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# D6.1 - Transversal Capacity-Building Guideline Document

# Preparatory Guideline for Candidate Centres to EUnetCCC Certification

WP6 – Strengthening Capacities and Quality Improvement in EUCCC

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# Version history

| Version Number | Publication Date | Details of the changes |
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| 1.0 | 15/09/2025 | Initial version |
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# Project information

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# Abbreviations and acronyms

**CCC** – Comprehensive Cancer Centre
**CCC-N** – Comprehensive Cancer Centre Niedersachsen
**CEO** – Chief Executive Officer
**CLB** – Centre Léon Bérard
**EHR** – Electronic Health Record
**EU** – European Union
**EU4Health** – European Union for Health Programme
**EUnetCCC** – European Network for Comprehensive Cancer Centres
**FPO-IRCCS** – Fondazione del Piemonte per l'Oncologia – Istituto di Ricovero e Cura a Carattere Scientifico
**ICO l'Hospitalet** – Institut Català d'Oncologia
**ICO France** – Institut de Cancérologie de l'Ouest
**IGR** – Institut Gustave Roussy
**IPO** – Instituto Português de Oncologia do Porto
**ISO** – International Organization for Standardization
**IT** – Information Technology
**OECI** – Organisation of European Cancer Institutes
**OUS** – Oslo University Hospital
**RACCC-30** – Readiness Assessment Checklist for Candidate Comprehensive Cancer Centres (30 items)
**RSYD** – Region of Southern Denmark (Lillebaelt Hospital)
**SOP** – Standard Operating Procedure
**UCCH** – University Cancer Centre Hamburg
**VHIO** – Vall d'Hebron Institute of Oncology
**WP6** – Work Package

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# Summary notes

**Objectives of the deliverable**

The launch of a certification process requires the activation of specific processes and workforce capacities within the candidate centres. Experience with certification processes vary among institutions, as it does the internal development of IT and Quality Departments, both essential leverages to underpin the process of certification. However, the preparatory process of a CCC certification goes beyond technical elements and encompasses other issues such as how to rule the process or what is the role for institutional communication.

A *Preparatory Guideline* should lay the groundwork for the subsequent deployment of interventions explicitly aimed –through capacity-building- at meeting the EUnetCCC Standards. The objective of the deliverable is to identify and approach all the transversal concepts and preparatory practices that may make the certification a transformational process for the candidate institutions to EUnetCCC.

**Format**

PDF file

**Target audience**

- Joint Action participants
- Upcoming CCCs involved in organisational capacity building processes
- Candidate CCC to EUnetCCC certification
- Governance structure / secretariat of the future network

**Content of the deliverable**

What will the deliverable include (parts, themes, functionalities)?

The guideline will include the essential capacities and components needed to be prepared by candidate centres that may improve the process of EUnetCCC Standards' introduction. Main themes will be:

- Early preparatory priorities
- Ruling the certification process (type of leadership, structures)
- Drivers of the certification process (core team, network of professionals...)
- Document management and generation of data
- Key preparatory areas (governance, patients' involvement, MDTs...)

What will not be included in the deliverable?

The Guideline will include only WP6 information on 3-4 CB activities related to the start of the certification process (e.g., maturity model, readiness assessment checklist), but in a synthetic manner, clarifying the connection between the Preparatory Guideline and such resources. So, we will avoid providing substantial information on WP6 issues. The focus should be only the preparatory processes for certification.

# 1. Introduction

## 1.1. EUnetCCC

The European Network for Comprehensive Cancer Centres (EUnetCCC) is a Joint Action under the EU4Health Programme, established to strengthen the quality and sustainability of cancer care, research, and innovation in Europe. Its overarching aim is to reduce inequalities and support the creation of a coherent European landscape of Comprehensive Cancer Centres (CCCs). A central element of this work is the development of a European certification system for CCCs, which ensures that centres operate according to harmonised standards of excellence. Certification provides external validation, facilitates mutual recognition across Member States, and supports centres in their continuous improvement efforts, thereby contributing to the long-term goals of the Europe's Beating Cancer Plan.

## 1.2. Strengthening Capacities and Quality Improvement in EUCCC

Work Package 6 (WP6) ambitions to supporting candidate CCCs in their journey towards EUnetCCC certification by providing structured guidance, practical tools, and opportunities for peer-to-peer learning, while bridging the gap between capacity-bridging processes and impact on quality improvement. A portfolio of capacity-building activities is designed, tested, and delivered to strengthen organisational maturity and ensure alignment with European standards. In this way, certification is made structured, achievable, and meaningful - serving not only as external recognition of excellence but also as a long-term driver of improvement and innovation.

*"Building capacities, shaping tomorrow's excellence"*

The mission of WP6 is to support candidate CCCs in building the capacity required for certification, to translate standards into practice through tailored tools and mutual learning methods, and to facilitate connections between candidate CCCs and CCC Coordinators (expert, certified centres in WP6) to enable shared learning. At the same time, WP6 emphasises the importance of continuous quality improvement, ensuring that certification is not approached as a one-time exercise but as an ongoing process of strengthening excellence and resilience. It is worth stressing that a defining feature of CCC certification under EUnetCCC - compared with other schemes - is the use of capacity building activity.

## 1.3. Goal and framework of the *Preparatory Guideline for Candidate Centres to EUnetCCC Certification*

Maintaining high-quality standards across Europe is essential; however, flexibility is equally important. Not all processes must be identical in every context, but the outcomes should be consistently excellent. Regional differences can therefore be accommodated without compromising overall quality, and centre-specific needs are recognised, since a single approach does not fit all.

The *Preparatory Guideline* is intended as a practical and strategic resource for centres aspiring to achieve CCC certification. Their level of readiness is related to factors such as the previous culture of certification, the staff competences and overall strategy when facing the CCC certification. In this line, we outline the preparatory steps and key considerations, helping centres to anticipate requirements and align their structures and processes accordingly. The *Preparatory Guideline* presented should be used:

- As a complimentary resource to the formal documentation related to the Certification Pathway.
- Consulted as a handbook, to be consulted flexibly according to the specific needs of each centre

Remarkably, the **primary target of this guideline** are those institutions that proved, through the process of admission in place, that they met the required thresholds, both in terms of clinical and research capacities. Such a feasibility perspective is even more crucial when it comes to a consortium of institutions, particularly where admission thresholds are not met by a single institution; the preparatory process involves additional challenges in governance, inter-institutional coordination, sharing of responsibilities, and harmonisation of practices. The journey towards certification is therefore longer, more demanding, and requires greater anticipation of organisational challenges.

### Framework of the Guideline within the Capacity-Building activities' architecture

The *Preparatory Guideline* is connected to two other capacity-building resources. First, the 7-Domain Guideline (MS41) — reference document on how to implement the EUnetCCC Standards — will include a clear preparatory component: a **list of necessary clinical and healthcare infrastructures** needed to ensure an adequate deployment of the tackle the certification. Second, the peer-support of the EUnetCCC certification — through quality management experts — will use the Preparatory Guideline as a baseline document for candidate centres.

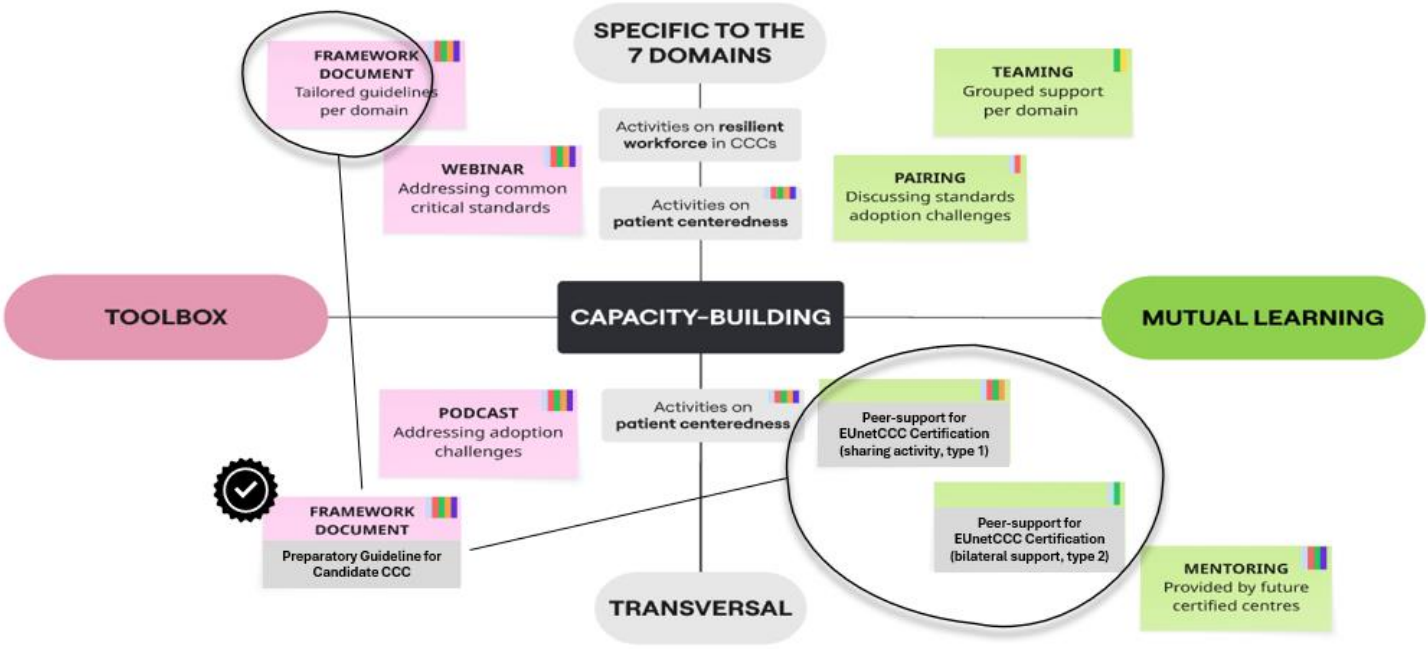


**Figure 1. The Preparatory Guideline within the architecture of the Capacity-Building activities.**

# 2. Methodology

## 2.1. Study design

This guideline has been developed based on interviews conducted (by JP and NA) between January 2025 and April 2025. The interviews were carried out with representatives from cancer centres across Europe that have undergone a CCC certification or re-certification process. A semi-structured interview format (see the script in Annex 1) was chosen to combine a common framework of questions with the flexibility to explore centre-specific experiences and perspectives in depth. The following two professional profiles were interviewed per centre: the leader of the certification (typically, a professional or a clinician with high credibility within the institution) and an expert in certification processes (e.g., quality manager). The sample included 26 interviewees from the following centres:

| | |
|---|---|
| Candiolo Cancer Institute (FPO-IRCCS) | University Cancer Centre Hamburg (UCCH) |
| Institut Gustave Roussy (IGR) | Lillebaelt Hospital RSYD |
| Institut Curie | Vall d'Hebrón Institute of Oncology (VHIO) |
| Institut de Cancérologie de l'Ouest (ICO France) | Instituto Português de Oncologia do Porto (IPO) |
| Centre Léon Bérard (CLB) | Oslo University Hospital (OUS) |
| Comprehensive Cancer Centre Niedersachsen (CCC-N) | West German Comprehensive Cancer Centre (WTZ) |
| Institut Català d'Oncologia (ICO l'Hospitalet) | |

Following the interviews, the material was systematically analysed through coding and thematic grouping (by JP, NA, LG and MI) to identify recurring challenges, successful strategies, and lessons learned. Insights were then synthesised and validated through internal discussions within the WP6 team, ensuring that the findings reflected both individual centre experiences and broader, cross-European patterns.

As a result, this guideline is based on first-hand and up-to-date experiences from centres across Europe. It illustrates which aspects of the certification process were perceived as most challenging and how these were addressed, highlights what worked well, and distils the key lessons that can support candidate centres in their own preparation. Anonymised verbatim of the interviewees are used across the document to better illustrate their views.

## 2.2. Structure of the Guideline

This preparatory guideline is organised to provide both strategic orientation and practical tools for candidate CCCs. The chapters follow the typical progression of the certification journey and can be read either sequentially or consulted individually, depending on a centre's needs.

Chapter 1 – **Introduction** - Presents EUnetCCC, the purpose of WP6, and the rationale for CCC certification.

Chapter 2 – **Methodology** - Explains how the qualitative insights generated through interviews were analysed and translated into practical recommendations.

Chapter 3 – **Purpose of CCC certification** - Explains the strategic drivers behind certification, showing how it strengthens institutional identity, fosters integration of care, research, and education, and enhances international visibility

Chapter 4 – **Steering the certification process** - Focuses on institutional support and governance, highlighting the role of leadership, communication, and quality and IT departments in enabling certification.

Chapter 5 – **Making the certification process operational** - Examines how certification is translated into practice. It highlights the role of certification leaders, the establishment of a dedicated core team, strategies for protecting clinicians, fostering collaboration, engaging services, and mobilising resources to ensure feasibility and sustainability.

Chapter 6 - **Data, documentation and processes** - Examines the organisational infrastructure required for certification, including systems for documentation, data collection, and indicator monitoring.

Chapter 7 – **Development practices and supportive tools** - Presents methodologies and instruments, such as the maturity model, readiness assessment checklist, and peer-support, that enable centres to adapt standards to their context and build capacity.

Chapter 8 – **Key preparatory areas** - Highlight the relevance of core areas that define what it means to be a Comprehensive Cancer Centre.

Chapter 9 – **Conclusion**

# 3. Purpose of CCC certification

Comprehensive Cancer Centre (CCC) certification is more than a technical requirement; it represents a strategic opportunity for institutions to strengthen their identity, visibility, and long-term capacity for excellence. In fact, all centres acknowledge the opportunity represented by the CCC certification and stressed purposes or views that should inspire the entire preparation process. They are as follows:

- ✓ Certification gives institutional recognition to the centre and provides reputation, prestige and identity to cancer care. This fact contributes to positioning the centre at the level of the health system once the challenge of certification is achieved. However, it is in the certification process that the engagement of internal stakeholders - including patients - takes place and the motivation of professionals increases based on fulfilling standards that represent the excellence. **It is the way towards the certification that leads to the foundation of the CCC, the creation of a mutual identity**.

- ✓ The idea of comprehensiveness goes beyond the idea of excellence in relation to specific services and interventions. The transformation towards a CCC implies formalising a model of care that integrates care, research and education, and that has continuous improvement as a principle. The certification recognises in some centres existing dynamics while in other becomes the way to gain momentum to improve care for patients. In any case, **the idea of comprehensiveness should be locally defined, understood and communicated at all levels**.

- ✓ Certification is a necessary condition for a real CCC to speak with its own voice at international level. **External validation of the excellence and quality of the institution is a key step to signal CCC's leadership at regional and/or national level** and for the centre to gain visibility and become itself a relevant stakeholder. In this vein, improving access to research networks and studies was mentioned iteratively.

- ✓ Healthcare services and research opportunities tend to expand but internal resources are limited. A CCC-like certification may **optimise resources' use while improving quality in a combined strategy** when all clinical care is framed by both multidisciplinary teams and the systematic use of care processes per cancer disease.

- ✓ In particular, **EUnetCCC** involves both the establishment of high-quality standards for cancer care across Europe and activities among the community of CCCs. This prevents the perception of the certification process as a narrow path, burdened with internal efforts, only. A dynamic environment, provided with many opportunities for collaboration and practices' sharing with other centres, **makes of certification a multi-level learning process that starts with the preparatory process**.

The purposes behind CCC certification highlight why centres choose to embark on this demanding journey and what strategic value certification brings at institutional, national, and European levels. However, translating these purposes into reality requires a strong organisational foundation. Aspirations alone cannot sustain the

process; they must be anchored in clear governance, visible institutional support, and effective communication structures.

For this reason, the next chapter focuses on institutional support, legitimation, and communication of the certification process. It addresses how centres can establish governance arrangements - particularly the role of the Cancer Centre Board - that provide legitimacy, coordination, and continuity throughout the certification journey.

# 4. Steering the certification process

Certification is not achieved through compliance with technical standards alone; it requires strong institutional commitment, effective governance, and transparent communication. This chapter outlines key institutional mechanisms that underpin certification such as well-functioning governance structures or embedding certification in strategic planning. It also highlights the role of communication as a strategic driver of engagement, enabling certification to become not just a technical exercise but an organisation-wide transformation.

## 4.1. Cancer Centre Board: effective governance from the outset

It is a main and common priority that the Cancer Centre Board, the central governance structure of a CCC, to be arranged before launching the certification process. In practice, this means that the EUnetCCC Standards on *Governance* should be seen as a prerequisite rather than as regular standards. At the outset, the Cancer Centre Board incarnates both the governance of cancer and the epicentre of the planning strategy to succeed with the certification process. Such *institutionalisation* implies that the roles and scope of the constituents of the CCC are clarified, which is even more critical in case of consortia. The formal expression of such step is a proper organigram, a chart with different layers that is both representative and operational.

> *"Don't you ever dare to start the certification without CEO and heads of service's strong commitment: it's doomed to failure."*
>
> *"It takes a long time to build up internal structures to a level that allows you to go into the certification process."*
>
> *"The decision to pursue the CCC certification was taken at the highest institutional level, reinforcing its strategic importance and ensuring access to senior leadership support."*

Effective institutional support forms the foundation of a successful CCC certification journey. When the process is launched through a clear top-down mandate, typically driven by the executive board or CEO, it tends to achieve stronger alignment with institutional priorities and greater mobilisation of internal commitment. Strategic endorsement alone, however, is not sufficient. Progress depends equally on operational leadership, with designated individuals actively coordinating certification activities, fostering communication, and sustaining momentum across the organisation.

The **competences and the specific role of the Cancer Centre Board** should be defined — at least at the beginning — in accordance with the governance culture and structure of the centre. For instance, with flat structures (i.e., lack of marked hierarchies), it is not expected that the Board is having a strong authority as a body. In that case, the fact that the directors and heads of services belong to the board *ex officio*, constitutes a power in itself. Two interactions from the board are of special importance regarding the certification process:

- ✓ The Core team leading the certification process (see 5.2) is "working for and with" the Cancer Centre Board and should be effectively supported and legitimated.
- ✓ The Quality Department tends to assume a strategic position in this process, particularly when its leadership is visible at the institutional level or integrated within executive structures. In such cases, quality leads act as intermediaries between governance and implementation, promoting coherence and accountability across departments.

> *"Executive leadership was closely involved throughout the process, ensuring visibility, legitimacy and alignment with broader institutional priorities."*
>
> *"All these people are division heads or department heads, and when they are deciding together, they have the authority in place; they were the ones that were the front face of this certification process."*

**Recommendation 1:** A strong governance structure means a clear institutional support of the top-managers, a supportive structure gathering all directors involved and an effective distribution of leadership across tumour-specific leads or thematic coordinators. This decentralised model reinforces local ownership while maintaining a shared institutional framework.

## 4.2. The CCC certification within centre's healthcare strategy

Quite a few centres obtained the CCC certification without creating real adherence among its departments and institutions. "Permanent struggles" were described, for instance, to deliver the information requested through the certification framework. Centres with extensive experience pointed to the huge lost opportunity that this represents, meaning that the certification process may be used to build a strong sense of ownership and impact on the identity of cancer care area as a whole.

In this vein, it is highly recommended to frame the certification within the strategic planning of the centre/s. Certification can be used as a goal in itself in order to create a new forward momentum, but many centres emphasise the need to **embed it in the centre's strategic plan in a way to facilitate the intense cross-cutting dynamics required by the CCC certification**. For example, one centre organised the hospital by 'knowledge areas' such as 'cancer', that is, going beyond the logic of departments, which had global and very concrete implications such as limiting the rotation of nurses within that area to promote their specialisation. Also, several centres associated the CCC certification with the "campus" concept to strengthen the relationship between the research institute, the university and the hospital through the new governance setting, the Cancer Centre Board.

Overall, it is critical to avoid the impression that certification is an objective that belongs to a particular speciality. According to the interviews conducted, resistance and indifference among professionals to change can be significant and is often due to the absence of a clear meaning of certification among the services and

professionals involved, a fact that is exacerbated when the candidate centre is a university hospital and not a cancer institute.

> *"There was some initial resistance or disengagement from some departments unfamiliar with the CCC model."*
>
> *"Departmental resistance emerged when asked to comply with CCC standards without additional support."*

**Recommendation 2:** Framing the certification within the centre's overall strategy facilitates the adoption and understanding of changes, with particular emphasis to the challenge of developing matrix structures and cross-service collaboration, typical of CCCs dynamics.

## 4.3. Governance structure supporting the certification

There are complex demands associated with the CCC Certification, and a supporting governance structure is needed to facilitate them. The Cancer Centre Board, which includes the main decision-makers of the CCC — typically, heads of department and of the cancer registry — tends to have a few members while the number of professionals and services required to implement the standards implies wider support. Creating supporting a governance structure is essential to align and assign the responsibilities to each department.

In this vein, **aspiring CCCs should make decisions on whether to build new structures from the scratch or use existing institutional bodies** (e.g., oncology boards, cancer commissions, or executive quality committees) that will be repurposed or extended to incorporate certification oversight. For example, in one centre where operated the so-called Professional Council (with representatives of the different professional groups), pathway leaders were incorporated due to the certification; instead, a CCC Research Board (under the umbrella of the Cancer Centre Board) was created to improve the research area and its connection to care.

The pre-existing structures tend to have established procedures for decision-making and cross-departmental coordination, which are valuable assets when navigating the above-referred complex demands. In centres where such structures are well-developed and widely recognised, they have served as anchors for the certification process, providing visibility and institutional coherence, reduce duplication and helping to embed the certification within the centre's strategic and operational routines. **However, this pragmatic approach may act as barrier for the whole governance area, subject to important transformations due to the certification process**. Thus, the experiences of mature CCCs indicate four guiding principles:

1. Introducing parallel structures without clear added value risks creating confusion, fragmentation, or resistance among staff.

2. Certification governance should evolve as an adaptive layer, sometimes strengthening the existing institutional architecture and sometimes bypassing it through new approaches.

3. The governance structures should be clarified early, during the preparatory process. A main reason is the need to support the Core Team managing the certification process. They might need scientific advice, technical guidance (e.g., understanding the meaning of a Standard), specific data or support in co-developing cross-department responses, **as some standards' implementation may need strong cooperation from several departments**.

4. Any proposal to be organised (as a governance structure) should allow the certification to be effectively embedded into day-to-day operations and overall development.

> *"We organised the board of directors [head of services] that meet every two or three months. Because if you have to change something in radiology, you have to talk with the director of the radiology department and you have to present this in front of all others in order to have this pressure to be accepted.* ***'You can't go and just knock the door and say, 'you have to change your waiting time list'****. That will never work".*
>
> *"The committee is an instrumental body that enables organisation was instrumental allowing fast decision-making."*
>
> *"For consortia or multiple-provider systems, a dedicated accreditation steering committee is essential."*

In practical terms, the governance structure (besides the Cancer Centre Board) has taken many forms: a "steering committee", a "board of directors", a "network of professionals and services", etc. Mature CCCs showed different institutional proposals and levels of involvement (e.g., with heads of services, with or without intermediate management positions) to ensure that all clinical departments and institutions became a single layer supporting the certification process. Clearly, not all directors and head of services gave the same priority to the certification demands. Nonetheless, while diverging interests should be expected, searching for their commitment with active communication (see sub-section 4.4), regular meetings, and, furthermore, a general endorsement — ensuring that they are "on board"—, is critical to accelerate the task of the Core team and improve their motivation as well as the overall understanding of the process.

> *"Sometimes they* [heads of non-oncological services] *don't care. They want to be accredited, certified and so on, but they have their own objectives. So, you have to put them on the board. You need to be endorsed".*
>
> *"In the context of a certification process,* ***clinicians*** *tend to speak also about clinical care and research. But if they are involved in discussions about governance and quality,* ***they start having a contextual vision and this is so relevant****, otherwise the view in only service-dependant."*

**Recommendation 3:** Candidate CCCs should not be afraid to experiment in the area of governance. The development of matrix structures, tumour-based leadership and dynamics that put an end to traditional hospital silos (e.g., services, units or centres in the case of consortia) involves obvious changes that must be adopted progressively.

### Role of health authorities

Health authorities can play a decisive role in driving and supporting CCC certification. When certification is embedded in the national strategy for research and cancer care, it functions as a strong governance tool. In one case, the health authorities also conduct (through a Commission) regular evaluations and audits in centres. This increases accountability and fosters a culture where quality standards become a clear priority for the whole healthcare system.

> *"Our Institute is monitored by Ministry of Health, with the Commission that comes, and see if there is any discrepancy between what we have declared and what they have, what they find."*

> *"The National Cancer Strategy included in its main priorities to establish CCCs covering the whole [country's name]."*

Certification can also be closely linked to institutional incentives such as a legal linkage of certification status to reimbursement for certain oncology treatments. Such mechanisms not only create motivation to obtain the certification but also anchor it at both the institutional and clinical level. Experience shows that when certification is perceived as a shared objective across the entire organisation – from leadership to clinical teams – both ownership and implementation capacity are strengthened.

Over time, a strong certification culture may help shift the focus from competition between centres towards knowledge-sharing and collaboration, thereby creating new opportunities for cross-learning and strengthen the CCC community.

**Recommendation 4:** Certification should be anchored in health system's frameworks, if feasible, in order to create ownership, legitimacy, and sustainability in the certification process.

## 4.4. Institutional communication

Commitment and motivation are key attributes of any successful preparation process. A CCC-type certification is a long process, and **preparation alone involves 5 to 7 months of work** according to most of the experiences analysed. In addition to building internal structures at a level that allows entering the certification process, change management and institutional communication should be used to influence the change of mindset among managers and healthcare professionals. **Institutional communication (both external and internal)**

**must be conceived as a strategy in itself**, as a consistent effort to align the certification-related activity with the institutional objectives and expectations pursued. Several reasons explain such importance:

- ✓ *Engagement of healthcare professionals*: It is the clinical community that must internalise the work by processes, the use of indicators and monitoring, the formalisation of multidisciplinary teamworking or the structuring of pathways to promote continuity of care, sometimes at a regional level —that is, spanning many types of organisational and cultural barriers. The added value of the certification process should be constantly expressed and enriched by professionals' views.

- ✓ *Fighting inertia and indifference among professionals*: The **inertia and indifference** towards change that often characterises many clinical services may prove to be a problem, as CCC certification is not a process that can be stopped but is characterised precisely by its dynamic dimension and continuous improvement. Throughout the time required for effective certification, there are many barriers difficult to overcome such as problems related to the difficulty of generating data or to multidisciplinary care. Professionals' understanding that this is a transformative process, and not a sum of tasks, is essential.

- ✓ *Rasing awareness about the CCCs' role in health systems:* CCCs represent the oncologic excellence, which requires explaining and making information on how they work available to all community stakeholders, starting with the patient organisations. Disclosure and transparency should be part of the preparatory process.

- ✓ *Stressing values and purposes, and not just operational challenges*: Manager and healthcare professionals should understand and stand up for the ultimate purpose of certification, the reason why it is decided to commit to a certification process leveraged on more than 300 standards, many of which produce effects in terms of comprehensiveness once they have been applied, and not before.

- ✓ *Creating shared overview and alignment of expectations:* Effective institutional communication ensures that all actors in the organisation know where they are in the certification process, what the next step is, and when they can expect to be involved, motivating to contribute at the right time and place. Clear communication also makes it possible to address potential delays or changes in the timeline in a constructive way. In this way, communication becomes a **tool for both maintaining momentum and sustaining trust among the professional** groups involved.

> *"We have to generate engagement at the beginning, and as part of it we had to train how to tell the sort of CCC Certification and how this could impact professional's ability to deliver the best care of patients".*

## Communication as a strategic driver

Communication is a decisive element in the certification process, both strategically and operationally. A well-structured communication creates transparency, and predictability helping to maintain engagement across all professional groups – not only leaders, but also key members of MDTs, nurses, and other clinical teams.

**Communication, however, must go beyond simple information-sharing**. It should actively convey why certification matters, what its purpose is, and how the standards contribute to improving quality, efficiency, and continuity of cancer care. When communication frames certification as part of a broader, patient-centred narrative and aligns it with the organisation's overall strategy, ownership and motivation are strengthened.

Experience shows that a lack of communication can lead to limited understanding of the certification's purpose, particularly in multidisciplinary or poly specialised environments where oncology is only one of many priorities. Explaining the significance of certification – both internally and at regional level – is essential to avoid the perception of certification as an isolated project without clear added value.

An important aspect is that communication should not only address operational challenges but also **support reflection on values and long-term goals**. When clinicians and researchers are engaged in dialogue about governance, quality systems, and decision-making processes, they develop a broader perspective that extends beyond their individual disciplines. This supports the cultural shift towards a shared CCC identity.

In this regard, it is also important to recognise that **staff may have different levels of knowledge and skills of English language, and that this may become a barrier**. Since the certification relies heavily on English terminology, documents, and interactions, ensuring a shared understanding across the organisation is crucial. This may involve clarifying key terms, providing translations or explanations where needed, and creating opportunities for staff to familiarise themselves with the language of the process — for instance, through mock audits —. In doing so, communication becomes not only a channel for information, but also a means of levelling the ground so that everyone can engage equally and meaningfully in the certification journey.

**Recommendation 5:** Communication should be treated as a strategic core task in the certification process. It must be continuous, transparent, and inclusive, with clear messages about purpose and values combined with practical orientation about the next steps. Such an approach strengthens ownership, creates shared direction, and supports both quality and cohesion within the organisation.

**Recommendation 6:** It is important to assess the level of English of the staff involved in certification. Limited use should lead to specific actions insofar as the language of the standards, the process and contact with operators is in English.

Chapter 4 underlined that successful CCC certification depends on institutional commitment, strong governance, and effective communication. Certified centres consistently emphasised the importance of establishing a Cancer Centre Board at the outset, embedding certification within strategic planning, and distributing responsibilities through supportive governance structures.

Building on these foundations, Chapter 5 turns to the operational dimension of certification. It examines how the process is made functional in practice, focusing on the role of certification leaders, the formation of dedicated core teams, the mobilisation of resources, and the creation of synergies across services. This chapter emphasises the importance of translating institutional commitment into concrete actions that keep the certification process dynamic, credible, and centred on quality improvement.

# 5. Making the certification process operational

This chapter explores the practical dimension of certification, focusing on the **roles, teams, and resources that bring the process to life**. It examines the profile and authority of the certification leader, the establishment and legitimisation of the core team, and the ways in which clinical professionals, support staff, and departments can be mobilised without overburdening them. Furthermore, it highlights the contributions of Quality and IT departments as technical enablers and stresses the importance of deliberate resource allocation to ensure sustainability. The insights presented show that making certification operational is above all about balance: combining leadership with inclusiveness, technical rigour with flexibility, and strategic priorities with practical execution.

## 5.1. Leader of the certification: profile and attributes

The need to institutionally support the Core Team or Secretariat – the task force that should lead the certification process – has been largely justified. At this point, it is worth highlighting the need for a highly committed key role linking the different levels of action: the project leader. Needless to say, the mature CCCs analysed showed different leadership and embedment types, but they all highlight one key aspect: the selection of the **leader** must be made on the basis of **avoiding the certification to turn into a mere administrative process**. Thus, the certification leader may hold different positions within the cancer centre: he or she may be the director of the quality department, the director of research or someone appointed *ex professo* as project leader, but in any case, he or she must be able to connect the need to introduce changes (e.g., pathways' development) with patient priorities and quality improvement.

> *"Don't lose sight of the focal point in the midst of the heavy administration: patients."*

In some cases, the designated leader does not possess all the technical skills required for the certification (typically around quality department) and relies on another professional who is fluent in the language of standards and has direct experience in certification processes. This partnership has worked perfectly in various situations. It is worth noting the importance of the context in the selection of a proper leader: being a cancer centre or a university hospital, being a single centre or a consortium, whether the quality department is under medical management or directly under the CEO, are all different scenarios. Internal alignment efforts may vary accordingly.

Also, in relation to the profile, it is worth mentioning the importance of his or her knowledge of the cancer field and the proximity to healthcare professionals. It is not uncommon for the certification leader to be a clinical leader within the institution, either directly leading the project or leveraging the decisions to be taken. In fact, clinicians who had prior experience in research or institutional governance were often able to bridge the

technical requirements of the certification with the professional culture of care and research. Their involvement not only lent credibility to the process but also facilitated peer engagement, the adoption of multidisciplinary practices, and the integration of new standards into clinical workflows.

Beyond the profile, a key attribute is **internal authority**. The leader must be recognised and legitimised in their role. When, on the other hand, he or she must constantly "ask for favours" or make excessive efforts to communicate why they are relevant, certification becomes a slow and costly process. Instead, it is optimal for the leader and the Core Team to be able to present themselves even at service meetings or educational events — not specific to certification — and explain the project and the opportunities behind it, in addition to requesting specific data or changes. This type of 'internal authority' is necessary considering the cross-cutting dynamics that certification aspires to and, relatedly, the challenge of changing the mindset of professionals towards a centre model that aspires to be comprehensive.

> *"Certification cannot succeed without respected, credible leadership. Particularly in the initial phases. You need someone with strong clinical or scientific recognition; someone others trust to represent the cancer centre and its strategic direction."*

> *"We have to change the mindset because if you don't change the mindset, then the directors will not understand what we are asking them, what we are telling them."*

Along the same vein, it is important for the certification **leader to have a connection with the CEO or Executive Board of the aspiring centre** while the Cancer Centre Board gains institutional weight and maturity. In practical terms, it is not just a matter of obtaining a generic endorsement, but of being able to maintain a direct dialogue with senior institutional figures and, vice versa, of routinely reporting back to them on progress. One practice that, in retrospect, was considered positive was for the CEO to send an email to the entire organisation informing them of the initiative and the specific people who would be leading the changes.

> *"Communication with the executive board was formalised through reporting mechanisms, keeping top management informed and engaged."*

## 5.2. A dedicated task force: the Core team

The establishment of a dedicated core team is a critical enabler of progress. Its effectiveness depends not only on internal expertise but also on how it is positioned within the organisational structure. Certain factors consistently influence performance: sustained executive backing, the ability to protect clinical teams from excessive operational burden and accountability of the team during the process. These conditions ensure that certification efforts remain feasible and meaningful across all levels of the institution.

To fulfil its role effectively, **the Core Team must be highly visible across the organisation** and actively engaged in day-to-day interactions. This often means "constantly moving around the organisation," attending meetings, presenting project requirements, and requesting specific data. Typically, the Core Team prepare tailored presentations to clarify the type of information needed, thereby establishing a dynamic of ongoing dialogue and building relationships with services. However, this work is far more challenging if the Core Team is not formally acknowledged and legitimised within the institutional structure.

> [The Core Team:] *"It was composed of four main stakeholders: the quality department, the Quality Department director, me (Scientific director) and an external consultant expert on ISO standards."*
>
> *"The process of assigning responsibilities with the process of launch the certification is essential."*
>
> [Consortium CCC context:] *"A core certification team was created and embedded within the institutional structure, coordinated by the Quality Department with support from clinical and administrative staff. This team operated with a clear mandate and internal authority, coordinating timelines, documentation, and the adaptation of standards to the local context.*

A central element is therefore the definition of clear operational profiles, including project managers, who can coordinate activities, ensure progress, and support communication between governance, clinical leaders, and care teams. Without this operational capacity, the certification process risks becoming fragmented and even more resource intensive. A step-by-step approach is shown to the effective development of the Core team:

**Step-by- step approach to setup the Core Team**

A well-functioning core team is the operational engine of the CCC certification process. It translates strategic objectives into coordinated actions, maintains institutional alignment, and ensures that certification activities are both feasible and sustainable. While each centre adapts its setup to local realities, several key steps consistently emerge across certified institutions:

**1. Secure executive endorsement and a clear mandate**

Before defining the composition of the team, it is essential to obtain formal backing from the executive board or senior leadership. This ensures that the team operates with legitimacy, access to resources, and strategic alignment from the outset. In some cases, the creation of the team is formally endorsed through an internal resolution or executive announcement.

**2. Define the team's role and scope**

The core team's primary function is to coordinate certification efforts across the institution. Its responsibilities typically include:

1. Interpreting and adapting certification standards
2. Coordinating documentation and evidence collection
3. Planning and monitoring timelines
4. Supporting departments in pathway development and indicator reporting
5. Organising internal audits and readiness assessments

Internal core team meetings should take place every 1-2 weeks

The team should also act as the interface between departments and the executive level, communicating progress and escalating structural challenges. Map out the different professional groups is essential to roll-out its activity.

**3. Keep the team compact and agile**

Experience suggests that smaller teams, typically composed of 2 to 5 dedicated individuals, are more agile and better able to maintain coherence and pace. Oversized teams may dilute responsibility and hinder decision-making. When needed, the core team can be supported by working groups, reference professionals, or tumour-site coordinators.

**4. Ensure strategic composition**

While composition varies, the following profiles are consistently included:

- ✓ **Certification Lead** (often from the Quality Department or a senior clinical role)
- ✓ **Project Coordinator** with experience in cross-departmental collaboration, planning and communication
- ✓ **Data or Quality Manager** responsible for indicator tracking, documentation and IT alignment
- ✓ **Clinical Liaison** to bridge technical implementation and professional practice

Where possible, team members should hold institutional credibility, command cross-departmental respect, and have access to key decision-makers.

**5. Establish reporting and governance mechanisms**

To maintain alignment, the core team should be embedded within the institution's governance structure. This may involve:

- Regular reporting to an executive committee or steering group
- Participation in multidisciplinary boards or tumour-site meetings
- Integration within existing quality or cancer-specific commissions
- Assigning permanent accountability for progress to dedicated coordinators o teams, supported by structured internal communication channels

Clear governance mechanisms help avoid overlaps, clarify accountability, and ensure certification does not operate as a parallel project. Permanent accountability further enables reliable progress tracking, early detection of challenges and coordinated responses, securing advancement throughout the certification journey.

## Connection with top management

While many centres initiate the certification process through a strategic decision by top management, sustaining executive engagement over time emerges as equally critical. Continuous support from the executive board or hospital leadership reinforces the institutional relevance of the process and helps ensure that certification remains a shared organisational priority rather than a siloed initiative.

Centres that have maintained this connection often implement structured mechanisms such as **regular updates to leadership, formal progress reports** circulated through executive channels, or the integration of **certification oversight into existing governance committees**. Where the Quality Department holds a formal link to executive governance, this connection tends to facilitate real-time alignment, strategic problem-solving, and the prioritisation of emerging needs. The visibility and legitimacy afforded by these governance channels support **broader departmental mobilisation** and enable timely resource allocation when challenges arise. In this sense, sustained leadership engagement acts not only as an initial enabler but as a continuous stabilising force throughout the certification process.

## Risk of overburdening clinical staff

Across centres, there is a consistent recognition of the need to protect clinicians from becoming overextended. The certification process introduces additional layers of documentation, coordination, and quality monitoring that, if poorly managed, risk generating **fatigue or disengagement** among staff already facing high clinical demands. To mitigate this, many institutions have concentrated the administrative and procedural workload within dedicated support teams, often coordinated by the Quality Department or a designated project unit. This organisational setup enables clinical professionals to contribute substantively, through pathway redesign, indicator validation, or peer review, without taking on excessive operational responsibilities.

Clear, contextual communication also plays a key role. Professionals tend to engage more actively when they understand how certification contributes to improving patient care or strengthening the institution. Conversely, when engagement is poorly timed or insufficiently framed, responses are often limited to passive compliance. Effective centres strike a balance: they value clinical expertise while deliberately shielding clinicians from the more burdensome aspects of implementation.

**Recommendation 7:** Clinicians should be protected from excessive administrative workload by assigning certification tasks to dedicated support teams, while ensuring that clinical staff remain meaningfully engaged - since they tend to participate more actively when they understand how certification contributes to improving patient care and institutional quality.

## 5.3. Define the synergy for certification: engaging professionals and services

Effective collaboration across departments, and in some cases, across geographically separate sites, is a fundamental requirement for navigating the complexity of the CCC certification process. Certified centres approached this challenge in different ways depending on their organisational structure.

The certification journey is not only a technical exercise but also a cultural one. In many institutions, the **notion of "comprehensiveness" is interpreted in a very narrow sense**, often limited to the multidisciplinary team or tumour group in which professionals are directly involved. For instance, a breast cancer unit may operate seamlessly across multiple organisational entities, with leaders engaged at several institutional levels, yet the broader CCC framework remains less tangible to those outside the immediate team. A key preparatory step, therefore, is to build a **shared understanding of what a Comprehensive Cancer Centre entails across the whole institution**, clarifying that certification is about more than strengthening individual pathways; it is about weaving them into an integrated and system-wide vision.

> *"Do not expect the whole organisation to be ready for the accreditation process."*

In single-site organisations, collaboration was fostered through internal networks of professionals or "reference group" spanning departments and roles. Such contacts were typically supported by regular coordination meetings, shared planning tools, and cross-cutting communication mechanisms. In practice, successful networking obeys a **dual logic**: on the one hand, ensuring that each service is represented and engaged in the process, and on the other, distribute the efforts to effectively foresee Standards' implementation. Relevantly, **the certification process can also act as a corrective to an environment marked by significant disease-based management differences** and insufficient coordination. Developing a vision of the EUnetCCC certification framework within the strategic planning is key and, according to the cases analysed, this can take place through a participatory process involving the definition of strategic lines and future objectives in a complementary way to the demands and opportunities that EUnetCCC certification incorporates.

Institutional culture and governance models further shape how collaboration is introduced. In settings with flat structures and traditions of informal cooperation, the process of implementing certification standards tends to encounter less resistance, as professionals are accustomed to working across boundaries and adjusting to new processes. Conversely, in more hierarchical settings, additional effort may be required to mobilise departments and ensure alignment.

In institutions operating within a **regional network or consortium model**, coordination was often organised through "fields of action", disease-specific programmes, shared clinical protocols and designated points of contact per site and program. This structure enabled flexible patient referrals to be developed, joint planning, and standardised decision-making across locations. Rather than centralising all activity, these centres worked to harmonise practices while respecting local specificities, which was particularly important in settings with multiple hospitals or service lines.

Resistance to change arise is more likely to arise from the management and heads of departments than from health professionals, scientists and professors themselves.

> *"Many hospital departments unlink to cancer or not dealing with patients, such as the biobank, reacted defensively saying: 'Are you going to give me extra work? And what's the benefit to me?'"*

While the models varied, centres that invested in structured, routine collaboration, whether within a single building or across institutional boundaries, reported greater coherence in the implementation of certification standards and stronger ownership of the process at all levels.

**Recommendation 8:** One common practice implied identifying reference professionals at each per department. They served as key contact points for the Core Team and helped translate certification requirements into the local context. These reference persons are not generic contacts but are expected to be responsive to the specific scope of activities needed to meet certification demands.

**Recommendation 9:** Aspiring CCCs should combine targeted incentives with intrinsic motivation to engage staff in certification. Recognition schemes, visibility, or performance-linked goals can support participation when transparently aligned with institutional strategy, but professional pride and collective achievement remain stronger drivers. Clear communication of certification as a shared milestone, together with financial governance that does not penalise multidisciplinary care, is essential to sustain commitment.

## 5.4. Quality and IT Departments: the needed allies

A peculiarity of the CCC-like certification is that the work of the Quality and IT departments are not enough to cope with that. However, centres with strong Quality departments, or established accreditation units, enter the certification process with a significant advantage since they often provide the technical and methodological backbone for implementation: defining indicators, managing document flows, organising audits, and ensuring traceability.

> *"Counting on knowledgeable professionals on certification, well-acquainted with the concept of a process, requirements, standards, SOP, etc., is essential, because in the end the certification process requires a methodology in itself."*

> *"The ISO know 9001 is covering the whole hospital and we have accreditations for other quality management systems, which is slightly different from a CCC certification, but it's still on the same page, the same understanding."*

Nonetheless, **the contribution of Quality and IT Departments is not limited to operations**. They also help build a culture of continuous improvement, where standards are not experienced as bureaucratic demands but as opportunities for reflection and refinement. Embedding the certification process within a broader quality culture requires early involvement of these units and sustained visibility throughout.

> *"How the certification process is organised, how to meet these standards… It is the **quality mindset**, and not all the head of departments have a quality mindset, but they can be guided to."*

It is worth noting a dose of realism in relation to the generation of the data needed for the certification — particularly regarding the quantitative one —, and the associated role of Quality and IT Departments. Even centres with experienced auditors in their staff stressed that many of the quantitative standards that were requested were not so easy to obtain, and that they performed ad-hoc actions. Furthermore, they explained that it was only after the first certification that they tried to implement the missing structural changes in data management (such as automated data collection). Improvements **in the quality area** (e.g., with enough staff, engineers, better connection to the Cancer Centre Board, etc.) **has frequently been the result of the certification process, and not the other way around**. Therefore, any preparatory improvement may contribute to streamline the process of data generation and collection in a regular fashion.

Finally, the Quality and IT Departments may also play a pivotal role in supporting governance. Their integration within or alongside existing boards enables smoother coordination and alignment with institutional priorities. They often act as **enablers**, guiding processes, facilitating interdepartmental or inter-hospital agreements when relevant, and building networks of referent professionals across domains. In this context, their function often extends beyond technical assistance; they become institutional brokers who help translate certification requirements into meaningful local action.

> *"The fact that we had experience from other national accreditations made it easier to prepare for the CCC certification. Having a culture of quality and continuous improvement is key."*

**Recommendation 10:** Assessing the level of readiness of centres in relation to the Quality and IT Departments is crucial in the preparatory process to strengthen their role as technical and methodological enablers, ensuring reliable data management, effective governance support, and a culture of continuous improvement

## 5.5. Resource mobilisation

While leadership, governance, and clinical engagement are essential, they must be underpinned by deliberate resource allocation to ensure feasibility and sustainability. Across centres, a common enabling factor was the strategic decision to allocate dedicated personnel to support certification efforts. This often included the hiring of new staff or the reassignment of existing personnel with specific expertise in project coordination, data management, communication, or quality assurance. These professionals operated within the core team or in direct collaboration with the Quality Department, assuming key responsibilities such as documentation

tracking, meeting facilitation, internal reporting, and liaison with clinical and administrative units. Experience shows that allocating certification tasks as an "extra duty" alongside existing jobs is ineffective; dedicated time and formal recognition of the role are essential.

Institutions that proactively anticipated resource needs and addressed them early in the process reported **smoother progress, better risk management, and fewer delays**. The presence of a full-time project manager or certification coordinator was often highlighted as particularly valuable in maintaining momentum and ensuring alignment between operational execution and strategic objectives. Some centres reinforced existing quality or accreditation units by adding staff, while others created entirely new positions or even sizeable teams dedicated to certification. These roles ranged from documentation and coordination to harmonising collaboration across sites, supporting clinical trial data collection, and making oncological activities more visible within the institution.

In parallel, some centres invested in tools and infrastructure to support certification activities, ranging from dedicated software for document sharing and audit tracking, to analytic capacity for baseline data gathering and indicator monitoring. While these investments varied according to local capacity and existing systems, they collectively reflected a shared understanding: **certification cannot be an add-on task but must be supported by explicit, planned resource deployment**. Securing flexible and sustained funding was considered particularly important, as it allowed centres to expand administrative capacity without compromising methodological independence and to maintain commitment in the periods between peer reviews.

> *"Initially the money invested in the preparatory steps to get ready for certification application was predominantly dedicated for human resources. But there were also IT infrastructures created as part of the certification process that have improved the access to data such as clinical trials by disease, molecular markers, sites…"*

> *"Seeing that the certification process requires many hours dedicated specifically to bureaucracy and contacting the different departments, a dedicated person was hired for this purpose. This person was the certification manager together with a member from the quality department, since they knew the methodology."*

This chapter underscores that certification is not a narrow compliance exercise but a process of institutional transformation. It also points to the need for robust systems of document management and data generation, which form the focus of the next chapter. Chapter 6 will examine how centres can build the infrastructure and processes necessary to manage documentation, generate reliable data, and ensure transparency throughout the certification journey.

# 6. Document and data management

Reliable documentation and accurate data are essential to demonstrate compliance with CCC certification standards. Many centres highlight that data generation and management are among the most underestimated challenges, often requiring ad-hoc solutions and significant resource investment. This chapter examines how centres can organise document flows, implement digital management systems, and structure data collection to ensure transparency, traceability, and efficiency throughout the certification process.

## 6.1. Document manager software

Effective management of documentation is a critical enabler for a structured certification process. Centres highlight the importance of having a centralised digital platform where all relevant materials, such as guidelines, SOPs, templates, and evidence documents, are securely stored and easily accessible to authorised personnel. Document manager software is seen as essential, not only for **efficiency and continuity when new staff arrive, but also for transparency, traceability, and version control**.

Implementation of document management systems varies. Some centres use comprehensive hospital content management solutions, quality and risk management systems, or dedicated online tools, while others rely on spreadsheets during transitional phases. More advanced solutions have also been used to link certification driven improvements with hospital wide strategic planning. Regardless of the format, the shift from manual, fragmented documentation toward integrated digital systems is seen as essential to enhance efficiency and reduce errors as well as crucial to streamline data sharing across departments, and to support evidence-based decision-making. However, technology alone is not enough. Several centres notes that even when the right software was available, it was often underused until dissemination and training activities were launched.

> *"Technology has evolved a lot since our process began. [...] But clinicians aren't always strong in this area, so it would be beneficial to involve people who actually understand the technology and can help others succeed with it."*

**Recommendation 11:** Centres should prioritise the implementation of digital documentation systems, but also ongoing training, dissemination, and support to ensure that these tools are accessible, accurate, and effectively used across the organisation.

## 6.2. Data collection and management

Data provision is a primary commitment for certification. However, it is worth considering that this structural component was rarely settled within the most advanced CCC in Europe at the onset of certification processes, where manual work, system's fragmentation (within the hospital and /or between different sites), potential inaccuracies or relevant gaps for data such a total number of patients treat per year, were common. Being

realistic meant for them and it will mean for candidates to EUnetCCC Certification to develop **ad-hoc actions** to generate the data needed as well as **setting clear priorities to progress in this area**. Strikingly, when the interviewees pointed out to the most underestimated effort of the certification process, they referred data generation and collection.

> *"Everyone can find a way to produce a number. But if you want accurate numbers, then it will take a lot of resources."*

More resources for it may mean dedicated staff, including data managers and IT personnel, to ensure accurate and timely data entry, while incorporating hospital cancer registries into discussions. Not rarely, many improvement plans (of CCCs being certified or re-certified) encompassed the huge area of data collection and management.

> *"There is a lot of data to collect, such as quantitative data like survival rates and waiting times, and we weren't able to provide this data when we started the process, and even at the end of the procedure. This is an action that requires several steps, which have already been identified and included in our improvement plan".*

The specific reasons to improve data generation and management were as follows:

1. Increase accuracy of the data provided to the dashboard
2. Gain consistency of data generated across departments and site
3. Avoiding manual and redundant work
4. Facilitate learning and collaboration processes with other centres

Four (not mutually exclusive) benefiting interventions that should guide the process of prioritisation in the area of data generation and management are as follows:

1. **Structure data collection at source**: Instead of validating and integrating data retrospectively, the focus should be on structuring data collection at source (e.g., within patients' Electronic Health Record, EHR). This would help improve the overall accuracy of data during patient consultations, ensuring that clinical data is collected comprehensively, a clear challenge in case of Consortium.

   > *"We are returning to the vision that we need to structure the data from the source, starting from the point where the doctor sees the patient during the outpatient visit. That's a huge task because it requires modifying the way the doctor works, really in a very operational way, whether it's the doctor or their medical assistant."*

2. **Automate data collection:** Wherever possible, automated data collection and integrate software's and tools. This can help avoid manual entry and duplication of effort, ensuring data consistency and improving efficiency.

   > *"It was a lot of manual counting, so it took a lot of time".*

3. **Data codification:** It is recommended to standardise the codification process and ensure consistency across departments to improve data quality and facilitate effective reporting. The inaccurate codification of patient data took place, for instance, when patients referred from other hospitals are not well-codified (e.g., with unspecific diagnosis) by physicians in charge due to high pressure and a system that do not support them.

> *"In terms of data collection, we were asking for favours in many services, and some were particularly underdeveloped in terms of data generation. Collecting waiting time-related data was very difficult."*

4. **IT system integration and interoperability**: To address the fragmentation of IT Systems (within and between centres), it is recommended to invest in interoperable solutions to connect all relevant systems. This approach could improve data flow, reduce redundancy, and enable more efficient use of resources across departments and sites, in case of consortia, where standardising quantitative indicators is critical. A unified informatics system has already proven to facilitate coordination of patient care across multiple sites.

> *"We did not have the same tools across all sites. Now, we have a unified informatics system, whereas before, each site had its own. This is a great solution and a significant improvement, making it easier to coordinate patient care across the three sites."*

5. **Implement common language models** in order to pull data out in structured a way. This is optional, but useful when data comes from various sources, as it allows information to be standardised and compared across departments or sites.

The experiences of certified centres show that successful preparation depends on establishing centralised document management systems, standardising data collection at source, and investing in IT solutions that enable interoperability. Automated processes and common data models can reduce manual workload and improve accuracy, but adoption requires clear governance and staff training. Above all, documentation and data should be understood not as a bureaucratic requirement but as a foundation for continuous quality improvement and institutional learning.

## On quality culture as a prerequisite for transformation

Beyond acquiring digital tools for document and data management, it is essential for the aspiring CCC to have a strong quality culture, fully integrated into management practices. This requirement is even more significant in the context of a consortium, where it is not only a matter of aligning the internal practices of a single institution, but also of bringing together several structures around a shared vision of quality and continuous improvement.

In a single institution, managerial agility and the dissemination of a quality culture are generally easier: decision-making chains are shorter, teams are closer, and the adoption of standards can be more homogeneous. Conversely, in a consortium, one must deal with different institutional cultures, varying levels of maturity, and sometimes heterogeneous management styles. Integrating a shared quality culture thus becomes a real challenge, but also an essential lever for achieving the transformation expected by certification.

**Recommendation 12:** Differentiating what is urgent from what is important in data collection and management is essential along the preparatory process to both succeeding with the certification and improving quality control.

**Recommendation 13:** The development of a strong quality culture is essential for transformation. The generation of data, the acquirement of digital tools or any institutional arrangement should finally respond to the concept of quality and continuous improvement, which is transversal in nature and transcends administrative compliance.

These insights naturally lead to the next chapter on development practices and supportive tools, which explores how processes, templates, guidelines, and digital instruments can further streamline preparation, reduce uncertainty, and translate certification standards into practical action.

# 7. Development practices and supportive tools

This chapter explores the methodologies and resources that enable candidate centres to navigate certification more effectively. It addresses the use of templates, document management systems, digital solutions, and structured practices that facilitate consistency, traceability, and cross-centre collaboration. By adopting these tools, centres can reduce uncertainty, strengthen internal capacities, and ensure that certification efforts become sustainable processes of continuous improvement rather than one-time exercises.

## 7.1. Preparatory steps for the certification

The path toward CCC certification is best understood as a structured sequence of steps rather than a set of isolated tasks. Each stage builds on the previous one, ensuring that the process remains both feasible and meaningful for the entire organisation. Based on prior experiences, the certification process typically encompasses the following steps:

1. **Understand EUnetCCC Standards and requirements:** The first step involves thoroughly studying the certification standards, including their definitions, criteria, and metrics, so that all professionals understand what is expected in concrete terms. Clarifications should be sought as needed, through meetings with coordinators or by translating key documents.

2. **Form the certification task force** to lead the certification process. This core team should include staff members with a quality background, certification leaders and direct access to top management or steering committees with broad representation across health services and professional roles.

3. **Develop the project plan:** Create a comprehensive project plan that outlines the activities and milestones leading up to the certification, taking the index year into account.

4. **Define the Timeline:** Establish a realistic timeline for the certification process. It is important to account for the full scope of work and avoid overly tight schedules.

5. **Engage and communicate:** Ensure effective communication and engagement across the organisation. Awareness of the certification process is essential at all levels, even if the depth of involvement varies between stakeholders. Promoting a culture of openness to change helps staff embrace improvements and understand their role in meeting certification standards.

6. **Balance operations:** It is essential to maintain a balance between regular operations and certification preparation. Many departments run parallel activities, so careful planning is required to avoid disrupting routine work and to ensure that staff workloads remain manageable.

**Timeline note:** Initiating the process well in advance is critical, typically, at least two years to understand internal needs, with 3–4 months to establish the internal team before starting the Self-Assessment.

## 7.2. WP6 tools to facilitate the preparatory process

Preparing for CCC certification requires not only institutional commitment but also access to practical resources that can guide centres step by step. To support this, WP6 has developed a set of tailored tools designed to help aspiring CCCs translate standards into practice, monitor progress, and build internal capacity. These tools provide structured methods for Self-Assessment, planning, and peer learning, making the certification process more transparent and achievable. By combining diagnostic instruments, coaching activities, and knowledge-sharing platforms, WP6 offers candidate centres a supportive framework that both complements and strengthens their internal efforts.

### Gap analysis: Maturity Model Webtool

The EUnetCCC Maturity Model is both a capacity-building instrument and a diagnostic tool designed to help candidate CCCs prepare systematically for certification. It translates the Set of Criteria and Standards into a practical framework that illustrates how centres can progress step by step towards full compliance and excellence.

The model covers seven key dimensions of a CCC, within which 36 criteria capture the essential standards and supporting requirements. By assessing performance against these criteria, centres can generate maturity scores that are aggregated to show both where the centre currently stands and what areas require further improvement.

The results can be used in multiple ways:

- **Self-Assessment** to measure standard implementation.
- **Gap analysis** to identify strengths and weaknesses.
- **Capacity building** by tailoring development activities to the centre's maturity level.
- **Benchmarking** to compare performance with other CCCs.

The maturity model provides candidate centres with a clear roadmap from early development to excellence. It offers insight into the logical sequence of steps required for progress, enables tracking of improvements over time, and generates evidence to guide WP6 activities such as teaming, coaching, and mentoring. In this way, the model supports centres not only in achieving certification but also in embedding a culture of continuous quality improvement.

### Readiness Assessment Checklist

The Readiness Assessment Checklist for aspiring CCCs (RACCC-30) has been developed to support both aspiring and existing centres in their certification journey. The checklist functions as a baseline evaluation tool, enabling

centres to assess their current capacities, identify potential gaps, and initiate structured dialogue with supporting Work Packages and coordinating bodies.

By completing the checklist, candidate centres gain:

- A clearer understanding of their baseline readiness for certification.
- An overview of strengths and gaps across four thematic areas: **leadership and culture of certification; organisational development; data and IT;** and **policy framework**.
- Access to a confidential feedback mechanism that supports internal quality development processes.

The RACCC-30 is designed for use by all types of centres aspiring to certification, including single-institution CCCs, consortia, network-based centres, and centres operating in smaller national contexts. Its structure is deliberately simple—30 essential items with a straightforward evaluation scale—to provide a practical and accessible tool that complements the broader certification framework and facilitates the early stages of preparation.

## Quality management of the certification: the Peer-Supporters' role

The *Peer supporters' of EUnetCCC Certification* is a specific capacity-building activity designed to strengthen the preparedness of candidate CCCs for certification. It provides a pragmatic and targeted approach by fostering open dialogue, peer-to-peer exchange, and practical knowledge transfer between experienced CCC Coordinators and aspiring CCC Candidates. The CCC Coordinator Supporter is at the core of this activity: a quality management officer or equivalent professional from a certified CCC with advanced expertise in certification processes and the implementation of CCC standards. Acting as a mentor, the peer supporter collaborates directly with their counterpart in a candidate centre, sharing skills and practical insights into organising, managing, and sustaining the certification process.

Peer supporters from different CCC Coordinators form a team, working collectively and on a voluntary basis to support candidate centres. This network approach ensures that interventions are coordinated, diverse perspectives are included, and candidates benefit from a breadth of experience, while preserving the autonomy of both candidates and coordinators.

The expected outcomes of this activity are twofold:

- ✓ Enhanced preparedness of candidate CCCs, with a particular focus on strengthening the capacity of quality departments to manage the certification process.

- ✓ Recognition of quality management as a central driver of institutional transformation and as a key enabler of the implementation of the EUnetCCC Set of Standards.

The activity acknowledges the pivotal role of quality management professionals. These individuals are uniquely positioned to understand the mechanisms, requirements, and practical challenges of certification, and their

empowerment is essential to guiding candidate centres successfully along the path toward becoming Comprehensive Cancer Centres.

**Recommendation 14:** Internal capabilities are equally important as capacities (a more dynamic concept). Centres' awareness on their capabilities, a ceiling that defines the possibilities of being capable to go through the whole certification pathway, is essential. Capabilities can be modified, but this presumes a specific effort to understand *what the centres can do* and *what they cannot do* when launching the certification process.

## 7.3. Developing practices

Certification is not only about meeting predefined standards but also about fostering a **culture of continuous improvement and innovation**. Developing practices refers to the methods, routines, and organisational habits that enable centres to embed certification requirements into their daily operations in a sustainable way. These practices go beyond compliance; they strengthen collaboration across departments, support learning from experience, and help create resilient systems that can adapt to future challenges.

In this section, the focus is on how candidate CCCs can cultivate such practices during the preparatory phase, ensuring that certification becomes a driver of long-term organisational development rather than a one-time achievement.

### Standards' active adaptation to local culture and specificities

Applying certification standards requires more than formal alignment, it involves translating generic requirements into a functional fit with national systems, clinical structures, and organisational culture. Several centres pointed to early challenges in understanding how to interpret definitions, calculate metrics, or assess compliance due to vague terminology or language barriers. These uncertainties were present both in preparatory phases and during the audit itself.

> *"In [country] we have a lot of national structures helping us. [...] Maybe you could say that nationally [country] is very well prepared for accreditation processes."*

> *"One of the major barriers is the barrier of different cultures. For instance, the standards from OECI—they are meant to cover many different countries, hospitals, and settings. So, we did have a lot of problems understanding the standards and translating them into our hospital and our culture. That's perhaps the greatest barrier in the process: understanding what is meant."*

A key insight is that adaptation must happen early. Standards often assume a certain logic or terminology that may not exist locally. This kind of adaptation is not about lowering quality or deviating from intent, rather, it's

about ensuring operational relevance. While certification frameworks allow flexibility in implementation, the outcomes must remain clear and verifiable. Experience suggests that when this interpretive work is prioritised early on it helps create a clearer structure and smoother coordination throughout the process.

Overall, centres approached adaptation as an early and necessary step, not to change the standards, but to make them understandable and applicable in their own setting.

**Recommendation 15:** Without structured efforts to break down and contextualise the requirements, teams risk misinterpreting expectations or duplicating existing efforts. It is worth establishing internal working groups to interpret the standards in light of their own systems, ensuring alignment without overcomplication.

## Measuring progress and the use of internal deadlines

Monitoring progress is essential to maintain momentum and avoid delays. Centres underline the need for clear internal deadlines, active process management, and synchronised involvement across departments to reach key milestones, including internal audits. Yet, current tools to measure progress are often described as inadequate, and many centres rely on improvised tracking before using the certification tools. A more structured approach strengthens accountability and ensures steady progress.

Several experiences point to the value of:

- ✓ **Setting internal deadlines:** Establishing internal target dates for tasks can help maintain pace and prevent delays. Deadlines can be flexible but having them in place encourages coordination across departments and clarifies priorities.

- ✓ **Using internal audits:** Periodic internal audits are useful both for preparation and for strengthening quality improvement. They can help teams identify gaps early, test internal procedures, and ensure that documentation and evidence are in order before submission.

- ✓ **Practical tracking tools:** While many centres find existing certification tools insufficient for monitoring progress, supporting tools such as checklists, dashboards, or document trackers can provide clarity and help visualise the state of tasks. Centres often develop their own systems to follow ongoing processes, collect data, and prepare answers, which can support consistency and accountability.

- ✓ **Celebrating milestones:** Recognising progress at each step, even the small ones, helps sustain motivation, reinforces team engagement, and builds a positive culture around the process. Celebrations can be informal, such as sharing successes in team meetings, or more structured, marking the completion of a major stage.

- ✓ **Communicating achievements and building networks:** Beyond the internal process, accreditation offers opportunities to share successes and highlight participation in a wider international network. Celebrating the final accreditation, as well as intermediate achievements, can foster collaboration, strengthen relationships with colleagues, and encourage ongoing engagement with the broader community of accredited centres.

By combining structured approaches with recognition of achievements, centres can maintain momentum, enhance collaboration, and make the certification journey both effective and rewarding.

## Benchmarking and peer-based collaboration

Benchmarking can play a central role in supporting effective certification management by allowing centres to learn from the experiences and best practices of others. Centres may find it valuable to exchange knowledge through visits, expert consultations, or network collaborations, which can provide practical insights and ideas for addressing common challenges. This can include areas such as diagnostic times, workflow processes, or innovations in digital clinical pathways. Experiences from multiple centres suggest that **it is useful to identify success models elsewhere and to adapt elements that fit one's own context rather than attempting to replicate a single model**. Engaging external expertise from established CCCs or consultants can also provide guidance and inspiration for innovation, process improvement, or digital development.

Collaboration and partnerships with other centres can help teams discuss challenges, exchange solutions, and share approaches to patient involvement or quality management. By comparing progress and methods with external examples, centres can anticipate potential difficulties, adopt proven solutions, reduce redundancies, and improve the likelihood of successful accreditation. Integrating benchmarking and collaboration into everyday practice supports continuous learning, encourages practical problem-solving, and fosters a culture of shared development and engagement across centres.

## Search for templates

Templates provide structured frameworks that help standardise documentation and processes during certification preparation. They often include patient pathways and Standard Operating Procedures (SOPs), which can be adapted from existing examples to fit local clinical and organisational contexts. Typically, multidisciplinary teams contribute clinical content and define target times, while quality departments ensure templates are used correctly. The use of templates supports formalisation of workflows. Additionally sharing and adapting templates across institutions or networks can facilitate consistency and efficiency in preparing for certification. Out of WP6 activities, one will be facilitating access to key templates.

> *"What really helps is having examples or templates of the documents you're asking for.* ***Many professionals know what they do, but not how to put it into formal documentation****. Even simple examples like how to describe governance structures or MDTs, can guide them and ease the process. It's not about copying, but about reducing uncertainty and helping teams, especially those less familiar with quality processes, move forward more confidently."*

CCi4EU already offers numerous templates and related services that can be explored and adapted for this purpose – follow the link here.

## 7.4. Internal auditing system

Several centres have highlighted the value of conducting internal or mock audits prior to formal reviews. These exercises allow staff to become familiar with the audit process, clarify expectations regarding evidence and scope, and build confidence. Centres may find it helpful to prepare sample questions and conduct walkthroughs with staff, including those only marginally involved to help everyone understand the types of inquiries they might face during the on-site visit.

> *"We prepared some mock questions and made some mock audits going around the Institute, asking people involved even marginally, to understand how they would respond and to give them questions similar to what they would receive during the on-site visit."*

Language considerations are an important factor in international certification. Staff may experience **anxiety** when responding in a language that is not their own. The centre also highlighted the importance of language preparation: *"…one of the important aspects is that everything is in the English language."* Centres may wish to simulate language requirements during mock audits, providing practice and support to reduce stress, build confidence, and ensure a smoother audit experience. By drawing on the experiences of other centres and focusing on well-structured internal audits and **mock** exercises, centres can strengthen team readiness, clarify expectations, and address potential challenges before the formal certification visit.

**Mock Audits: Purpose, Principles, and Practice**

A mock audit simulates an external audit for preparational purposes. Its goal is to uncover gaps or areas needing improvement before the external auditors arrive, ensuring the organisation is fully prepared.

Importantly, the purpose is not to "pass" the audit, but to identify and address gaps so the organisation is stronger when the real audit comes.

**Guiding Principles: How to Make Internal Audits Work Effectively**

- **Build on teamwork and engagement** – Involve all relevant professionals and create shared ownership. Internal audits work best when staff recognise issues from their own practice and feel responsible for change
- **Focus on knowledge-sharing** – Position the audit as a learning opportunity. Dedicate time to reflect and exchange knowledge about care pathways and daily practice.
- **Ensure local champions** – Let respected peers lead the process. Champions foster ownership, motivate colleagues, and push for concrete improvements.
- **Encourage open feedback** – Create a safe culture where feedback flows freely across all levels, regardless of hierarchy.

**Step-by-step**

1. **Set objectives and scope** – Clarify what you want to review, why, and which areas or processes are in focus.
2. **Prepare team and materials** – Assign an audit lead, gather all relevant documentation, checklists, and interview guides, and schedule the audit day for smooth execution.
3. **Run the audit –** Review documents, trace patient pathways, observe practice, and conduct staff interviews, ensuring a learning-focused approach.
4. **Debrief and follow up** – Share immediate feedback, document strengths and gaps, prioritise actions, assign responsibilities, and plan re-audit or follow-up to track improvements.

**Recommendation 16:** Establishing a robust internal auditing system can be particularly helpful for identifying gaps and areas for improvement early in the certification process. Centres may wish to consider maintaining a pool of trained internal auditors and organising multiple audit waves to ensure that all relevant aspects are reviewed thoroughly.

# 8. Key preparatory areas

Certification ultimately depends on the centre's ability to demonstrate maturity across a set of core areas that define what it means to be a Comprehensive Cancer Centre. This chapter highlights some of these areas, offering guidance on where centres should concentrate their resources, coordination, and development. For consortia, additional emphasis is placed on harmonising practices across institutions, ensuring compatibility in infrastructure, and building trust through shared structures. By addressing these areas early and systematically, centres can reduce uncertainty, strengthen alignment, and ensure that certification becomes a driver of institutional transformation rather than an administrative exercise.

## 8.1. Governance

Governance is not only about creating new bodies but about ensuring that existing structures, roles, and institutional priorities are aligned towards shared goals. For single institutions, the certification process often acts as a catalyst to formalise or reinforce governance arrangements. Certification provides the mandate to remodel certain parts of the hospital, harmonise practices, and create authority for leaders and teams to drive internal change. For consortia, governance introduces additional layers of complexity. Certification demands that inter-institutional collaboration be more than an aspiration: it must be structured, functional, and trusted. Difficulties often arise from uncertainty about how to collaborate effectively across organisations with different cultures, priorities, or infrastructures.

> *"I can say that we have reorganised the hospital through the manual. So, we usually say that **we are getting adapted to a more international structure**."*
>
> *"You have to remodel some parts of the hospitals and create a **harmony** among different institutions; you have to be prompt to change and you have to have the power to change things internally."*
>
> *"Of the classical way of organising the hospital, the speciality-based silos, ten or 11 out of 14 in our hospital were related to cancer. So, the question was: **where is actually the cancer centre?** And we couldn't answer that."*
>
> *"One of the main hurdles was how to **work across silos, and we were not prepared for that**, like assigning the responsibility to leaders that typically have a narrow focus without anyone in charge of the total outcome of cancer."*

**Lessons learned on governance from well-established consortia** result on the following recommendations**:**

**Recommendation 17 [only for consortia CCC configuration]:**

- **Focusing on complementarity rather than competition**. Centres tend to be more specialised in one cancer disease or patient profile than on another. The process of creating a consortium should reinforce this specialisation rather than neutralising it. Collaboration, generosity, and a global vision are essential for decisions related to roles' division.

- **Mirroring leadership positions in hospitals**, facilitating interaction between managers and clinicians' 'counterparts' within the framework of a common Cancer Centre Board. In other words, dialogue is simplified if the governance charts are similar in all sites making up the consortia.

- **Avoiding unnecessary duplication while ensuring high-quality**: an opportunity for consortia is optimising the use of multi-site infrastructures and services. Optimisation should be planned hand-in-hand with a careful approach to patients' access to services.

- **Development of shared infrastructures**, such as online clinical trial platforms, further strengthens collaboration and transparency.

- **Setup of common 'fields of action' and educational interventions.** Governance in consortia therefore requires joint committees, working groups, and regular executive board meetings that ensure consistent alignment and a shared strategic vision. Scientific meetings, educational events, and thematic working groups (e.g., radiotherapy, research, risk management) reinforce cooperation and maintain momentum.

> *"*[In consortia] *Each oncology centre, particularly those within academic hospitals, is expected to provide specialised care and expertise. It is often beneficial to* ***join forces and explore how different areas of expertise can complement one another****. In oncology, going the extra mile to identify not just who can take on a task, but who is best equipped to do so, can make a real difference. This kind of approach tends to be far more effective when embedded within a collaborative network."*

Equally important are the **soft skills that underpin governance**. Trust, transparency, and the ability to act as a unified team are indispensable. As one interviewee noted, success depends on "being able to provide full transparency in regard to strategic, scientific, and clinical plans for further development." The experience of centres also shows that governance is not static. Certification often strengthens governance by clarifying roles, promoting prospective planning, and embedding quality indicators into institutional decision-making. In this

sense, governance is both a prerequisite for and an outcome of certification, evolving in parallel with the organisation's capacity to act as a true CCC.

## 8.2. Patients' involvement

The integration of patient perspectives into cancer centre governance, quality improvement, and service design represents a growing area of focus within the CCC certification processes. While the principle of patient-centred care is broadly shared, the degree to which patients are actively involved in institutional decision-making varies significantly across centres.

In more advanced settings, patients are formally represented within advisory boards, steering committees, or quality forums, where they contribute to discussions on service delivery, communication materials, or improvement priorities. These representatives are often trained and supported to engage meaningfully with clinicians, administrators, and researchers. Their input is regarded not as symbolic but as a structured element of institutional governance, helping to align care models with patient expectations and lived experience.

Other centres, however, report more limited progress in this area. While patient feedback mechanisms, such as surveys, satisfaction reports, or complaint channels, are typically in place, **direct patient participation in governance structures remains underdeveloped**. In some cases, this gap has been flagged during external evaluations, with the requirement to enhance patient involvement included as a condition for reaccreditation. Common barriers include the absence of formal committees, limited access to representative patient groups, and uncertainty about how to select and support patient participants.

> *"I'll be very honest: in the first accreditation patients were involved marginally; it was more formal than substantial. But because of the accreditation, the Institute also realised how important the patient involvement is."*

> *"We have a patient committee, and their involvement is truly integrated into our processes. They contribute to internal audits, participate in projects where they can share their needs and perspectives, and are active in working groups — for example, those focused on improving patient information. They help us update materials, support training activities, and offer feedback on what really matters to them. Looking ahead, they'll also be involved in developing indicators like PROMs, so we can better understand patient outcomes and experiences across the care pathways."*

At the same time, many centres acknowledge that progress remains uneven. **Barriers** for patient involvement include the absence of formal committees, difficulty in accessing representative patient groups, and uncertainty about selecting and supporting participants. Some institutions also report that patients are reluctant to take on ongoing roles, preferring episodic or project-specific engagement. However, some centres have developed innovative mechanisms to engage patients. For example, by empowering the "citizens' advice bureau" that any centre has, which enables patients to describe their care journeys and identify priority areas for process improvement. Some experiences indicate the possibility for this unit (or similar formula) to fostering patient's co-involvement in shaping projects, organising self-help groups and co-designing patient

safety materials and institutional communication. A **stepwise approach (e.g., 4-6 years)** led to a some advanced CCCs in this area to create annual patient congresses or patient academies in order to formalise and scale up involvement. Notably, carers, and not just patients, are the focus of the most developed experiences.

These experiences point to the need for a pragmatic, stepwise approach. Early actions can include engaging patient associations, piloting involvement in pathway redesign, or testing advisory roles in specific projects. Over time, these experiences can be consolidated into formal committees, advisory boards, or quality forums. Ultimately, meaningful patient involvement requires both formal structures and informal, trust-based relationships that give patients a genuine voice in shaping institutional priorities. Relevantly, a couple of experiences highlighted the role of patients in spreading "the role of the CCC" at local or regional level, including the certification process.

> *"It is important to involve the patients in a way that their input can be considered in a useful and positive way. So, what has happened is that we have formalised the users board. It's not called as patients board because they may be also people who are caregivers and may not be direct patients."*

**Recommendation 18:** Centres at earlier stages of development are encouraged to adopt a stepwise approach. Initial efforts may include identifying patient associations willing to collaborate, piloting patient and carers involvement in pathway redesign or patient information materials, and progressively formalising roles and responsibilities. Over time, these experiences can be systematised into governance practices that reflect both institutional priorities and patient values.

## 8.3. Multidisciplinary teams

Multidisciplinary teams (MDTs) form the backbone of a comprehensive cancer approach and are one of the most visible and functional expressions of the CCC model. Far beyond a structural requirement, MDTs are operational hubs where diagnostic, therapeutic, research, and supportive care perspectives meet. Their role in certification is not only to ensure coordination, but to embody a model of shared decision-making, continuous learning, and cross-disciplinary accountability.

Centres entering the certification process often find themselves needing to re-express their existing MDTs in terms of formal structure, documentation, and alignment with broader institutional goals. This involves clarifying participation criteria, standardising meeting formats, and developing protocols for case discussion, referral, and follow-up. Institutions with prior experience in MDT-based care, particularly those that have participated in national networks or specialised programmes, tend to have a stronger starting point. However, certification brings an added layer of scrutiny which focuses on how MDTs are integrated into the institution's quality framework, how they contribute to pathway development, and how their activity is monitored over time.

Furthermore, MDTs represent a strategic opportunity for alignment across care, research, and teaching. Some institutions use MDTs to introduce clinical trials, discuss molecular findings, or integrate supportive and palliative care earlier in the disease trajectory. When used this way, MDTs become vehicles for the broader transformation that certification aims to achieve.

As a preparatory step, institutions are encouraged to:

- ✓ Map existing MDTs across tumour types and identify gaps or redundancies.
- ✓ Define clear governance and coordination mechanisms for MDT activity.
- ✓ Establish documentation practices that allow traceability, evaluation, and learning.
- ✓ Ensure alignment between MDTs and the development or revision of clinical pathways.
- ✓ Involve quality teams in supporting MDTs through tools, templates, and process reviews.

Interviews with certified centres highlight additional lessons regarding MDTs:

- ✓ **Consistency and coordination**: Many centres reported that MDT meetings lacked consistent structures across tumour types. Certification acted as a driver to formalise formats, standardise coordination, and strengthen cross-team accountability.
- ✓ **Integration of supportive and palliative care**: A recurring gap was the limited integration of palliative care into the MDT framework. Addressing this often-required focused training and capacity-building efforts, particularly targeting nursing staff, to ensure early and meaningful incorporation of supportive services.
- ✓ **Cultural change and motivation**: Certification was widely perceived as both a symbolic and strategic milestone, reinforcing the institution's identity as a comprehensive cancer centre. MDT-related improvements contributed to professional motivation by recognising clinical teams, offering opportunities to benchmark practices, and fostering a shared sense of advancement.
- ✓ **Formalising good practices**: While the certification process was intensive, it was also seen as a chance to systematise and formalise good practices already in place, thereby strengthening the multidisciplinary culture and ensuring sustainability.

**Recommendation 19:** Preparing MDTs for certification requires more than administrative adjustments. It often entails a cultural shift, especially in centres where multidisciplinary practices remain informal or uneven among cancer diseases. MDTs must be recognised institutionally as key arenas for clinical excellence, not merely as meeting obligations. This includes ensuring they have protected time, access to relevant clinical and diagnostic data, and mechanisms for feedback and evaluation.

## 8.4. Care pathways

Care pathways are not only tools for coordination but also an example of comprehensiveness. Their development and refinement during the certification process allow institutions to translate the CCC model into specific, observable practices. In general, pathways provide a framework for defining roles, timelines, referral flows, and performance indicators, all of which under the key objectives of improving the continuity of care through a standardised approach while contributing to improve quality of care delivery. When well-articulated, pathways also expose bottlenecks and allow for targeted improvement planning. Importantly, the certification process often reveals inconsistencies in how pathways are documented, monitored, and evaluated. Building the capacity to address these gaps, both technically and organisationally, is a critical early achievement.

Pathways are also strengthened through peer learning and cross-centre collaboration. Shared templates and models have been used as reference points, helping centres formalise their own documentation and processes. Quality Departments can provide the methodological structure for filling in pathway templates, while MDTs contribute the clinical content and define target times, but initiatives such as CCi4EU further enhance this process by offering a comprehensive set of templates, tools, and support services that facilitate the development and implementation of patient pathways across institutions. CCi4EU serves as a collaborative platform where centres can access best practices, adapt standardised materials, and engage in mutual learning to strengthen alignment and quality in certification preparation. In several cases, a reference disease, such as sarcoma or breast cancer, was used as a pilot for developing the first detailed pathway, which was then progressively extended to other cancer diseases and linked to SOPs governing MDT functioning, patient access, and care coordination. This approach helps test the integration of care, research, and education under real conditions.

Overall, the experience shows that **pathways are not static documents but dynamic frameworks** that evolve with practice, regional collaboration, and certification. They embody the principle of comprehensiveness by bringing together care, research, and education into structured processes and by creating a common language that facilitates coordination across institutions. It is worth noting the advantage for those candidate CCCs where the national or regional health systems have introduced cancer-related pathways. However, it a common view that national pathways lacked sufficient detail to cover the many actions and coordination efforts required across departments and regions. Certification processes have therefore acted as a catalyst to refine these tools, making them more precise, adaptable, and aligned with the comprehensive model.

The use of care pathways is also foreseen as a major instrument of governance and evaluation in the case of CCCs having a **consortium configuration or being the 'hub' of a regional or national network** (where the 'spokes' are not certified as such but the care for highly complex cancer diseases is based on the CCC). Thus, it is a critical idea for different interviewees the need to use care pathways to help regionally integrate the CCC with other providers in a way to show, for instance, that times from diagnosis to first treatment are similar regardless of patients' reference hospital.

> *"We appointed centre appointed tumour-site coordinators to interpret certification standards in their respective domains and liaise with the core team. This distributed model of coordination ensured local ownership and contextualised implementation. Regular coordination meetings and shared planning sessions allowed for cross-departmental alignment and the identification of bottlenecks."*

**Recommendation 20:** Some overarching structure is needed to coordinate all pathway leaders since pathways themselves encompass different system-levels to be implemented and sustained.

# 9. Conclusion

The preparatory guideline has demonstrated that achieving CCC certification is far more than an administrative exercise; it is a transformative process that reshapes institutions to deliver truly comprehensive cancer care. By addressing governance, leadership, patient involvement, multidisciplinary teamwork, and pathway development; centres lay the foundation for excellence across care, research, education, and innovation.

A recurring message throughout is that certification must be institutionally owned and strategically supported. Strong governance structures, visible commitment from senior leadership, and the mobilisation of dedicated resources are indispensable enablers. At the same time, cultural change is required: clinicians, researchers, administrators, and patients must all recognise certification as a shared journey that strengthens identity, credibility, and long-term sustainability.

The tools and practices highlighted- such as the readiness checklist, coaching activities, and structured capacity-building measures- are designed to guide centres through this process step by step. Flexibility remains key: while standards are common across Europe, their implementation must accommodate regional realities and institutional diversity without compromising quality.

Ultimately, the value of EUnetCCC certification lies in its ability to connect institutions to a European community committed to excellence, collaboration, and continuous improvement. For aspiring centres, preparation is not simply about meeting external requirements, but about embedding a culture of comprehensiveness that benefits patients, professionals, and society. Certification is both a milestone and a starting point: it affirms readiness while setting the stage for ongoing development and innovation in cancer care.

# 10.Annex 1. Interview script

## Preparatory processes when Launching the CCC Certification – Interview

**Background and Experience**

1. What motivated your organisation to pursue the certification as a CCC? When were you first certified?

**Pre-Certification Preparations, Governance, and Leadership**

2. Considering the comprehensiveness of the certification and the multiple processes involved, was your organisation culturally ready for the process?
3. What were the key steps or preparatory phases your organisation undertook prior to initiating the certification process?
4. What governance structures were established or adapted before starting the certification process?
5. What role did the leadership play during the preparation phase?
6. How did you engage and align internal stakeholders (e.g., heads of services)?
7. How did you engage and align external partners, particularly universities and research institutes?
8. Which contextual factors had an impact on the pursuit of the certification (geography, public/private...)?
9. Did health authorities play any role in the pursuit of the certification?

**Workforce, Capacity Building, Tools, and Documentation**

10. Were any specific roles or teams created to manage the process?
11. How did these roles or teams function internally?
12. What type of capacity-building (CB) support would have been useful to develop the set priorities and organise the preparatory process as a whole?
    - Did you contact other certified centres for support?
13. In accordance with OECI/DKH requirements, how did you involve patients at an institutional level?
14. Were there any major gaps or challenges your organisation had to address before applying (e.g., mobilising resources, training, databases)?
15. Did you use data management tools during the preparation phase of the certification?

- If not, what type of tools would have been useful?

**Lessons Learned**

16. Looking back, what do you think was the most essential element in your success in preparing your organisation?

17. In hindsight, what do you consider the main mistakes or areas you would handle differently in the certification process?
18. What advice would you give to an organisation preparing for its first comprehensive-like certification process?
19. As a final question, is there anything you think should absolutely be included in a preparatory guideline for centres starting a certification journey?