

Rigshospitalet &
Herlev og Gentofte Hospital

CCCC

Copenhagen
Comprehensive
Cancer Center



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Action Plan 1	The listed standards and numbers (#) are covered by this action plan:	1 Governance: Standard 3 #1, # 2, #3, Organisation of Quality Systems: Standard 7 #2, Quality Reporting standard 9 #1, Organisation of Quality Systems: Standard 10 #1, Treatment: Standard 57 #1
	Opportunity	The OECI peer review identified the need to strengthen the common quality management cycle across Copenhagen Comprehensive Cancer Center by integrating annual quality reporting, prospective risk management, implementation of new technologies and systematic monitoring of clinical quality indicators into one coordinated Quality Management and Improvement Cycle. This action is supported by the governance structure established through the CCCC Governance Charter (Appendix 1) and forms part of the Annual Governance and Quality Cycle.
	Action	- Integrate quality management activities into the Annual Governance and Quality Cycle described in the CCCC Governance Charter (Appendix 1). - The CCCC Quality Council will review and qualify the Annual Quality Report and prepare proposals for cross-organizational quality improvement plans within the following areas: - Annual Quality Report and Quality Improvement Plan (Standard 3.3) - Risk management and organizational learning based on adverse events (Standard 7.2) - Prospective risk assessment before implementation of new technologies, medical equipment and clinical interventions (Standard 10.1) - Action plan for systematic pain screening using validated assessment tools documented in the electronic health record (EPIC) (Standard 57.1) - The governance structure, organisational roles, responsibilities, decision - making processes and the Annual Governance and Quality Cycle are described in the CCCC Governance Charter (Appendix 1). - The centre will publish summarised information on feedback from external quality inspections and accreditations on its website.
	Goal/ desired result	Establish a common Annual Governance and Quality Cycle that ensures: - An annual Quality Report resulting in defined quality improvement initiatives. - systematic follow-up of adverse events and organizational learning. - prospective risk assessment before implementation of new technologies and medical equipment - systematic use of validated pain assessment tools documented in the electronic health record (EPIC) - continuous monitoring, evaluation and follow-up through the governance structure described in the CCCC Governance Charter (Appendix 1) Implementation and progress will be monitored through the Annual Governance and Quality Cycle described in the CCCC Governance Charter Appendix 1). Progress and recommendations will be reviewed by the CCCC Leadership and reported annually to the CCCC Board in accordance with the CCCC Governance Charter (Appendix 1).

	Actions description	• Include the Annual Quality Report as a fixed agenda item in the Annual Governance and Quality Cycle (March 2027). • The CCCC Quality Council reviews and qualifies the Annual Quality Report and prepares recommendations for cross-organisational quality improvement initiatives. Recommendations are submitted to the CCCC Leadership, which coordinates, prioritises and prepares recommendations for the CCCC Board. The CCCC Board provides strategic oversight and approves relevant strategic priorities in accordance with the CCCC Governance Charter (Appendix 1). • Develop a common procedure for prospective risk assessment before implementation of new technologies, medical equipment and clinical interventions. • Develop and implement a common action plan for systematic pain screening using validated assessment tools integrated into the electronic health record (SP). • Report annually on implementation, quality indicators, risk management activities and improvement initiatives to CCCC Leadership and the CCCC Board through the Annual Governance and Quality Cycle.
	Who is involved and responsible for result	Responsible • CCCC Leadership Involved • CCCC Quality Council The CCCC Quality Council reports to the CCCC Leadership. The CCCC Leadership reviews the recommendations, coordinates implementation and submits relevant strategic recommendations to the CCCC Board in accordance with the CCCC Governance Charter (Appendix 1).
	Start (date)	October 2026
	Evaluation (date)	October 2027
	Deadline (date)	March 2028
	Priority – High / Medium	High
	Progress	
FUP	Status of implementation	
	Results achieved	

Action plan 2	The listed standards and numbers (#) are covered by this action plan:	2 Governance: Standard 4 #1
	Opportunity	To implement a multi-annual budget for CCCC's activities to systematically identify financial risks that may affect the delivery of cancer services and strategic initiatives.
	Action	CCCC defines, monitors, and annually updates a multi-annual budget framework ensuring sustainability of its activities as far as practicable within the Danish healthcare system.
	Goal/ desired result	Establishing a structured multi-year financial planning framework that enable CCCC to aligns strategic priorities, investments, operational costs, across the CCCC. The budget will enable CCCC to perform an annual risk assessment of the balance of regional funding and resource requirements and perform strategic decisions of major initiatives an investment. In the future develop a consolidated financial dashboard for CCCC activities.
	Actions description	Develop a rolling 5-year financial plan covering major cancer centre activities in CCCC and strategic initiatives across HGH and RH. The plan will be reviewed annually. The financial plan will include; Regional funding, resource utilization indicators, workforce, research funding (external) The financial plan should also include an overview of planned major investments and their financial implications over a 5-year period. The action plan for 2027 will ensure financial impact analysis of the investment in new radiotherapy equipment and a 10-year long-term plan for CCCC
	Who is involved and responsible for result	- CCCC board and secretariat - Finance Departments HGH and RH - Regional Finance Representatives
	Start (date)	February 2027
	Evaluation (date)	January 2028
	Deadline (date)	January 2029
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 3	The listed standards and numbers (#) are covered by this action plan:	3 Organisation of Quality Systems: Standard 7 #2 & #10; Standard 11 #3, Standard 14 #2, #3, #4, Standard 15, Standard 16, Standard 47 #6, #7 and #8.
	Opportunity	The OECI peer review identified the need for a dedicated organizational structure with responsibility for an integrated Quality Management System across Copenhagen Comprehensive Cancer Center. Although quality management activities are well established at Herlev and Gentofte Hospital and Rigshospitalet, an integrated governance structure is required to support a common Quality Management System across Copenhagen Comprehensive Cancer Center .
	Action	Establish and implement an integrated Quality Management System for Copenhagen Comprehensive Cancer Center through the CCCC Governance Charter (Appendix 1). • CCCC Quality Council • CCCC Leadership • CCCC Board • Common governance model • Annual Governance and Quality Cycle. • Systematic monitoring and follow-up of quality, patient safety, risk management and improvement initiatives. The governance structure, organisational roles, responsibilities, reporting lines, decision-making processes and the Annual Governance and Quality Cycle are described in detail in the CCCC Governance Charter (Appendix 1).
	Goal/ desired result	Establish a permanent and integrated Quality Management System for Copenhagen Comprehensive Cancer Center that: • establishes a dedicated organisational structure responsible for the integrated Quality Management System across Copenhagen Comprehensive Cancer Center. • defines clear governance, roles, responsibilities and decision-making processes • ensures systematic monitoring of quality, patient safety and risk management • supports continuous quality improvement based on data and performance monitoring • ensures implementation and follow-up of recommendations from the OECI peer review • links strategic priorities, quality improvement initiatives and organisational follow-up through the CCCC Governance Charter and the annual governance cycle. Implementation and progress will be monitored through the Annual Governance and Quality Cycle. Progress and recommendations will be reviewed by the CCCC

		Leadership and reported annually to the CCCC Board in accordance with the CCCC Governance Charter (Appendix 1).
	Actions description	- Develop and implement the CCCC Governance Charter as the overarching governance framework for Copenhagen Comprehensive Cancer Center. - Establish the CCCC Quality Council as the dedicated multidisciplinary advisory body responsible for supporting quality management across the Comprehensive Cancer Center. - Define the Quality Council's terms of reference, responsibilities, membership and meeting structure. - The CCCC Quality Council reviews and qualifies information and prepares recommendations for the CCCC Leadership. The CCCC Leadership coordinates, priorities and prepares recommendations for the CCCC Board. The CCCC Board provides strategic oversight and approves relevant strategic priorities in accordance with the CCCC Governance Charter (Appendix 1). - Implement a common annual governance and Quality Cycle covering quality, performance, patient safety, risk management, patient involvement, research and education. - Establish systematic monitoring of quality indicators, quality dashboards, audits, complications, risk management activities and improvement initiatives. - Establish an internal audit system following an annual plan in all relevant departments. - Present an annual quality status report to the CCCC Board and ensure systematic follow-up on agreed actions. - The implementation of the CCCC Governance Charter will ensure that quality management, performance monitoring, patient safety, risk management and continuous quality improvement are integrated into the organisational governance of Copenhagen Comprehensive Cancer Center.
	Who is involved and responsible for result	Responsible CCCC Leadership - CCCC Quality Council - One physician from Herlev and Gentofte Hospital - One physician from Rigshospitalet - One nurse from Herlev and Gentofte Hospital - One nurse from Rigshospitalet - One Chief Nurse from Herlev and Gentofte Hospital - One Chief Nurse from Rigshospitalet - Quality Director, Herlev and Gentofte Hospital (Chair) - Clinical Director, Department of Oncology, Rigshospitalet (Vice Chair) The CCCC Quality Council reports to the CCCC Leadership. The CCCC Leadership reviews the recommendations, coordinates implementation and submits relevant strategic recommendations to the CCCC Board in accordance with the CCCC Governance Charter (Appendix 1).
	Start (date)	October 2026
	Evaluation (date)	October 2027
	Deadline (date)	April 2028
	Priority – High / Medium	High
F	Progress	

	Status of implementation	
	Results achieved	

	The listed standards and numbers (#) are covered by this action plan:	4 Organisation of Quality Systems: Standard 26 #3 #4
Action Plan 4	Opportunity	Patient experience is already an integrated part of the quality improvement system at Copenhagen Comprehensive Cancer Center (CCCC). Patients experience data are systematically collected through the Danish National Survey of Patient Experiences (LUP), adverse event reporting and other feedback channels, and reviewed through existing quality and management structures. CCCC already uses both Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs). The OEI review identified an opportunity to further standardise and integrate their use across the centre. PROMs assess how patients are doing, including symptoms, treatment-related side effects, functional impact, quality of life and palliative care needs. CCCC already uses PROMs for treatment-related side effects, palliative care needs through the validated PRO-PAL questionnaire, and is implementing PROMs in radiotherapy for weekly assessment of side effects and quality of life. In addition, all patients complete a standardised assessment of their individual support needs together with a nurse on their first or second visit. PREMs assess how patients experience the care they receive. CCCC primarily uses LUP (The Danish National Survey of Patient Experiences) as its standardised PREM framework. LUP is a national survey covering key aspects of patients' experiences, including information, communication, involvement, contact with healthcare professionals, coordination and overall experience of care. Data are collected continuously with monthly reporting and an annual status based on the preceding year's data. LUP results are used to identify trends and areas for quality improvement. The opportunity is therefore to consolidate these well-established PROM and PREM activities within a common CCCC framework, ensuring their systematic use as integrated components of the CCCC quality management system while allowing pathway-specific validated measures where clinically appropriate.
	Action	Establish and implement a common CCCC framework for the systematic collection, use and follow-up of PROM and PREM data across Herlev Hospital and Rigshospitalet, building existing validated PROMs and the national LUP framework. The framework will be progressively integrated into clinical workflows and electronic systems as the digital infrastructure develops.
	Goal/ desired result	The objective is for CCCC to have a coherent and integrated approach to patient-reported outcomes and experiences across the cancer pathway, irrespective of which CCCC clinical unit or hospital provides the care.

		The strengthened approach should: • ensure systematic use of relevant PROMs to assess symptoms, treatment-related side effects, functional impact, quality of life and palliative care needs. • ensure systematic use of LUP as the common PREM framework for monitoring patients' experiences of care. • ensure that PROMs are collected at clinically relevant time points and, where appropriate, before consultations or treatment, enabling patient-reported problems to be addressed during the clinical encounter. • use patient-reported data both for individual patient care and for quality improvement at clinical unit and CCCC level. • support further implementation of pathway-specific validated PROMs, including radiotherapy PROMs. • strengthen the systematic review and follow-up of LUP results and identified areas for improvement. • progressively integrate PROM and PREM data into electronic clinical systems and the CCCC quality management system. • provide a coherent overview of patient-reported outcomes and experiences across the entire CCCC.
	Actions description	• Map and document the PROMs and PREMs currently used across CCCC and identify opportunities for further standardisation and integration. • Continue the use of validated PROMs, including EORTC measures and PRO-PAL, and support implementation of PROMs in radiotherapy. • Continue electronic reporting of treatment-related side effects from home before treatment where clinically relevant. • Continue the standardised assessment of patients' individual support needs at the first or second visit. • Establish LUP as the documented PREM component of the CCCC quality management framework, including its continuous monthly data collection, reporting and annual status. • Ensure that relevant LUP results are reviewed within the existing CCCC and clinical quality and management structures and lead to improvement actions where relevant trends or concerns are identified. • Use LUP results over time to monitor the effect of quality improvement initiatives. • As electronic systems develop, progressively integrate PROM and PREM data into clinical workflows and the CCCC quality management system. • Report relevant PROM and PREM developments, results and improvement actions through the CCCC Governance and Quality Cycle.
	Who is involved and responsible for result	• CCCC Leadership • CCCC Quality Council • Clinical departments and units across Herlev Hospital and Rigshospitalet • Quality and patient safety functions • Relevant palliative care and radiotherapy teams • Patient representatives / the joint Advisory Board of Cancer Patients

		• Relevant digitalisation and IT functions CCCC Leadership and the CCCC Quality Council are responsible for the overall framework, coordination and systematic follow-up across the centre. Implementation takes place across the clinical units at Herlev Hospital and Rigshospitalet as part of the common CCCC quality management system. Progress will be monitored through the existing CCCC governance structures and the annual Governance and Quality Cycle.
	Start (date)	January 2027
	Evaluation (date)	January 2028
	Deadline (date)	June 2029
	Priority – High / Medium	High
	Progress	
	Status of implementation	
	Results achieved	

Action Plan 5	The listed standards and numbers (#) are covered by this action plan:	5 Patient Involvement and Empowerment: Standard 19 #1
	Opportunity	There is an opportunity to increase the level of involvement and benefit from more fully utilising patient participation in the planning and organisation of the comprehensive centre – that is Patient and Public Involvement (PPI) in governance, strategic decision-making and service development. - strengthen and formalize the integration of patient and caregiver perspectives in leadership, governance and development activities, ensuring that user input systematically informs priorities, decisions and new initiatives, when relevant. - Involve patients and patients' voluntary organisations and support groups in the planning and organisation of services f.x. through systematic use of focus group interviews and through a joint Advisory Council
	Action	1. Establish user involvement in governance and establish a joint Advisory Board of Cancer Patients
	Goal/ desired result	The patient perspective will be embedded within CCCC governance through patient representation. Patient perspectives are a standing item on the CCCC Leadership agenda and will be further integrated through project development guided by a joint Advisory Board of Cancer Patients, as well as through systematic patient involvement processes. The impact of patient input will be documented, demonstrating how it has informed strategic decisions and contributed to service improvements.
	Actions description	- Appoint two selected patient representatives to participate in relevant parts of discussions and provide advice on strategic priorities in the CCCC board. Introduce "User Perspective" as a standing agenda item at the CCCC Leadership meetings. - Create a joint Advisory Council based on the CCCC User Panel and Rigshospitalet's Patient and Carer Panel, meeting 2–4 times annually - in addition to the work of the two patient advisory panels. Using Patient Experience Surveys, including the Danish National Survey of Patient Experiences (LUP), and other large-scale studies of cancer patients' experiences fx from The Cancer society. - Systematically document user input, recommendations and resulting actions, and monitor involvement through indicators covering activity, quality, impact and organizational anchoring.

	Who is involved and responsible for result	Responsible - CCCC daily Leadership - Communication Consultant HGH and communications Consultant RH Involved: CCCC daily Leadership, Board members, Advisory Board members, patient representatives, project leaders and quality/development staff. - The joint Advisory Board of Cancer Patients
	Start (date)	September 2026
	Evaluation (date)	November 2027
	Deadline (date)	May 2028
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 6	The listed standards and numbers (#) are covered by this action plan:	6 Patient Involvement and Empowerment: Standard 22 #5 , Standard 25 #3, Multidisciplinarity: Standard 30 #2, Treatment: Standard 58, Treatment: Standard 64 #1, Education and Training: Standard 83 #6
	Opportunity	There are already several support, counselling, and rehabilitation services available to patients during and following cancer treatment. However, there is a need for more systematic and consistent implementation and dissemination of these services across the two departments. There is an opportunity to strengthen: 1. Integration and consistency of supportive care across the patient pathway, including systematic referral to relevant supportive care services and healthcare professionals based on identified patient needs. 2. Updated patient information with clear reference to Information on supportive care, including steroid treatment and its potential side effects. 3. The use of the regional needs assessment tool, “Support for Life with Cancer”, which includes information about – dialogue about lifestyle habits. 4. The use of CCCC’s counselling and resource guides for patients aged 15–39 years (Resource Guide for Young Cancer Patients) and for patients aged 40 years and older (Resource Guide for Patients Aged 40 Years and Older); [herlevhospital.dk]. 5. The documented review of patients’ individual needs, available support services, and follow-up plans at the completion of treatment – survivorship plan. 6. Formalised collaboration with municipalities in order to ensure consistent and equitable information on supportive care through the Danish Knowledge Centre for Cancer Late Effects including Committed collaboration and feedback through dialogue, surveys, meetings, and a dedicated patient and public involvement •
	Action	Establish clear referral pathways from needs assessment to appropriate supportive disciplines, including psychosocial, nutritional, rehabilitation, and symptom-management services. Implementing systematic use of patient information with clear reference to Information on supportive care, including steroid treatment and its potential side effects, the use of the regional needs assessment tool, “Support for Life with Cancer”, the use of CCCC’s counselling and resource guides for patients aged 15–39 years and for patients aged 40 years and older and a documented review of

		patients' individual needs, available support services, and follow-up plans at the completion of treatment.
	Goal/ desired result	The objective is to ensure that all patients receive individualized supportive care throughout their cancer pathway, based on regular needs assessments and age-related guidance. This approach should enable the timely identification and management of supportive care needs during treatment. Systematic collaboration with the municipalities through the Danish Knowledge Center for Late Effects to strengthen the patient pathway. The patient's individual needs, relevant support services, and follow-up plan should be reviewed and documented within the existing care pathway plan throughout the cancer pathway and at the completion of treatment, forming the basis for the individual survivorship plan (which is discussed with the patient and includes details of all support services and support groups available) and supporting the transition to survivorship. Enhanced collaboration with allied health professionals, municipalities, and other stakeholders to promote consistent and equitable information on supportive care through the Danish Knowledge Centre for Cancer Late Effects."
	Actions description	The initiative builds on CCCC's existing Patient Information about supportive care, which will be supplemented with information about steroid treatment and its potential side effects, the Care Pathway Plan (<i>Plejeforløbsplan</i>) will be further developed through the systematic use of the regional needs assessment tool "<i>Support for Life with Cancer</i>", the age-specific counselling and resource guides, and a documented survivorship plan at the completion of active treatment. Finally, the supportive care services routinely and consistently will be integrated into clinical sessions across all pathways in both hospitals when relevant - also in the field of cancer survivorship, led by the Danish Knowledge Centre for Cancer Late Effects, including collaboration, annual training programs and feedback from patients, allied health professionals, municipalities, and potential stakeholders.
	Who is involved and responsible for result	• CCCC Leadership • The joint Advisory Board of Cancer Patients • The Quality Council • Oversygeplejersker (Head Nurses) • Kliniske Sygeplejespecialister (Clinical Nurse Specialists) • Nurses from HGH and RH (Herlev Hospital and Rigshospitalet) •
	Start (date)	January 2028
	Evaluation (date)	January 2029

	Deadline (date)	June 2029
	Priority – High / Medium	Medium
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 7	The listed standards and numbers (#) are covered by this action plan:	7 Patient Involvement and Empowerment: Standard 26 #3 #4
	Opportunity	Patient experience is an integrated part of the quality improvement system at Copenhagen Comprehensive Cancer Center (CCCC). Patients experience data are systematically collected monthly through the Danish National Survey of Patient Experiences (LUP). In addition, departments within the CCCC use both Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) for adverse event reporting, radiotherapy side effects as well as overall symptoms and quality of life scoring. The OECl review identified an opportunity to further standardize and integrate their use across the center. The opportunity is therefore to consolidate the established PROM and PREM activities within a CCCC framework by establishing systematic review and discussion of all PRO data at the CCCC board level.
	Action	Establish and implement a common CCCC framework for the systematic collection, use and follow-up of PROM and PREM data across Herlev Hospital and Rigshospitalet, building upon existing validated PROMs and the national LUP framework. The framework will be progressively integrated into clinical workflows and electronic systems as the digital infrastructure develops.
	Goal/ desired result	The objective is for CCCC to have a coherent and integrated approach to patient-reported outcomes and experiences across the cancer pathway, irrespective of which CCCC clinical unit or hospital provides the care. Furthermore, CCCC will increase the use of PROM in the clinic, ensuring relevant and timely data on patients' symptoms, side effects, functional impact, QoL and palliative care needs. This increase will feed into electronic clinical systems and the CCCC quality management system to support the CCCC in a coherent and integrated use and monitoring of PROM/PREM data.
	Actions description	Map and document the PROMs and PREMs currently used across CCCC and identify opportunities for further standardisation and integration.

		- Further extend and develop the use of validated PROMs in all parts of the CCCC. - Establish LUP as the documented PREM component of the CCCC quality management framework, including its continuous monthly data collection, reporting and annual status, as well as ensure that relevant LUP results are reviewed within the existing CCCC and clinical quality and management structures and lead to improvement actions where relevant trends or concerns are identified. As electronic systems develop, progressively integrate PROM and PREM data into clinical workflows and the CCCC quality management system.
	Who is involved and responsible for result	Implementation takes place across the clinical units at Herlev Hospital and Rigshospitalet as part of the common CCCC quality management system. Progress will be monitored through the existing CCCC governance structures and the annual Governance and Quality Cycle.
	Start (date)	January 2028
	Evaluation (date)	January 2029
	Deadline (date)	June 2029
	Priority – High / Medium	Medium
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 8	The listed standards and numbers (#) are covered by this action plan:	8 Multidisciplinary: Standard 31 #7 and Standard 33 #1
	Opportunity	Strengthening governance, quality assurance and standardization of Multidisciplinary Team (MDT) meetings across the Copenhagen Comprehensive Cancer Center (CCCC). This initiative will further develop communication and collaboration between MDT groups, hospital management and leaders.
	Action	Establish a permanent CCCC MDT Audit Group responsible for continuous quality improvement, governance and standardisation of all MDT conferences across CCCC.
	Goal/ desired result	• Annual documented evaluation of adherence to national clinical guidelines in MDTs • A common CCCC MDT SOP implemented across all tumor-specific MDTs • A structured governance model supporting continuous quality improvement, peer learning and organisational development • Increased consistency in MDT organisation while maintaining tumor-specific flexibility • Improved quality assurance, transparency and documentation of MDT performance
	Actions description	The CCCC MDT Audit Group will consist of representatives from hospital management, departmental leadership, MDT clinical leads (including surgical, medical/radiation oncology and one additional diagnostic specialty such as pathology or radiology), oncology nursing, supportive care and patient representatives. The group will oversee development and continuous improvement of MDT conferences which may include the following initiatives: • An annual Quality Improvement Plan for each MDT • Development and implementation of a common CCCC MDT SOP describing minimum standards for MDT conferences including patient involvement, quality assurance and annual review of MDT performance. • Annual MDT Audit Conference, where each MDT presents itself and its future improvement priorities. • Annual peer-review audits, where MDTs are paired and perform structured reciprocal reviews using a common audit framework. • Rotation of external MDT observers. MDT members visit, observe and feedback other MDT groups within the CCCC. • Introduction of an annual Guideline Adherence Audit, reviewing a representative sample of MDT decisions against current national (DMCG) clinical guidelines. • Development of targeted MDT Improvement Programmes for MDTs experiencing organisational or quality challenges.
	Who is involved and responsible for result	CCCC board and leadership group
	Start (date)	October 2026

	Evaluation (date)	October 2027
	Deadline (date)	January 2029
	Priority – High / Medium	Medium
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 9	The listed standards and numbers (#) are covered by this action plan:	9 Prevention and Early Diagnosis: Standard 38 #4
	Opportunity	To ensure psychological support is offered in a specialized setting as part of Oncogenetic Services and in-house in CCCC.
	Action	Employment of specialised psychologist(s) with specialisation in Genetic counselling. The psychologist provides psychological and psycho-social support for patients and families with highly complicated psychological cases incl. help to identify the needed help for the future and how to proceed. Also, the psychologist provide input for research, and e.g., support for patients and families with fragile X Syndrome.
	Goal/ desired result	Genetic counseling is offered in a highly specialized set up, including by trained genetic counselors as part of a multidisciplinary team, which also includes a psychologist and medical genetics specialists with a focus on psychosocial support of the individual patient as well as timely risk intervention and support for communication in the family.
	Actions description	All genetic counsellors work within the paradigm of “the complete human” and are trained in offering psychosocial support as part of genetic counselling routinely.
	Who is involved and responsible for result	CCCC Education Lead and Oncogenetic Department and services within CCCC. Regional Late-effect clinic and CCCC leadership.
	Start (date)	November 2026
	Evaluation (date)	June 2028
	Deadline (date)	January 2029
	Priority – High / Medium	Medium
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 10	The listed standards and numbers (#) are covered by this action plan:	10 Diagnosis: Standard 40 #3
	Opportunity	To ensure the Radiologist's written report is available to attending doctors at the latest 72 hours after the examination was performed. We aim to fulfil this for at least 80% of the patients in CCCC.
	Action	Via structured and efficient work-streams and utilisation of AI and digital imaging review tools, CCCC aim to decrease the imaging review and reporting time from 7 days to 3 days (72 hours).
	Goal/ desired result	Timely availability of written pathologist reports will ensure due diligence and efficient patient courses, where the waiting time for e.g., multidisciplinary Team Conference discussions are not postponed due to insufficient imaging report availability etc.
	Actions description	CCCC Leadership and the Leadership of the Radiologist departments will collaborate to identify, how the most efficient cancer patient courses can be supported by delivering even faster availability of imaging reports. Hence clinicians can evaluate and discuss the best treatment with cancer patients more efficiently. Involvement and support from patient course coordinators to identify potentially gaps/delays in referrals, booking, imaging and review/writing of imaging reports. Technical review and services regarding the AI solutions becoming available – validation of new tools needed.
	Who is involved and responsible for result	CCCC leadership in collaboration with Radiology department leaders, and the leaders of The Nuclear Medicine Departments.
	Start (date)	November 2026
	Evaluation (date)	June 2027
	Deadline (date)	January 2028
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 11	The listed standards and numbers (#) are covered by this action plan:	11 Diagnosis: Standard 45 #4
	Opportunity	Improvement of timelines in pathology reporting
	Action	
	Goal/ desired result	Routine histology and immune-histochemistry are provided within 5 days
	Actions description	Background In agreement with the referring clinicians, primary diagnostic pathology, most often biopsy material, is prioritized ahead of surgical resection specimens. This ensures timely cancer diagnosis, relevant immunohistochemical biomarker reporting and rapid clinical decision-making regarding MDT planning, surgery, neoadjuvant treatment or systemic therapy. Surgical specimens remain subject to agreed turnaround times, but are often received later in the treatment course, when diagnosis has been established and treatment has been initiated or, in some cases, completed. Turnaround times and pathology service are continuously discussed with clinical departments through regular pathway meetings, MDT-related dialogue and quality meetings. The departments aim to provide the right answer at the desired time, based on agreed clinical needs and patient pathways, including diagnostic clarification, MDT planning, surgery and oncological treatment. Data available from HGH show that, based on 2.100 needle biopsies suspected of breast cancer from January-May 2026, 91.1% were reported by day 4, with a substantial proportion already reported by day 2–3. Similarly, gastrointestinal cancer pathway biopsy data from the same time period, show that 92.4% were reported on day 4. These data demonstrate that the department prioritizes rapid primary cancer diagnosis and clinically relevant biopsy reporting in the early diagnostic pathway. Action The departments have the necessary tools to systematically monitor turnaround times for routine pathology as well as for cases requiring additional immunohistochemical, molecular or other supplementary analyses. Monitoring is performed across specimen types and subspecialties, allowing distinction between routine/simple cases, complex surgical specimens and cases requiring extended diagnostic work-up. Some larger resection specimens, including prostatectomies, cystectomies, rectal resections and mastectomies, require up to 48 hours of formalin fixation after receipt before safe and diagnostically sufficient macroscopic handling can be performed. This limits the feasibility of achieving a five-working-day turnaround time for these specimen types. Nevertheless, even where extended turnaround times have been agreed with referring clinicians, the departments strive to provide the shortest clinically appropriate reporting time. We will continue our dedicated work with workflow optimisation and, through the planned recruitment of additional pathologists during 2027 and 2028, we expect to improve turnaround times further.

	Who is involved and responsible for result	Leadership of department of pathology (HGH and RH)
	Start (date)	September 2026
	Evaluation (date)	March 2028
	Deadline (date)	September 2028
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 12	The listed standards and numbers (#) are covered by this action plan:	12 Treatment: Standard 54 #1
	Opportunity	The anticancer drug pathway/production can be improved by a completely digital system
	Action	To implement a digital system for preparation of anticancer drugs in the pharmacy
	Goal/ desired result	A complete digital system for preparation of drug in the pharmacy unit
	Actions description	Assess the production flow on HeH and RH to clarify scope of the production system / project The production has been analysed and found feasible for digitalisation. However, a more complete digitalisation depends on alignment of clinical procedures between RH and HeH. The steering committee has just decided to withhold the project until the merge of the two regional pharmacies and thereby the organisation of cytostatics production across Herlev, Copenhagen, Køge, and Næstved has been aligned and completed. This will allow greater flexibility between production sites and support the expansion of pre-hospital treatment across a larger geographical area.
	Who is involved and responsible for result	Program responsible: - Kristian Vammen, program leader, regional pharmacy main capital Project steering committee: (Representatives from The Capital Region of Denmark) - Marianne Hald Clemmesen, Director clinical pharmacy & Cytostatika, Rigshospitalet - Helle Byg Armandi, Director clinical pharmacy & Cytostatika, Herlev-Gentofte Hospital - Hasna Ghziel, Department Manager Cytostatica Rigshospitalet - Theis Wolter Bork Petersen, Department Manager Cytostatica Herlev Hospital (Representative from Region Zealand) - Jacob Hartvig Løpner, Director cytostatica production, Roskilde, Køge, Næstved hospitals External consultants: - EPISTA
	Start (date)	November 2026
	Evaluation (date)	TBD
	Deadline (date)	Expected 2029
	Priority – High / Medium	Medium - due to fusion of the two regional pharmacies from The Capital region and Region Zealand
FUP	Progress	Pending until fusion of our two regional pharmacies
	Status of implementation	
	Results achieved	

Action Plan 13	The listed standards and numbers (#) are covered by this action plan:	13 Treatment: Standard 55 # 8
	Opportunity	The OEI peer review identified the need to strengthen and better document the systematic quality and risk management related to the administration of anti-cancer drugs by providing a coordinated overview of the existing governance, quality assurance and patient safety processes across CCCC.
	Action	Strengthen and document the existing quality and risk management processes related to the administration of anti-cancer drugs through a coordinated monitoring and evaluation framework across CCCC.
	Goal/ desired result	Quality and risk management related to the administration of anti-cancer drugs are systematically documented, monitored and continuously used to improve patient safety, quality of care and compliance with clinical standards across CCCC.
	Actions description	Administration of anti-cancer drugs is performed only by nurses who have successfully completed the mandatory competency-based training programme in systemic anti-cancer treatment. Nurses may administer anti-cancer drugs only after completing the training programme and demonstrating the required competencies. Specialist oncology nurses are appointed in all outpatient clinics and inpatient wards where systemic anti-cancer treatment is administered. They act as local clinical experts and are responsible for supporting the implementation of national and local guidelines, promoting best clinical practice and ensuring continuous competency development within their units. Quality and patient safety are continuously monitored through the established incident reporting system for adverse events and medication-related incidents. Departmental management regularly reviews medication errors, patient safety events and identified risks to ensure learning, prevention and implementation of improvement initiatives. A close collaboration is maintained between the clinical departments and the Cytotoxic Preparation Unit to ensure the safe preparation, handling and administration of anti-cancer drugs, the implementation of updated procedures and the continuous optimisation of clinical workflows. To further strengthen the systematic quality and risk management of anti-cancer drug administration, relevant quality indicators, medication incidents, audit findings and improvement initiatives will be reviewed annually by the CCCC Quality Council as part of the Governance and Quality Cycle. The results will be incorporated into the Annual Quality Report and reported annually to the CCCC Board in accordance with the CCCC Governance Charter (Appendix 1).
	Who is involved and responsible for result	• Specialist Oncology Nurses • Department Management (Chief Physicians and Chief Nurses) • CCCC Quality Council • Cytotoxic Preparation Unit
	Start (date)	September 2026
	Evaluation (date)	March 2028

	Deadline (date)	September 2029
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 14	The listed standards and numbers (#) are covered by this action plan:	14 Treatment: Standard 59 #1, #2, #3
	Opportunity	Cancer patients have access to psycho-oncology support, but the service is mainly outside the CCCC and a systematic screening with a validated assessment tool is not routinely applied in all patient pathways and the effect and follow-up need to be documented.
	Action	Structured screening with validated assessment tools is to be systematically used and documented. Procedures should be defined about the way to refer patients to the psycho-oncology service, including patients in psychological distress. Establish a formal collaboration agreement between the Cancer Centre and the Department of Psychiatry.
	Goal/ desired result	All patients with psychological distress will have equitable access to appropriate psycho-oncology support through clearly defined referral pathways. The patients will have structured and timely access to psycho-oncology expertise with oncology-specific competencies through a formalized collaboration model.
	Actions description	Implementation of a screening with a validated distress tool (PROM) Define screening time points: at diagnosis, during treatment, follow-up where relevant. Integrate screening results into clinical documentation. Train healthcare professionals in use and interpretation of screening results. Describe referral options to: Psychiatry Department, municipal services, Danish Cancer Society support programs, relevant other regional psychological services (palliation, hospice). Documentation of result, referral and follow-up in patient record. Formal collaboration agreement with Psychiatry Department Pathway for referral of patients with health anxiety and fear of recurrence
	Who is involved and responsible for result	Senior and specialist nurses Chief nurses CCCC board
	Start (date)	June 2026
	Evaluation (date)	June 2027
	Deadline (date)	June 2028
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 15	The listed standards and numbers (#) are covered by this action plan:	15 Treatment: Standard 62 #1
	Opportunity	Nutritional care is already an integrated part of the cancer pathway at Copenhagen Comprehensive Cancer Center (CCCC). Patients have access to dietetic support, and patients with identified nutritional needs are referred to assessment and intervention. Newly referred outpatients are screened at their first or second visit, while inpatients are screened within 24 hours. The OECl review identified an opportunity for CCCC to further strengthen and harmonise nutritional screening and access to dietetic support across its clinical units. Current identification of nutritional risk is based on local practices, including the VIP SOP, and a standard nutritional screening tool in the electronic system.
	Action	CCCC will establish and implement a common approach to nutritional screening and referral across its clinical units at Herlev Hospital and Rigshospitalet, including the systematic use of a standardized nutritional screening tool. The common approach will also support consistent and timely access to dietetic assessment and nutritional intervention based on identified patient needs.
	Goal/ desired result	The objective is for CCCC to ensure that patients at risk of malnutrition are identified early and receive timely and appropriate nutritional assessment and support, irrespective of which CCCC clinical unit provides their care. The strengthened approach should establish a common CCCC standard for nutritional screening across relevant cancer pathways to ensure early identification of patients at risk of malnutrition or with increased nutritional needs.
	Actions description	- CCCC will review and harmonise current nutritional screening practices and referral pathways across its clinical units. - Establish a standardized nutritional screening tool appropriate for the CCCC cancer population and relevant clinical settings. - Integrate the common screening approach into existing clinical workflows, including screening of newly referred outpatients and inpatients. - Define common criteria for referral to dietitians and other relevant nutrition specialists based on screening results. - Ensure that nutritional screening, identified needs and relevant interventions are documented and followed - Provide education and guidance to relevant clinical staff on the common screening approach and referral criteria.
	Who is involved and responsible for result	CCCC Leadership and the CCCC Quality Council are responsible for the overall framework, coordination and systematic follow-up across the centre. The common CCCC approach will be implemented across the clinical units at Herlev Hospital and Rigshospitalet as part of the integrated CCCC quality

		management system. Clinical units are responsible for implementation within their respective pathways, while dietitians and nutrition specialists provide specialist assessment, intervention and follow-up.
		Progress will be monitored through the existing CCCC governance structures and the annual Governance and Quality Cycle.
	Start (date)	October 2027
	Evaluation (date)	October 2028
	Deadline (date)	June 2029
	Priority – High / Medium	Medium
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 16	The listed standards and numbers (#) are covered by this action plan:	16 Research: Standard 69 #1, #2, #3
	Opportunity	CORE There is a regularly updated research strategic plan covering at least three years, which is integrated in the overall strategy of the cancer centre.
	Action	
	Goal/ desired result	The research strategy plan is regularly updated.
	Actions description	Strategic Priorities for 2026–2029 - Advancing Clinical Research in Collaboration with Users, Industry, and the Public Sector - Increase the number of clinical trials and patient participation across all specialties, including both investigator-led and industry-sponsored studies. - Introduce new clinical trial models that reflect advances in personalized medicine and incorporate interdisciplinary approaches. - Ensure high-quality, patient-centered research in all fields and develop more centers of clinical research excellence. - Expand national and international collaboration on multicenter clinical trials. - Strengthening Translational Research as a Link Between Basic and Clinical Science - Promote more collaboration between basic and clinical researchers through joint appointments and shared meeting spaces. - Expand biobanks and associated research registries to ensure optimal access to biological materials and data. - Support curiosity-driven, long-term research by providing stable frameworks for outstanding research environments. - Ensure access to infrastructure and core facilities that support advanced, resource-intensive methodologies. - Enhancing Data Management, Analysis, and Sharing - Improve the infrastructure for the use of health data in research. - Promote open science and establish secure data-sharing systems that protect privacy. - Facilitate the use of high-performance computing and artificial intelligence in both clinical and translational research, including as tools for treatment. - Automate data flow between electronic health records and research registries wherever possible, using AI and LLM - Support national quality registries in achieving complete, representative data collection and feedback for quality improvement and research. - Provide researchers with secure, user-friendly IT systems for data extraction, storage, and collaboration. - Implement electronic, dynamic patient consent systems. - Supporting Research Careers and Recruitment - Create support programs for early-career researchers across all professional groups.

		• Enable joint roles that combine clinical practice and research following PhD completion. • Encourage international engagement, including participation in global research networks and mobility programs. • Increase international recruitment of researchers. Actions The strategic plan will be updated every three years. #1. The research board will define key performance indicators for the priorities, including publications, grants and innovations. #2 These will be reported annually in the annual report of the center #3.
	Who is involved and responsible for result	Research board (HGH and RH)
	Start (date)	September 2026
	Evaluation (date)	March 2028
	Deadline (date)	September 2029
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 17	The listed standards and numbers (#) are covered by this action plan:	17 Research: Standard 70 #1, #2, #3
	Opportunity	CORE There is a regularly updated research strategic plan covering at least three years, which is integrated in the overall strategy of the cancer centre.
	Action	
	Goal/ desired result	The organisational responsibilities within the research, innovation and development structure are clearly defined
	Actions description	The ambition for establishing CCCC is primarily to strengthen and future-proof cancer treatment and care for patients. The organization as a center contributes to strengthening the quality within all aspects of the cancer area, which is positive for both patients, relatives, and employees of CCCC. The Centre also aim to contribute to improve treatment and research collaborations nationwide. We will implement further collaboration and systematic approaches to the research initiated and performed in CCCC. This will be achieved by: • Strengthened and more systematic execution of operational aspects of initiating new clinical trials • Utilizing the advantages of “large-scale economics” for legal and contractual issues, finances, and the framework for grant-applications and funding • Improve the sense of community and uniformity between the multiple research departments/units in CCCC, to further focus on collaboration and multicenter engagement • Clear structure and methodology, thereby enabling one patients’ treatment to create experience and evidence for the treatment of future patients, thereby benefiting the next patients/generations • Strengthened focus on both doctor, nursing, and interdisciplinary research • Increased focus on prevention of cancers by strengthened university collaboration within basic/translational research and the clinic • The CCCC board's influence on European and international networks/collaborations is brought further into play. Actions The research board will ensure representation of all fields of cancer research to achieve comprehensiveness of research. The board will consist of senior researchers from basic and clinical research, including oncologists, surgeons, diagnostic fields, nursing, radiotherapy, hematology, pediatric oncology, supportive care and survivorship. Partners from the university, including the technical university, are also represented. The delegates of the board will represent their field and report accordingly.

		The board defines the specific focus areas and follows key performance indicators to ensure implementation of the strategic plan. The research board will meet four times a year and hold the responsibility for the annual meeting and the annual scientific report. #1 All research groups will be described and mapped in the organisational chart. #2 Qualifications and responsibilities of group leaders will be defined and described within the first years, in order to be included in the first scientific report. #3
	Who is involved and responsible for result	Research board (HGH and RH)
	Start (date)	September 2026
	Evaluation (date)	March 2028
	Deadline (date)	September 2029
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 18	The listed standards and numbers (#) are covered by this action plan:	18 Research: Standard 71 #1
	Opportunity	CORE The cancer research budget covering both external and internal funding for the cancer centre is defined each year.
	Action	
	Goal/ desired result	A planned cycle for resourcing the infrastructure of research activities is defined
	Actions description	A. The State determines the overall health policy values, goals, and framework for the public health service, including the framework for the hospital area. B. The regions run the hospitals and are responsible for general practitioners and private specialist clinics. All cancer treatment is being performed in public hospitals. C. The municipalities are responsible for prevention, care, rehabilitation (not during hospitalization), and home nursing etc. Accordingly, a dedicated research budget will not be allocated to the CCCC. But an excellent infrastructure is at place, and basic and clinical scientists are partly employed based on regional core funding. In addition, research is being funded by private and public funding bodies at a competitive level. Actions We will prioritize: • Strengthening evidence-based approaches to prevention, diagnosis, treatment, care, rehabilitation, and patient pathways—ensuring all relevant professional groups and research traditions are involved. • Enhancing patient involvement in research—from identifying research needs to evaluate the perceived impact and value of treatments and care. • Ensuring that all hospitals in the region allocate a minimum portion of their total budget to research across all specialties as part of their operational responsibilities. Research Support for Specialized Treatments As a regional healthcare provider, we have a particular responsibility to ensure sufficient and relevant research activity in specialized treatments. This includes areas requiring advanced equipment, specific expertise, and often involving smaller or more complex patient groups. We aim to continue developing clinical research in specialized treatments. In the coming years, we will lead efforts to support research into new treatment methods, which are increasingly characterized by being gentler, tailored, or personalized. We hope that specialized research will help us develop more effective and less invasive treatments, benefiting both patients and the healthcare system. We will prioritize:

		- Ensuring that research enables the region to maintain or expand the number of specialized functions at its hospitals. - Supporting the continued development of excellent research environments. - Promoting opportunities for clinical research into future, more personalized and less invasive treatments. Optimal Conditions for Research and Dissemination We aim to provide researchers with the best possible guidance and support throughout the research process, creating frameworks that both support and professionalize research environments. We want to ensure conditions that allow researchers to thrive and realize their full potential. We strive to create attractive research environments that retain, attract, and develop talented researchers. These environments should foster learning between emerging and established research groups and promote active and effective knowledge sharing—both in terms of research processes and clinical implementation. Our research and its results must be openly and continuously evaluated and communicated, so that research-based knowledge is quickly translated into education and practice. This includes active knowledge sharing about new treatments and clinical workflows. We will prioritize: - Ensuring fast and easy access to high-quality data and maintaining short processing times for legal and ethical approvals. - Supporting emerging research environments through internal prioritization and partnerships with excellent research groups. - Actively implementing Open Science principles in the dissemination of research results. The annual scientific reports will report on both external and internal funding for the cancer centre each year. #1.
	Who is involved and responsible for result	Research board (HGH and RH)
	Start (date)	September.2026
	Evaluation (date)	March 2028
	Deadline (date)	September 2029
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 19	The listed standards and numbers (#) are covered by this action plan:	19 Research: Standard 72 #1, #2
	Opportunity	CORE An external Scientific Advisory Board (SAB) meets at regular intervals and advises the cancer centre on its cancer research strategy, organisation, infrastructure and overall performance, and the performance of each research group is externally or internally reviewed at regular intervals.
	Action	
	Goal/ desired result	Periodical external site visits of research are organized.
	Actions description	CCCC will during Q3 and Q4 in 2026 establish its Scientific Advisory Board to provide regular reviews of scientific output, quality and performance and giving advice on research strategy. The SAB will consist of up to six highly distinguished scientists that represent a variety of different scientific backgrounds in basic, translational and clinical cancer research. Collectively, they should have complementary competencies and a long track record of scientific and strategic leadership experience. They are thus very well equipped for evaluating scientific activity at the institute. Actions The SAB will be appointed and bylaw presented during the fall of 2026. The first SAB visit will be arranged in the first half of 2027. #1 The SAB will provide regular reviews of scientific output, quality and performance and advice on the research strategy. #2.
	Who is involved and responsible for result	Research board (HGH and RH)
	Start (date)	September 2026
	Evaluation (date)	March 2028
	Deadline (date)	September 2029
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 20	The listed standards and numbers (#) are covered by this action plan:	20 Research: Standard 77 #1, #2
	Opportunity	There is an internal review of grant submission and an internal evaluation of the success of grant proposals.
	Action	
	Goal/ desired result	There is a procedure for dealing with grant proposals.
	Actions description	Resources for identifying funding opportunities and supporting the preparation of applications are being established to increase both the number and quality of external funding proposals. This is part of a new strategic plan for research and innovation of the hospitals. Enhanced research support/grant support will be beneficial to increase the level of large-scale projects being led or coordinated by CCCC researchers. Regional support is available for EU grants, and training courses in grant writing are offered to students. Actions The research board will develop a model to peer-review larger strategic national and international applications. #1 Smaller national applications will not be included in this process initially. A systematic evaluation of grant-proposal success will be implemented by the research board to ensure a high level of success. #2
	Who is involved and responsible for result	Research board (HGH and RH)
	Start (date)	September 2027
	Evaluation (date)	March 2029
	Deadline (date)	September 2029
	Priority – High / Medium	Medium
	Progress	
FUP	Status of implementation	
	Results achieved	

Action Plan 21	The listed standards and numbers (#) are covered by this action plan:	21 Research: Standard 79 #1
	Opportunity	Innovations strategy is an explicit part of the strategic plan of the centre.
	Action	
	Goal/ desired result	There are policies in place for the protection of intellectual property and innovation.
	Actions description	There are regional strategies in place to support innovation in health research. This includes strategic partnerships with the Technical University (DTU) and several pharmaceutical companies. Rigshospitalet and Herlev Hospital are part of the Regional Innovations Missions, including the Beta Health Program, supported by the Novo Nordisk Foundation. Regional support guidelines for researchers are available, alongside a regional framework for intellectual property ownership (with IP owned by the region) and a regional TTO is available to provide support for the protection and utilization of intellectual property. The National Center for Cancer Immune Therapy (CCIT) from HGH provides support for business development arising from research. Actions Innovation will be incorporated in the core strategy of CCCC.
	Who is involved and responsible for result	Research board (HGH and RH)
	Start (date)	September 2026
	Evaluation (date)	March 2028
	Deadline (date)	September 2029
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 22	The listed standards and numbers (#) are covered by this action plan:	22 Research: Standard 80 #4, #5, #9, #10, Standard 81 #1
	Opportunity	The unit has an annual plan for its activities, and the cancer centre has a policy for promoting clinical trials, including internal and public information on trial availability. CORE The cancer centre keeps an up-to-date database of clinical trials, including the accrual of patients. The cancer centre executes an annual report on clinical trial activities. The cancer centre publishes the ongoing clinical research trials on its website for patients and external physicians.
	Action	
	Goal/ desired result	Tasks of the Clinical Research Management unit and Institutional Review Board (IRB) are defined. The cancer centre promotes and disseminates internally and externally clinical research projects and their results.
	Actions description	Clinical trial management units (CTU) are in place at both HGH and RH, with the expertise to run Phase I, II and III trials. These are separate and located at departments of Oncology, Hematology and Pediatric Oncology. At total of more than 100 study nurses and coordinators are full-time employed in the units. The units meet every six months to ensure strategic alignment and common workflow. All trial proposals are discussed at local protocol meetings. The CCCC utilises the Ethics Committee for the Capital Region as review board. Open trials are listed on the CCCC website, although not in lay format. Trials are managed digitally on an individual basis, with no centralised overview available. Personal data protection follows the Capital Region's data protection policy. Actions The Research Board will provide an overview of all research activities and make an annual plan for activities, including the annual meeting and other meeting activities #4. One of the research goals is that all patients should have the opportunity to contribute to research. The research board will invite all new patients to consent to data collection for research and inform about clinical trials. This includes a public list of ongoing clinical trials #5. Each CTU has already up-to-date databases of clinical trials and inclusion, but the research board will implement a common list of trials and accrual, which will be a part of KPI management for the annual reporting #9. The CCCC website will be updated with information both for physicians and patients/relatives. This will include links to the patient organization The Danish Cancer Society, to ensure all information is updated accordingly. (Standard 81 #1) As part of the annual scientific report of the center, clinical trial activities will be reported. #10.

	Who is involved and responsible for result	Research board (HGH and RH)
	Start (date)	September 2026
	Evaluation (date)	March 2028
	Deadline (date)	September 2029
	Priority – High / Medium	High
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 23	The listed standards and numbers (#) are covered by this action plan:	23 Education and Training: Standard 84 #4and Standard 85 #3
	Opportunity	Undergraduate education To strengthen and clarify the role of CCCC in ensuring relevant oncology education and competencies for supportive disciplines involved in cancer care. Undergraduate education for supportive disciplines such as physiotherapists, occupational therapists, psychologists, dietitians, pharmacists and social workers is primarily organised by the respective universities and higher education institutions and is therefore not directly governed by CCCC. As cancer represents a substantial part of the patient population, students within these disciplines are exposed to cancer-related topics and patients as part of their undergraduate education and clinical training. The opportunity for CCCC is therefore to strengthen coordination with the departments employing supportive disciplines and to ensure access to relevant cancer-specific continuing and postgraduate education. Postgraduate education and competence development Postgraduate education and competence development for supportive disciplines are primarily organised within the hospital departments employing these professional groups. Within the relevant disciplines and hospital specialties, dedicated development functions and designated professionals with responsibility for specialty-specific competence and professional development are established. These structures ensure that specialist knowledge is maintained and developed locally. However, these functions are currently organised mainly within individual professions, departments and hospitals. CCCC therefore has an opportunity to strengthen cross-organisational collaboration between the professionals responsible for development and specialty-specific competencies, improve the overview of existing oncology-specific postgraduate educational opportunities, and identify areas where additional coordination or educational activities may add value.
	Action	CCCC will map existing educational pathways and cancer-specific educational opportunities for supportive disciplines and establish a structured collaboration with the hospital departments responsible for these professional groups. Based on this mapping, CCCC will define its role in supporting and coordinating oncology-specific postgraduate and continuing professional education for supportive disciplines That may involve providing educational seminars, e-learning modules and recorded lectures
	Goal/ desired result	A documented overview of existing cancer-specific educational opportunities for supportive disciplines relevant to CCCC. Clearer coordination between CCCC and the hospital departments employing supportive disciplines. Improved access to relevant, high-quality oncology-specific continuing and postgraduate education. A sustainable model in which CCCC complements, rather than duplicates, undergraduate programmes provided by universities and other higher education institutions.

	Actions description	Map the undergraduate educational pathways and clinical placements relevant to supportive disciplines working within cancer care. Map existing cancer-specific educational resources and courses available to these professional groups, including external educational providers such as Skaccd.org and other relevant national organisations. Identify the hospital departments and professional leads responsible for competence development of physiotherapists, occupational therapists, psychologists, dietitians, pharmacists, social workers and other supportive disciplines involved in CCCC. Establish a CCCC network connecting development and specialty-responsible professionals across supportive disciplines, departments and the two hospitals. Use the network to share educational resources, identify common competency needs and disseminate relevant developments in oncology across professional groups. Identify gaps in existing continuing education and, where relevant, develop or facilitate additional multidisciplinary oncology education. Provide access to e-learning modules and recorded lectures through the CCCC website
	Who is involved and responsible for result	CCCC Education Lead and the Knowledge Center for Late Effects together with CCCC leadership
	Start (date)	November 2027
	Evaluation (date)	January 2028
	Deadline (date)	January 2029
	Priority – High / Medium	Medium
FUP	Progress	
	Status of implementation	
	Results achieved	

Action Plan 24	The listed standards and numbers (#) are covered by this action plan:	24 Education and Training: Standard 84 #6 and Standard 85 #5
	Opportunity	Undergraduate education and exchange International exchange programmes and support structures for undergraduate students already exist through the University of Copenhagen and other educational institutions. However, CCCC currently lacks a comprehensive overview of the opportunities for international medical, nursing and supportive discipline students to undertake oncology-related clinical placements and educational activities within CCCC departments. The opportunity is therefore to improve coordination and visibility of existing international undergraduate educational opportunities and to identify potential gaps or barriers to international exchange. Postgraduate education and exchange International postgraduate educational and exchange opportunities are available through universities, professional organisations and international cancer networks. These may include clinical observerships, professional exchanges, courses and other educational activities offered through organisations and networks such as OEI, ESMO and ECCO. However, CCCC currently lacks a coordinated overview of both the opportunities for international healthcare professionals to undertake postgraduate educational or clinical placements within CCCC and the opportunities for CCCC professionals to participate in international postgraduate exchanges and educational activities. The opportunity is therefore to map and coordinate existing opportunities and subsequently assess whether additional CCCC-level initiatives are needed. Also, the CCCC wish to increase visibility of educational offerings through CCCC website and international networks (e.g., OEI, ESMO, ECCO).
	Action	CCCC has the possibility to exchange medical/nursing/supportive discipline students from other countries via University of Copenhagen and Metropol (nursing, supportive disciplines). CCCC will establish a consolidated overview of existing international undergraduate and postgraduate educational and exchange opportunities relevant to cancer care. This will include opportunities for international students and healthcare professionals to undertake clinical placements, observerships or other educational activities within CCCC, as well as opportunities for CCCC staff to participate in international postgraduate education and exchange programmes. Based on the mapping and an assessment of identified gaps and barriers, the CCCC Board will decide whether further initiatives are required.
	Goal/ desired result	A comprehensive overview of international undergraduate and postgraduate oncology education and exchange opportunities relevant to CCCC. Improved visibility of opportunities for international students and healthcare professionals wishing to undertake educational activities within CCCC. Improved awareness among CCCC staff of international postgraduate education, observership and exchange opportunities.

		Identification of practical and organisational barriers to international exchange. Stronger use of existing university, professional and international cancer networks. A strategic decision by the CCCC Board on whether additional CCCC-level initiatives or dedicated exchange programmes are required.
	Actions description	Map existing international undergraduate exchange programmes and support structures available through the University of Copenhagen and other relevant educational institutions. Map opportunities within CCCC departments for international medical, nursing and supportive discipline students to undertake clinical placements or other oncology-related educational activities. Map existing opportunities for international postgraduate healthcare professionals to undertake clinical placements, observerships or educational activities within CCCC. Map opportunities for CCCC healthcare professionals to participate in international postgraduate education, observerships and exchange programmes, including opportunities available through relevant organisations and networks such as OEI, ESMO and ECCO. Identify relevant entry points, application procedures, contact persons and eligibility requirements for the identified opportunities. Identify barriers to international exchange, including language requirements, supervision capacity, funding and administrative requirements. Establish a consolidated overview of international educational and exchange opportunities and make this accessible to relevant CCCC professionals, educational partners and prospective international participants. Present the mapping and gap analysis to the CCCC Board. Based on the findings, the CCCC Board will decide whether additional measures are required. These may include improved coordination and promotion of existing opportunities, formal partnerships with external institutions and cancer networks, or establishment of dedicated CCCC undergraduate and/or postgraduate exchange programs.
	Who is involved and responsible for result	CCCC Education Lead together with CCCC leadership
	Start (date)	January 2027
	Evaluation (date)	January 2028
	Deadline (date)	January 2029
	Priority – High / Medium	Medium
	Progress	
	Status of implementation	
	Results achieved	