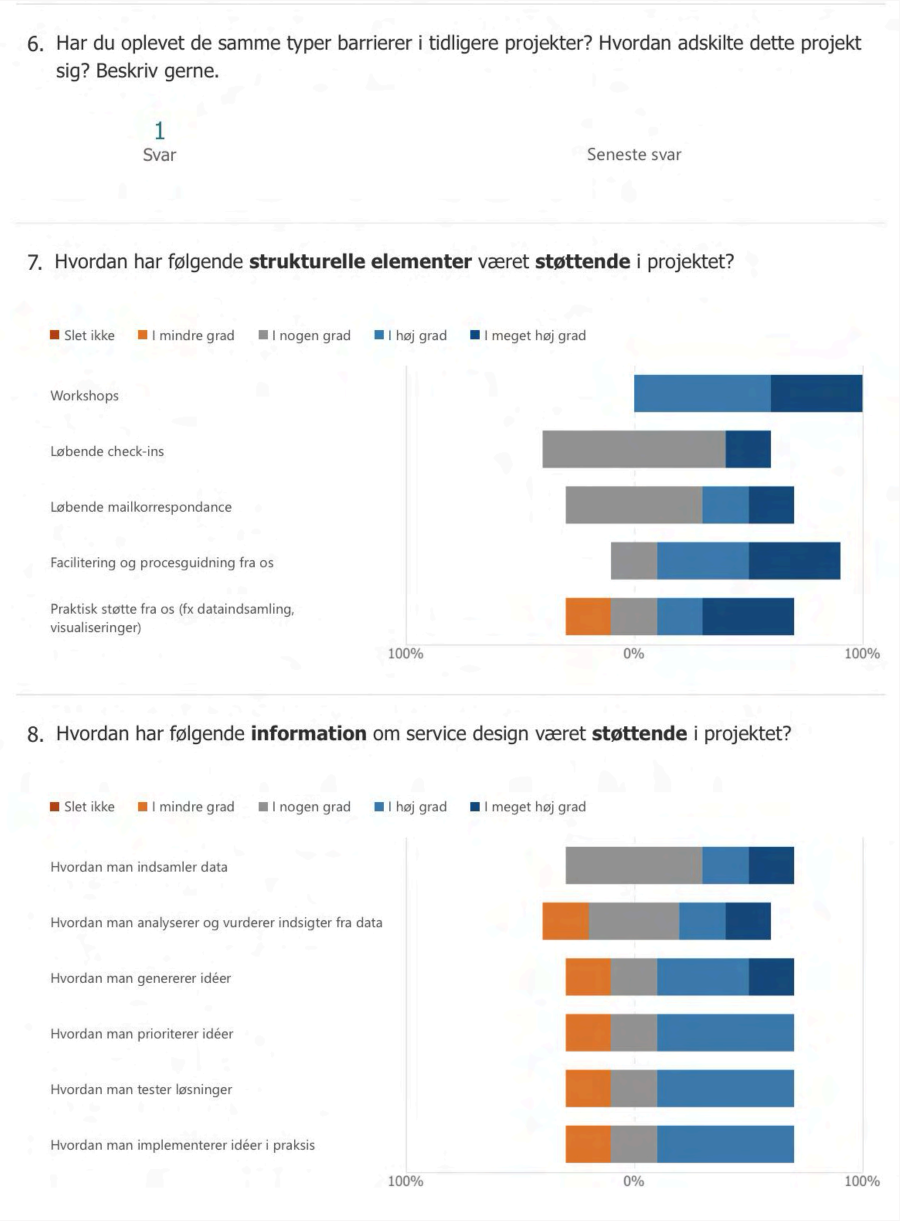


4. I hvilken grad oplevede du følgende som **barrierer i projektet?**

5. Var der andre barrierer, som påvirkede projektet? Beskriv gerne.

1
Svar

Seneste svar
""



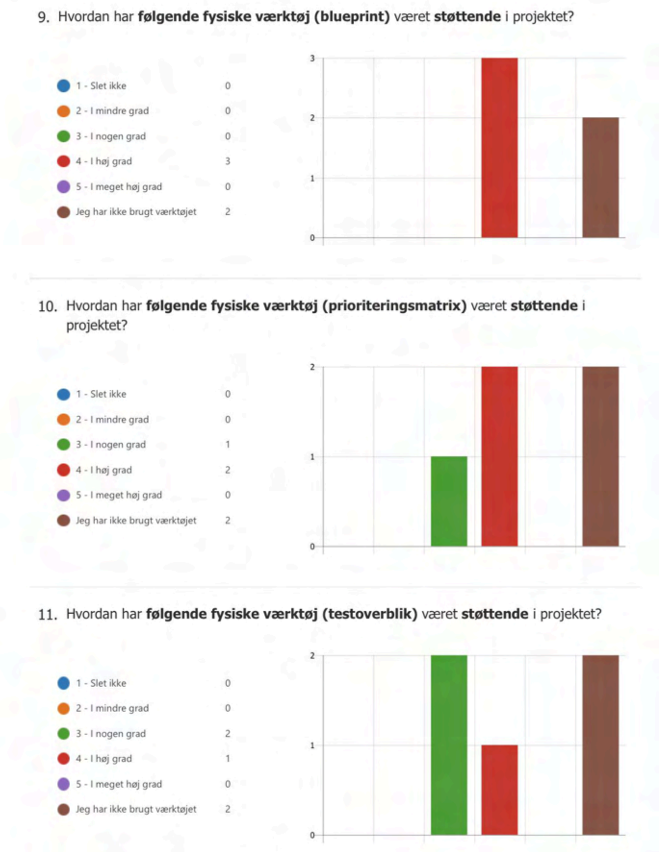
6. Har du oplevet de samme typer barrierer i tidligere projekter? Hvordan adskilte dette projekt sig? Beskriv gerne.

1
Svar

Seneste svar

7. Hvordan har følgende **strukturelle elementer** været **støttende** i projektet?

8. Hvordan har følgende **information** om service design været **støttende** i projektet?



9. Hvordan har **følgende fysiske værktøj (blueprint)** været **støttende** i projektet?

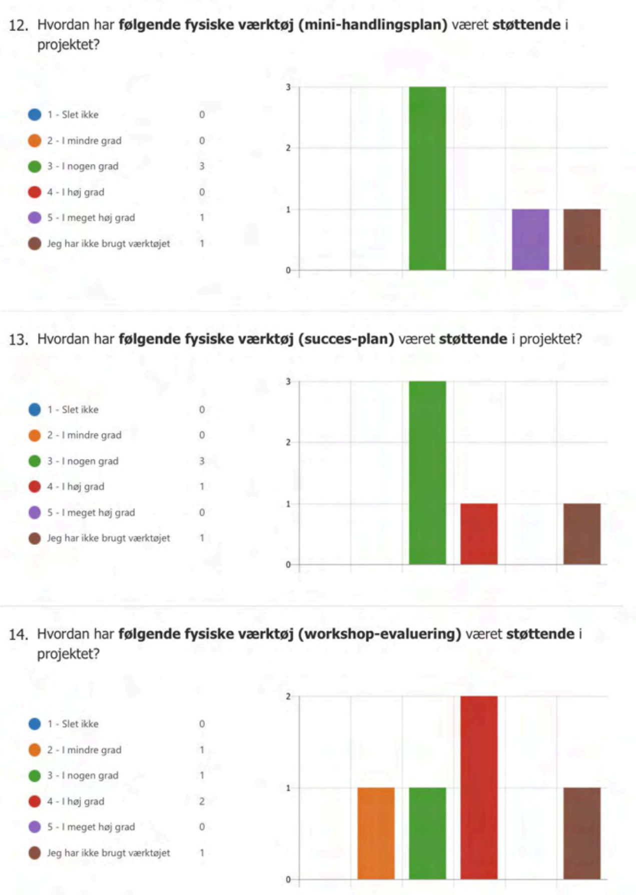
● 1 - Slet ikke	0
● 2 - I mindre grad	0
● 3 - I nogen grad	0
● 4 - I høj grad	3
● 5 - I meget høj grad	0
● Jeg har ikke brugt værktøjet	2

10. Hvordan har **følgende fysiske værktøj (prioriteringsmatrix)** været **støttende** i projektet?

● 1 - Slet ikke	0
● 2 - I mindre grad	0
● 3 - I nogen grad	1
● 4 - I høj grad	2
● 5 - I meget høj grad	0
● Jeg har ikke brugt værktøjet	2

11. Hvordan har **følgende fysiske værktøj (testoverblik)** været **støttende** i projektet?

● 1 - Slet ikke	0
● 2 - I mindre grad	0
● 3 - I nogen grad	2
● 4 - I høj grad	1
● 5 - I meget høj grad	0
● Jeg har ikke brugt værktøjet	2



12. Hvordan har **følgende fysiske værktøj (mini-handlingsplan)** været **støttende** i projektet?

● 1 - Slet ikke	0
● 2 - I mindre grad	0
● 3 - I nogen grad	3
● 4 - I høj grad	0
● 5 - I meget høj grad	1
● Jeg har ikke brugt værktøjet	1

13. Hvordan har **følgende fysiske værktøj (succes-plan)** været **støttende** i projektet?

● 1 - Slet ikke	0
● 2 - I mindre grad	0
● 3 - I nogen grad	3
● 4 - I høj grad	1
● 5 - I meget høj grad	0
● Jeg har ikke brugt værktøjet	1

14. Hvordan har **følgende fysiske værktøj (workshop-evaluering)** været **støttende** i projektet?

● 1 - Slet ikke	0
● 2 - I mindre grad	1
● 3 - I nogen grad	1
● 4 - I høj grad	2
● 5 - I meget høj grad	0
● Jeg har ikke brugt værktøjet	1

15. Hvordan har **følgende fysiske værktøj (evalueringsskema)** været **støttende** i projektet?

● 1 - Slet ikke	0
● 2 - I mindre grad	0
● 3 - I nogen grad	1
● 4 - I høj grad	0
● 5 - I meget høj grad	2
● Jeg har ikke brugt værktøjet	2

16. Hvilke metoder eller aktiviteter har været mest værdifulde for dig, og hvorfor? Beskriv gerne.

2
Svar

Seneste svar
"samarbejdet og opbakning fra alle partner, og den gode stemning"

17. I hvilken grad føler du dig i stand til at tage initiativ til forbedringer i din egen praksis efter dette projekt?

5
Svar

3.2
Gennemsnitligt antal

18. Hvordan har du oplevet samarbejdet på tværs af klinikker i denne perioden?

4
Svar

Seneste svar
"God"
"det har været meget positivt, og fremmende for fremtiden"

19. Hvordan oplevede du, at service design værktøjer fungerede i en sundhedsfaglig kontekst? Beskriv gerne.

3
Svar

Seneste svar
""
"når der er tid og ressourcer så kan vi bruge det og giver os nye idé...

20. Hvad har været det vigtigste udbytte af projektet for dig? Beskriv gerne.

3
Svar

Seneste svar
"at der kommet noget konkret ud af projektet, og at vi har fået et t...

21. Er der andet, du vil tilføje om processen?

2
Svar

Seneste svar
"Jeg tror at servicedesign kan bruges meget mere i vores kontekst, ...

Appendix S: Toolkit: Instruction Manual

TOOLKIT

Sammen på tværs

Værktøjer, der hjælper jer med at udvikle, afprøve og justere løsninger sammen.

“Lidt forskel gør en stor forskel”

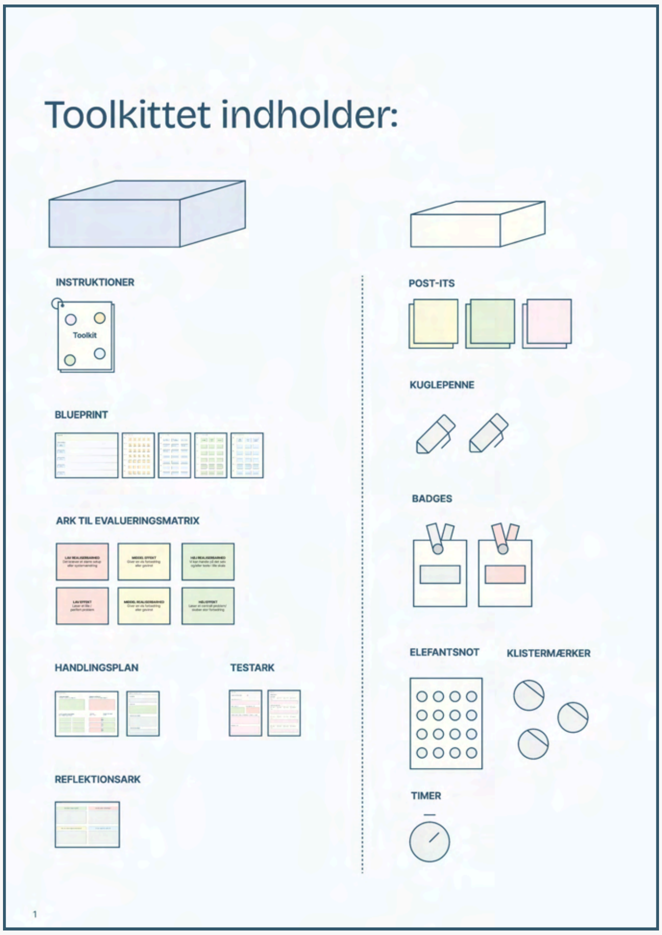
OM TOOLKITTET

Dette toolkit er udviklet som en del af projektet *Patientforløb på tværs af Afdeling for Urinvejskirurgi* (2113) *og Afdeling for Kræftbehandling* (4222) på Rigshospitalet i samarbejde med specialestuderende i service design fra Aalborg Universitet med fokus på at skabe mere sammenhæng, tryghed og klarhed i patientforløb på tværs.

Toolkittet samler de værktøjer, som gennem projektet har understøttet arbejdet med at forstå udfordringer, udforske muligheder og udvikle idéer, der kan omsættes til praksis i en kompleks sundhedsfaglig hverdag. Målet er, at værktøjerne også kan inspirere andre til at tage små skridt, afprøve idéer tidligt og skabe større forandringer gennem tæt samarbejde og løbende læring.

En særlig tak til projektgruppen, de involverede medarbejdere fra de to afdelinger og Center for Kræft og Organsygdomme for deres engagement, åbenhed og værdifulde bidrag undervejs. Deres villighed til at afprøve værktøjerne i praksis samt dele konkrete erfaringer og feedback har været afgørende for at forme og kvalificere toolkittet.

Udviklet og designet af:
Emily Brophy, Lea Texmo Limstrand og Erika Strazio.
Første udgave, trykt i maj 2026.



Toolkittet indholder:

INSTRUKTIONER

BLUEPRINT

ARK TIL EVALUERINGSMATRIX

HANDLINGSPLAN

TESTARK

REFLEKTIONSARK

POST-ITS

KUGLEPENNE

BADGES

ELEFANTSNOT

KLISTERMÆRKER

TIMER

Tre tips til at bruge toolkittet

1
Fordel roller

At fordele roller hjælper med at skabe tydelige ansvarsområder og et bedre flow i processen. Facilitatoren holder styr på processen, hjælperen støtter med det praktiske, og deltagerne bidrager med erfaringer, idéer og perspektiver. Med de tilhørende badges kan I holde styr på rollerne undervejs, så alle kan huske, hvad deres rolle er, og hvad de særligt skal prioritere. Prøv gerne at bytte roller i forskellige værktøjer, hvis det giver mening. Det kan give nye perspektiver.

Sørg også for at inkludere nøglepersoner med forskellige perspektiver fra flere grupper og afdelinger, så arbejdet bliver samskabende.

2
Udforsk

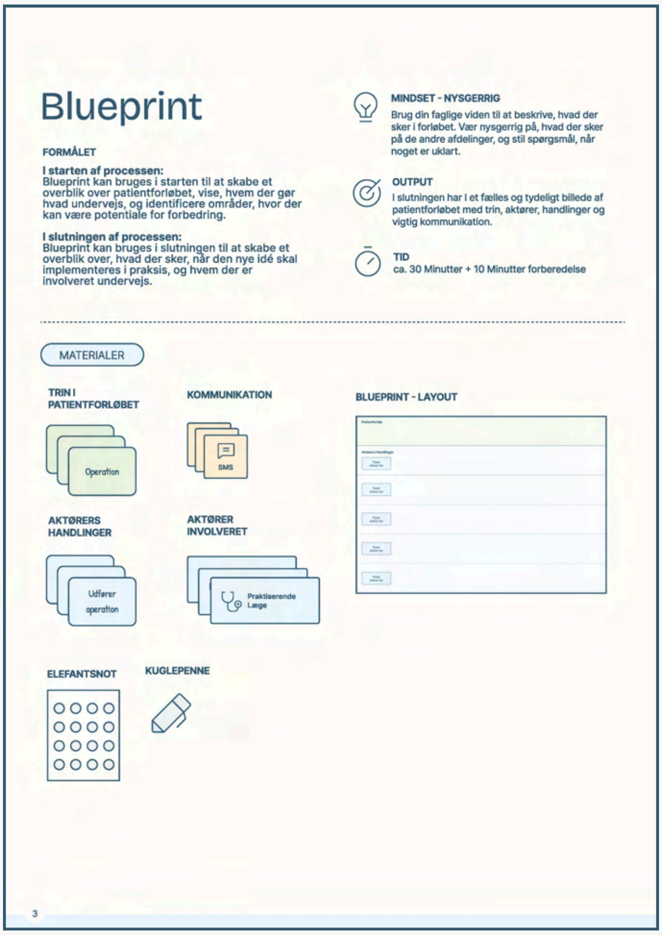
Hvert værktøj har sin egen korte instruktion, som guider jer igennem processen, men vær ikke bange for at tilpasse den til jeres egen kontekst. Værktøjerne er skabt til at understøtte mange forskellige typer processer, men de fungerer bedst, når de bruges med fleksibilitet og tilpasses den kontekst, de indgår i.

I kan også selv definere rammerne for jeres workshop, for eksempel hvor lang tid I vil bruge, og hvilke skabeloner der giver mest mening.

Det er helt naturligt at begynde et sted, vende tilbage senere og justere undervejs. Værktøjerne er tænkt som noget, der kan udvikles iterativt.

3
Reflektér

Efter processen anbefaler vi at bruge reflektionsarket (s. 13) til at samle op på det, der fungerede godt, det, der var udfordrende, og det, I tager med jer videre. Tag et øjeblik til at reflektere, og del gerne jeres tanker med hinanden.



Blueprint

FORMÅLET

I starten af processen:
Blueprint kan bruges i starten til at skabe et overblik over patientforløbet, vise, hvem der gør hvad undervejs, og identificere områder, hvor der kan være potentiale for forbedring.

I slutningen af processen:
Blueprint kan bruges i slutningen til at skabe et overblik over, hvad der sker, når den nye idé skal implementeres i praksis, og hvem der er involveret undervejs.

MINDSET - NYSGERRIG
Brug din faglige viden til at beskrive, hvad der sker i forløbet. Vær nysgerrig på, hvad der sker på de andre afdelinger, og stil spørgsmål, når noget er uklart.

OUTPUT
I slutningen har I et fælles og tydeligt billede af patientforløbet med trin, aktører, handlinger og vigtig kommunikation.

TID
ca. 30 Minutter + 10 Minutter forberedelse

MATERIALER

TRIN I PATIENTFORLØBET

KOMMUNIKATION

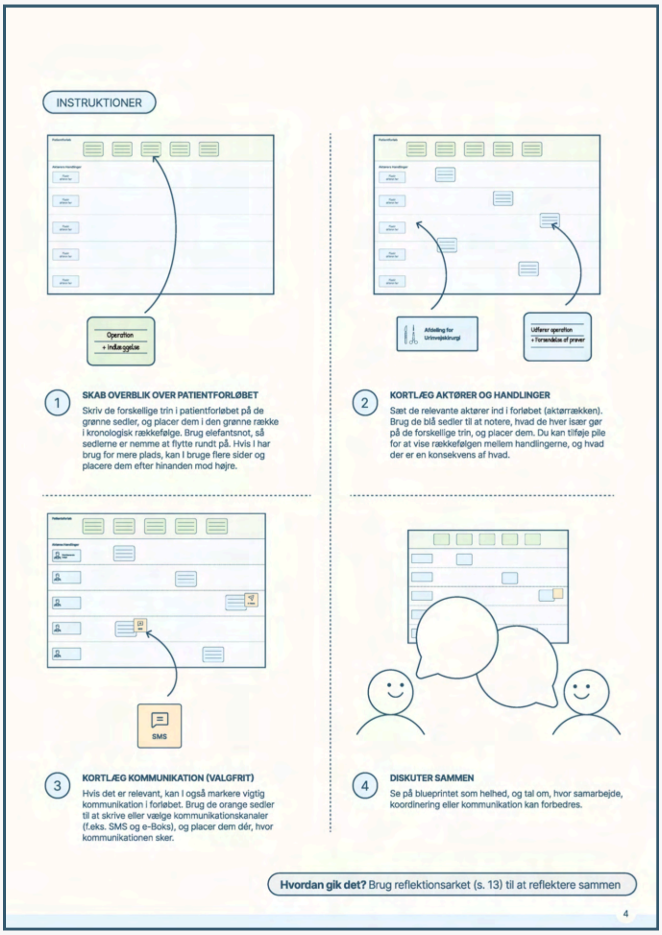
AKTØRERS HANDLINGER

AKTØRER INVOLVERET

ELEFANTSNOT

KUGLEPENNE

BLUEPRINT - LAYOUT



INSTRUKTIONER

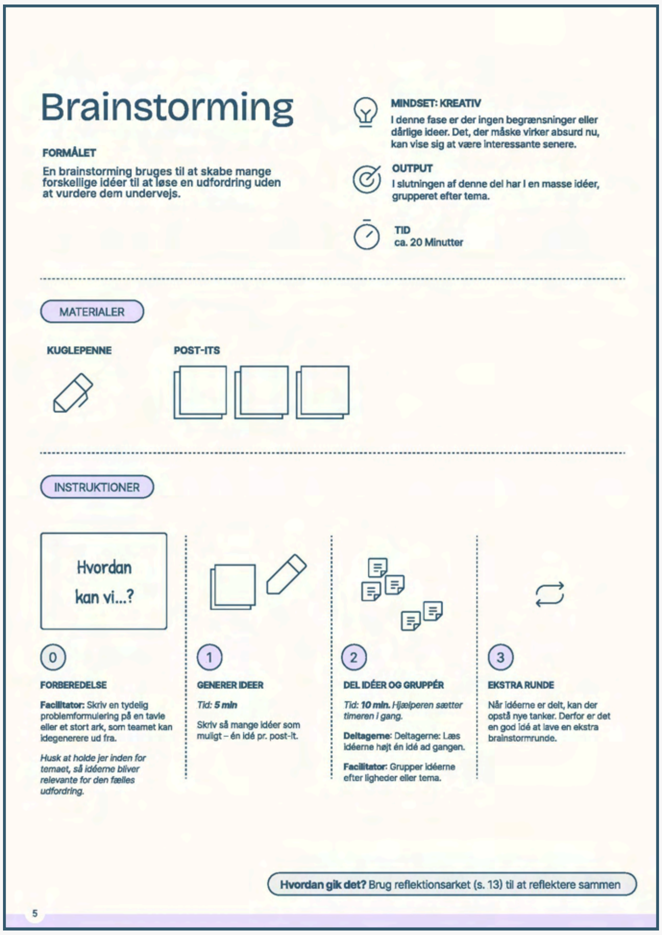
① **SKAB OVERBLIK OVER PATIENTFORLØBET**
Skriv de forskellige trin i patientforløbet på de grønne sedler, og placer dem i den grønne række i kronologisk rækkefølge. Brug elefantsnot, så sedlerne er nemme at flytte rundt på. Hvis I har brug for mere plads, kan I bruge flere sider og placere dem efter hinanden mod højre.

② **KORTLÆG AKTØRER OG HANDLINGER**
Sæt de relevante aktører ind i forløbet (aktørrækken). Brug de blå sedler til at notere, hvad de hver især gør på de forskellige trin, og placer dem. Du kan tilføje pile for at vise rækkefølgen mellem handlingerne, og hvad der er en konsekvens af hvad.

③ **KORTLÆG KOMMUNIKATION (VALGFRIT)**
Hvis det er relevant, kan I også markere vigtig kommunikation i forløbet. Brug de orange sedler til at skrive eller vælge kommunikationskanaler (f.eks. SMS og e-Boks), og placer dem dér, hvor kommunikationen sker.

④ **DISKUTER SAMMEN**
Se på blueprintet som helhed, og tal om, hvor samarbejde, koordinering eller kommunikation kan forbedres.

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen



Brainstorming

FORMÅLET

En brainstorming bruges til at skabe mange forskellige idéer til at løse en udfordring uden at vurdere dem undervejs.

MINDSET: KREATIV

I denne fase er der ingen begrænsninger eller dårlige ideer. Det, der måske virker absurd nu, kan vise sig at være interessante senere.

OUTPUT

I slutningen af denne del har I en masse idéer, grupperet efter tema.

TID

ca. 20 Minutter

MATERIALER

KUGLEPENNE

POST-ITS

INSTRUKTIONER

Hvordan kan vi...?

0

FORBEREDELSE

Facilitator: Skriv en tydelig problemformulering på en tavle eller et stort ark, som teamet kan idegenerere ud fra.

Husk at holde jer inden for temaet, så idéerne bliver relevante for den fælles udfordring.

1

GENERER IDEER

*Tid: **5 min***

Skriv så mange idéer som muligt – én idé pr. post-it.

2

DEL IDÉER OG GRUPPÉR

*Tid: **10 min.** Hjælperen sætter timeren i gang.*

Deltagerne: Deltagerne: Læs idéerne højt én idé ad gangen.

Facilitator: Grupper idéerne efter ligheder eller tema.

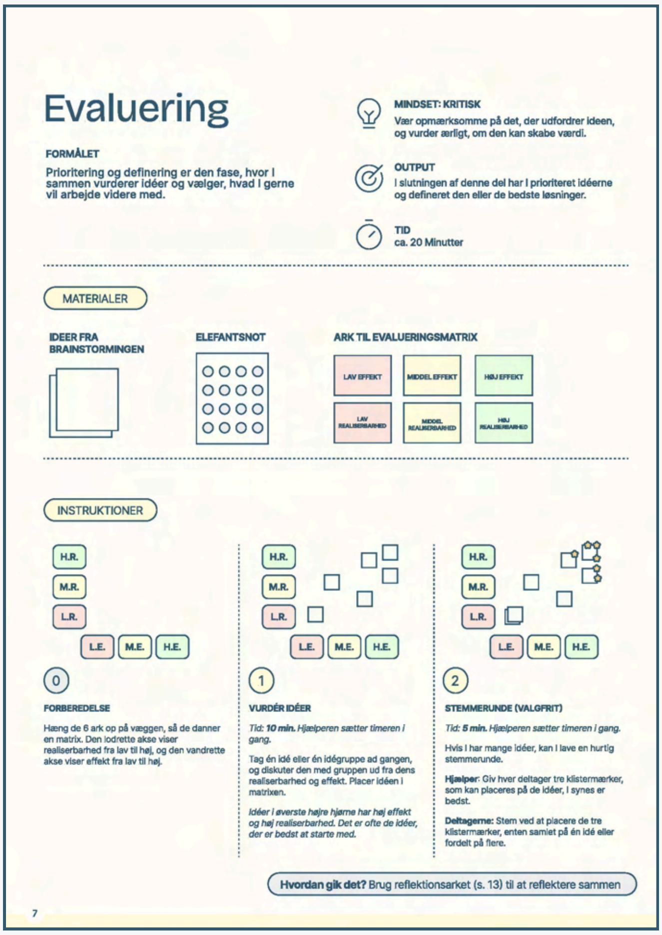
3

EKSTRA RUNDE

Når idéerne er delt, kan der opstå nye tanker. Derfor er det en god idé at lave en ekstra brainstormrunde.

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

5



Evaluering

FORMÅLET

Prioritering og definering er den fase, hvor I sammen vurderer idéer og vælger, hvad I gerne vil arbejde videre med.

MINDSET: KRITISK

Vær opmærksomme på det, der udfordrer ideen, og vurder ærligt, om den kan skabe værdi.

OUTPUT

I slutningen af denne del har I prioriteret idéerne og defineret den eller de bedste løsninger.

TID

ca. 20 Minutter

MATERIALER

IDEER FRA BRAINSTORMINGEN

ELEFANTSNOT

ARK TIL EVALUERINGSMATRIX

LAV EFFEKT	MIDDEL EFFEKT	HØJ EFFEKT
LAV REALISERBARHED	MIDDEL REALISERBARHED	HØJ REALISERBARHED

INSTRUKTIONER

0

FORBEREDELSE

Hæng de 6 ark op på væggen, så de danner en matrix. Den lodrette akse viser realiserbarhed fra lav til høj, og den vandrette akse viser effekt fra lav til høj.

1

VURDÉR IDÉER

*Tid: **10 min.** Hjælperen sætter timeren i gang.*

Tag én idé eller én idégruppe ad gangen, og diskuter den med gruppen ud fra dens realiserbarhed og effekt. Placer idéen i matrixen.

Idéer i øverste højre hjørne har høj effekt og høj realiserbarhed. Det er ofte de idéer, der er bedst at starte med.

2

STEMMERUNDE (VALGFRIT)

*Tid: **5 min.** Hjælperen sætter timeren i gang.*

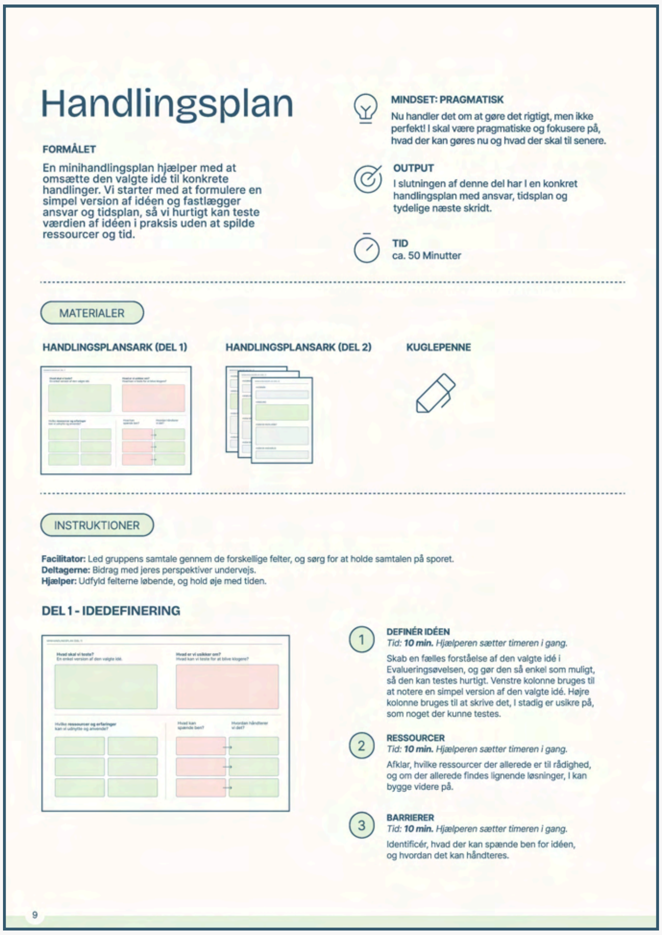
Hvis I har mange idéer, kan I lave en hurtig stemmerunde.

Hjælper: Giv hver deltager tre klistermærker, som kan placeres på de idéer, I synes er bedst.

Deltagerne: Stem ved at placere de tre klistermærker, enten samlet på én idé eller fordelt på flere.

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

7



Handlingsplan

FORMÅLET

En minihandlingsplan hjælper med at omsætte den valgte idé til konkrete handlinger. Vi starter med at formulere en simpel version af idéen og fastlægger ansvar og tidsplan, så vi hurtigt kan teste værdien af idéen i praksis uden at spilde ressourcer og tid.

MINDSET: PRAGMATISK

Nu handler det om at gøre det rigtigt, men ikke perfekt! I skal være pragmatiske og fokusere på, hvad der kan gøres nu og hvad der skal til senere.

OUTPUT

I slutningen af denne del har I en konkret handlingsplan med ansvar, tidsplan og tydelige næste skridt.

TID

ca. 50 Minutter

MATERIALER

HANDLINGSPLANSARK (DEL 1)

HANDLINGSPLANSARK (DEL 2)

KUGLEPENNE

INSTRUKTIONER

Facilitator: Led gruppens samtale gennem de forskellige felter, og sørg for at holde samtalen på sporet.
Deltagerne: Bidrag med jeres perspektiver undervejs.
Hjælper: Udfyld felterne løbende, og hold øje med tiden.

DEL 1 - IDEDEFINERING

1

DEFINÉR IDÉEN

*Tid: **10 min.** Hjælperen sætter timeren i gang.*

Skab en fælles forståelse af den valgte idé i Evalueringsøvelsen, og gør den så enkel som muligt, så den kan testes hurtigt. Venstre kolonne bruges til at notere en simpel version af den valgte idé. Højre kolonne bruges til at skrive det, I stadig er usikre på, som noget der kunne testes.

2

RESSOURCER

*Tid: **10 min.** Hjælperen sætter timeren i gang.*

Afklar, hvilke ressourcer der allerede er til rådighed, og om der allerede findes lignende løsninger, I kan bygge videre på.

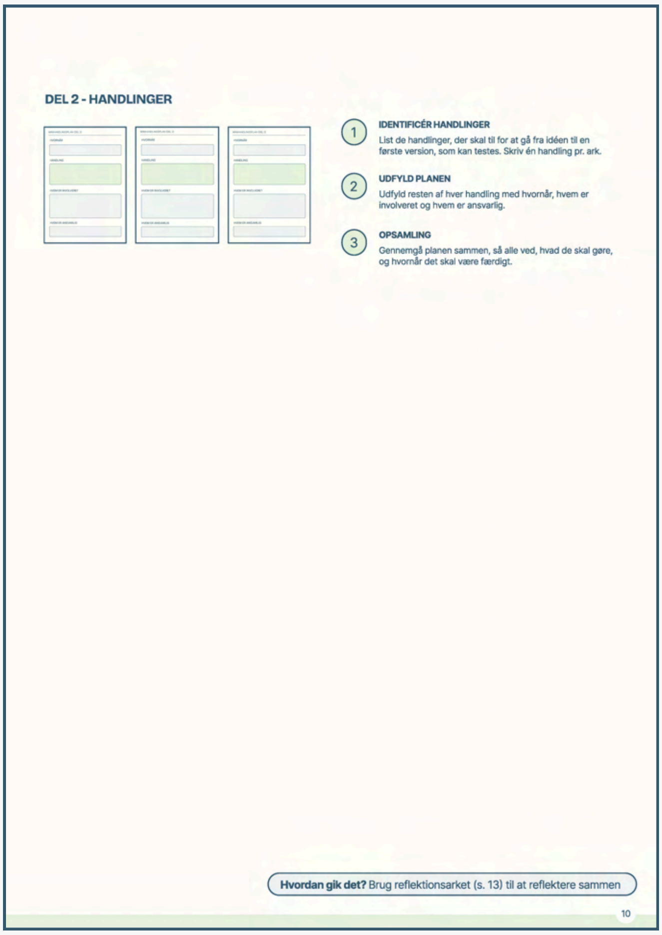
3

BARRIERER

*Tid: **10 min.** Hjælperen sætter timeren i gang.*

Identificér, hvad der kan spænde ben for idéen, og hvordan det kan håndteres.

9



DEL 2 - HANDLINGER

1

IDENTIFICÉR HANDLINGER

List de handlinger, der skal til for at gå fra idéen til en første version, som kan testes. Skriv én handling pr. ark.

2

UDFYLD PLANEN

Udfyld resten af hver handling med hvornår, hvem er involveret og hvem er ansvarlig.

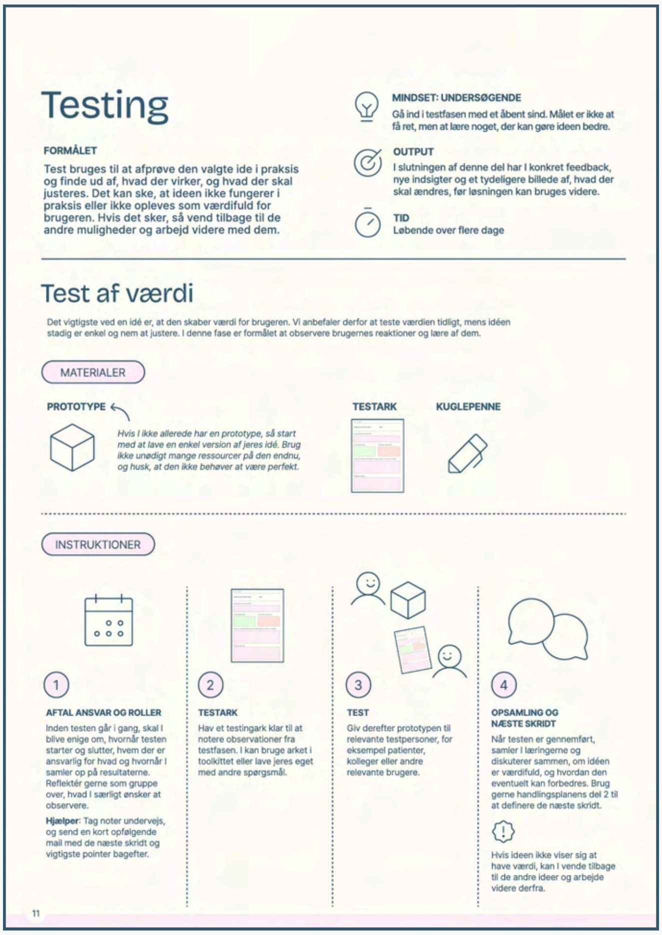
3

OPSAMLING

Gennemgå planen sammen, så alle ved, hvad de skal gøre, og hvornår det skal være færdigt.

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

10



Testing

FORMÅLET

Test bruges til at afprøve den valgte ide i praksis og finde ud af, hvad der virker, og hvad der skal justeres. Det kan ske, at ideen ikke fungerer i praksis eller ikke opleves som værdifuld for brugeren. Hvis det sker, så vend tilbage til de andre muligheder og arbejd videre med dem.

MINDSET: UNDERSØGENDE

Gå ind i testfasen med et åbent sind. Målet er ikke at få ret, men at lære noget, der kan gøre ideen bedre.

OUTPUT

I slutningen af denne del har I konkret feedback, nye indsigter og et tydeligere billede af, hvad der skal ændres, før løsningen kan bruges videre.

TID

Løbende over flere dage

Test af værdi

Det vigtigste ved en idé er, at den skaber værdi for brugeren. Vi anbefaler derfor at teste værdien tidligt, mens idéen stadig er enkel og nem at justere. I denne fase er formålet at observere brugernes reaktioner og lære af dem.

MATERIALER

PROTOTYPE

Hvis I ikke allerede har en prototype, så start med at lave en enkel version af jeres idé. Brug ikke unødigt mange ressourcer på den endnu, og husk, at den ikke behøver at være perfekt.

TESTARK

KUGLEPENNE

INSTRUKTIONER

1

AFTAL ANSVAR OG ROLLER

Inden testen går i gang, skal I blive enige om, hvornår testen starter og slutter, hvem der er ansvarlig for hvad og hvornår I samler op på resultaterne. Reflektér gerne som gruppe over, hvad I særligt ønsker at observere.

Hjælper: Tag noter undervejs, og send en kort opfølgende mail med de næste skridt og vigtigste pointer bagefter.

2

TESTARK

Hav et testingark klar til at notere observationer fra testfasen. I kan bruge arket i toolkittet eller lave jeres eget med andre spørgsmål.

3

TEST

Giv derefter prototypen til relevante testpersoner, for eksempel patienter, kolleger eller andre relevante brugere.

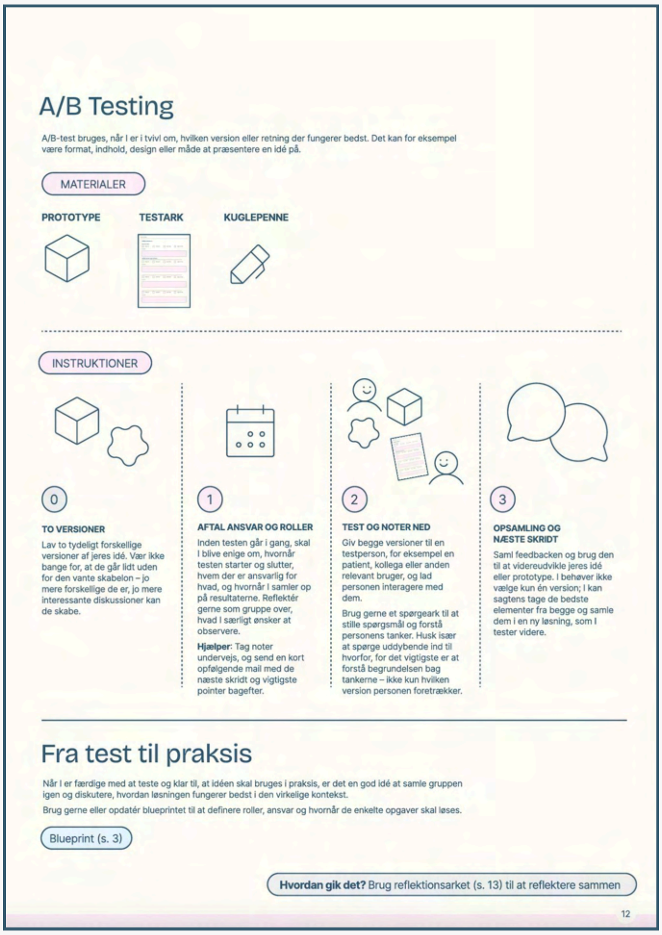
4

OPSAMLING OG NÆSTE SKRIDT

Når testen er gennemført, samler I læringerne og diskuterer sammen, om idéen er værdifuld, og hvordan den eventuelt kan forbedres. Brug gerne handlingsplanens del 2 til at definere de næste skridt.

Hvis ideen ikke viser sig at have værdi, kan I vende tilbage til de andre ideer og arbejde videre derfra.

11



A/B Testing

A/B-test bruges, når I er i tvivl om, hvilken version eller retning der fungerer bedst. Det kan for eksempel være format, indhold, design eller måde at præsentere en idé på.

MATERIALER

PROTOTYPE

TESTARK

KUGLEPENNE

INSTRUKTIONER

0

TO VERSIONER

Lav to tydeligt forskellige versioner af jeres idé. Vær ikke bange for, at de går lidt uden for den vante skabelon – jo mere forskellige de er, jo mere interessante diskussioner kan de skabe.

1

AFTAL ANSVAR OG ROLLER

Inden testen går i gang, skal I blive enige om, hvornår testen starter og slutter, hvem der er ansvarlig for hvad, og hvornår I samler op på resultaterne. Reflektér gerne som gruppe over, hvad I særligt ønsker at observere.

Hjælper: Tag noter undervejs, og send en kort opfølgende mail med de næste skridt og vigtigste pointer bagefter.

2

TEST OG NOTER NED

Giv begge versioner til en testperson, for eksempel en patient, kollega eller anden relevant bruger, og lad personen interagere med dem.

Brug gerne et spørgeark til at stille spørgsmål og forstå personens tanker. Husk især at spørge uddybende ind til hvorfor, for det vigtigste er at forstå begrundelsen bag tankerne – ikke kun hvilken version personen foretrækker.

3

OPSAMLING OG NÆSTE SKRIDT

Saml feedbacken og brug den til at videreudvikle jeres idé eller prototype. I behøver ikke vælge kun én version; I kan sagtens tage de bedste elementer fra begge og samle dem i en ny løsning, som I tester videre.

Fra test til praksis

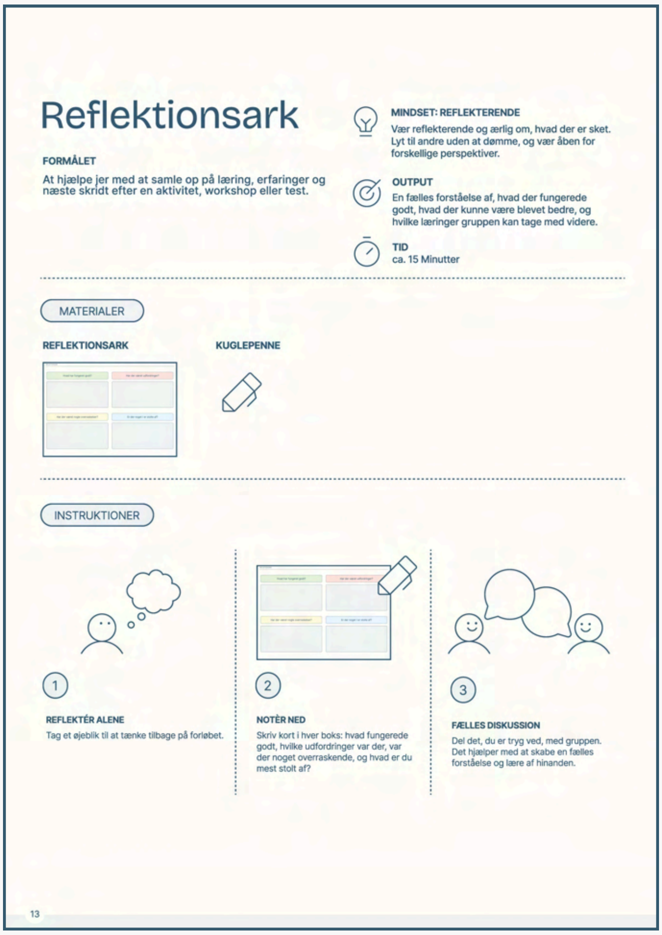
Når I er færdige med at teste og klar til, at idéen skal bruges i praksis, er det en god idé at samle gruppen igen og diskutere, hvordan løsningen fungerer bedst i den virkelige kontekst.

Brug gerne eller opdatér blueprintet til at definere roller, ansvar og hvornår de enkelte opgaver skal løses.

Blueprint (s. 3)

Hvordan gik det? Brug reflektionsarket (s. 13) til at reflektere sammen

12



Reflektionsark

FORMÅLET

At hjælpe jer med at samle op på læring, erfaringer og næste skridt efter en aktivitet, workshop eller test.

MINDSET: REFLEKTERENDE

Vær reflekterende og ærlig om, hvad der er sket. Lyt til andre uden at dømme, og vær åben for forskellige perspektiver.

OUTPUT

En fælles forståelse af, hvad der fungerede godt, hvad der kunne være blevet bedre, og hvilke læringer gruppen kan tage med videre.

TID

ca. 15 Minutter

MATERIALER

REFLEKTIONSARK

KUGLEPENNE

INSTRUKTIONER

1

REFLEKTÉR ALENE

Tag et øjeblik til at tænke tilbage på forløbet.

2

NOTÈR NED

Skriv kort i hver boks: hvad fungerede godt, hvilke udfordringer var der, var der noget overraskende, og hvad er du mest stolt af?

3

FÆLLES DISKUSSION

Del det, du er tryg ved, med gruppen. Det hjælper med at skabe en fælles forståelse og lære af hinanden.

13

Tak, fordi I har brugt toolkittet

Vi håber, at værktøjerne har givet jer lyst til at undersøge, teste og udvikle idéer sammen. Vær stolte af det, I har skabt, del jeres erfaringer med andre, og lad jer inspirere af hinandens perspektiver.

Afslut med at skrive en kort besked i boksen. Del gerne noget, I er stolte af, en læring, I vil tage med videre, eller en tanke, I håber, kan inspirere andre.

Vær stolt af det, I har skabt!

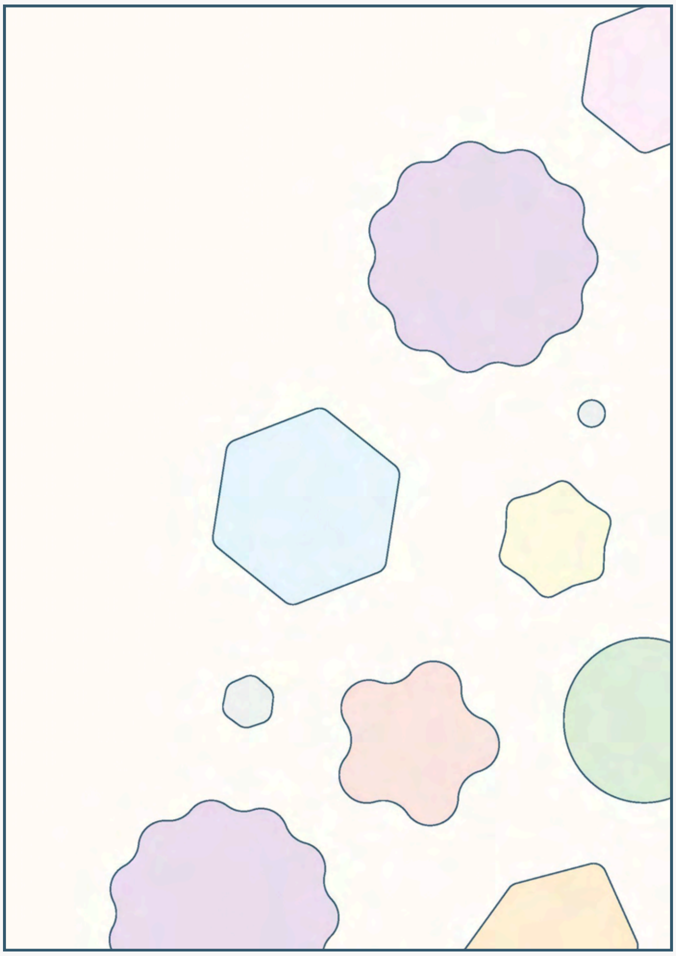
Fejr indsatsen og det, I har lært sammen.

Del idéen med andre

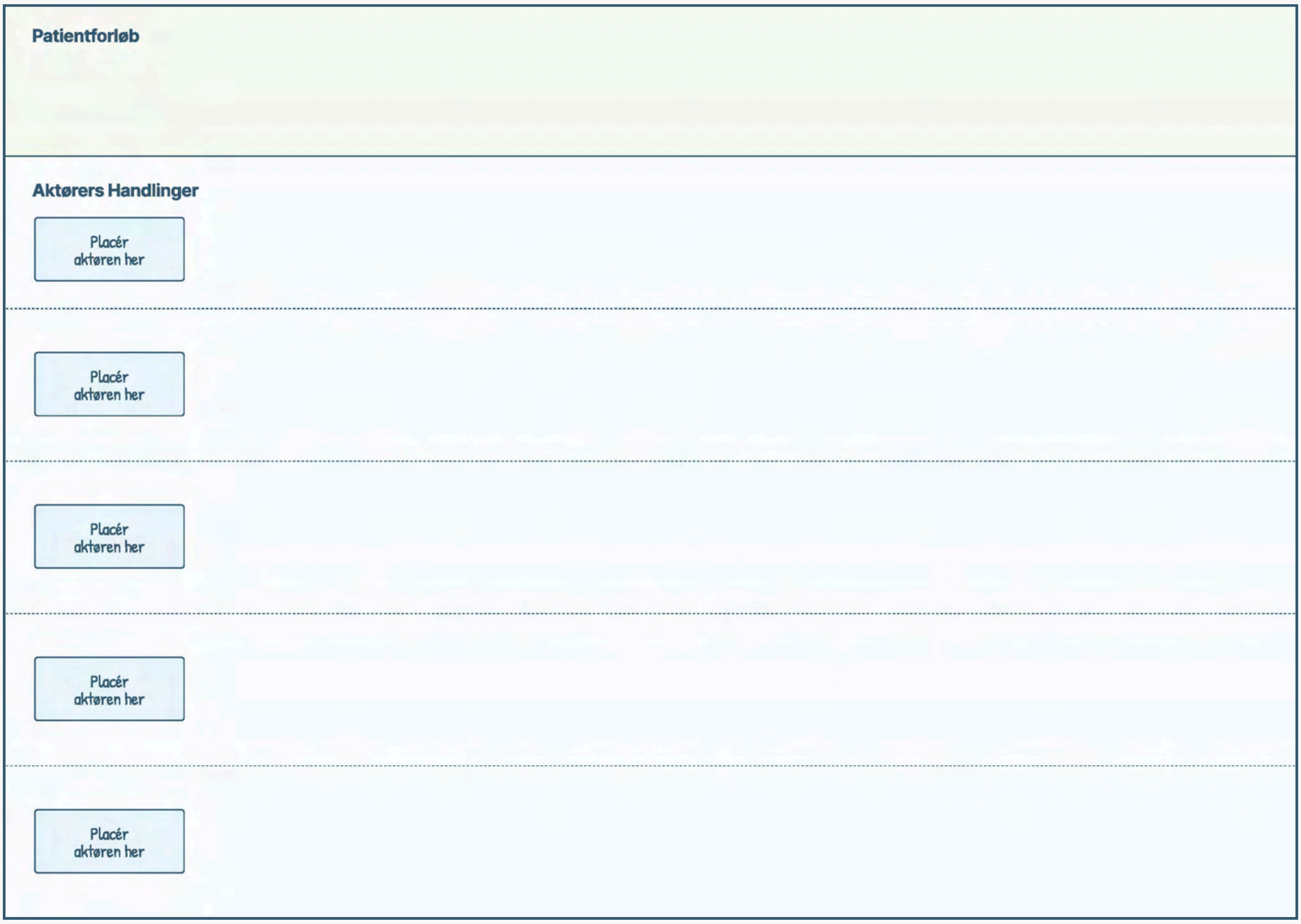
Vis den frem til kolleger, så flere får kendskab til den og kan bygge videre på den.

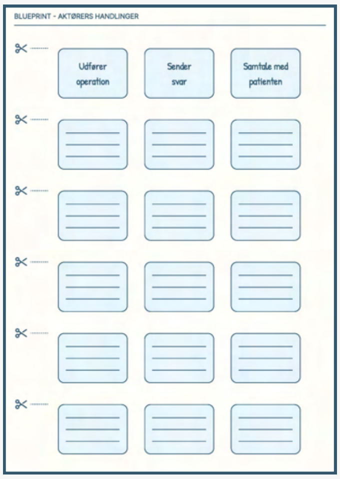
Inspirér andre til at prøve selv

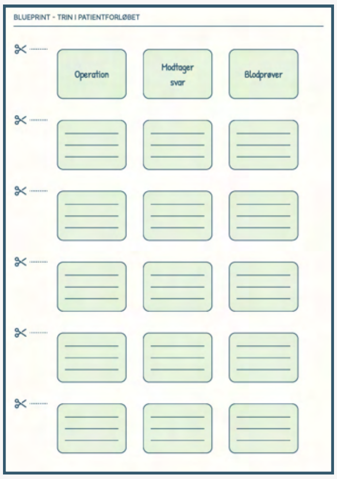
Lad jeres erfaringer blive startskuddet for nye idéer hos andre.

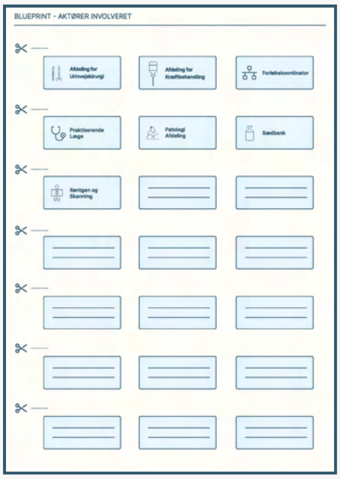


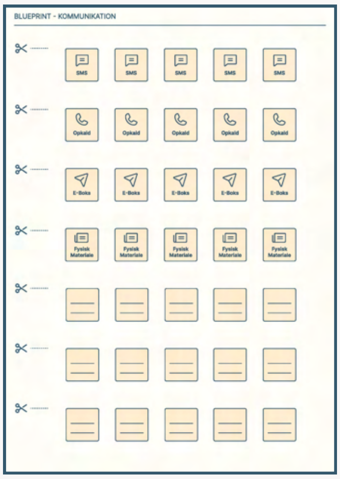
Appendix T: Toolkit: Blueprint



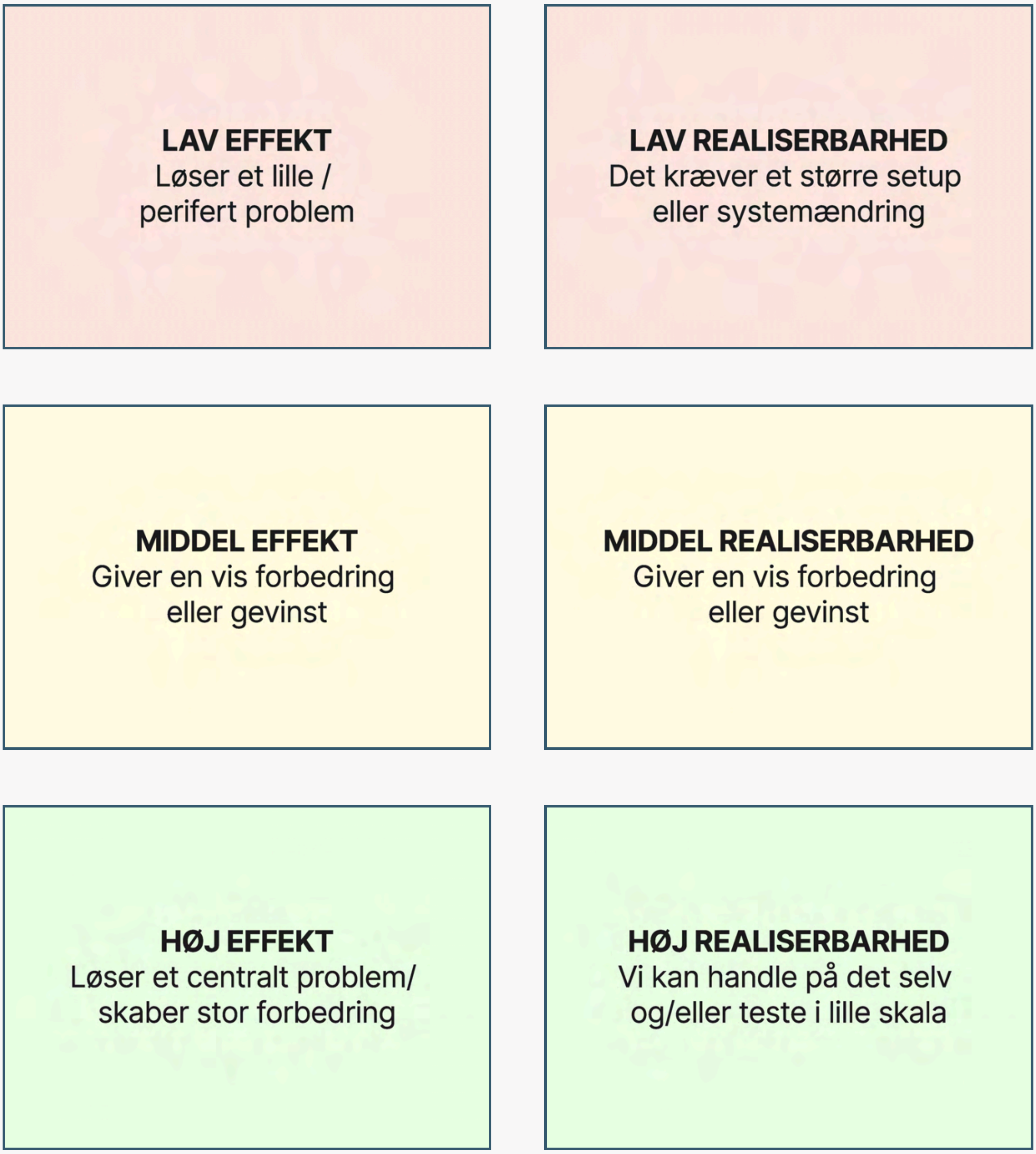






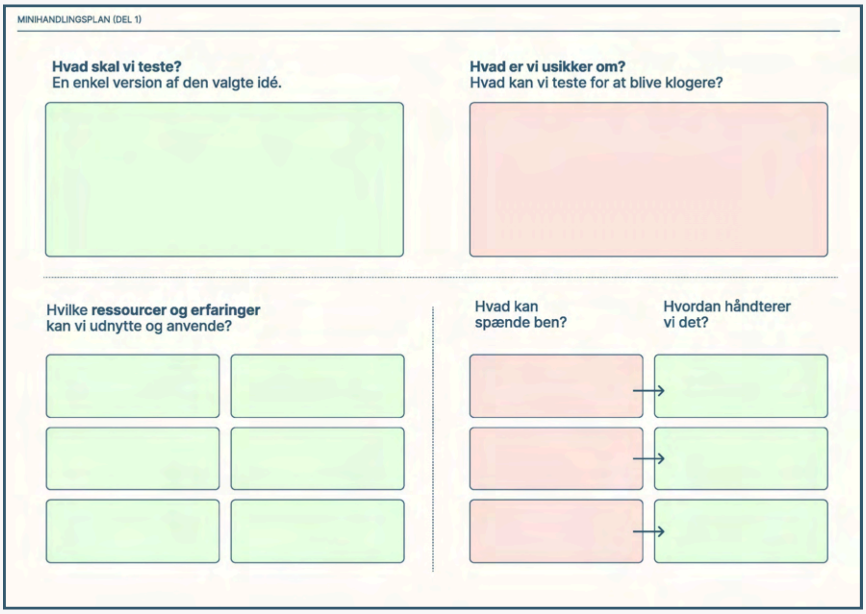


Appendix U: Toolkit: Evaluation Matrix



LAV EFFEKT Løser et lille / perifert problem	**LAV REALISERBARHED** Det kræver et større setup eller systemændring
MIDDEL EFFEKT Giver en vis forbedring eller gevinst	**MIDDEL REALISERBARHED** Giver en vis forbedring eller gevinst
HØJ EFFEKT Løser et centralt problem/ skaber stor forbedring	**HØJ REALISERBARHED** Vi kan handle på det selv og/eller teste i lille skala

Appendix V: Toolkit: Execution Plan



MINIHANDLINGSPLAN (DEL 1)

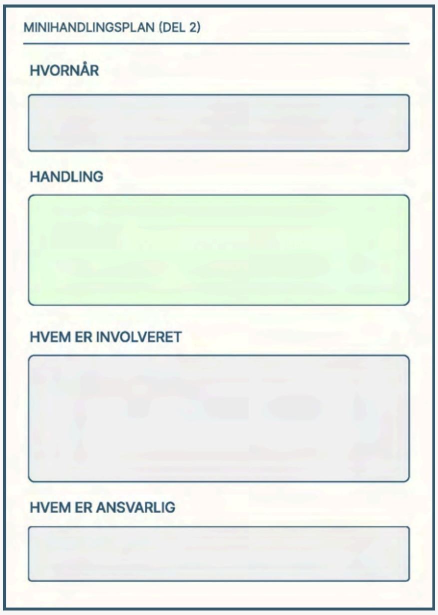
Hvad skal vi teste?
En enkel version af den valgte idé.

Hvad er vi usikker om?
Hvad kan vi teste for at blive klogere?

Hvilke **ressourcer og erfaringer** kan vi udnytte og anvende?

Hvad kan spænde ben?

Hvordan håndterer vi det?



MINIHANDLINGSPLAN (DEL 2)

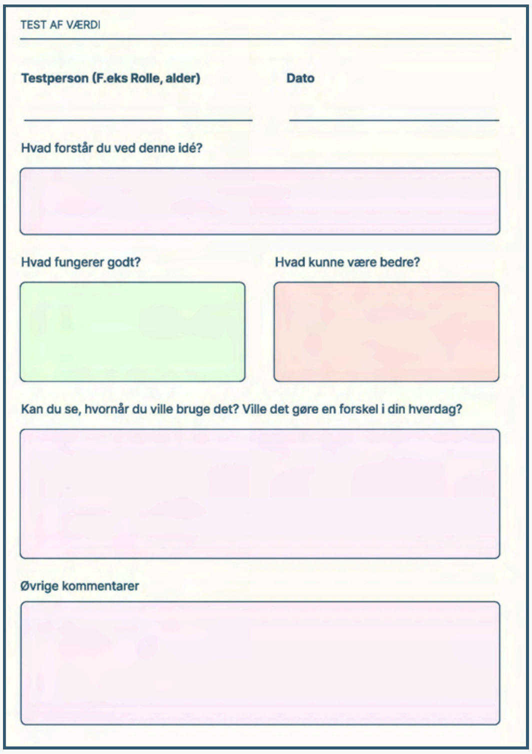
HVORNÅR

HANDLING

HVEM ER INVOLVERET

HVEM ER ANSVARLIG

Appendix W: Toolkit: Testing Sheets



TEST AF VÆRDI

Testperson (F.eks Rolle, alder)

Dato

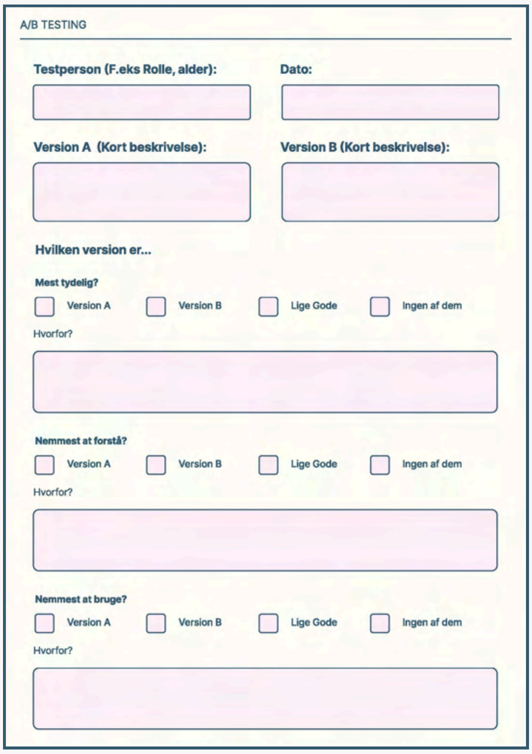
Hvad forstår du ved denne idé?

Hvad fungerer godt?

Hvad kunne være bedre?

Kan du se, hvornår du ville bruge det? Ville det gøre en forskel i din hverdag?

Øvrige kommentarer



A/B TESTING

Testperson (F.eks Rolle, alder):

Dato:

Version A (Kort beskrivelse):

Version B (Kort beskrivelse):

Hvilken version er...

Mest tydelig?

☐ Version A ☐ Version B ☐ Lige Gode ☐ Ingen af dem

Hvorfor?

Nemmest at forstå?

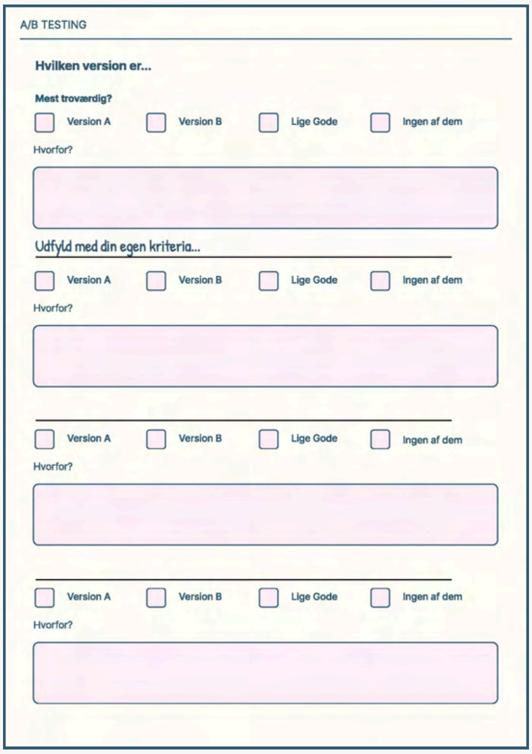
☐ Version A ☐ Version B ☐ Lige Gode ☐ Ingen af dem

Hvorfor?

Nemmest at bruge?

☐ Version A ☐ Version B ☐ Lige Gode ☐ Ingen af dem

Hvorfor?



A/B TESTING

Hvilken version er...

Mest troværdig?

☐ Version A ☐ Version B ☐ Lige Gode ☐ Ingen af dem

Hvorfor?

Udfyld med din egen kriteria...

☐ Version A ☐ Version B ☐ Lige Gode ☐ Ingen af dem

Hvorfor?

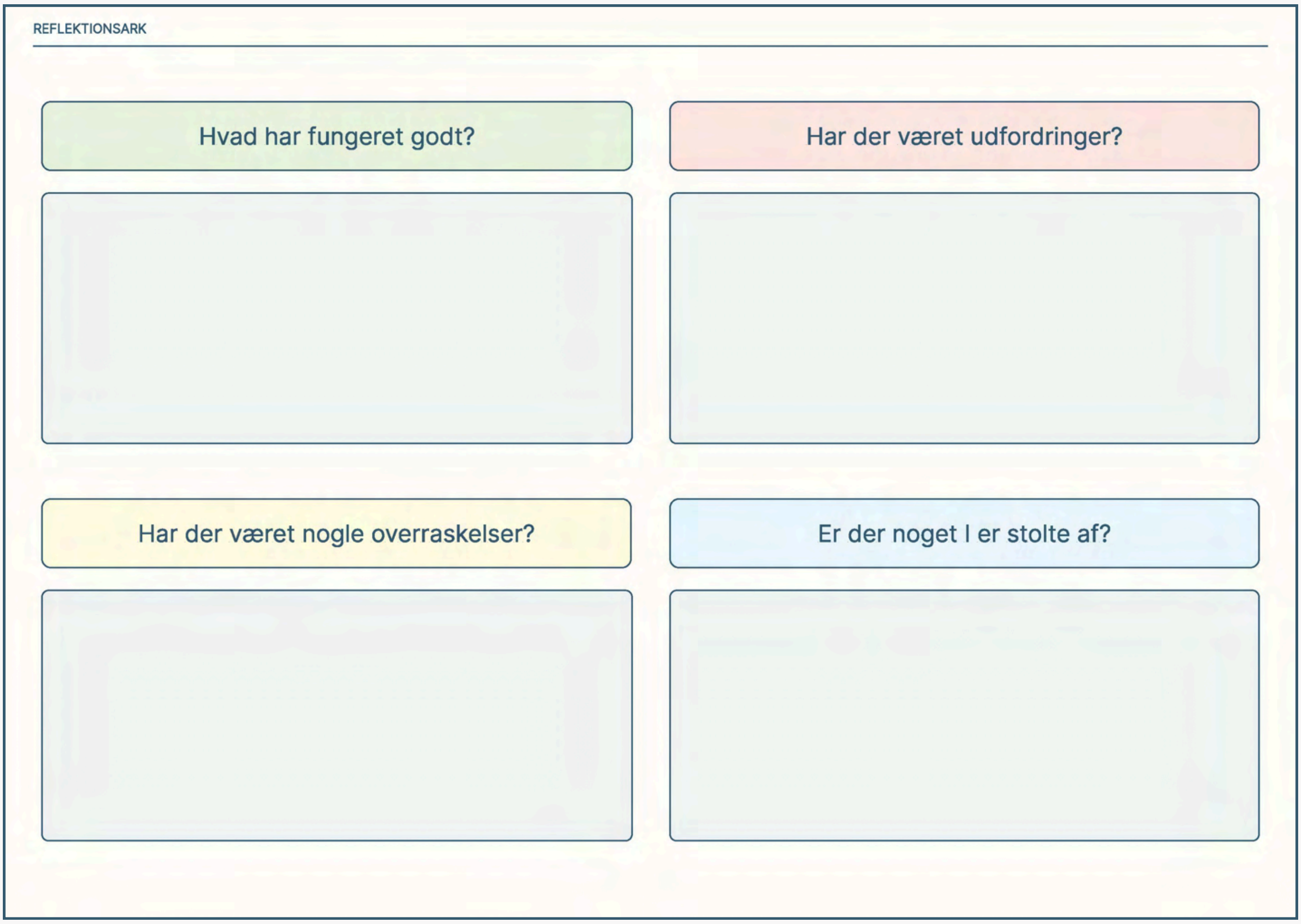
☐ Version A ☐ Version B ☐ Lige Gode ☐ Ingen af dem

Hvorfor?

☐ Version A ☐ Version B ☐ Lige Gode ☐ Ingen af dem

Hvorfor?

Appendix X: Toolkit: Reflection Sheets



REFLEKTIONSARK

Hvad har fungeret godt?

Har der været udfordringer?

Har der været nogle overraskelser?

Er der noget I er stolte af?