OECI Accreditation and Designation

OECI Qualitative standards

How to read the document:

- Table 1 below shows the topics of all the standards in total.
- Table 2 (starting at page 4) shows all standards with the sub-questions.
- The related quantitative questionnaire is in a separate document with parallel chapter headings.

- **Table 1: OECI A&D revised standards: topics (as proposed)**

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Table 2: OECI A&D revised standards and sub-questions

Chapter 1: Governance of the cancer centre (standard 1 to 6)

Structure of the cancer centre – identifiable entity	
Standard 1:	
The cancer centre has an identifiable governing entity (board of directors/executive committee).	
1.	CORE The cancer centre has an identifiable governing entity (board of directors/executive committee) with accountability for: - strategic plan for cancer care - strategic plan for research - quality and safety - budget

Structure of the cancer centre – Quality management	
Standard 2:	
The administrative/board level of the cancer centre includes quality management.	
1.	CORE There is an identifiable director who has quality and risk management as his/her responsibility.
2.	The director who has quality and risk management as his/her responsibility is a member of the board of directors or senior management team of the cancer centre.

Strategy and quality cycle of the cancer centre	
Standard 3:	
A periodical planning and control cycle concerning oncology policy and strategy is present.	
1.	CORE There is a written strategic plan for the cancer centre which covers at least three years, and which is formally endorsed by the board.
2.	Each main service or department of the centre has an annual or multi-year plan which is consistent with the centre's overall strategy plan for cancer.
3.	CORE According to the planning and control cycle the centre produces a (multi-)annual report which results in a quality improvement plan.

Financial stewardship	
Standard 4:	
The centre has processes for ensuring financial sustainability.	
1.	The cancer centre defines a multi-annual budget for its activities which ensures sustainability as far as is practicable.

Cooperation with universities	
Standard 5:	
Written cooperation agreements concerning educational and research activities with at least one university are present and periodically evaluated.	
1	CORE For training and postgraduate education activities.
2.	CORE For research activities.

Cooperation with external partners

Standard: 6	
There are written agreements concerning the allocation of responsibilities and tasks for referrals of patients.	
1.	CORE There are written agreements or regulations, which are currently implemented, with other hospitals and cancer centres, setting out the goals for cooperation, the division of responsibilities and tasks.
2.	There are written agreements or regulations, which are currently implemented, with special cancer care service providers for all services needed that are not directly provided by the cancer centre (e.g. hospices, rehabilitation services or specialist radiology).

Chapter 2: Organisation of quality systems (standard 7 to 18)

Integrated quality, risk and safety management	
Standard: 7	
The cancer centre has a structured policy for quality, risk and safety management.	
1.	CORE There is a quality management system based upon continuous quality improvement and risk based thinking and promoted by the line management.
2.	The quality management system contains risk management (prospective risk assessment and prevention).
3.	The quality management system contains safety management for patients, employees and visitors.
4.	There is a Standard Operating Procedure (SOP) for undesirable events. This procedure is well known and accessible to all.
5.	There are defined processes for reporting, investigating and taking action in response to safety incidents, adverse events and near misses, covering all departments.
6.	Patients are informed of adverse events which affect them.
7.	All activities of the cancer centre follow, when applicable, the guidelines of Good Clinical Practice, good Laboratory Practice and Good Manufacturing Practice.
8.	The centre has an IT, Data storage and processing system(s) which operates to Health Level 7 (HL7) standards.
9.	There is a document management system that facilitates the retrieving and the updating of all SOPs.
10.	CORE There is a dedicated unit or department responsible for the quality system.

Quality analysis and improvement	
Standard: 8	
The cancer centre has an integrated quality, risk, and safety management system.	
1.	There is a quality, risk and safety dashboard with standardised indicators (including overall survival, patient satisfaction, patient quality of life, MDTs' activities).
2.	CORE This dashboard is analysed on a regular basis by senior management and acted upon.
3.	CORE The line management of the centre are responsible for implementing improvements after analysing results of quality and risk and safety factors.

Quality reporting	
Standard: 9	
The centre publishes summary reports or grades from inspections and accreditations.	
1.	The centre systematically publishes on its website summary information on feedback from external quality inspections and accreditations.

Introduction of new practices	
Standard: 10	
There is a standard process for the introduction of new practices	
1.	Systematic risk assessment is performed before the introduction of a new technology or a new intervention.

Quality assurance	
Standard: 11	
Quality assurance programmes (QAPs) are in place.	
1.	Quality assurance programmes are part of the policy for quality and risk management covering all departments.
2.	There is a QAP for clinical research.
3.	CORE There is an internal audit system following an annual plan covering all departments.

Cancer data registration	
Standard: 12	
Cancer patient data are used for developing strategic planning and quality improvement of care processes.	
1.	CORE The number of new patients, newly diagnosed patients and treated patients by tumour type in the cancer centre are available annually at the cancer centre level.
2.	The diagnostic trends of cancer patients by tumour type/stage are known at an institutional level and reported annually to the board of the cancer centre for future planning.
3.	The centre reports all new cancer patients to the regional or national cancer registry.
4.	The treatment trends of cancer patients by tumour type are known at the cancer centre level and MDT level and reported annually to the board for future planning.
5.	The outcome data of cancer patients by tumour type are known at the cancer centre and MDT level and are used by management for strategic planning or policy decisions.

Waiting and throughput times	
Standard: 13	
For critical stages in the care process the maximum waiting times are defined.	
1.	There are standards for the maximum waiting times between referral and first visit to outpatients' clinic or admission to the cancer centre.
2.	There are standards for the maximum waiting time between first visit and the time of definitive diagnosis.
3.	There are standards for the maximum waiting times between definitive diagnosis and first treatment.
4.	There is a record and continuous monitoring of the actual waiting times against the standards.
5.	CORE If maximum waiting times are exceeded improvement actions are defined promptly.

Complications registry	
Standard: 14	
The Board of the cancer centre gets standardised reports on complications and Serious Adverse Events at regular intervals for future evaluations.	
1.	CORE The cancer centre has a comprehensive system for reporting, registration and assessing complications and Serious Adverse Events.
2.	The global report of complications registry data is reported to the medical management at least annually.
3.	Improvement actions are developed and implemented in agreement with all departments and disciplines concerned.
4.	The effect of improvement actions is measured and reported at least annually.

Technical quality of medical equipment	
Standard: 15	
Medical equipment is safe, efficient and accurate.	
1.	There is a maintenance programme for medical equipment, including calibrations and safety checks.
2.	Safety checks and calibrations are carried out as scheduled.
3.	Medical devices used for diagnosis are periodically certified by an authorised authority.
4.	The centre has processes to ensure that only trained and competent personnel handle specialised technical equipment (including new equipment).

Human Resources Management – staffing	
Standard: 16	
Staffing levels are planned.	
1.	Staffing levels of key disciplines are planned in all clinical departments so as to ensure safety and high quality care and by reference to the guidelines or standards of professional societies or regulators, where applicable.

Human Resources Management – appraisal policy and support system	
Standard: 17	
The centre has a comprehensive appraisal policy and support system for its staff..	
1.	CORE Regular appraisal of all staff (medical, nursing, supportive disciplines, technicians, administrative) is part of the human resources management of the cancer centre.
2.	Appraisal is done at defined intervals (preferably annually).
3.	The results of appraisal are documented and used for individual training needs.
4.	Every member of staff has a training record.
5.	The centre ensures that all employees hold current appropriate practicing certificates.
6.	Mental health support programmes are available to all employees.

Privacy, protection of and access to personal data	
Standard: 18	
Written procedures regarding privacy and protection of and access to personal data are present.	
1.	CORE Personal data protection is guaranteed for patients according to the General Data Protection EU Regulation (GDPR) 2016/679.
2.	There is an institutional data protection officer.
3.	There is a policy on access for patients to their own patient record.
4.	The centre has a policy for sharing a patient health record with other health care providers for the benefits of that patient and in accordance with the privacy regulations.
5.	There is a patient charter that is periodically evaluated and renewed.
6.	CORE There are policies on informed consent for diagnostics, treatment and research, that meet national laws and regulations.

Chapter 3: Patient involvement and empowerment (standard 19 to 28)

Patient involvement	
Standard: 19	
It is the mission of the centre to encourage patient involvement in services.	
1.	CORE The cancer centre involves patients and patients' voluntary organisations and support groups in the planning and organisation of services.
2.	The standard process of introducing new practices in clinical care ensures that patients are involved.
3.	There is a committee representing patients and serving as a link between the cancer centre and the patients for advice and consultation.

Patient education programmes	
Standard: 20	
Patient education programmes are in place.	
1.	There are policies in place for patient education programmes where responsibilities and accountabilities of the staff are stated.
2.	CORE There are patient education programmes that aim at improving patient understanding of their illness, diagnosis, including information on self-care and how to manage multiple aspects of their illness or survivorship.
3.	The centre makes specific provisions for access for individuals with disabilities and special needs (e.g. reduced mobility, visual and hearing difficulties).
4.	CORE An information and support centre is available in the cancer centre and easily accessible for staff, patients, family members and caregivers.
5.	The centre organises public events to showcase advances in cancer research.

Patients' rights and preferences	
Standard: 21	
The centre has a policy on patients' preferences	
1.	The centre has a policy on respecting patients' preferences (religious, cultural, social).

Patient information	
Standard: 22	
Information is provided to patients.	
1.	CORE The cancer centre provides information material that is readable, up-to-date, appropriate and available in languages commonly spoken by the population served.
2.	Information about diagnostic and treatment options is provided.
3.	The information includes information about follow-up after treatment.
4.	The information includes information about clinical trials available.
5.	The information includes information about supportive care.
6.	The information includes information about palliative care.
7.	Information on relevant patients' rights is provided to patients and their caregivers.

Informing patients about their care	
Standard: 23	
There are procedures for informing patients about the diagnostic results, treatment and follow-up, and survivorship support.	
1.	CORE There are procedures in place which specify how and by whom patients are informed about their diagnostic results, treatment options, follow-up, and survivorship support, which involve shared decision-making.
2.	Expertise and specific training on communicating with patients and their families is available for staff.
3.	The information communicated to the patient is recorded in the patient's record.
4.	If patients are referred to another healthcare provider, they are informed about the continuity of their care.

5.	Patients receive information about their contact person for all matters related to their care.
6.	CORE All patients are given contact information of clinical staff in case of emergency.

Informing patients on admission	
Standard: 24	
Cancer patients are informed about the cancer centre admission and welcoming procedures.	
1.	All patients visiting the cancer centre receive general information about the hospital.
2.	Detailed information about the admission procedure is available and communicated to patients.
3.	Information about patients' associations and about self-help and support groups is given to patients and their caregivers.

Discharge procedure, follow-up and survivorship care planning	
Standard: 25	
Discharge procedure and related care plans are defined.	
1.	CORE There is a defined discharge procedure including giving information on further treatment, follow-up, re-admission and home care.
2.	The centre has processes to inform the patients' General Practitioner of a transfer of care.
3.	The patient is provided with an individual survivorship plan which is discussed with the patient and includes details of all support services and support groups available .
4.	The patient is provided with an individual plan for end-of-life care, which is discussed with the patient and caregivers.

Patient satisfaction/experience	
Standard: 26	
Patients' experience of cancer care is an integrated part of the quality improvement system of the centre.	
1.	CORE The cancer centre has methods to regularly gather patients' experiences during outpatient and inpatient care.
2.	CORE Satisfaction surveys are analysed, reported and acted upon through the line management of the centre.
3.	The centre uses questionnaires to ascertain the perceptions of the patients' health status, level of impairment, disability and health-related quality of life (e.g. Patient-Reported Outcome Measures (PROM)).
4	The centre uses questionnaires to assess the impact of the process of care on the patient's experience, e.g. communication and timelines of assistance (e.g. Patient-Reported Experience Measures (PREM)).

System for receiving and managing complaints	
Standard: 27	
The cancer centre has a complaints procedure.	
1.	The cancer centre has a defined complaints procedure.
2.	CORE The cancer centre has a clearly identified complaints officer or a complaints office.
3.	The actions undertaken by the complaints officer are recorded in a file that is used to produce an annual report.
4.	The complaints officer gives feedback on his/her findings to any member of staff who is the subject of a complaint.

Collaboration with patient organisations	
Standard: 28	
The cancer centre collaborates with patient organisations.	
1.	The cancer centre identifies and co-operates with existing patient organisations.

Chapter 4: Multidisciplinarity (standards 29 to 36)

Patient Pathways[1]	
Standard: 29	
Patient pathways are defined for all tumours and sub-types treated in the centre, which chart the process from patient admission up to the end of follow-up of care.	
1.	CORE There is a written patient pathway for each tumour (sub)type treated in the centre, except for very rare cancers.
2.	The functions of the different disciplines involved in the diagnosis, treatment and follow-up of the patient are defined and described in the patient pathways.
3.	Supportive and palliative care is specifically included in the patient pathways.

Patient Pathways: co-ordination of patients on the pathways	
Standard: 30	
Patients have co-ordination to ensure their continuity of care on the pathway.	
1	CORE For every patient there is an identified co-ordinator or manager (or written process for case management) of their pathway from admission until end of follow-up, including the implementation of MDT recommendations.
2.	There are routines in place for referral and feedback amongst nursing, palliative care and supportive disciplines.
3.	There are procedures in place for informing the patients' General Practitioner about key recommendations, decisions and diagnostic and treatment results in a timely manner.

Implementation of guidelines	
Standard: 31	
For each type of cancer, consensus has been reached among the disciplines involved about the clinical guidelines used for diagnosis, treatment and follow-up.	
1.	CORE It is formally agreed which clinical guidelines (institutional/local/regional/national/international) are used for diagnostics, treatment and follow-up.
2.	The guidelines are easily accessible in written and/or digital form.
3.	The guidelines are updated on a regular basis (at least every year) according to new evidence and evaluation of processes and outcomes.
4.	It is defined who is responsible for updating and authorising the guidelines.
5	All new clinical staff are made familiar with the guidelines relevant to their work.
6.	There is a policy that each decision that differs from the guidelines is recorded in the patient's record.
7.	An evaluation of deviations from the guidelines is made by the MDT at regular intervals (at least once a year).

Electronic patient record	
Standard: 32	
There are electronic patient records to assure the safety, timeliness and continuity of care.	
1.	Each patient has an Electronic Patient Record which enables all relevant disciplines along the patient pathway to access the full information concerning the patient.

[1] A patient pathway (sometimes called a "care pathway" or "clinical pathway") is a plan for decision-making and organisation of diagnostic and care processes for a well-defined group of patients in well-defined stages, beginning with first suspicion of cancer to survivorship/follow-up or end of life. This is distinct from a "care plan" which is personal to an individual patient.

Process of multidisciplinary team meetings	
Standard: 33	
The centre has MDT groups covering every tumour type which follow a Standard Operating Procedure (SOP).	
1.	CORE An SOP exists for every MDT which specifies core and extended attendance from all relevant diagnostic and therapeutic disciplines, including oncology nursing and supportive care.
2.	CORE SOPs state for each MDT whether all patients are fully discussed or listed on the agenda according to standard patient pathways following definitive diagnosis.
3.	All patients are listed for an MDT discussion when newly managed in the centre and before any complex decision in the management of the patient (for instance regarding metastasis).
4.	There is a defined procedure to inform the members of the MDT with sufficient notice which patients will be discussed.
5	The inclusion of patients in clinical trials is a structured aspect of the MDT meeting.
6.	The MDT meetings take place in a room with facilities to show the relevant results of the examinations (imaging, pathology).

Multidisciplinary team meetings	
Standard: 34	
Information, dissemination and access to expertise in the MDT.	
1.	The medical record of the patient is available during the MDT meeting.
2.	The conclusions and recommendation resulting from the MDT meeting are documented in the medical record of the patient.
3.	The conclusions and advice resulting from the MDT meeting are accessible for all physicians and other disciplines involved in the care, in the medical record of the patient at most 24 hours later.
4.	According to a defined procedure the conclusions and recommendations resulting from the MDT are communicated to the patient for shared decision-making, in which the patient has the right to consent to or refuse a particular treatment.
5.	Access to and information from the molecular tumour board should be made available in the MDT when relevant.

MDT review	
Standard: 35	
Multidisciplinary team (MDT) review.	
1.	CORE Every MDT meets at least twice a year in a learning event to review outcomes, quality of procedures, patient pathways and indicators, for quality improvement.
2.	Patient pathways are updated regularly, based upon the review.

Rare cancers	
Standard: 36	
Management of rare cancers.	
1.	Procedures are in place to consult or to refer patients with rare cancers to a designated reference centre or a European Reference Network.

Chapter 5: Prevention and early detection (standards 37 to 39)

Screening and early detection	
Standard: 37	
Involvement in screening and early detection.	
1.	The cancer centre participates in regional or national screening programmes.
2.	The cancer centre participates in specific early detection programmes.
3.	The cancer centre participates in research into early detection, risk stratification and/or screening.

Oncogenetic service	
Standard: 38	
Access to an oncogenetic clinic is available.	
1.	CORE An oncogenetic clinic is available and accessible to all appropriate patients.
2.	Guidelines for referral to oncogenetic services are available.
3.	Recommendations for individuals at increased risk are based on guidelines.
4.	Psychological support is offered in the oncogenetic service.

Cancer risk reducing strategies in the cancer centre	
Standard: 39	
Cancer risk reducing strategies in the cancer centre.	
1.	CORE Information is available through the cancer centre on overall healthy living in the fields of: diet, smoking, alcohol, exercise, spotting signs and symptoms.
2.	CORE There is a non-smoking policy in the cancer centre.
3.	All public parts of the cancer centre are clearly designated smoke-free areas.
4.	CORE Support is provided to patients to quit smoking.
5.	Access to services is offered to patients to reduce alcohol intake where appropriate.
6.	Support is provided to employees to quit smoking.

Chapter 6: Diagnosis (standards 40 to 45)

Radiology	
Standard: 40	
The radiology department is sufficiently staffed, resourced and effectively managed.	
1.	Staffing levels of key disciplines are planned so as to ensure safety, accuracy and high quality care.
2.	The unit has up-to-date Standard Operating Procedures which describe the imaging methods and are reviewed at least once a year.
3.	The radiologist's written report is available to the attending doctors at the latest 72 hours after the examination.
4.	There is a record of waiting times for radiology, measured from the time of notification by the physician to the performing of the radiological examination.
5.	The department holds learning events for quality improvement at least twice per year.
6.	Clinical audits are carried out in accordance with national procedures.
7.	All images (mammograms, ultrasound documentation, MRI) are stored in a digital format.
8.	Equipment is no older than ten years.
9.	Quality control of all equipment used for imaging is routinely performed, according to the relevant national protocols and/or European guidelines.

Nuclear medicine	
Standard: 41	
The nuclear medicine department is sufficiently staffed, resourced and effectively managed.	
1.	Staffing levels of key disciplines are planned so as to ensure safety, accuracy and high quality care.
2.	The unit has up-to-date Standard Operating Procedures which describe the imaging methods and are checked at least once a year.
3	The nuclear medicine specialist's written report is available to the attending doctors at the latest 72 hours after the examination.
4.	There is a record of waiting times for nuclear medicine, measured from the time of notification by the physician to the performing of the examination.
5.	The department holds learning events for quality improvement at least twice per year.
6.	Clinical audits are carried out in accordance with national procedures as required by EU COUNCIL DIRECTIVE 2013/59/EURATOM.
7.	All images are stored in a digital format.
8.	Equipment is no older than ten years.
9.	Quality control of all equipment used for imaging is routinely performed, according to the relevant national protocols and/or European guidelines.

Logistics of scheduling diagnostics examinations	
Standard: 42	
Agreements have been reached about scheduling appointments and giving priority to urgent examinations (CT, MRI, mammography).	
1.	There is a policy for scheduling diagnostic examinations.
2.	Arrangements are in place about giving priority to urgent examinations (CT, MRI, mammography).
3.	There is a Standard Operating Procedure for keeping appointment slots available for emergencies.

Molecular diagnostics	
Standard: 43	
Arrangements are in place for molecular diagnostics.	
1.	CORE The cancer centre has a molecular diagnostics programme for the use of all tumour sub-types where clinically validated.
2	The pathology laboratory/institute has specialists and equipment for molecular pathology for those tumour sub-types for which clinically validated tests are approved.
3.	The molecular diagnostics laboratory works to Good Clinical Practice and Good Laboratory Practice standards.
4.	The centre has a formal link with a molecular tumour board to support therapeutic decisions.

Pathology	
Standard: 44	
The pathology laboratory/institute is sufficiently staffed, resourced and effectively managed.	
1.	The pathology laboratory/institute processes at least 10,000 histologies/year.
2.	CORE The pathology laboratory/institute has sufficient Board-certified pathologists available to fulfil the requirements of each specialty served by an MDT in the centre.
3.	A sufficient number of qualified medical technical assistants/technical assistants are on regular duty according the Good Clinical/Laboratory Practice and European/National guidelines.
4.	CORE The laboratory has Standard Operating Procedures covering the collection, pre-analytical and analytical phases, reporting and storage of specimens of all kinds which follow international standards.
5.	The laboratory has a recognised quality management (QM) system.
6.	The laboratory participates regularly in quality assurance inter laboratory tests.

Pathology reporting	
Standard: 45	
Arrangements are in place for pathology reporting	
1.	For frozen sections for intra-operative reports the actual time from arrival in pathology to communication of the result is recorded (guidance value maximum 30 minutes).
2.	Standardised pathologists' reports include lymph nodes and resection margins specification, according to guidelines.
3.	Pathologists' reports contain histological type according validated international classifications.
4.	CORE Pathologists' reports for routine histology and immuno-histochemistry are provided within five working days of reception of the specimen.
5.	The laboratory/institute holds oncology-focussed learning events for quality improvement at least once per year.

Chapter 7:Treatment (standards 46 to 68)

24/7 access to specialist care	
Standard: 46	
Arrangements are in place for 24/7 care by specialised staff.	
1.	CORE There are arrangements in place to provide all relevant specialist care for patients 24 hours a day, every day.
2.	There is an acute oncology assessment unit particularly for patients with toxicities which operates according to Standard Operating Procedures.
3.	The cancer centre can admit patients during day and night in the event of an emergency.
4.	Time slots for outpatient appointments are allocated according to patients' needs (e.g. longer times for new patients).

Surgical oncology	
Standard: 47	
The surgical oncology department is sufficiently staffed, resourced and effectively managed.	
1.	CORE Minimum surgical volumes per cancer surgeon are defined for each tumour type.
2.	There is 24-hour availability of surgical oncologists in all major specialties including at weekends and on public holidays.
3.	All treatment plans and recommendations of the MDT form the basis for surgery.
4.	If there are any deviations from the surgical treatment plan, they are recorded in the patient record and communicated appropriately to the patient and multidisciplinary team.
5.	Technical and organisational processes for fresh tissue, frozen sections and biobanking are in place for all surgical procedures.
6.	30-day mortality after surgery is recorded and evaluated.
7.	Unexpected re-admissions to surgery within 90 days is recorded and evaluated.
8.	The technical quality of surgery is regularly monitored for all procedures.

Reconstructive surgery	
Standard: 48	
Reconstructive surgery is offered to all appropriate patients.	
1.	CORE There is a full range of reconstructive surgery, immediate or delayed, including aesthetic and functional restoration surgery for all body regions.
2.	Patient information about reconstructive surgery is proactively provided in written form and includes benefits and risks.

Radiotherapy	
Standard: 49	
The radiotherapy department is sufficiently staffed, resourced and effectively managed.	
1.	CORE Staffing levels of key disciplines are planned so as to ensure safety, accuracy and high quality care.
2.	CORE The centre has a 24-hour on-call service outside working hours (including weekends and public holidays), if necessary through co-operation agreements.
3.	CORE The radiotherapy department has a written contingency plan.
4.	Each patient has a medical consultation prior to the commencement of radiotherapy.
5.	Adequate information is provided to each patient about diagnosis and therapy planning, which includes explanation of treatment options, side effects and self-management during therapy.
6.	The relevant radiation data (e.g. RT treatment technique, single dose, total dose, total treatment time) are recorded in line with the guidelines.
7.	Any deviation from the dose prescribed by the physician is justified and documented.
8.	The unit has processes for recording the complications of treatment in the patient record and at department level for quality purposes.
9	The department holds learning events for quality improvement at least twice per year.

Radiotherapy equipment	
Standard: 50	
The radiotherapy department is sufficiently equipped and medical equipment is safe, efficient and accurate.	
1.	CORE The radiotherapy department has at least two megavoltage linear accelerators.
2.	There is one megavoltage linear accelerator for every 350 new cancer patients per year.
3.	CORE The main radiotherapy department of the centre has sufficient linear accelerators to meet the demands of providing radiotherapy to all its patients.
4.	There is a maintenance programme for medical equipment, including calibrations and safety checks.
5.	Safety checks and calibrations are carried out as scheduled.
6.	Medical devices used for treatment are periodically certified by an authorised authority.

Radio-chemotherapy	
Standard: 51	
Chemo-radiation therapy follows appropriate standard procedures.	
1.	The unit has an SOP for sequential / simultaneous radio-chemotherapy.
2.	Blood count monitoring and laboratory tests are documented during radio-chemotherapy.
3.	The side effects of radio-chemotherapy are recorded and evaluated.

Palliative radiotherapy	
Standard: 52	
Palliative radiotherapy is offered	
1.	In the case of patients with spinal cord compression and neurological symptoms, a plan for treatment is drawn up within 24 hours of the suspected diagnosis.
2.	In palliative radiotherapy, the therapeutic goal (local control or solely symptom alleviation) is documented.

Medical oncology (oncology and haemato-oncology)	
Standard: 53	
The medical oncology and haemato-oncology departments are sufficiently staffed, resourced and effectively managed.	
1.	CORE Staffing levels of key disciplines are planned so as to ensure safety and high quality care.
2.	CORE There are sufficient chairs and beds to manage patient numbers for systemic therapies.
3.	The department holds learning events for quality improvement at least twice per year.
4.	Adequate information is provided to each patient about diagnosis and therapy planning, which includes explanation of treatment options, side effects and self-management during therapy.
5.	The time between the patient consultation agreeing to the treatment plan (post MDT) and the commencement of treatment does not exceed 21 days (if there are no medical contra-indications).

Medical oncology, anti-cancer drugs: prescription and pharmacy preparation	
Standard: 54	
There is a system for the prescription, preparation and distribution of anti-cancer drugs.	
1.	CORE There is a quality assured digital system for the prescription, preparation and administration of anti-cancer drugs.
2.	CORE There is an SOP for the prescription of anti-cancer drugs.
3.	Anti-cancer drugs are prepared in a centralised pharmacy unit.
4.	There are SOPs for the preparation of anti-cancer drugs in pharmacy.
5.	Anti-cancer drugs are prepared under the direct supervision of a qualified pharmacist.
6.	CORE A validation procedure for the whole process, including prescription, preparation and distribution, is implemented.

Medical oncology, anti-cancer drugs: administration	
Standard: 55	
Administering of anti-cancer drugs is controlled and effectively managed	
1.	CORE There are SOPs for the administration of anti-cancer drugs.
2.	Anti-cancer drugs are administered only in oncology or haemato-oncology wards (for inpatients).
3.	There are dedicated day-care units for the administration of anti-cancer drugs.
4.	CORE Anti-cancer drugs are administered by nurses who have completed a specific training programme for chemotherapy administration.
5.	CORE Each patient has a medical consultation prior to the commencement of systemic therapy.
6.	Adequate information is provided to each patient about diagnosis and therapy planning, which includes explanation of treatment options, side effects and self-management during therapy.
7.	The time between the patient consultation agreeing to the treatment plan (post MDT) and the commencement of treatment does not exceed 21 days (if there are no medical contra-indications).
8.	The relevant data (dosage and total treatment time) are recorded in line with the guidelines.
9.	A specific procedure for reporting unexpected side effects of anti-cancer drugs is implemented.
10.	Quality and risk management practices for anti-cancer drugs are regularly evaluated.

Nursing, tasks and responsibilities of oncology nurses	
Standard: 56	
The cancer centre employs nurses formally educated in oncology whose tasks and responsibilities are defined according to the level of their education.	
1.	For each technical, clinical or outpatient department where patients with cancer are treated, there are nurses trained in oncology.
2.	The cancer centre employs nurses with expertise in most of the tumours that are treated in the cancer centre.
3.	The cancer centre employs Advanced Practice Nurses according to the EONS definition who have acquired an expert cancer nursing knowledge base, complex decision-making skills and clinical competencies for expanded practice.
4.	There are job descriptions including the tasks and responsibilities of cancer nurses.
5.	Roles and responsibilities of nurses with additional expertise/focus are described (e.g. palliative care, stoma care, wound dressing, pain, social care nurses, bone marrow transplant nurses, care pathway coordinator etc.).
6.	The nursing staff has among its members a Lead Cancer Nurse.

Pain service	
Standard: 57	
A protocol for pain control is implemented in the cancer centre.	
1.	CORE There is systematic screening of pain with validated assessment tools throughout the pathway of the patient.
2.	CORE Guidelines regarding pain treatment for patients with cancer are implemented in all relevant departments.
3.	There is regular education for staff on pain management according to a yearly plan.
4.	Patients and their caregivers receive verbal and written information about pain management.
5.	CORE A defined pain team or pain specialists as part of the palliative care team are available to both in- and outpatients.

Referral to supportive disciplines	
Standard: 58	
There is a standard policy concerning access of patients to supportive disciplines.	
1.	CORE There are guidelines which define the indications for referral and the types of intervention from supportive disciplines.
2.	In appropriate cases, supportive disciplines are regularly part of clinical sessions.

Psycho-oncology	
Standard: 59	
Cancer patients have access to psycho-oncology services.	
1.	CORE There is a psycho-oncology service with competence in oncology psychiatry and/or clinical psychology.
2.	CORE Structured screening with validated assessment tools is systematically used.
3.	Procedures are defined about the way to refer patients to the psycho-oncology service, including patients in psychological distress.

Rehabilitation	
Standard: 60	
There is access to rehabilitation services cancer patients.	
1.	CORE There is timely access to rehabilitation services with multidisciplinary interventions for cancer patients and survivors.
2.	There is a defined procedure for referral to cancer rehabilitation services within and outside the centre.

Social counselling	
Standard: 61	
Social counselling for cancer patients is provided according to guidelines.	
1.	CORE Social counselling is organised according to guidelines and is accessible for all cancer patients throughout the cancer pathway.
2.	CORE Domains of social counselling provided include benefits advice, employment rights and housing needs.

Nutrition	
Standard: 62	
There is access to nutrition specialists for cancer patients.	
1.	There are screening tools which are used to identify patients who will benefit from support of nutrition specialists.
2.	There is timely access to nutrition specialists for cancer patients throughout the patient pathway.

Involvement of caregivers	
Standard: 63	
Arrangements for the involvement of caregivers are defined.	
1.	In agreement with the healthcare team, caregivers can participate in certain personal activities (e.g. meals, washing).
2.	Each inpatient ward has a room for meetings with caregivers.
3.	Visiting time restrictions are lifted according to the needs of the patient and caregivers, including the possibility of overnight stay of caregivers if necessary.

Survivorship support	
Standard: 64	
Advice and support is offered to all patients and caregivers during treatment and survivorship.	
1.	CORE Advice and support is given to patients and caregivers on prevention of recurrence and overall healthy living in the fields of: diet; exercise; spotting signs and symptoms.
2.	Information is given to patients on relevant peer groups for patients with similar cancers.
3.	Information and support is given to patients about the potential late effects of their cancer.
4.	Information and support is given to patients about self management.

Support to children and caregivers of cancer patients	
Standard: 65	
Support to children and caregivers of a cancer patient is provided.	
1.	Caregivers are given specific support and advice for helping patients.
2.	Specific support for children of cancer patients is provided by trained staff (e.g. a family therapist).

Palliative care[2] team	
Standard: 66	
The composition and tasks of the palliative care team are defined.	
1	The composition of the palliative care team is defined.
2.	The palliative care team is led by a specialised physician in palliative medicine.
3.	All patients referred for palliative care are discussed during scheduled meetings of the palliative care team, according to an SOP.
4.	The palliative care team provides education and guidance of palliative care (e.g. symptom control) for patients, caregivers and health professionals.

[2] The palliative care team should include at least palliative care physicians and specialist nurses, working with an extended team of workers from different supportive disciplines like social workers, physiotherapists and dieticians, and with pain specialists and psycho-oncologists.

Palliative[3] care	
Standard: 67	
Palliative care is organised according to written procedures.	
1.	CORE The centre has a written policy which defines when and how patients are referred to specialised palliative care services as part of their care pathway.
2.	Palliative care is specifically described in the patient pathways within the cancer centre and beyond (such as primary care and hospices).
3.	There is a help line service covering the immediate needs of palliative care patients.

End of life care	
Standard: 68	
End-of-life care is appropriately and sensitively arranged according to patients' needs and wishes.	
1.	CORE There is a policy for ascertaining the wishes and preferences of patients and relatives for end-of-life care.
2.	The centre provides information on end-of-life services available both within the centre and the local community (e.g. hospices, at home services).
3.	End-of-life care is a part of the care pathway of cancer patients with incurable disease offered in collaboration with palliative care providers in the community or hospice.
4.	The centre provides access to spiritual care and bereavement support services.

[3] Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Chapter 8: Research (standards 69 to 82)

Strategic planning for oncology research	
Standard: 69	
The research strategy plan is regularly updated.	
1.	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.
2.	Specific aims for research performance are defined (publications, grants, innovations etc.).
3.	CORE The cancer centre research performance/activity is regularly evaluated and communicated in a scientific report.
4.	CORE[4] The centre has research groups and output covering basic, translational and clinical research.

Research - Organisational structure	
Standard: 70	
The organisational responsibilities within the research, innovation and development structure are clearly defined.	
1.	CORE There is a defined organisational structure specifically for research and innovation related to cancer.
2.	The individual research group structures are clearly defined.
3.	The qualifications and responsibilities of research group leaders are clearly defined.
4.	The centre has a dedicated phase I/II clinical research unit.

Means for conducting research activities	
Standard: 71	
A planning cycle for resourcing the infrastructure of research activities is defined.	
1.	CORE The cancer research budget covering both external and internal funding for the cancer centre is defined each year.
2.	CORE The cancer centre provides access to shared technological platforms for research activities.
3.	The cancer centre provides internal funding for research activities.
4	The use of financial resources and accounting of research activities is monitored and reported.

Periodical external site visit/review	
Standard: 72	
Periodical external site visits of research are organised.	
1.	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.
2.	CORE The performance of each research group is externally or internally reviewed at regular intervals.
3.	There is a periodical external site visit/review for research support facilities.

Research collaboration	
Standard: 73	
The cancer centre is part of research networks.	
1.	The cancer centre supports formalised collaborations with international research organisations and networks.
2.	The cancer centre co-ordinates international research projects.

[4] This is only a core standard for an OECI Comprehensive Cancer Centre

Scientific interaction and integration	
Standard: 74	
There is structured co-operation between researchers and clinicians.	
1.	CORE Regular briefings on research activities, results and new opportunities are organised through information sharing and meetings for laboratory researchers and clinicians.
2.	CORE There are funding mechanisms and/or programmes to give clinicians protected time for clinical and/or translational research.

Scientific dissemination programme	
Standard: 75	
A scientific knowledge transfer programme is present in the cancer centre.	
1.	CORE There is a structured, documented and up-to-date scientific programme in the cancer centre through colloquia, seminars and theme-specific conferences.
2.	There are procedures in place to ensure that results from internal and external research are translated into new practice (e.g. diagnostic tools, treatment or prevention).

Research talent development	
Standard: 76	
There is a policy for research talent development.	
1.	There is a programme in place for research talent development.

Grant proposals	
Standard: 77	
There is a procedure for dealing with grant proposals.	
1.	There is an internal review of grant proposals before submission to funding bodies.
2.	There is an internal evaluation of the success of the grant proposals.
3.	CORE The cancer centre has training programmes and supportive services for grant applicants.

Prevention and detection and handling of scientific misconduct	
Standard: 78	
Conduct of research is defined by core principles of research integrity	
1.	There is a code of conduct regarding good research practices, covering the research environment, data practices and management, publication and dissemination, such as those of the European Code of Conduct for Research Integrity.
2.	There is a procedure to deal with violation of research integrity, such as research misconduct.

Intellectual property and innovation	
Standard: 79	
There are policies for protection of intellectual property and innovation.	
1	Innovation strategy is an explicit part of the strategic plan of the centre.
2.	There are rules for ownership of intellectual property and patents.
3.	There is a unit providing support for the protection and utilisation of intellectual property (Technology Transfer Office).
4.	There is a unit (internal or external) providing support for business development arising from research.

Organisation of clinical research	
Standard: 80	
Tasks of the Clinical Research Management unit and Institutional Review Board (IRB) are defined.	
1	CORE There is a Research Ethical Committee (internal or external) or Institutional Review Board (IRB) that evaluates ethical aspects of all research proposals on human subjects or material.
2.	There is a scientific review board/committee that evaluates the quality, feasibility and priority of clinical trial proposals.
3.	CORE There is an institutional clinical research management unit dedicated to cancer patients.
4.	The unit has an annual plan for its activities.
5.	The cancer centre has a policy for promoting clinical trials, including internal and public information on trial availability.
6.	The unit has dedicated personnel ensuring that clinical trials are conducted according to the trial protocols and Good Clinical Practice guidelines.
7.	The unit assures the process of administrative, scientific and ethical/legal review and approval as well as the feasibility of new clinical trials.
8.	The unit co-ordinates and monitors the clinical research activities as well as their financial management.
9.	CORE The cancer centre keeps an up-to-date database of clinical trials, including the accrual of patients.
10.	The cancer centre provides an annual report on clinical trial activities.
11.	Personal data protection is guaranteed for patients in clinical trials according to the appropriate legislation, including GDPR.
12.	The inclusion of a patient in a clinical trial is immediately available in the medical file of the patient, including the signed informed consent.
13.	The institutional clinical research management unit has specific resources (expertise and financial) to manage investigator initiated trials.

Promotion of clinical research	
Standard: 81	
The cancer centre promotes and disseminates internally and externally clinical research projects and their results.	
1	The cancer centre publishes the ongoing clinical research trials on its website for patients and external physicians.
2.	The cancer centre promotes the participation to clinical trials to the patients by means of brochures, website, etc.
3.	The researchers publish or participate in the publication of the results of the clinical trials, both in scientific and public papers.
4.	The cancer centre organises internal meetings to share the results of the clinical and translational research realised in the centre among its research community.
5.	The results of the clinical trials are communicated on the website.

Biobank	
Standard: 82	
Biobanking is conducted according to defined procedures.	
1	The cancer centre has a written policy for biobanking patient samples.
2.	CORE There are SOPs defining the patient information, informed consent, collection, storage, registration, recovery and use of the biological samples.
3.	CORE There is a centralised biobank database which provides linking to detailed clinical data.
4.	The cancer centre biobank has facilities for long-term storage of paraffin blocks for research purposes.

Chapter 9: Education and training (standards 83 to 85)

Analysing and providing for oncology training needs	
Standard: 83	
The cancer centre analyses the specific training and continuous education needs in oncology and defines training and educational programmes.	
1.	The cancer centre analyses the specific training and oncological continuous education needs of its staff regularly (preferably annually, cross reference to Chapter 2, Standard 17).
2	CORE Relevant training is provided to all staff according to individual needs, institutional requirements, and regulatory requirements, including Good Clinical Practice.
3.	Based on the analysis, the institution defines an annual or multi-annual oncology training programme for physicians.
4.	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for researchers.
5.	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for nurses.
6.	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for supportive disciplines.
7.	The cancer centre collects and analyses feedback about the quality of the continuous professional education and training programmes.

Undergraduate academic education in oncology	
Standard: 84	
The cancer centre provides oncology education for undergraduate degrees.	
1.	CORE The cancer centre provides undergraduate oncology education.
2.	The cancer centre provides undergraduate oncology education for medical students.
3.	The cancer centre provides undergraduate oncology education for nursing students.
4.	The cancer centre provides undergraduate oncology education for supportive discipline students.
5.	The cancer centre collects and analyses feedback about the quality of the undergraduate oncology education.
6.	The cancer centre offers oncology education to medical/nursing/supportive discipline students from other countries, e.g. through exchange programmes.

Postgraduate academic education in oncology	
Standard: 85	
The cancer centre provides oncology education of postgraduate students.	
1.	CORE The cancer centre provides postgraduate oncology education for physicians.
2.	CORE The cancer centre provides postgraduate oncology education for nurses (including palliative care).
3.	The cancer centre provides education in oncology for supportive disciplines.
4.	The cancer centre collects and analyses feedback about the quality of the postgraduate education.
5.	The cancer centre offers oncology education to physicians/nurses/supportive disciplines from other countries, e.g. through exchange programmes and/or organisation of specific courses.