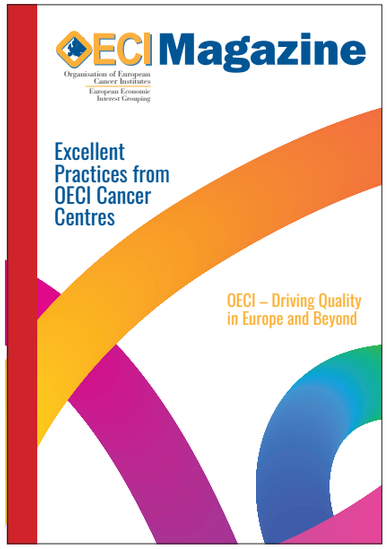
OECI Magazine
Organisation of European Cancer Institutes
European Economic Interest Grouping
SPECIAL ISSUE
Number 2 - Year 10
June 2026

# Excellent Practices from OECI Cancer Centres

## OECI – Driving Quality in Europe and Beyond




***Editors:***
*Giovanni Apolone and Claudio Lombardo*

***Authors:***
*Simon Oberst, Mef Nilbert, Harriet Blaauwgeers, Paulina Bravo, Jean-Benoît Burrion, Marjet Docter, Wendy Dontje, Jorrit Enserink, Vanesa Gregorc, Eva Jolly, József Lövey, Claire Noonan, John V. Reynolds, Wim van Harten, Jolanda van Hoeve, Janneke Verloop, Willien Westerhuis*

***Editorial Office:***
*OECI Liaison Office*

**Publisher:**
Organisation of European Cancer Institutes
European Economic Interest Grouping
c/o Fondation Universitaire, Rue d'Egmont 11
B-1000 Brussels, Belgium
www.oeci.eu oeci@oeci.eu
RPM N. 0473647634
Royal Library of Belgium
N.: D/2026/12.243/2

**ISBN N.:** 9789464782813

**Graphic Designer:**
Studio Sichel, Piacenza, Italy
Diana Kochegarova, Genoa, Italy

*This Magazine has been realised in collaboration with:* SOS europe

# Index

*SPECIAL ISSUE 2026*


OECI
Organisation of European Cancer Institutes
European Economic Interest Grouping

# OECI TRAINING ACCREDITATION AND DESIGNATION AUDITORS

***OECI Training A&D Auditors***
*Villa Verganti Veronesi*
*INVERUNO*
*24-26 October 2026*

*Welcome to the OECI training for new auditors at the lovely Villa Verganti Veronesi, Inveruno.*
*The aim of this course is to provide the trainees with the knowledge and skills required to perform an internal audit of a cancer centre participating to the OECI Accreditation Programme.*
*Over the two training days, you will learn the A&D standards, how to do a successful interview and report your findings using the e-tool. This interactive programme was developed in cooperation with Kerteza.*
*We hope it will be an inspirational environment to prepare you for your future A&D peer reviews.*
*We wish you a pleasant and informative stay!*



# A New Edition of the OECI A&D Excellent Practices

*Since the launch of the OECI Excellent Practices initiative in 2021, we have continued to build on our shared goal: strengthening collaboration, knowledge exchange, and continuous improvement across Europe's cancer care and research community. The first edition showed how the strengths identified through the Accreditation & Designation (A&D) Programme can be turned into a valuable source of collective learning. It also confirmed that the expertise within our network deserves ongoing visibility.*

*This new edition represents the next step in that ongoing cycle. We began with a broad list of more than 70 strengths taken from recent audit reports. Using the same criteria as before (relevance, effectiveness and efficiency, patient-centredness, transferability, and sustainability), we assessed and scored each practice. We also ensured that all major domains of the A&D framework, such as Governance, Research, and Education, were represented. Through this structured review and discussion, 32 strengths were selected as Excellent Practices.*

*As with the previous edition, the aim is straightforward: to highlight practices that have proven their value in individual centres and that could also benefit others. By sharing these experiences in a clear and consistent format, we hope to encourage dialogue, inspire local adaptation, and support centres in connecting around solutions that strengthen care, research, and organisational performance.*

*This updated edition reinforces our commitment to supporting a dynamic culture of improvement within the OECI community. In addition to this special edition of the OECI Magazine, the Excellent Practices will also be published on the A&D pages of the OECI website, ensuring broad access and allowing centres to explore them whenever needed.*

*We hope this edition will spark new exchanges, encourage fresh proposals for future rounds, and recognise the dedicated teams whose work continues to advance cancer care and research across Europe.*

**Simon Oberst**
OECI Quality & Accreditation Director

**Mef Nilbert**
Chair of the OECI Accreditation and Designation Board

# Catalan Institute of Oncology

## Governance

**Tarsila Ferro**
Director of Strategy and Quality Management
E-mail: tferro@iconcologia.net

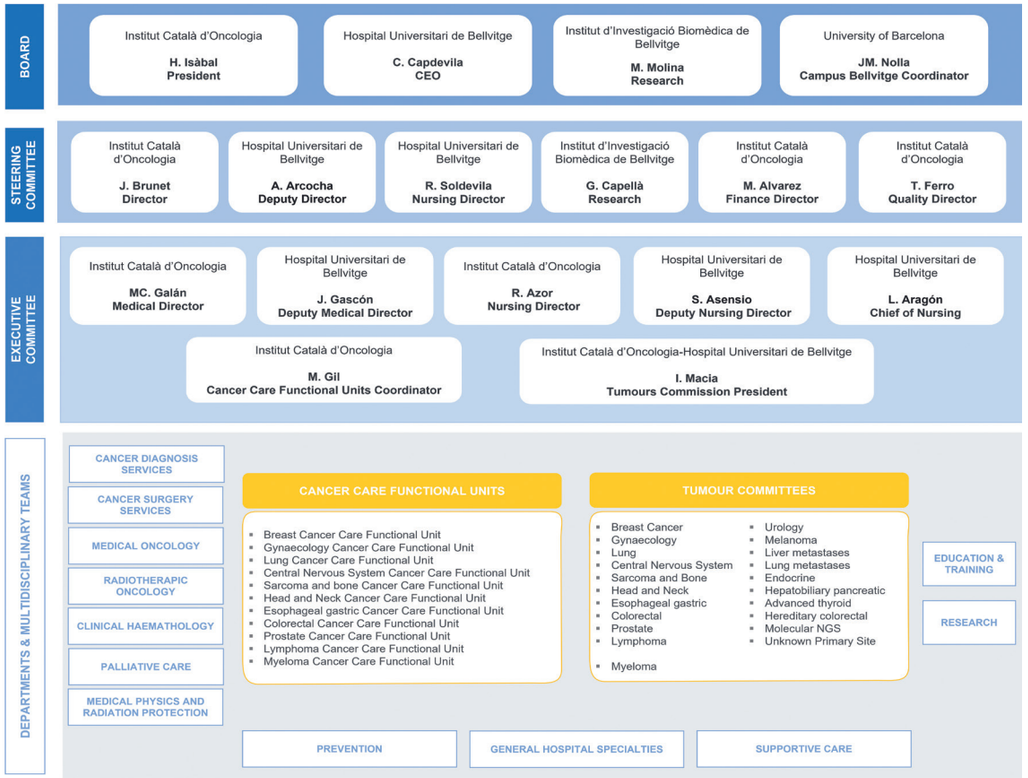
### Challenge addressed by the practice

The CCC ICO–HUB comprises two hospitals. On the one hand, the Catalan Institute of Oncology (ICO) is a cancer center that offers all types of oncological services and treatments. On the other hand, Bellvitge University Hospital is a highly complex general hospital that provides diagnostic and surgical procedures in oncological care. Together, they are responsible for providing cancer care to an adult population of 1.7 million, working in coordinated multidisciplinary teams for more than 30 years. As two different public institutions, they also work with the Research Institute and the University of Barcelona on the same campus, making it a challenge to establish joint governance as a comprehensive cancer center.

### Solution

Joint governance was established with representation from the Campus entities with specific roles for the governance of the comprehensive cancer centre and avoiding duplication. Three levels of governance were established (chart below):

- **Board**: With representation from CEOs of each of the institutions ICO–HUB, IDIBELL (research institute), and the University of Barcelona. It meets annually with the CCC director to analyse progress and approve the strategic plan.
- **Steering Committee**: This body is responsible for the CCC's strategy elaboration and guarantee its implementation. It meets at least three times a year to approve the proposals of the Executive Committee, especially those related to the budget or organisational measures with a significant impact. It is led by the CCC's Director. The rest of members are directors, representatives of care, research, quality management, and finance.
- **Executive Committee**: Its members are medical and nursing representatives. They meet monthly to set annual objectives for the multidisciplinary teams involved in clinical care, research, and training. The body manages the oncology activity, the multidisciplinary care teams, and all the services involved.




### Impact

This type of governance has made it possible to:

- Establish an optimal multidisciplinary oncology organisation, with a unique oncology process
- Operationalise the strategy in harmony with the respective strategies of each centre
- Promote joint decision-making rather than decision-making by services or institutions, especially those related to economic costs
- Contribute to strengthening the internal culture of organised multidisciplinarity (top-down; bottom-up)

### Critical success factors

The following key points have been identified:

- Definition of a framework document on the oncology process at the Campus. This sets out how to organise multidisciplinary oncology care and the professional roles involved.
- Formal agreement on oncology organisation on the Campus, specifying the different institutional contributions to the oncology process, as well as financial transactions, in the context of public companies belonging to the Catalan Department of Health.
- Agree on a governance structure that contributes to and supports the organisation of oncology care. Explicit designation of the functions of each level of governance.

### Next steps

- Given that the ICO has a network of regional hospitals, it is planned to incorporate this reality into the current governance.
- Create a Patient Council with stable representation on the Steering Committee.

# HSE West North West, University of Galway

## Governance Structure

**Geraldine Cooley**
General Manager, HSE WNW Cancer Network of Care
E-mail: geraldine.cooley@hse.ie

### Challenge addressed by the practice

Prior to formal redesign, cancer services in the HSE West and North West region were governed by a governance structure not dedicated to cancer. This posed significant challenges for consistent quality, integrated clinical pathways, research alignment, and performance oversight. Serving a population of over 830,000, the region required cancer services to operate within a coherent clinical, academic, and quality governance framework aligned with the Saolta Group Strategy 2019–2023, the National Cancer Strategy 2017–2026, and the international standards of the OECI Accreditation Programme. The geographically dispersed nature of services necessitated standardisation of care, equitable access to complex and specialised treatments, and the formal integration of research and education into clinical practice. In the absence of an integrated governance mechanism, the ability to monitor performance, disseminate best practice, and systematically drive quality improvement across all sites was limited, challenging progress towards recognised European cancer centre status and strategic alignment.

### Solution

The governance challenge was addressed through the establishment of the Saolta Cancer Managed Clinical and Academic Network (MCAN) in 2020, providing a single, structured governance framework for cancer services across the region. The MCAN is led by a clinically driven Executive Management Team comprising of a Clinical Director, General Manager, and Director of Nursing, with Associate Clinical Directors representing each hospital site. This model integrates clinical leadership with executive accountability and is supported by Quality and Patient Safety, Human Resources, Communications, Finance, and Information Services. The MCAN Executive Team meets monthly to oversee strategy, performance, quality, research, and workforce planning. Cancer services are provided in a hub-and-spoke model of care across the network, with complex cancer care delivered at the cancer centre, while appropriate treatments, including SACT, are provided closer to patients' homes. The structure enables standardised policies, shared clinical pathways, integrated research and education, and consistent performance monitoring aligned with national and OECI standards.


### Impact

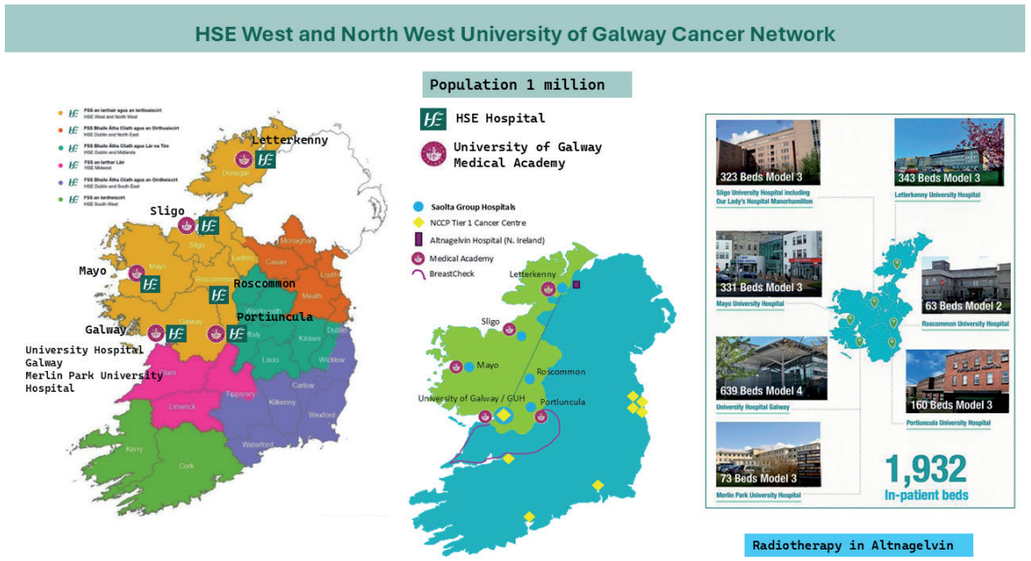
The introduction of the Cancer MCAN has delivered demonstrable improvements in the governance, coordination, and quality of cancer services across HSE West and North West, resulting in standardised clinical governance and performance oversight, strengthened patient safety, reduced unwarranted variation, and improved consistency of care across hospital sites. The model has supported equitable access to specialised cancer services through a well-defined hub-and-spoke approach, enabling patients to receive appropriate care closer to home where clinically suitable. Enhanced data collection and KPI monitoring have improved compliance with NCCP performance targets and informed service planning. Importantly, the governance framework underpinned successful engagement with the OECI Accreditation Programme, embedding quality management, multidisciplinary collaboration, and research integration into routine practice. Collectively, these developments have contributed to safer, more coordinated, and patient-centred cancer care across the region.

### Critical success factors

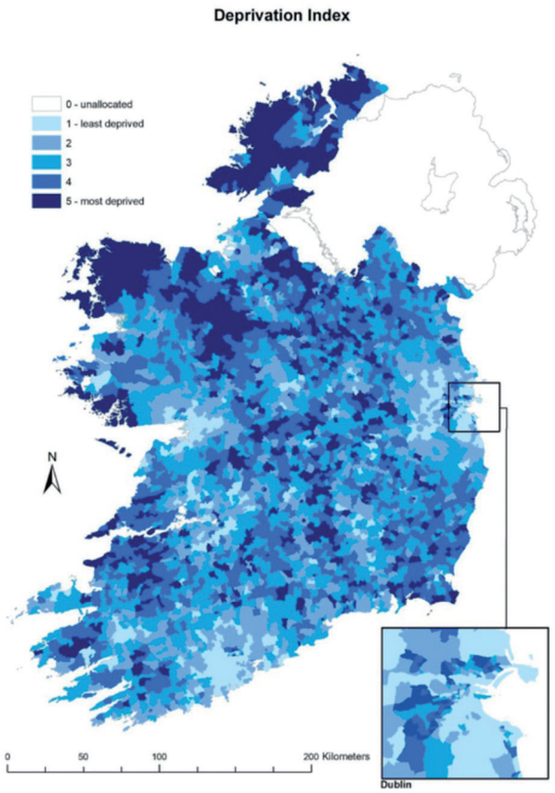
Critical success factors included strong clinical leadership embedded within the governance structure, ensuring that service planning and quality improvement were clinically driven and patient focused. Clear lines of accountability between hospital sites, the MCAN Executive, the Saolta Group Executive, and national bodies enabled effective performance management and decision-making. The active involvement of Associate Clinical Directors at site level was essential in translating regional strategy into local implementation. Integration of quality, patient safety, and performance data into regular governance meetings supported timely identification of risk and continuous improvement. The depth of cancer expertise across the network was a key critical success factor, as was staff willingness to engage in quality improvements across the network. Alignment with national cancer policy and international OECI standards provided a clear framework for benchmarking and assurance. Strong collaboration with academic partners ensured research and education were embedded alongside clinical care, reinforcing a culture of evidence-based practice across the network.

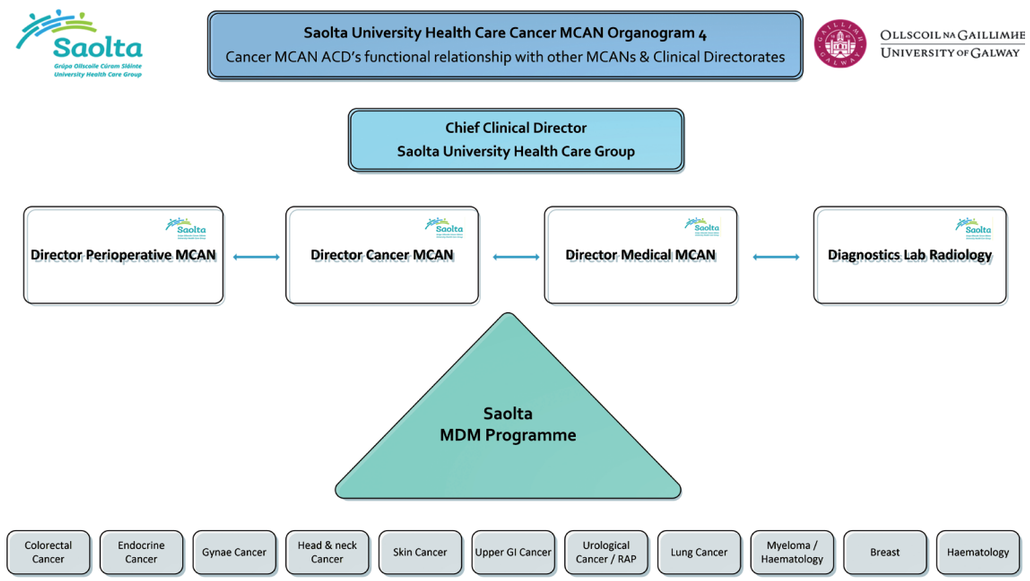
### Next steps

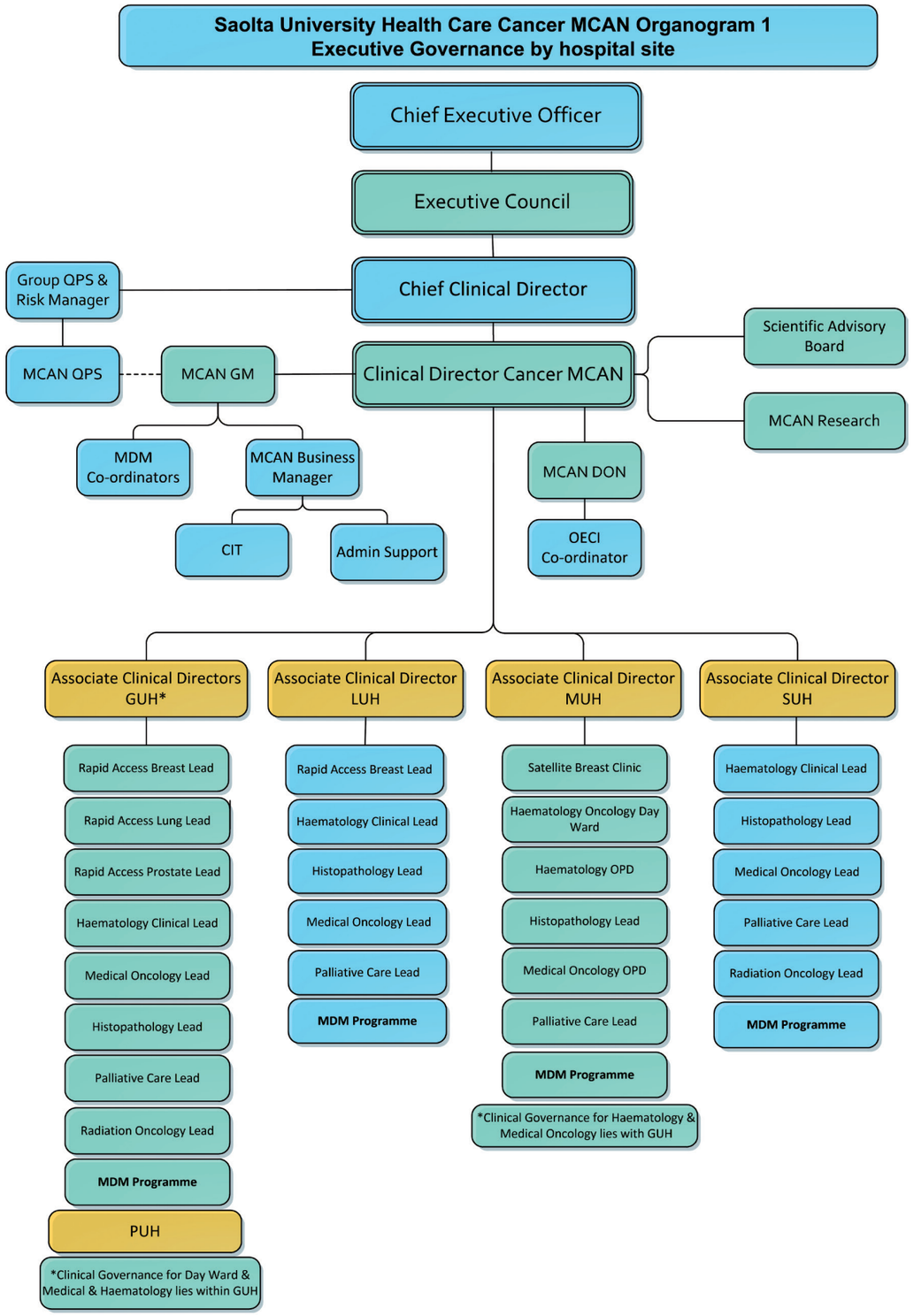
As part of National Health Service reform by the HSE, the Cancer MCAN is transitioning into the HSE West and North West Cancer Network of Care, reflecting the move to formal regionalisation. This evolution will expand governance to include community-based services such as screening, palliative care, prevention, and survivorship. Strengthened performance and accountability arrangements under the Regional Executive Officer will enhance oversight across quality, access, people, and finance.



Continued alignment with the NCCP, the emerging National Cancer Strategy, and OECI standards will support integrated, high-quality cancer care across acute and community settings. Continued implementation of the recommendations of the Scientific Advisory Board (SAB) will enhance the research ecosystem across the network.



# Leuven Cancer Institute

## Governance

**Evy Lobbestael**
Institute Manager
E-mail: evy.lobbestael@kuleuven.be

## Challenge addressed by the practice

As a comprehensive cancer center embedded within both KU Leuven and University Hospitals Leuven (UZ Leuven), LKI operates in a complex institutional environment.

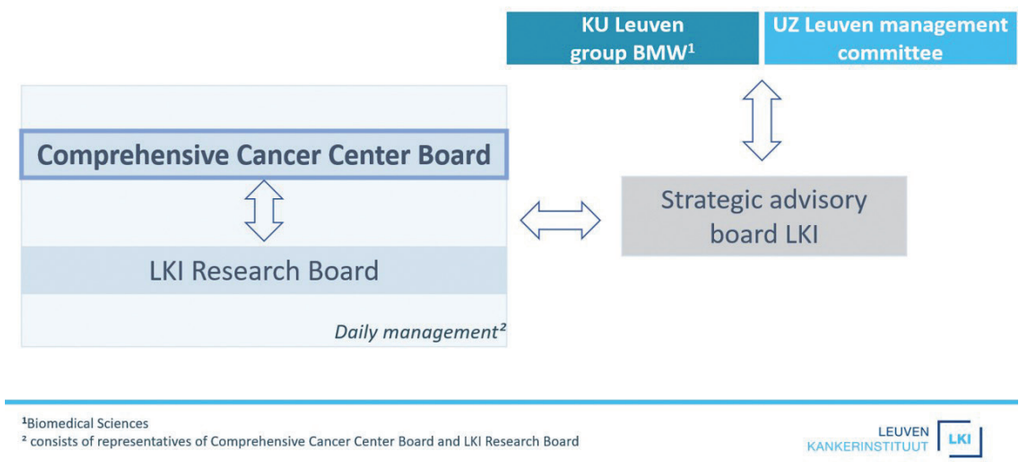
- A central challenge is developing a governance model that aligns closely with the strategic priorities of its parent institutions, while at the same time fostering engagement, shared accountability, and clear communication across a diverse member community.
- Additional challenges include avoiding fragmentation and siloed activities across departments and services, coordinating cross-cutting oncology activities in research, care, and education, and ensuring transparent, consensus-based decision-making.
- Balancing strategic oversight with operational efficiency, while safeguarding responsiveness to emerging opportunities and challenges in oncology, requires continuous coordination, evaluation, and alignment across multiple governance and operational layers within a broader university and university hospital setting.

## Solution

To address these challenges, LKI has implemented a multi-layered governance structure:

- At its core is the Comprehensive Cancer Center Board (CCCB), comprising hospital leadership, KU Leuven representatives, thematic coordinators, domain experts, and a dedicated management support team. This board is responsible for developing, approving, and implementing the overall LKI strategy.
- A Strategic advisory board ensures high-level alignment with KU Leuven, UZ Leuven, and VIB-CCB (part of the Flemish Institute for Biotechnology) strategies.
- Research priorities are defined within the LKI Research board, which integrates university policy mandates, focus group leaders, central platform representatives and innovation managers.
- Daily operations and coordination are ensured by the Daily Management, enabling coherent implementation across research, care, and education.

Clear terms of reference, consensus-based decision-making, structured reporting, and transparent communication underpin all boards.




## Impact

This governance model has strengthened the visibility and integration of LKI within the University Hospital (currently 26 oncological care programmes) and KU Leuven structures. It supports coherent strategic planning across the full spectrum of LKI activities, underpinned by a robust planning-and-control cycle.

Enhanced cross-departmental integration has reinforced collaboration, enabling LKI to collectively anticipate and respond to scientific, clinical, and societal challenges, while reducing siloed activities across departments and services. The close connection between the cancer center and the university further strengthens alignment between clinical practice, research, and education, with many clinicians actively contributing.

## Critical success factors

- Strong institutional embedding: high-level engagement from hospital and university leadership ensures strategic alignment and institutional support.
- Clear governance roles: clearly defined terms of reference, transparent reporting, and regular communication foster trust, accountability, and shared ownership. The presence of a dedicated management structure ensures continuity, coordination of daily operations, and effective implementation of strategic objectives across our institute.
- Clear responsibilities: a deliberate focus on department-transcending activities prevents siloed (competitive) initiatives and maximises the use of available expertise without interfering with topic-specific activities and visions.
- Consensus-based decision-making to strengthen mutual trust, promote collective ownership of decisions, and support well-balanced outcomes that are broadly supported across disciplines and organisational levels.

## Next steps

LKI aims to further strengthen engagement and ownership among board members and broaden communication, interaction, and involvement across its membership. The board structure will be modestly expanded, with an increased emphasis on domain/expertise-based rather than department-based representation to reinforce cross-cutting perspectives. Community-building, facilitation, and broader internal communication stays a priority to get a thriving institute.

# OncoZON Network MUMC+

## Governance Structure

**Fabrizia Ketelaars**
Network Manager OncoZON
E-mail: f.ketelaars@mumc.nl

### Challenge addressed by the practice

To enable effective collaboration among ten institutions, safeguard shared responsibilities, and sustainably achieve common goals—while respecting the autonomy of the individual organisations—a clear and unambiguous governance structure is essential. This structure should clearly define decision-making authority and accountability at each level, with a scope that not only covers care delivery but also explicitly addresses research and education.
In addition, governance must ensure that a shared vision is translated into concrete and measurable objectives. In a network of multiple autonomous organisations, a clear governance framework helps prevent fragmentation by facilitating joint decision-making and striving for alignment and uniformity where possible and appropriate, for example, in the areas of quality, data, and care pathways, as well as in research and education.
A clear governance structure also enhances transparency, thereby contributing to trust, stability, and continuity within the network. Finally, it supports the timely identification and effective management of risks.

### Solution

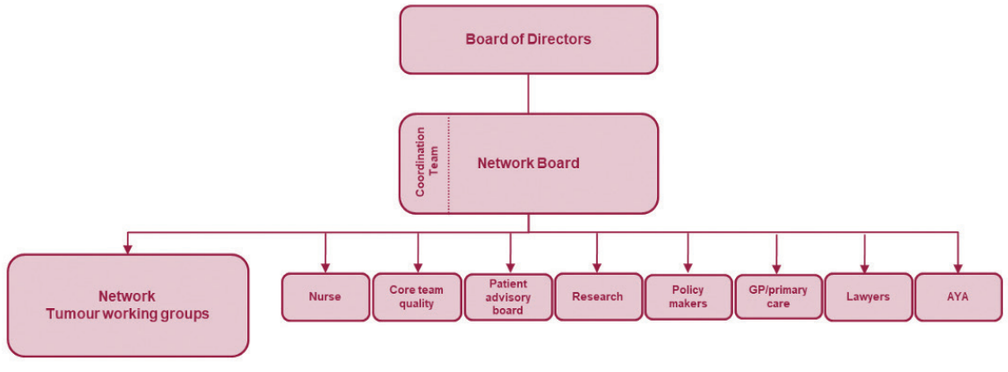
A suitable solution to the above is the development of a single collaboration agreement for all ten OncoZON institutions. This agreement should be drafted jointly, with medical and business managers as well as legal representatives from all participating institutions, and should explicitly address the topics outlined above. Ultimately, the agreement should be formally approved and signed by all member organisations.

### Critical success factors

Critical success factors include the shared confidence of all institutions in the objective that formal network formation genuinely adds value, both for the network as a whole and for the individual institutions. There must be a common vision and strategy, as well as commitment from all partners to adhere to the agreed-upon arrangements. In addition, an independent and trustworthy leadership capable of maintaining the confidence of all participating institutions, is of great importance.

### Impact

A single collaboration agreement provides a strong foundation, particularly during the initial phases of network development. It establishes a clear framework for implementing agreements and ensures that roles, responsibilities, and expectations are formally documented. With the agreement signed by all participating institutions, there is transparency and clarity, which enables the network to make concrete and measurable progress.




### Next steps

It is important to review the current collaboration agreement to ensure that all provisions remain relevant and to determine whether any updates are needed. In the Netherlands, a national governance model has been developed, and it is valuable to compare and align the OncoZON governance model with that of the broader Dutch oncology networks.

# Leuven Cancer Institute

## Towards a Sustainable Culture of Quality of Care

**Dirk De Ridder**
Quality Director of UZ Leuven and Member of the LKI Comprehensive Cancer Center Board
E-mail: dirk.deridder@uzleuven.be

LEUVEN CANCER INSTITUTE LKI

### Challenge addressed by the practice

**Engaging all staff members in a shared quality culture.**

The goal is to embed sustainable quality principles into the daily workflow of the healthcare organisation, ensuring long-term benefits for patients, their families, and all healthcare stakeholders. Our current quality system is built on the FlaQum Quality Model, which provides a structured framework for continuous improvement of the quality system.
We are now transitioning toward a more integrated quality management system, Qubuz. This system aims to centralise document management and create a single, accessible platform where all components of quality management (SOPs, audit, incident management, improvement, etc.) are integrated and easy to consult. By streamlining access and improving coherence, Qubuz supports a stronger, more consistent quality culture across the organisation.

### Solution

- The practice focuses on embedding a person-oriented quality policy into the hospital's daily operations in an innovative and transparent way. The quality department supports this by providing measurement and learning systems, project monitoring, and both centralised and decentralised training and information on procedures and practices. Collaboration with UZ Leuven hospital staff and network partners is driven by a constructive, proactive, and learning-oriented mindset.
- In addition, patients are involved in quality projects whenever possible to strengthen relevance and impact (e.g. patient panels, PREMS).
- (Quality) information sharing is structured by analogy with our matrix structure, with Care Programme (CP), Activity Center (AC), and Competence Center (CC) dimensions within the hospital. This means that information is made available per position on the axes. The data is made centrally available via an internal website that everyone can access. Each employee can access information according to his position on the matrix. Active work is being done to expand the available data.
- Our new quality management system (Qubuz) is currently being developed and will become operational in 2026.

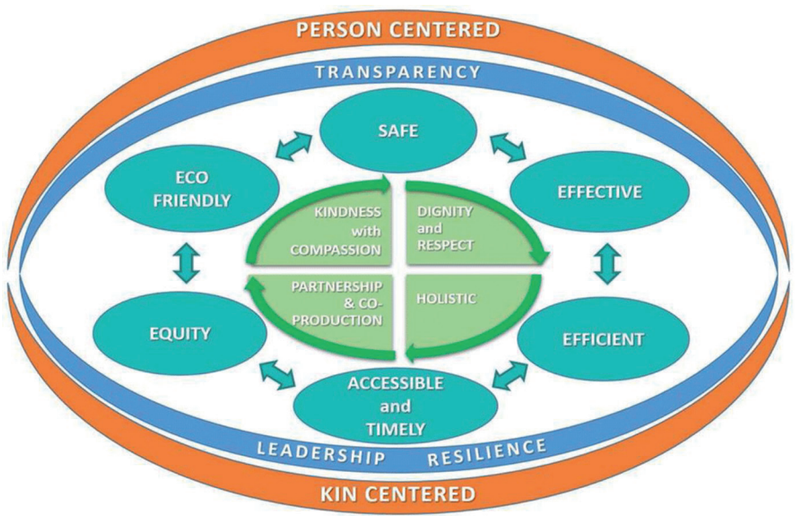



*Figure 1. A multidimensional quality model (Lachman et al, 2021 and Claessens et al, 2022)*

### Impact

The impact of the practice is monitored through an annual evaluation report that documents progress, challenges, and measurable effects on quality management (within cancer care). These evaluations assess, for example, how well quality initiatives are embedded in daily clinical and research activities, and how effectively staff and patients are engaged.
Updated results can be obtained by contacting Prof. Dirk De Ridder (see contact details above).

### Critical success factors

A key success factor is the active commitment of all professionals. The quality management system can only advance when every staff member recognises that quality and safety are shared responsibilities, fully aligned with the FlaQuM principles.

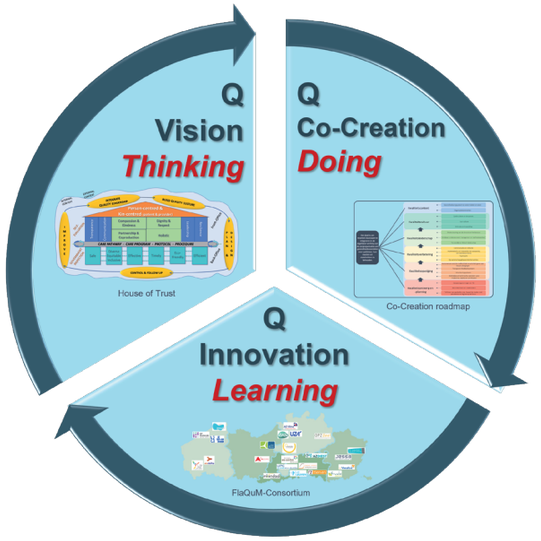



*Figure 2. The three FlaQuM pillars*

### Next steps

The next steps focus on strengthening a sustainable quality culture by encouraging continuous learning, innovation and shared responsibility. The aim is for quality to be fully embedded in every employee's daily workflow, ensuring consistent, person-centered care.
In parallel, further development of the integrated quality management system, Qubuz, will continue.

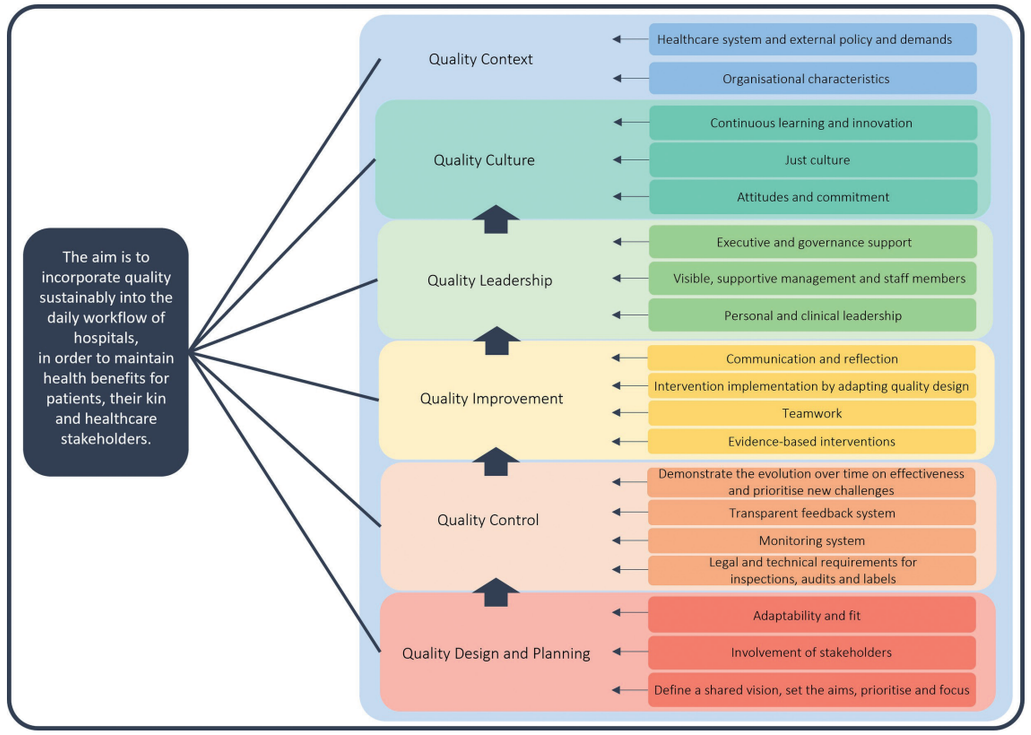



*Figure 3. FlaQuM Co-Creation model (Claessens et al, 2021)*

# Rijnstate Cancer Centre

## Dashboards for Quality Improvement and Shared Decision Making

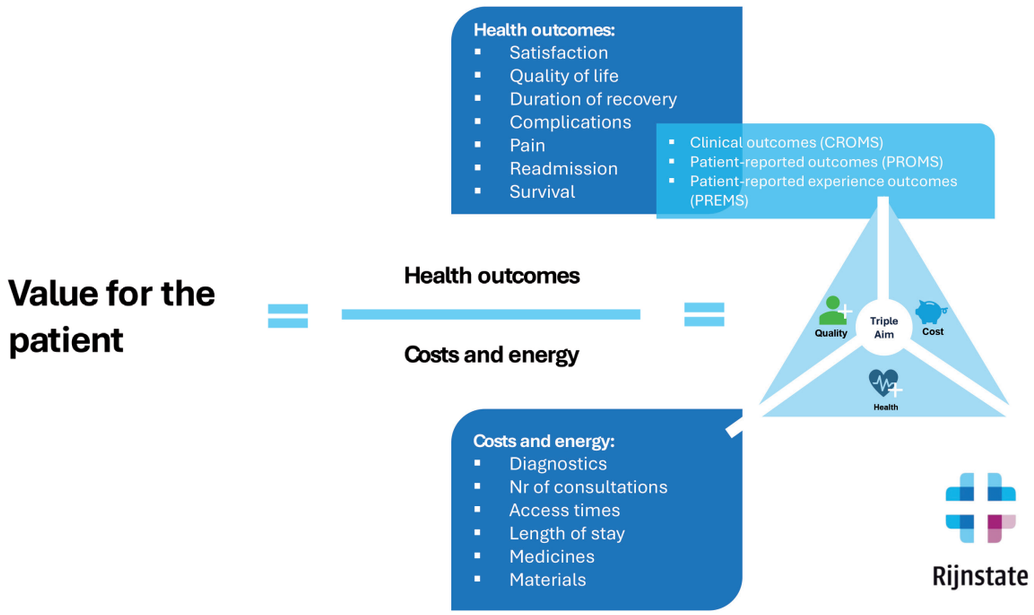
**Marjet Docter**
Policy and Quality, programme Cancer Care
E-mail: mdocter@rijnstate.nl

### Challenge addressed by the practice

Rijnstate Cancer Centre operates according to the principles of Value-Based Health Care to effectively monitor the relationship between quality, clinical outcomes, and financial performance. The aim is to make information available in a timely, reliable, and directly applicable way for both strategic and clinical decision-making.
High-quality and complete data on clinical outcomes, patient-reported outcomes, and finances are essential to further improve care results at both individual and group level. The ambition is to use care outcomes transparently for shared decision-making in the consultation room. For this reason, the Rijnstate Cancer Centre invests in a robust and future-proof data infrastructure that provides a solid foundation for the further development of personalised care. The main challenge is to clearly define the required management information and to effectively integrate these data sources into a single, coherent structure.

### Impact

Within the Rijnstate Cancer Centre, there are strong cross-links between different tumour working groups. By working with dashboards, teams have learned from and inspired each other.
By recognising that quality improvement starts with conversations about needs and preferences, concrete opportunities for improvement emerge. In the Netherlands, a broad set of national dashboards for quality registries is available, including DICA and the Netherlands Cancer Registry. The cancer care dashboards at Rijnstate provide a valuable addition by offering insight into local data at both team and patient level.
These dashboards enable more in-depth analyses of trends and underlying causes of variation. They combine information on clinical outcomes, patient-reported outcomes and experiences (PROMs and PREMs), process indicators (such as throughput and access times), and costs and benefits.




### Solution

This has been achieved through close collaboration between the Tumour Working Groups, the Business Intelligence & Data Analytics team, and the Quality team. In recent years, comprehensive dashboards have been developed that provide real-time insight into key outcomes. Based on a dataset grounded in the principles of Value-Based Health Care, these dashboards have been flexibly adapted to the needs of the tumour teams.
The main indicators may differ per tumour working group. As a result, one team may focus on shared decision-making based on patient-reported outcome measures (PROMs) for prostate cancer treatment, while another focuses on throughput times along the patient journey for breast cancer patients. In breast cancer, one key focus area is diagnostics. Radiologists and pathologists work with fully structured reporting, allowing imaging and pathology data to be directly linked. This enables a real-time overview of all biopsies performed, including the corresponding BI-RADS classification and histopathological outcomes.

### Critical success factors

- Insights from dashboards are used in the consultation room to support personalised treatment choices. Close collaboration with a patient council or patient organisation is essential for this.
- Strong and accessible collaboration between tumour working groups, the Business Intelligence & Data Analytics team, and the Quality team.
- Monthly tumour working group meetings with dedicated time to review results, perform analyses and identify concrete improvement actions.
- A focus on improvement priorities rather than developing large, complex dashboards.
- Positive experiences and good examples from healthcare professionals help build enthusiasm among other teams.
- As the available time of all stakeholders is limited, this requires clear choices and sharp prioritisation of improvement initiatives. This ensures efforts remain feasible and focused on what truly makes a difference. Discussions and analyses also require time investment from multiple disciplines.

This video (in Dutch) explains how value-driven working with data is implemented at Rijnstate:
https://youtu.be/2iZgPVfuLIY

### Next steps

**Continuous improvement process**

- Insights from data can help make better-informed decisions. It is essential to have a clear objective in advance: which question do we want to answer, and with which data?
- Objectives and processes may change over time, and the data requirements change accordingly.
- Data products such as dashboards require maintenance to ensure they provide the right information at the right time.
- By also considering which data is not needed, clarity is maintained and it becomes easier to focus on what is important.
- A large number of dashboards can fragment information. A clear key-indicator dashboard provides guidance at management level and helps keep priorities sharp.
- Maintaining focus on value-based healthcare and data-driven analysis within tumour working groups supports continuous quality improvement.
- Exploring benchmarking initiatives.

# Vall d'Hebron Barcelona Hospital Campus

## Implementation of a Value-Based Model through Integrated Knowledge Areas and Clinical Quality Management to Enhance Person-Centred Care and Clinical Outcomes

**Accreditation and Strategic Support Unit**
E-mail: acreditaciohuvh1@vallhebron.cat

## Challenge addressed by the practice

The healthcare environment faces rising costs, aging populations, and fragmented care. Key challenges include reducing clinical variability, and safety incidents while adapting professional profiles to meet new patient demands for shared decision-making. Vall d'Hebron Barcelona Hospital Campus is one of Spain's largest and most complex healthcare ecosystems, with over 11,000 professionals, 1,211 beds, and 2,200 clinical trials.

Ensuring high-quality, safe, and coordinated care required addressing fragmented clinical pathways and process variability. Consequently, the hospital launched "The New Vall d'Hebron" strategy, aligned with the Strategic Plan, supported by a transversal foundation of modern infrastructure, technology, and data.

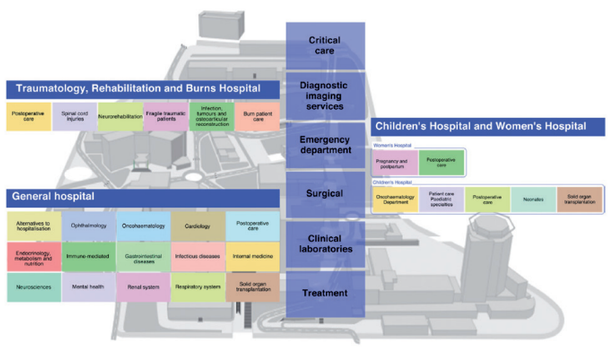
This base enables cultural change through three pillars: a new organisational model based on integrated knowledge areas, a new way of working focused on clinical leadership, shared accountability, and continuous improvement, and a new stakeholder engagement approach. These changes aim to strengthen continuity of care and improve clinical outcomes, patient experience, and efficiency.

**Strategy**


**Infrastructure, technology and data**

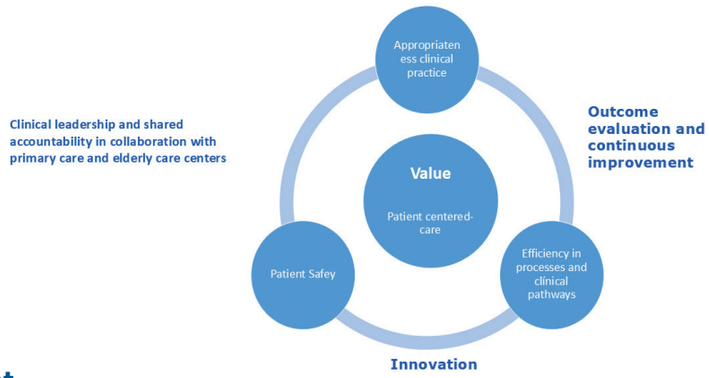
## Solution

Vall d'Hebron implemented a comprehensive approach combining a robust Quality Management System (QMS) with a new integrated organisational and care model to drive cultural change. The QMS supports continuous improvement and risk management through eight strategic lines in the Quality and Safety Plan. The Quality, Processes, and Innovation Department supports the hospital's strategy by integrating process improvement, patient safety, appropriateness, healthcare innovation, and accreditation into a unified framework. These pillars are monitored through cancer-specific dashboards tracking adverse events and clinical outcomes. The new organisational model is structured into 35 integrated knowledge areas to reduce fragmentation, enhance teamwork, and deliver person-centred care using the ATIC classification system to adapt care intensity in hospitalisation. A Clinical Management Model fosters value-based care through leadership, shared accountability, and continuous improvement. Finally, the ICE Model (Information, Co-creation, and Strategy) ensures structured participation of patients and families, enabling shared decision-making.




**Integrated Knowledge Areas**

**Quality Management Model**




## Impact

The implementation of the integrated organisational and quality system has resulted in measurable improvements:

- **Quality and Safety**: Continuous monitoring and risk management have reduced adverse events and improved patient safety.
- **Patient Experience**: More personalised, agile, and responsive care with better continuity across transitions; cancer-specific dashboards allow targeted interventions.
- **Clinical Outcomes**: Improved health outcomes through better adjustment of nursing care intensity, reduced fragmentation, and increased efficiency via stronger multidisciplinary integration.
- **Professional Development**: Clear responsibilities, emergence of new roles, reinforced leadership, and enhanced teamwork.
- **Replicable Model**: Provides a benchmark for other OECI-designated Cancer Centres seeking integrated, person-centred, and outcome-oriented care delivery.

This approach has strengthened continuity of care, improved clinical outcomes, and enhanced patient experience, while fostering cultural change and collaboration across professionals, patients, and institutions.

## Critical success factors

Success was driven by a combination of organisational, cultural, and technological enablers. Strong clinical and executive leadership, permanent structured organisational communication, and clear governance ensured alignment of quality initiatives with organisational priorities and facilitated decision-making. A fully staffed Quality, Processes, and Innovation Department provided the structure to coordinate patient safety, accreditation, and continuous improvement hospital-wide. Interdisciplinary collaboration within Integrated Knowledge Areas reduced fragmentation, promoted teamwork, and reinforced shared accountability. Active engagement of professionals, patients, and families fostered ownership and adherence to new workflows, embedding person-centred care principles. Robust monitoring systems and cancer-specific dashboards enabled data-informed decisions and targeted interventions. Finally, continuous quality improvement, risk management, and external accreditation cultivated a culture of innovation and trust, essential for sustaining change and scaling the integrated model across the healthcare ecosystem.

## Next steps

- **Technological advancement**: Future developments will integrate personalised medicine, predictive analytics, AI-driven tools, and expanded cancer-specific dashboards to enhance early risk detection and optimise care pathways.
- **Professional development**: Continuous professional development and interdisciplinary training programs will reinforce shared accountability and innovation.
- **Patient-centered strategy**: Structured patient and family engagement will be strengthened through co-creation models to ensure care remains person-centred.
- **Sustainability and scale**: These steps aim to scale the integrated model across services, ensuring sustainability and measurable improvements in quality, safety, and patient experience.

# Antoni van Leeuwenhoek Netherlands Cancer Institute

## Chatbot Anne

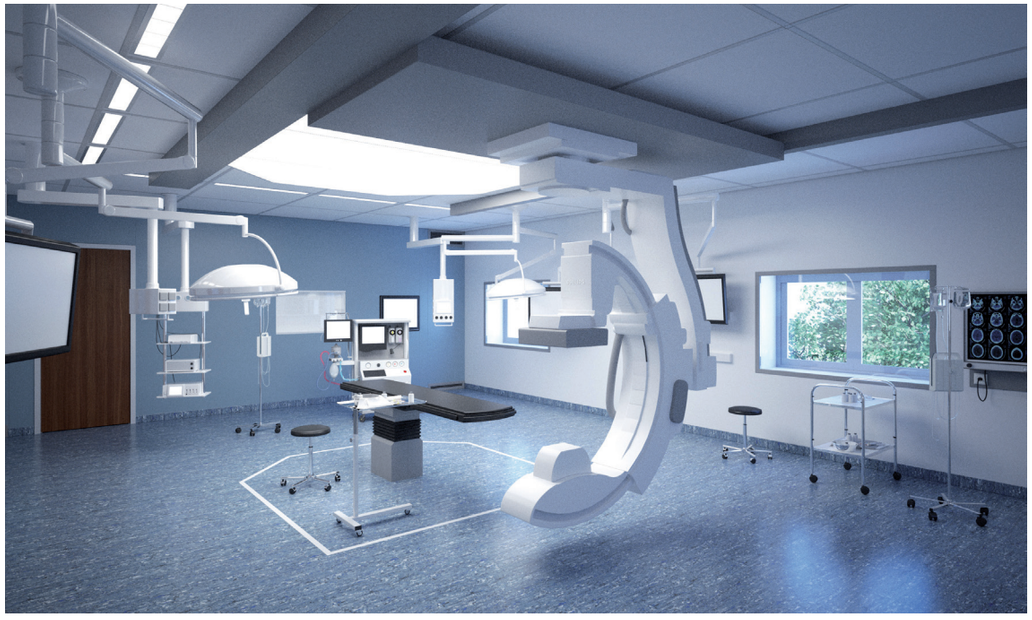
**Dorien de Vries**
Quality and Safety Advisor
E-mail: d.d.vries@nki.nl

## Challenge addressed by the practice

AVL identified a growing need for accessible, reliable, and patient-oriented information for patients and their loved ones. Website visitors often search for information about care, treatments, and processes at moments when they have little certainty and are unsure how to formulate their questions. Although most of the required information is available on the website, it was not always easy to find through the existing search function. In addition, the hospital is only partially reachable outside office hours, while the need for information is continuous. As a result, phone and email are also used for relatively simple questions, increasing pressure on telephone lines and service desks. Furthermore, there is a growing group of visitors who prefer digital communication or have limitations that make phone calls difficult. AVL therefore sought an additional, low-threshold way to better guide visitors in their information needs without closing existing contact channels.

## Solution

In 2022, AVL developed the service-oriented chatbot Anne in collaboration with Pexlife. Anne was designed as a conversational partner: helpful, practical, and empathetic. The chatbot assists visitors step by step in finding relevant and reliable information, even when they are unsure what exactly they are looking for. Anne deliberately does not provide personal medical advice but can offer general information about cancer, explain care processes (such as fast diagnostics), and refer users to appropriate next steps or other contact channels. Recently, Anne was expanded with a live chat feature: when the chatbot cannot provide an answer, a live chat with a staff member is offered. This ensures that the service remains human and prevents frustration. Anne is available 24/7 and recognises medical terms and keyword combinations better than the regular search function.



## Impact

After its repositioning in 2024, usage of Anne nearly doubled. Visitors now prefer the chatbot over the search bar, leading to faster access to information, reduced frustration, and an improved online experience—especially for sensitive or complex topics. The addition of live chat strengthens this effect by offering human support when needed. Anne also provides valuable insights into patient and visitor needs, which AVL uses to continuously improve its website and services.


## Critical success factors

A key success factor is Anne's human-centered and service-oriented design. The chatbot has a clear and recognisable character and is carefully built with complex dialogues tailored to the oncology audience. Anne is explicitly not a gatekeeping mechanism but supports users and quickly refers them to various options for personal contact when needed. Continuous optimisation based on usage data and strategic placement on prominent web pages contribute to success. This makes Anne stand out from more generic chatbots.

## Next steps

In the coming period, AVL will focus on further optimising the chatbot's visibility and user-friendliness, ensuring Anne is immediately visible when pages load. The live chat will be evaluated for impact, service experience, accessibility, and phone traffic. User feedback and insights from chat and live chat data will be actively used to enrich dialogues and website content. AVL is also exploring how to guarantee optimal staffing for live chat, which can be challenging with a small team. In the longer term, AVL will consider expanding with additional AI support, while keeping the human touch, factual accuracy, and patient-centered approach at the core.

# The Christie NHS Foundation Trust

## Patient Involvement and Support

**David Wright**
Associate Chief Nurse for Quality and Patient Experience
E-mail: d.wright26@nhs.net

The Christie NHS
NHS Foundation Trust

### Challenge addressed by the practice

The Christie Hospital is a comprehensive cancer centre that provides services to patients across a regional, national, and international footprint. The Trust recognises that the variety and complexity of specialist cancer services covered by the organisation have the potential to make it difficult for patients to be as involved in their care and the services that support them as they would like to be. The challenge is how to overcome this in ways that are holistic and reflective of the diversity of patients attending for treatment and support. There is also an understanding from the highest levels of the organisation that to achieve optimum patient involvement requires time, support, and a commitment to engage and involve them in decision-making and governance processes.

### Solution

The Christie Hospital has committed resource over many years to support the development and growth of patient involvement and support. The aim is to deliver a holistic support package to patients across the trajectory of their treatment pathway. This is reflected in the following:

- A comprehensive suite of patient information that combines locally developed material appropriate to specialist treatments alongside material from national cancer organisations
- A holistic therapies team that supports patients across the trajectory of their treatment
- Development of the Supportive Oncology directorate and service to reflect the changing nature of cancer therapies and survivorship
- Collaborative work with cancer charities to support the delivery of pre- and post-treatment information support sessions
- A Christie members' monthly meeting
- A well established Young People's forum that supports the development of TYA services
- Patients embedded within the governance structure of the Trust
- Research focused PPI engagement groups

### Impact

Examples of the impact of the work that has been done to enhance support and involvement include:

- Improved signage that supports those who have a dementia diagnosis and need to attend the Trust.
- Development of a comprehensive network of services that support care closer to home; these include chemotherapy, radiotherapy, and blood sampling.
- Year-on-year positivity from the Trust's national survey results and regularly high Friends and Family scores.
- Specific clinics developed to support the supportive oncology team, allowing rapid access for patients living with the effects of treatment.
- Delivery of Spotlight events with clinical and research teams.
- Patient and carer feedback incorporated into the Trust accreditation processes.
- Involvement in the development of satellite sites.

### Critical success factors

The success of the Trust is based on several key factors:

- A strong sense of the need to embed patient experience at the heart of the Quality Agenda, ensuring that care and treatment are holistic.
- Strong support from the highest levels of the organisation in recognising the value of patient involvement and the opportunities available for further development.
- An embedded desire to work with key partners such as charities, academic institutions, and research organisations to function as a comprehensive cancer centre.
- A culture that has allowed a passionate and dedicated workforce to trial new ways of working so as to find new and optimum ways of supporting and involving patients.
- A visibility of senior leadership through executive and governor walk rounds.

### Next steps

- Updated quality plan 2026–2028 with patient and carer involvement at its heart.
- Launch of the Patient and Carer Engagement Forum
- Further development of the processes and access to patient information
- Embedding the newly created role of Patient Equality, Diversity and Inclusion Lead.
- Continued work to increase feedback that is representative of the ethnicity of the patient population attending the Trust.
- Support for the continued development of the patient portal to further empower patients treated by the Trust.

# Vall d'Hebron University Hospital
## Multichannel Patient Involvement

**Claudia Valverde**
Comprehensive Cancer Centre Coordinator
E-mail: cvalverde@vhio.net, claudia.maria@allhebron.cat

### Challenge addressed by the practice
We have developed our Patient Pathways (PP) in a multidisciplinary way for nearly all the tumour types treated at the center, but we have not had the opportunity in the past to include a broad patient perspective. We realised that, especially, long-term care was not completely structured or personalised. This year, we decided that we needed to implement a survivorship program, starting from a general guide for cancer survivors.

### Solution
Based on our previous experience, we decided to use 3 different and complementary approaches for involving patients:

1. **VHIOtalks** are a series of conferences that bring together patients and leading voices in cancer research, treatment, and survivorship. Designed for patients and the wider community, these sessions offer an interactive space where attendees can learn from and engage directly with experts. Examples include talks on quality of life after cancer and the role of nutrition in cancer prevention and treatment.
2. **CET Oncology** is a stable working group that meets regularly (every 2 months online and 1 face-to-face meeting every year). Participants include hospital staff (doctors from different tumour-type groups and cancer nurses), a primary care representative, representatives of cancer patient associations that have an agreement collaboration with the hospital (8–10 regularly participating), and support staff from the hospital's citizen participation office (secretariat).
3. **Patient involvement workshop**: this was a 3-hour workshop with professionals and individual patients from our institution. Approximately 30 attendees were divided into small groups of 5–8 to work on different PPs (5 in total, displayed on the wall). They were asked specific questions and could also add comments. At the end, they nominated a representative to share their feedback with the whole group. The same process was followed for the draft structure of the survivorship guide.

### Impact
After the face-to-face workshop, we gathered different comments on the PP that needed to be included in the next version of the PP. For example, patients asked to include a structured question about the depth of the information each patient wanted to have on treatment objectives and prognosis at certain time points in the PP (second visit and after progression), to supplement the casual and open question that may arise in a normal visit. They also validated the general structure of the survivorship guide, but added some issues not previously mentioned, like problems with driving license or the need for consultation with specialists we had not thought about, like dentists.
The CET worked on the proposed structure of the guide to complete all the information required, and the patients representatives of the group are working on assuring that the language is understandable, inclusive, and not intrusive for patients.
The growing popularity of VHIOtalks is evidenced by an average attendance of approximately 100 participants per session, demonstrating their success. This impacts directly on the knowledge and the empowerment of the society and the patients in respect to cancer prevention, diagnostic, and treatment. It's an excellent tool to disseminate our survivorship plan.

### Critical success factors
- The existence of other stable working groups (CETs). This structure is present and quite mature in other areas of the hospital. This fact accelerated our learning curve in CET Oncology.
- The fact of having voluntary agreements with patient associations makes it very easy to create this kind of groups.
- Inviting patients from the clinic by their own physician increases the probability that they want to engage in workshops and other activities.
- Seeing the results of previous CET activities (like the New patient guide) also increased their commitment.
- The broad scope of the VHIOtalks is a key element to reach a more general public.

### Next steps
After finishing the Survivorship Guide, we want to create a patient version of the patient pathways, as requested by the CET and Workshop components, and to fully develop and test our survivorship program.


# Karolinska Comprehensive Cancer Center

## Multidisciplinarity, Clinical Pathways and My-Care Plan

**Berit Sunde**
Nurse Director Cancer Theme
E-mail: berit.sunde@regionstockholm.se

Karolinska Comprehensive Cancer Center

### Challenge addressed by the practice

Multidisciplinary care is embedded in clinical practice through structured collaboration across health professionals, ensuring coordinated care planning, timely decision-making, and reduced duplication of assessments. This approach enables holistic, integrated care that addresses the patient's medical, psychosocial, and supportive needs.
These principles are operationalised through My Care Plan and the assigned contact nurse. My Care Plan provides each patient with a personalised, structured care pathway outlining treatments, timelines, and relevant information. The contact nurse serves as the patient's primary point of contact, coordinating and providing continuous practical and emotional support throughout the care process. Together, these practices ensure transparency, shared decision-making, continuity, and seamless collaboration across the multidisciplinary team.

### Solution

The implementation of My Care Plan and the Contact Nurse role is a key part of Swedish cancer care, based on the National Cancer Strategy and Regional Cancer Center (RCC) guidelines. At Karolinska CCC, these practices are fully integrated into the clinical pathway and have improved both patient experience and care quality.
My Care Plan gives each patient a personal overview of their cancer journey, including examinations, treatments, timelines, and relevant information. It is available digitally and on paper and is mainly used by contact nurses. The care plan supports clear communication, patient involvement, and shared decision-making.
The Contact Nurse is the patient's main point of contact and ensures continuity and coordination between different care providers. The role includes updating the care plan, monitoring waiting times, and offering psychosocial and practical support.

Examples of what we measure:
- Percentage of patients with a documented My Care Plan
- Patient-reported sense of security and access to care (PREM)

### Impact

This practice has shown clear and documented benefits for cancer care and patient outcomes. Patients feel better informed and more actively involved in decisions about their treatment, which increases empowerment, trust, and confidence in care. Clear and predictable care pathways, supported by My Care Plan and the Contact Nurse role, improve continuity of care and reduce uncertainty and stress throughout the cancer journey. Communication between patients and care teams is strengthened through digital tools that enable two-way dialogue and timely information sharing. Shared decision-making is supported through the joint development of the care plan, promoting patient autonomy and partnership in care. Accessibility and continuity are ensured by having a clear and consistent point of contact in the care team. Patients' physical, social, and existential needs are systematically assessed and addressed using PROMs (Patient Reported Outcome Measures) tools such as Hälsoskattningen, enabling early identification of needs and more person-centred care.

### Critical success factors

Several factors were critical for the successful implementation of My Care Plan and the Contact Nurse role. A clear national and regional framework, based on the Swedish Cancer Strategy and RCC guidelines, created a shared direction and common goals. Strong involvement of contact nurses was essential, as they have main responsibility for using, updating, and following up the care plan together with the patient. The structured but flexible design of My Care Plan made it easy to adapt to individual patient needs while still supporting standardised care pathways. Availability in both digital and paper formats ensured accessibility for all patients. Continuous focus on patient involvement and shared decision-making strengthened trust and engagement. Finally, regular use of patient-reported measures supported systematic follow-up of needs and outcomes, helping teams to see the value of the practice and sustain its use over time.

### Next steps

The next step is to further standardise and develop the Contact Nurse role across Cancer Theme, in line with national guidelines, to ensure equal, high-quality, and person-centred care throughout the cancer pathway. Continued training and clearer role descriptions will strengthen coordination and follow-up. A key development is to integrate Hälsoskattningen more clearly as a structured part of cancer rehabilitation, supporting systematic assessment of physical, social, and existential needs. Future evaluations will focus on patient-reported outcomes, continuity of care, and how well rehabilitation needs are identified and addressed over time.

**Berit Sunde**

# OncoZON Network MUMC+

## Multidisciplinarity – Network Multidisciplinarity Teams

**Grard Nieuwenhuijzen** and **Esmee Volders.**
GI and Oncological Surgeon and Policy Advisor OncoZON
E-mail: esmee.volders@mumc.nl

Oncologisch Netwerk Zuidoost-Nederland

### Challenge addressed by the practice

Significant regional variation existed in the management of oesophageal and gastric cancer patients, including large differences in the likelihood of receiving curative treatment (54–83% for oesophageal cancer and 37–100% for gastric cancer) and associated survival differences between hospitals. Evidence showed that patients were not consistently discussed with an expert centre, resulting in unequal access to optimal treatment strategies and clinical trials. This undermined the principle of "equal care for equal patients" across the network. Referral pathways were fragmented, multidisciplinary expertise was unevenly applied, and decision-making quality depended heavily on local hospital capacity and experience. These disparities were further exacerbated for older patients, those with comorbidities, or those presenting with metastatic disease, who were less likely to be discussed in expert settings. The challenge was therefore to reduce unwarranted variation, ensure equitable access to expert advice, and standardise high-quality multidisciplinary decision-making.

### Solution

The Brainport Upper GI Network within OncoZON implemented a regional, online MDT for all patients with oesophageal and gastric cancer. Instead of referring all patients to an expert centre, all cases are discussed jointly with the expert centre in a weekly regional video MDT. A harmonised regional care pathway and service-level agreements were established, defining what care can be delivered locally and what requires centralised expertise. Case submission was made low-threshold and efficient: referring hospitals submit a minimal dataset, coordinated by dedicated case managers, with second-opinion radiology and centralised preparation. The MDT includes all relevant disciplines (surgery, oncology, radiotherapy, gastroenterology, radiology, nuclear medicine, pathology, and nursing specialists) and results in a single, shared treatment plan covering what, where, when, and how. Clinical trials are always taken into consideration. Gradual implementation across hospitals took place between 2014 and 2017, supported by digital infrastructure and quality monitoring.

### Impact

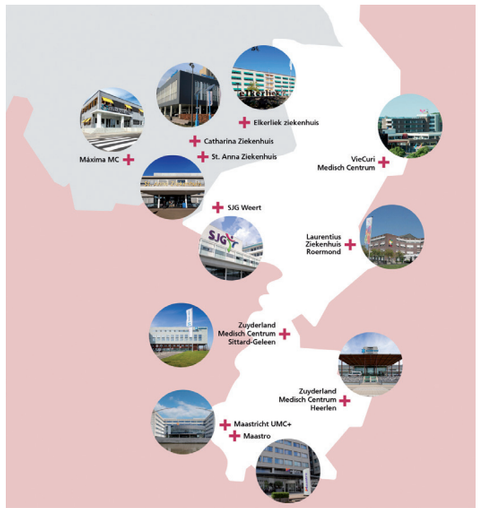
After implementation, the proportion of patients discussed in an expert setting increased substantially, and variation between hospitals in access to multidisciplinary expertise disappeared. The likelihood of receiving curative treatment became more uniform across the region. Data analyses demonstrated improved consistency of care, more appropriate treatment allocation, and increased inclusion in clinical trials. Importantly, survival outcomes improved, both for the total patient population and for patients treated with curative intent. Hospitals reported higher satisfaction and engagement, and collaboration between centres intensified. The MDT advice matched the treatment actually delivered in 97% of cases, indicating high-quality and actionable decision-making. Patients benefited from more equitable access to expertise, reduced unwarranted variation in care, and a higher probability of receiving guideline-concordant, personalised treatment. Overall, the regional MDT contributed to better clinical outcomes, improved quality of care, and strengthened network-wide cooperation.

### Critical success factors

Key success factors included strong clinical leadership from the tumour working group, formal regional agreements on care pathways and roles, and full multidisciplinary participation. Low-threshold referral procedures and minimal administrative burden for referring hospitals were essential for uptake. Dedicated case managers ensured coordination, data completeness, and continuity. Centralised second-opinion radiology and structured MDO preparation improved decision quality. Clear scheduling, strict time management, and rotating chairmanship supported efficient meetings. Digital infrastructure enabled secure data exchange and high-quality video conferencing. Continuous quality monitoring using regional indicators and national cancer registry data (IKNL) provided feedback and supported iterative improvement. Regular network meetings fostered trust, shared ownership, and alignment across institutions. Importantly, the explicit commitment to "equal access to the best treatment" created a shared vision that motivated sustained participation and long-term embedding of the MDT within routine clinical practice.

### Next steps

Next steps include extending the regional MDO model to additional tumour types within OncoZON, further standardising digital data exchange, and integrating structured decision-support tools. The network aims to enhance patient-reported outcome monitoring, strengthen links with clinical research infrastructure, and further reduce residual variation in care for vulnerable subgroups. International benchmarking and knowledge exchange, including through OECI, will be used to refine the model and support broader European implementation.




# OncoZON Network MUMC+

## Multidisciplinarity – Tumour Working Groups

**Daniëlle Faessen-Holthuijsen** or **Esmee Volders**
Policy Advisor
E-mail: danielle.holthuijsen@mumc.nl or esmee.volders@mumc.nl

Oncologisch Netwerk Zuidoost-Nederland

### Challenge addressed by the practice

OncoZON aims to provide the best possible cancer care as close to home as possible for patients in the region. Achieving this ambition requires that all organisations within the network are able and willing to deliver the same high-quality, evidence-based care. In practice, however, variation in clinical practice and outcomes between hospitals still existed, which could lead to unwarranted differences in patient care.

Although quality indicators were often monitored at the level of individual hospitals, there was limited systematic use of these indicators at network level. As a result, opportunities to learn from each other, to benchmark performance, and to jointly improve care across the network were not fully utilised.

To truly function as an integrated oncology network, OncoZON needed a structured approach to align care, reduce variation, and collectively take responsibility for the quality of care delivered to all patients within the network.

### Solution

OncoZON established Tumour Working Groups (TWGs) for all tumour types as multidisciplinary, tumour-specific teams at network level to align oncological care across all participating organisations. Each hospital is represented by two to three professionals per TWG, who are responsible for translating network-level agreements into local practice and ensuring feedback to their clinical teams.

Standardised care pathways (newly developed and regularly revised) are a standing agenda item in TWGs. By jointly agreeing on pathways, indicators, best practices, and studies, the TWGs create shared standards and expectations, enabling all organisations in the network to consistently deliver the same high-quality care.

Within the TWGs, quality indicators are systematically reviewed to identify unwarranted variation in care and outcomes. The Netherlands Comprehensive Cancer Organisation (IKNL) supports this process by providing and discussing regional benchmarking reports. Several TWGs have dedicated quality sub-teams led by OncoZON's quality advisor that analyse these indicators and propose targeted improvement actions.

### Impact

Several TWGs now have regional care pathways in place, which are intended to be consistently followed by all hospitals in the network. In addition, some TWGs have established Service Level Agreements with specific hospitals to ensure aligned care for complex or specialised procedures, helping to standardise practice and clarify expectations across institutions.

A concrete example of the TWGs' impact is the management of sentinel node (SN) procedures in cT1N0 breast cancer patients. Following a network-wide TWG decision to stop this procedure for eligible patients, quality indicators and outcome data showed a clear reduction in SN procedures after the decision date, demonstrating the effect of coordinated guidelines combined with systematic monitoring. Another example is that a unified care pathway in the thyroid cancer group reduced the number of fine-needle aspirations (FNAs) without compromising malignancy detection.

This structured, network-wide approach has positioned OncoZON as a benchmark for other cancer networks across Europe.

### Critical success factors

Several key factors underpin the TWG success. The multidisciplinary composition of the groups, including oncologists, surgeons, radiotherapists, nurses, and other professionals, ensures comprehensive discussion, shared decision-making, and agreements across all aspects of patient care.

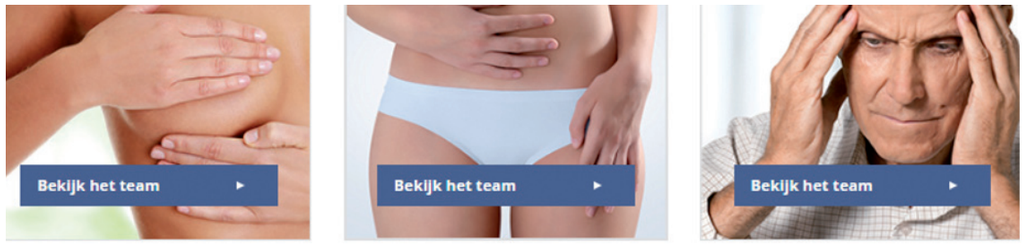
Regular network meetings create opportunities for professionals to speak openly, learn from each other, and build trust. This trust, combined with the intrinsic motivation and sense of ownership of TWG members, is essential for reducing unwarranted variation and translating network-level agreements into clinical practice. Structured agenda items (covering care pathways, quality indicators, and research studies) combined with agile subgroups (e.g. consensus group lung cancer) ensure continuity, short communication lines, and rapid follow-up.

Clear governance, with all hospitals formally committed to the TWG agreements, provides the framework for alignment and accountability across the network. In addition, policy staff play a crucial role by facilitating meetings, coordinating data, and supporting follow-up, enabling clinical members to focus on content and decision-making.

### Next steps

While TWGs have improved collaboration and care alignment, challenges remain. Not all groups function equally well; ensuring consistent attendance, engagement, and a shared sense of responsibility is still a priority. Members must feel accountable for implementing network-level agreements locally.

OncoZON plans to scale quality indicator use to more tumour groups, with dedicated sub-teams monitoring outcomes and driving improvements. Research discussions will also be expanded across all TWGs, ensuring every patient in the region has equal opportunities to participate in clinical studies. By addressing these challenges, OncoZON aims to provide consistently high-quality, uniform care across the network.



# The Christie NHS Foundation Trust

## Early Cancer Detection in High Risk Individuals

**Andrew Renehan**
Professor of Cancer Studies and Surgery; Anal Cancer MDT lead
E-mail: andrew.renehan@nhs.net
**Sacha Howell**
Senior Lecturer and Honorary Consultant in Medical Oncology; Director of Manchester Breast Centre
E-mail: sacha.howell@nhs.net

The Christie NHS
NHS Foundation Trust

### Challenge addressed by the practice

Populations at high risk of Breast Cancer (BC) and Anal Cancer (AC) need to be identified to initiate effective screening and early treatment strategies, when mortality is reduced. At The Christie we have established two exemplar services to address these challenges:

- In women treated with radiotherapy to cure lymphomas and other cancers, in adolescence there is a very high risk of BC and BC mortality in later life. We identified that the existing screening service was ineffective (Howell et al., BJC 2009) and implemented a new national programme: Breast Cancer After Radiotherapy Dataset (BARD).
- There are around 1,600 new AC cases in the UK every year with incidence rising by 78% since 1990 and predicted to reach 2,400 by 2038. High stage disease requires chemoradiotherapy, associated with much morbidity and 20% risk of long-term stoma. Anal cancer can be detected early because it is preceded by a detectable precursor lesion, known as anal intra-epithelial neoplasm (AIN).

### Solution

- The Breast Cancer After Radiotherapy Dataset (BARD) was established by Christie oncologists and is a national database and referral system for women treated with radiotherapy (as above). BARD prospectively identifies all women in England, eligible for early screening and refers directly into the NHS very high-risk breast screening programme (VHRBSP). Adoption into the VHRBSP was in 2020 and is the only point of entry for such women to the screening service nationally. The BARD project manager, based at The Christie, is now co-funded by NHSE and The Christie.
- We have implemented a new technique called high-resolution anoscopy (HRA) for the surgical ablation of AIN, the earliest precursor of AC. This technique requires specialist training with a limited number of centres across the UK using therapeutic HRA. International efforts, including our own, have better defined the categories at high-risk of AC and this knowledge can now feed into our clinical pathways.

### Impact

- We have identified 4,552 women nationally at increased risk of breast cancer. All eligible women have been referred for MRI-based annual breast screening which has previously been shown to reduce mortality in high-risk populations. National audit of uptake and outcomes is ongoing. The BARD research group was established to personalise risk prediction in this cohort: 2 BARD PhD students to date, one completed 2024 and one ongoing.
- In September 2023, the Christie extended the existing early anal cancer service and introduced HRA. The service expanded to a second colorectal surgeon from October 2025. We now run two theatre lists per month with 8 patients undergoing HRA. In 2023, there were 23 new referrals from outside the Christie; in 2025, there were 47 new external referrals. The new HRA service has underpinned two PhD projects, and the HRA service practice guidelines underpin new national guidelines.

### Critical success factors

**BARD**

- Recognition of increased risk in the BARD population and ineffective coverage of current screening service (Swerdlow AJ…Radford JA JCO 2012; Howell SJ BCJ 2009)
- Grant funding for a dedicated project manager who developed relationships with all radiotherapy centers to achieve complete national coverage
- Integration with NHS England and the NHS VHRBSP through persistent lobbying
- BARD newsletter, website, and responsive email address to provide information to patients and oncology teams

**HRA Service**

- Between 09/2023 and 12/2025, 140 HRA procedures were performed in 88 patients, with laser ablations in two-thirds
- Among 54 women, 43% had additional intra-epithelial neoplasia of the vulva or vagina, known as MZIN cases, are at high risk of cancer development and are challenging for complete clearance of precursor lesions
- 7 new anal cancers, all T1 and cured by simple local surgery
- We have developed patient information documents and refined our clinical pathways

### Next steps

**BARD**

- Extend eligibility to BARD through the national screening committee to include irradiated age <10 years, non-lymphoma diagnoses, and TBI
- Further research to personalise breast cancer risk, including modern radiotherapy techniques, the amount of radio-dense breast tissue involved in RT fields, and integration with other hormonal and genetic risk factors
- Development of a national virtual service for BARD cancer prevention.

**HRA Service**

- Develop HRA in the outpatient setting
- Improve integration with gynaecologists for women with MZIN disease
- Develop certified training courses to disseminate the use of this surgical technology to other national centres
- Widen the research portfolio to HRA-based early trials

# OncoZON Network MUMC+

## Diagnosis – Specific Examples of Innovation: The 48-hour Breast Cancer Diagnostic Pathway

**Esmee Volders**
Policy Advisor
E-mail: esmee.volders@mumc.nl

### Challenge addressed by the practice

Before 2018, breast cancer patients in the OncoZON region experienced major variation in diagnostic waiting times, ranging from same-day clarification to delays of several weeks. This caused anxiety, uncertainty, and inequity between hospitals. Patient organisations, particularly the Dutch Breast Cancer Association (BVN), advocated for a maximum of 48 hours between referral and diagnostic clarification, but this was not structurally implemented. In addition, patients often felt insufficiently informed about what would happen during the diagnostic phase and when they would know whether their abnormality was benign or malignant. The combination of long waiting times, fragmented communication, and unequal access undermined patient-centred care and trust. OncoZON therefore identified the need for a network-wide, patient-centred and standardised rapid diagnostic pathway that would provide all patients with timely clarity about malignancy status.

### Solution

In 2018, OncoZON implemented a network-wide 48-hour diagnostic pathway for breast cancer, ensuring that all patients quickly know whether their abnormality is benign or malignant. Core diagnostics (imaging, biopsy, and initial pathology) are completed within two working days, while additional tests (e.g., MRI or staging) may follow later. The breast cancer tumour working group harmonised the regional care pathway and aligned it with BVN standards.

A key design element addressed result communication: patients are offered the option to receive the first result by phone on the same day or next morning, followed by a face-to-face consultation within 1–2 days for detailed discussion and treatment planning. This approach proved highly valued by patients. Uniform patient information materials explain the process, timelines, and next steps. OncoZON coordinated implementation and continuous optimisation across all hospitals.

### Impact

The 48-hour pathway has eliminated variation in diagnostic waiting times across the region and significantly improved the patient experience. Patients now receive rapid clarity on whether their abnormality is benign or malignant, even if additional diagnostics are still required to fully characterise the tumour or determine staging. This early certainty reduces anxiety and allows patients to mentally and practically prepare for the next steps. Patients know in advance what tests they will receive, when results will be available, and what possible outcomes mean for their treatment. Offering the option to receive the first diagnostic result by telephone has proven highly valuable, allowing patients to process the news in their own environment before the follow-up consultation. All patients, regardless of the hospital where they enter the network, receive the same diagnostic speed and the same information. The approach has strengthened multidisciplinary collaboration and increased trust in the regional breast cancer pathway.

### Critical success factors

Key success factors included strong clinical leadership within the tumour working group, patient-driven standards from BVN, and OncoZON's governance structure enabling alignment across hospitals. A shared and explicit definition of the 48-hour target—focused on providing clarity about benign versus malignant status—created realistic expectations for both professionals and patients. The development and use of uniform patient information materials ensured that all patients received consistent, understandable explanations of the diagnostic process and timelines. Close cooperation between radiology, pathology and clinical teams was essential to achieve the 48-hour target. A dedicated policy team coordinated implementation, monitored compliance and resolved bottlenecks. The shared commitment to equity, transparency, and patient-centred care motivated all institutions to adopt and sustain the pathway.

### Next steps

OncoZON is further integrating the 48-hour pathway with digital patient information, real-time monitoring and broader breast cancer care pathways. The network aims to embed performance indicators that distinguish between time to malignancy clarification and time to full diagnostic completion. This model will be used as a blueprint for other tumour types and shared within OECI, including both the organisational framework and the patient-communication approach, to support adoption by other European cancer networks.

# OncoZON Network MUMC+

## Molecular Tumour Board

**Lizza Hendrik**
Pulmonologist
E-mail: lizza.hendriks@mumc.nl
**Léon van Kempen**
Clinical Molecular Biologist (Pathology)
E-mail: leon.van.kempen@mumc.nl
**Hanneke van der Wijngaart**
Medical Oncologist
E-mail: hanneke.van.der.wijngaart@mumc.nl

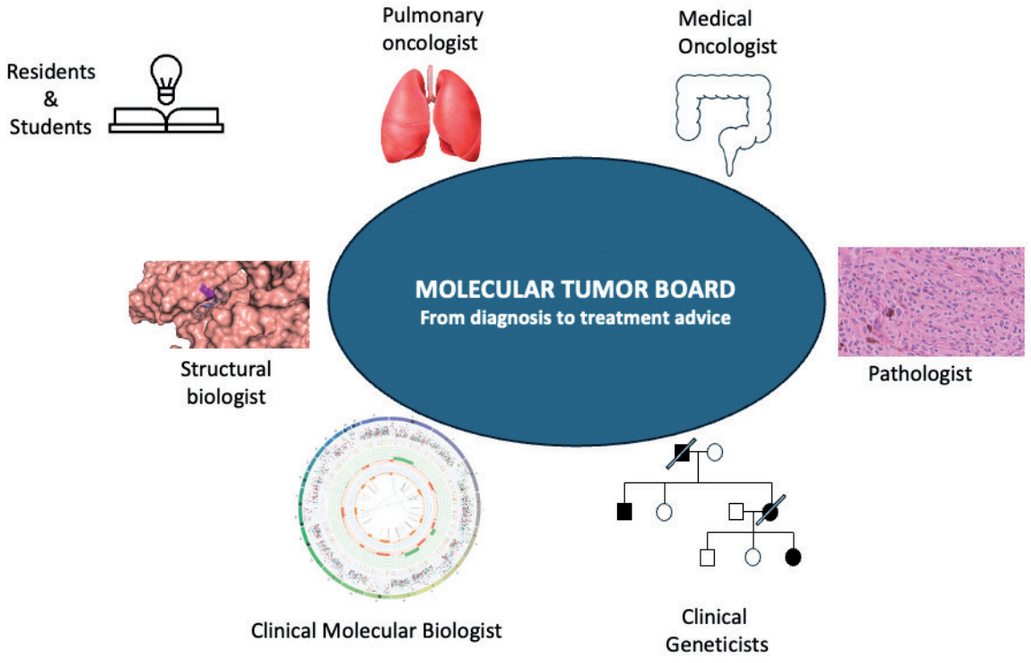
Oncologisch Netwerk Zuidoost-Nederland

### Challenge addressed by the practice

Physicians often find it difficult to interpret molecular results obtained with broad panel Next Generation Sequencing or Whole Genome Sequencing (tissue or liquid biopsy). Due to an expanding number of targeted treatments available for patients with specific genomic features in their tumour tissue, molecular diagnostic testing is becoming more mainstream in clinical oncology practice, both in academic and non-academic hospitals. Mutations are often rare and limited data is available guiding best practice and treatment. Additionally, it is often difficult to have a complete overview of all ongoing clinical trials and available early access/named patient programs for rare oncogenic drivers or resistance mutations. Therefore, a structure is needed where physicians can easily discuss these molecular results with experts in the field, and obtain advice on how to optimally treat their patient.

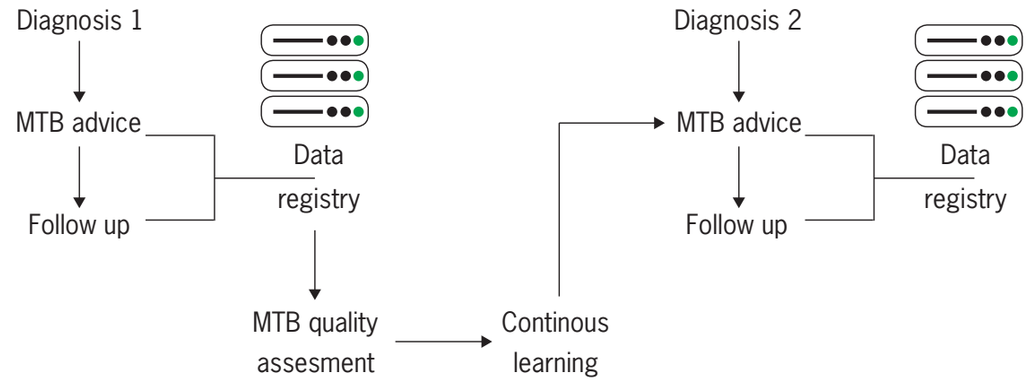
### Solution

The weekly molecular tumour board (MTB), led by Maastricht UMC+, but accessible via videoconferencing for all OncoZON regional hospitals, enables timely discussion of molecular results. The MTB gives advice on the biological features of the molecular aberrations found in a tumour (i.e. effect on tumour growth, sensitivity to specific anti-cancer drugs) and advises on treatment options (both on- and off-label), (early phase) clinical trials, and expanded access/named patient programs (also outside of the region). There is a standardised format referring physicians need to fill in, and all patients are discussed at a specific time at the MTB, with referring physicians encouraged to attend the MTB to discuss their patient via secured video access. Specialist from clinical molecular biology, pathology, medical oncology and pulmonology always participate. Other experts such as clinical geneticists can be consulted as necessary. For all cases, a standardised letter with advice is sent to the treating physician and stored within the electronic patient record.




### Impact

Every week between 1–5 cases are discussed in the MTB. Physicians value the possibility to discuss these challenging cases. The MTB facilitates cohesion in the OncoZON region and fulfills an important role regarding education of physicians who are not (yet) trained in molecular diagnostics in oncology, or for colleagues who desire to deepen their understanding of molecular biology in cancer. Regularly, clinical trials, named patient, or early access programs are recommended, resulting in extra treatment options for patients. For quality control, MUMC+ participates in anonymous sharing of cases with other MTBs in the Netherlands, and high consensus is being achieved. Annual review of the uptake of treatment advice and clinical follow-up of the patient is performed.




### Critical success factors

We work with a dedicated and ambitious team, with no cancellation of the MTB, a standardised format for referral, and structural registration of the advice, as well as trained molecular biologists and trial-minded pulmonologists and medical oncologists.

### Next steps

- Enabling rapid data extraction to support periodic evaluation of MTB performance (number and complexity of cases discussed, uptake of the advice, and follow-up of treatment responses)
- Creation of a shared Dutch database
- Strengthening the educational role of the MTB for colleagues working in non-academic OncoZON hospitals

# Cancer Center Clínica Universidad de Navarra

## Implementation of a Comprehensive Educational Framework for Oncology Nursing Practice

**Marian Soteras**
Nurse Manager of the Cancer Center
E-mail: masoteras@unav.es

### Challenge addressed by the practice

Nursing care for oncology patients requires advanced competencies to ensure patient safety and high-quality care. The main challenge is to ensure that nurses are adequately prepared to support patients and their families. This includes safely administering increasingly complex treatments in a context of continuous therapeutic innovation and high clinical workload. Consequently, it was essential to implement a sustainable training model that integrates technical competence, scientific updating, and the development of communication skills, ensuring that nursing practice consistently meets the highest standards of quality and safety. This model encompasses different levels of nursing education, including a master's-level programme in oncology care for newly recruited registered nurses, continuous professional development for experienced oncology nurses, and targeted training for nurses from other clinical areas who also care for oncology patients and administer complex treatments, such as intensive care, paediatrics, or the operating theatre.

### Solution

To work as a nurse in the Cancer Center, specific education in Oncology Nursing is required, provided through either a 60-ECTS master's degree or a postgraduate expert diploma, both academic programmes embedded within the Faculty of Nursing of the University of Navarra. The academic leadership of the master's programme is led by the Nursing Professional Development Area of the Clinic. Training needs are identified through direct observation of clinical practice, annual competency assessments, accreditation and quality requirements, incident reporting systems and indicators, evaluation of training activities, and a dedicated request form available on the intranet. The administration of antineoplastic treatments is limited to nurses with accredited training. In clinical areas such as intensive care, paediatrics, and the operating theatre, annual training and specific competency assessment procedures are in place to ensure safety and excellence in complex oncological treatments.

### Impact

The implementation of a structured nursing education model has ensured that all nurses working in the Cancer Center share a solid foundation of knowledge and competencies in oncology nursing, supported by comprehensive educational programmes that guarantee advanced oncology nursing competencies. Continuous professional development enables ongoing updating of clinical practice in line with therapeutic advances and evolving care needs. In addition, mandatory annual training for nurses administering treatments in critical care, operating theatres, and paediatric settings ensures that complex oncological therapies are consistently delivered by appropriately qualified professionals. This comprehensive approach has contributed to greater consistency in clinical practice, strengthened patient safety, and reinforced a culture of excellence and professionalism within the nursing team. Furthermore, the existence of these structured educational programmes supports the Center's positioning as a reference institution for advanced oncology nursing education, aligned with international quality and safety standards.

### Critical success factors

The successful implementation of this educational model is based on several critical factors. First, the integration of specialised oncology education (master's or postgraduate expert level) into the onboarding pathway for oncology nurses ensures a high level of clinical competence from the outset. Second, close collaboration with the Nursing Professional Development and Research Area enables systematic identification of training needs and continuous adaptation of educational activities to scientific advances and clinical demands. Third, standardised annual training in critical care, operating theatres, and paediatric settings promotes ongoing updating and consistency in nursing practice, to showcase good practices across the whole organisation. In addition, formal competency assessment procedures support effective workforce planning and appropriate allocation of responsibilities. Strong institutional support reinforces a shared culture of safety, excellence, and professional accountability, underpinning the sustainability of the model.

### Next steps

Future developments will focus on consolidating and expanding the educational model through a continuous quality improvement approach. Training programmes will be systematically updated to incorporate advanced therapies and emerging clinical challenges. Interdisciplinary educational activities will be strengthened to improve coordination across care pathways. Specific indicators will monitor and evaluate the impact of education on patient safety, quality of care, and clinical outcomes, enabling long-term benchmarking. In parallel, communication skills and humanised care training will be further reinforced to support a comprehensive, patient- and family-centred model of oncology care.

**Amaya Villanueva**

**Marian Soteras**


# Institut du cancer Paris CARPEM AP-HP.Centre Université Paris Cité

## From Play to Practice: How Games Can Support Skills Development in Paramedical Professionals

**Valérie Quevreux**
Oncological Nurse Manager
E-mail: valerie.quevreux@aphp.fr

### Challenge addressed by the practice

Several challenges led us to implement this annual training initiative for paramedical professionals.

- During our first OECI accreditation visit, experts identified an area for improvement related to paramedical training, which needed to be better encouraged and structured.
- The Paris CARPEM Cancer Institute was also facing a shortage of paramedical professionals following the COVID-19 pandemic. Releasing staff to attend training sessions was difficult due to limited workforce availability.
- In addition, new generations of professionals have different expectations regarding training: they want to learn while being actively involved. Training modalities therefore need to adapt to these new aspirations.
- Finally, another major challenge was to promote a transversal culture of patient safety across professional categories and to strengthen cohesion and the sense of belonging within a multi-site cancer institute.

### Solution

Institut du cancer Paris CARPEM designed an annual, multimodal, and playful training program dedicated to paramedical professionals, including nurses and radiology technologists. Developed in line with OECI recommendations, this training combines innovative educational formats such as simulation using virtual reality, “error room” scenarios, role-playing, a board game, and interactive quizzes.
The themes addressed in these workshops focus on the entire patient pathway, from initial care to palliative care. In addition, adverse events reported during the previous year were used to prioritise the topics addressed in the error room scenarios.
These workshops (scenarios and games) are made available to nurse managers so they can be easily deployed directly within clinical units throughout the year.


### Impact

This training brought together 60 healthcare professionals from all departments and all sites of the institute.
A before-and-after knowledge assessment and a satisfaction survey were conducted.
Knowledge levels increased by 30% by the end of the day, and overall participant satisfaction reached 87%, with an average score of 4.5/5.
Key strengths identified included the clinical relevance of the workshops, improved cohesion between different professional categories, better understanding of each profession, and the playful and immersive nature of the training.
Areas for improvement included extending the duration of post-workshop debriefings, adjusting the dynamics of certain games, and addressing difficulties some participants experienced when using the virtual reality headset.
The organisation of this initiative mobilised management teams, functional departments, and medical teams. Their feedback was also very positive regarding the topics covered, the co-creation of tools, and the organisation and facilitation of the workshops.

### Critical success factors

Several factors were decisive in the success of this initiative.
First, the co-construction of the program with a wide range of stakeholders—including physicians, paramedical professionals, and functional departments—helped engage the entire community and ensured that the training was aligned with clinical realities.
Second, the use of playful and innovative learning methods increased participant engagement and satisfaction. Games proved to be an effective tool for improving knowledge and updating skills.
In addition, before all workshops, organisers emphasised that participants were free to make mistakes without consequences or judgment. This reminder fostered a climate of trust and reduced stress during the training.
Finally, participants worked in small groups during the workshops, allowing active participation, frequent exchanges, and close interaction with trainers.

### Next steps

This training initiative is now sustainable and will be repeated annually.
Adjustments will be made based on feedback from participants and organisers to further improve the program.
The scope of the institute was recently expanded to include pediatric oncology.
The training program reflects this change, with pediatric oncology specifically integrated into the error room scenarios.

# Instituto Português de Oncologia de Coimbra Francisco Gentil, E.P.E. (IPO-Coimbra)

## Specific Diabetic Service for Cancer Patients within Endocrinology

**Jacinta Santos**
Physician (Endocrinologist)
E-mail: 3677@ipocoimbra.min-saude.pt
**Margarida Afonso**
Nurse
E-mail: 1058@ipocoimbra.min-saude.pt

IPO COIMBRA

### Challenge addressed by the practice

Cancer patients have a high prevalence of diabetes mellitus and a significant risk of developing treatment-related dysglycaemia, particularly during corticosteroid therapy, immunotherapy, perioperative periods, and other systemic cancer treatments. Poor glycaemic control adversely affects cancer outcomes, increases complication rates, delays treatment delivery, and leads to higher hospitalisation rates. In a tertiary oncology centre, the increasing complexity and volume of patients made it challenging to ensure timely, specialised, and consistent diabetes management across both inpatient and outpatient settings. This resulted in variability in clinical practice, an increased risk of hypo- and hyperglycaemic events, and limited opportunities for professional training, patient education, and systematic quality improvement in diabetology within oncology care.

### Solution

A Functional Diabetes Unit was established within the Endocrinology Department to provide structured and specialised diabetes care for oncology patients. The unit coordinates a dedicated Diabetes Clinic, ensures expert assessment in both inpatient and outpatient settings, and supports perioperative and treatment-related diabetes management. Internal referral criteria were established for patients with diabetes mellitus or those at risk of hyperglycaemia, and clinical protocols were developed for the most frequent diabetology-related scenarios. These include, for example, “hypoglycaemia during hospitalisation” and “hyperglycaemia associated with corticosteroid therapy”. The unit promotes continuous professional education for physicians and nurses, provides patient-tailored educational materials, and fosters close collaboration with other clinical services. Telemedicine and digital tools were evaluated to enhance follow-up and accessibility. The unit also contributes to regular reviews of clinical practice and supports continuous professional development through participation in scientific meetings, congresses, and educational workshops, ensuring consistent, high-quality, and evidence-based diabetes care integrated into oncology practice.

### Impact

The implementation of the Diabetes Unit improved the organisation and consistency of diabetes care for oncology patients. Clinical practice became more standardised, reducing variability and minimising preventable glycaemic events. Early involvement of endocrinology specialists facilitated improved metabolic control during cancer treatments, perioperative periods, and hospital admissions. Educational initiatives enhanced patients’ understanding of diabetes within the oncological context. Overall, the initiative strengthened the quality of clinical support provided to patients, contributed to safer care delivery, improved clinical outcomes, and reinforced the role of endocrinology within comprehensive cancer care.

### Critical success factors

Key success factors included strong institutional support and the designation of responsible clinicians for the Diabetes Unit. A fundamental element was the presence of a dedicated multidisciplinary team, comprising physicians and a specialised nursing team with expertise in diabetes management. Diabetes nurses played a crucial role in the implementation of therapeutic plans, patient education, and glucose monitoring.
The development and implementation of clear clinical protocols for diabetes management in oncology patients ensured consistent and safe practice across care settings. Awareness and educational initiatives, including activities organised for World Diabetes Day, increased professional engagement and patient awareness. Continuous professional training ensured alignment with evolving clinical evidence.

### Next steps

Future developments will focus on the progressive integration of advanced diabetes technologies, including continuous glucose monitoring systems and insulin pump therapy, into routine oncology care. Ongoing training and regular updates for healthcare professionals will be prioritised to ensure the safe, effective, and evidence-based use of these technologies. The unit also aims to expand telemonitoring and remote follow-up models, reducing the need for patient travel while ensuring clinical safety and continuity of care. Continuous professional development, supported by institutional commitment and adequate resource allocation, will further enhance the sustainability and effectiveness of the unit.

# Instituto Português de Oncologia Francisco Gentil de Lisboa (IPO-Lisboa)

## The DUROS Consultation

**Ana Teixeira**
Pediatrician
E-mail: consultaduros@ipolisboa.min-saude.pt

## Challenge addressed by the practice

Most children diagnosed with cancer survive five or more years after diagnosis. In a conventional setting, patients are followed at IPO Lisboa during the treatment phase and for the subsequent five years, after which they are discharged. While this transition to community care has advantages, it also results in the loss of long-term follow-up of survivors, which is particularly important for those who survived cancer in childhood.

The side effects of antineoplastic therapies may appear late, years after their administration, which requires regular monitoring. Moreover, the oncology center team is more alert to potential complications that may arise, due to their experience in managing these cases, thus providing more targeted surveillance of cancer survivors.

## Solution

IPO Lisboa is a national reference center for pediatric oncology and was the first institution in Portugal to establish a survivorship follow-up consultation, which remains to date the only one operating under this model. The DUROS consultation (Duros meaning the tough ones), created in 2007, is dedicated to survivors of childhood cancer who have completed treatment at least five years earlier. Follow-up is maintained until 18 years of age for survivors at low risk of late effects, and up to 40 years of age for those with a higher likelihood of developing late complications related to the oncological disease or its treatment.

Currently, approximately 1,100 survivors are under follow-up. The consultation is conducted by a multidisciplinary team comprising three pediatric oncologists, three nurses, a psychologist, and a social worker. Survivors are seen once a year or every two years, depending on their individual risk profile.

## Impact

- **Clinical Follow-up and Surveillance**
  The DUROS consultation aims to assess and reduce the impact of cancer on quality of life by ensuring regular and targeted monitoring of potential late effects of antineoplastic treatments.
- **Early Identification of Needs**
  It enables the early detection of physical, emotional, and social needs, and facilitates coordination with other healthcare professionals or institutions to ensure appropriate support for survivors.
- **Information and Education**
  The consultation provides written information regarding the oncological disease, treatments received, associated risks, and long-term follow-up recommendations.
- **Research and Data Contribution**
  Consultation records contribute to national and international databases, supporting research on late effects of cancer treatment, including secondary malignancies, endocrine disorders, and behavioral changes.
- **Social and Administrative Support**
  The consultation also supports survivors with administrative matters in adulthood, such as documentation required for loan applications, representing an important social support component in long-term follow-up.

## Critical success factors

- **Support from IPO Lisboa Leadership**
  Backing from both the service directors and the hospital administration.
- **Collaboration Across Departments**
  Cooperation from all departments within IPO Lisboa.
- **Provision of Written Information**
  Written materials provided to survivors, covering both the disease and the treatments they received.

## Next steps

The next step is to strengthen the coordination between IPO Lisboa and other healthcare institutions in the long-term follow-up of survivors. The moment of discharge from IPO Lisboa, at age 18 or 40, is critical. We plan to proactively promote contact between our nursing team and the primary care teams who will continue to follow the patient, ensuring a smoother transition and better integration of care. Ideally, we aim to establish a clinical team fully dedicated to this consultation, which would allow us to expand our activities and enhance our capacity to respond to the needs of survivors.

# Kortrijk Cancer Centre AZ Groeninge

## Onco@home

**Laura Tack**
Quality Lead Oncology
E-mail: Laura.Tack@azgroeninge.be
Due to maternity leave, please include
Louis.Vanslambrouck@azgroeninge.be in all communications

### Challenge addressed by the practice

As a result of the increasing cancer prevalence, the demand for cancer care is growing. In the oncology day clinic of the Kortrijk Cancer Centre, we reached the maximum capacity a few years ago. At the same time, the importance of providing integrated, high-quality, patient-centred, and cost-efficient care is globally emphasised. As a consequence, there is an urgent need to evaluate alternative healthcare models meeting these challenges. A different approach was developed with our onco@home model, targeting cancer patients receiving ambulatory systemic cancer therapy at the Kortrijk Cancer Centre. This model allows us to redesign ambulatory cancer care and optimise the capacity of the oncology day clinic by providing two circuits that allow a reduction in the number of hospital visits and/or the duration of hospital stays by shifting certain specialised procedures from the hospital to the patient's home.

### Solution

The onco@home models are standard of care (when applicable):

- **Model A**: On Day 1, a certified primary home care nurse visits the patient at home and performs blood sampling, symptom assessment, and vital sign measurements. This enables the treating physician to assess treatment safety in advance and prepare therapy or select matched blood units for transfusion ahead of arrival at the oncology day clinic (Day 0). This proactive approach avoids unnecessary hospital visits when treatment cannot proceed due to impaired blood values or poor tolerance of side effects. It also facilitates anticipation of additional investigations, resulting in a more efficient day admission and earlier discharge.
- **Model B**: Subcutaneous administration of certain anticancer therapies at home by a specialised hospital nurse visiting the patient at home, after a telephone-based symptom assessment on Day 0. Unlike Model A, the patient no longer needs a therapy administration in the hospital.

### Impact

- **Care coordination and continuity**: Delivering oncological care in the home setting requires close coordination between hospital-based teams, home care services, and primary care providers. Ensuring seamless communication and continuity of care across settings can be complex. To manage this logistical and organisational complexity, 1 FTE administrative employee organises home visits, medication delivery, monitoring and follow-up of all home visits.
- **Careful patient selection**: Not all patients or treatments are eligible for home-based oncological care. Adequate patient selection, risk stratification and clear clinical protocols are essential to maintain patient safety and treatment quality.
- **Training healthcare professionals**: Nurses involved in the onco@home circuit need specific clinical competences.

Previous RCT highlighted the following impact in numbers:

- Equivalence of both models in terms of patient-reported QoL with 77% and satisfaction (88%)
- Model A: reduced waiting times for therapy administration at the day care unit by 45% per visit
- Model B: significantly fewer hospital visits
- 60% preferred onco@home above usual care

### Critical success factors

- Adequate patient selection following established guidelines (including safety and risk management)
- Multidisciplinary approach with all stakeholders included
- Clear and efficient communication between all healthcare professionals and the patient
- Digital infrastructure and monitoring: to follow up on our patients included in the onco@home circuit, an accessible and patient-friendly EHR is essential
- Diminished waiting times: a thorough quality-improvement study resulted in a 42% reduction in the average patients' waiting times for therapy administration (Model A). No hospital visit is required to receive anticancer therapy (Model B).
- Available financial framework
- Available legal framework
- Education of staff and other partners involved
- Above all, the population of patients needs to be supportive of this type of intervention, as well as all stakeholders involved

### Next steps

In future, onco@home models are indispensable for providing integrated cancer care. The concept is believed to meet the new needs of an ageing population with chronic illnesses and increasing multimorbidity by providing continuous patient-centred care. Furthermore, it is believed to improve population health, improve individual experiences of care and reduce costs of care per capita, known as the Quintuple Aim Objectives for healthcare.
For Model A, we will have to deal with blood draw further in advance than Day 1, as cleanroom PIC/S regulations are set to become mandatory in Belgium starting January 1, 2026. For Model B, there is a positive trend in the reimbursement of several anticancer therapies eligible for subcutaneous treatment. It will be a challenge to prepare our organisation for this and/or the potential transfer of this activity to external, specialised home care services.

Laura Tack

# Kortrijk Cancer Centre Az Groeninge
## Specialised Nurses Oncology

**Lisa Deprez**
Head of Specialised Nurses Oncology
E-mail: lisa.deprez@azgroeninge.be

## Challenge addressed by the practice
Patient care is becoming increasingly comprehensive and complex. From the moment a tumour process is suspected, patients enter a fast-paced sequence of diagnostic tests and procedures, often along with prolonged waiting times for results. From the start of an oncological journey, the impact on patients is substantial. It is therefore difficult for them to process and understand the large amount of information. In addition, patients often have to make important decisions even before the start of treatment, at times that are emotionally and physically very demanding.
Throughout their oncological journey, patients come into contact with a wide range of disciplines and healthcare providers, which may lead to fragmentation of care. It is important to pay attention to the patient's needs and choices and to actively encourage shared decision making.
Furthermore, attention must also be given to the patient's family, immediate environment, and broader context.

## Solution
The specialised nurse in oncology supports the patient as a guiding thread throughout the entire care trajectory. Tailored support is provided to both the patient and their family, adapted to their specific needs and context.
In addition, the specialised nurse coordinates the entire care process and acts as a bridge between the oncology department and the organ-specific department, ensuring continuity and coherence of care. When necessary, patients are referred to additional supportive services.
We provide patients with the right information at key moments, enabling them to better understand their disease and treatment pathway. From the very beginning of the illness, the specialised nurse serves as the primary point of contact for patients and their families. By meeting patients shortly before or immediately after diagnosis, a trusting relationship is established. We adopt an accessible approach that encourages them to reach out whenever they have questions and to actively engage in their care process.

## Impact
- **Improved treatment adherence**: Patients are better informed and have a clearer understanding of the purpose and potential effects of their therapy.
- **Increased patient empowerment**: Through structured education and coaching, patients are able to better recognise and manage their symptoms, and encouraged to express their needs and actively participate in decisions regarding their care.
- **Referral and coordination role**: The specialised nurse ensures that the appropriate services are involved at the right time. This also promotes better collaboration among the various multidisciplinary teams and healthcare providers.
- **Reduced waiting times and proactive support**: Through coordination and guidance of the care process, patients supported by a specialised nurse may experience reduced waiting times. The availability of a clear and accessible point of allows an earlier identification of emerging problems and contributes to timely interventions.
- **Higher patient satisfaction**: Patients who are supported by a specialised nurse report higher levels of satisfaction with their care.

## Critical success factors
- **Perspective of other healthcare providers**: Whereas the role was previously seen mainly as supportive, the specialised nurse is now recognised as a key figure in the patient pathway.
- **Specialisation by tumour type**: Each specialised nurse is assigned to one or at most two tumour types, allowing for in-depth expertise and continuity of care.
- **Adequate training and continuing education**
- **Integrated patient care**: By embedding the specialised oncology nurse within the care pathway, fragmentation of care is reduced and coordination is improved, resulting in more integrated patient care.
- **Collaboration with treating physicians**: Good and effective collaboration between the specialised nurse and treating physicians is essential to ensure alignment of care decisions, timely interventions, and direct benefits for the patient.
- **Team stability**: A stable team is essential for continuity of care and for maintaining knowledge within the team.
- The hospital's strategic choice to financially invest in the hiring of specialised nurses.

## Next steps
We continue to invest in the further professionalisation of the specialised oncology nurse within the new care ladder (level 6, +20 ECTS). For each tumour group, we cover the entire patient pathway and adapt care to new treatments. In addition, we incorporate digital tools to better inform patients about their patient journey. Furthermore, we contribute to the development of care pathways, guidelines, and procedures specific to our patient population, and initiate quality improvement projects. These efforts aim to continously advance patient-centred care, optimise outcomes, and reinforce the role of the specialised oncology nurse as a central coordinator throughout the oncological journey.

Lisa Deprez

# OncoZON Network MUMC+

## Treatment – Prehabilitation, all Patients Fit4Surgery

**Daniëlle Faessen-Holthuijsen**
Policy Advisor
E-mail: danielle.holthuijsen@mumc.nl

### Challenge addressed by the practice

How can we reduce complications and enhance recovery in major oncological surgery? It is known that physically and mentally fitter patients have better outcomes after surgery. Programs to improve patients' resilience to the impact of such procedures will potentially lead to less complications, early discharge, a better quality of life, and a reduction of in-hospital costs.

### Solution

Prehabilitation is a multimodal programme to improve patients' condition prior to surgery. The programme consists of 5 pillars and is individualised based on baseline measurements:

1. Training, supervised, on strength and endurance
2. Nutritional support and supplementation of protein and vitamins
3. Mental support and optimal patient education
4. Cessation of smoking, if needed, and other lifestyle interventions
5. Correction of iron deficiency in anemia

These five pillars work synergistically: protein and vitamins are needed to optimise muscle mass gain in training. A mentally fit patient will be able to train better and, the other way around, exercise will improve cognitive functions and satisfaction. Adequate haemoglobin will support all other pillars.
Máxima Medical Center has played a leading role in the field of prehabilitation in our network and beyond. They have developed a prehabilitation program called Fit4Surgery and have initiated and participated in several prehabilitation studies.

### Impact

The impact of prehabilitation is best documented in colorectal cancer surgery, supported by evidence from randomised and real-world studies. These studies show that both fit and less fit patients benefit, with four-week improvements of 20–35% in muscle strength and a 17% increase in cardiorespiratory fitness (steep ramp test). Compared to usual care, prehabilitation is associated with 20–25% fewer postoperative complications and a reduction in hospital stay of 1–2 days. Cost-benefit analyses indicate favourable economic effects.
At Máxima MC (MMC), prehabilitation is embedded as standard of care for both frail and non-frail patients, resulting in participation rates above 90%. Within the OncoZON network, systematic knowledge exchange, among others, through working groups on oncology rehabilitation and gastrointestinal tumours, has supported centres in developing or further strengthening their own prehabilitation initiatives. This has contributed to more consistent availability of prehabilitation across the network, promoting alignment and equity of care.

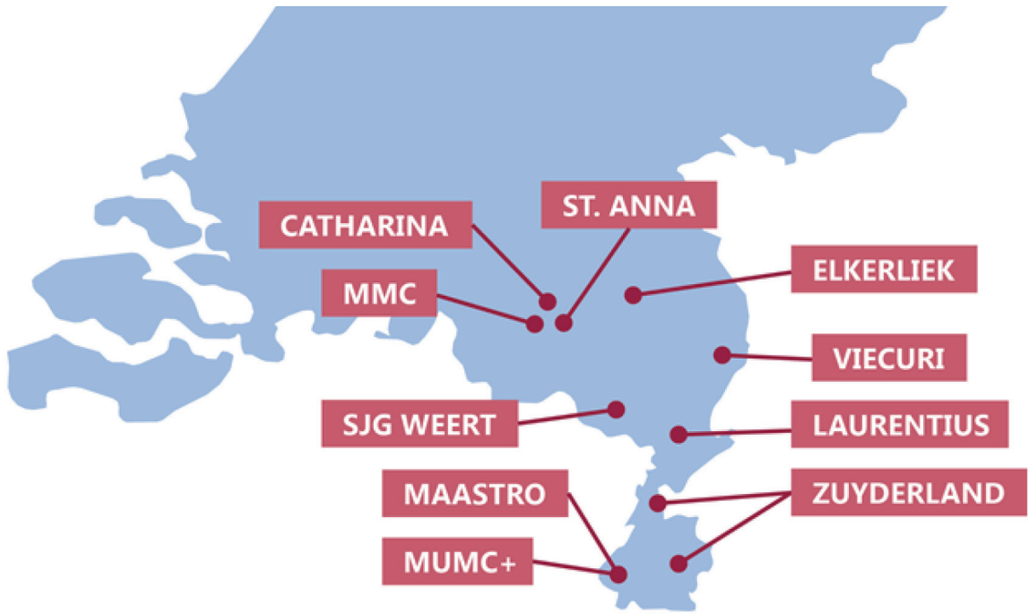
### Critical success factors

Successful implementation of prehabilitation requires optimisation of the entire patient pathway. The diagnostic and work-up phase must be efficient, ensuring sufficient time remains before surgery to offer a meaningful prehabilitation programme. Embedding prehabilitation early in the pathway is therefore essential.
Given the multimodal nature of prehabilitation (exercise, nutrition, psychological support), strong coordination between disciplines is critical. Centres that adopted prehabilitation early provided valuable insights into organisational design, logistics, and role allocation, facilitating implementation in other hospitals.
Though evidence on the effects of prehabilitation is growing, it is still weak due to heterogeneity in the programmes and the fact that randomised studies of such programmes are difficult to execute. Patients are highly motivated to participate and do not want to be randomised, and clinicians are increasingly reluctant to withhold prehabilitation from their patients.

### Next steps

Although evidence on the effects of prehabilitation is growing, it is still considered relatively weak, and guideline policy makers are awaiting a higher level of evidence. Further research is needed to determine whether there is a subgroup of patients who may not benefit from prehabilitation, such as very fit patients at baseline. In addition, it remains unclear whether the effects of prehabilitation need to be demonstrated separately for each type of major oncological surgery, or whether prehabilitation can be implemented more broadly across surgical pathways based on existing evidence. Máxima MC is willing to support any clinic in starting up prehabilitation.

**Gerrit Slooter**



# The Christie NHS Foundation Trust

## Supportive Oncology

**Richard Berman**
Consultant, Supportive Oncology
E-mail: r.berman@nhs.ne

The Christie NHS
NHS Foundation Trust

### Challenge addressed by the practice

- The rising incidence of cancer signals a deepening clinical and societal challenge. In the UK, the number of people living with cancer will rise from 3.5 million in 2025 to 5.3 milliion by 2040. The impact will extend across the healthcare system, escalating demand not only for cancer therapies but also for care related to treatment- and disease-associated complications.
- Supporting people through treatment is becoming increasingly complex, compounded by longer treatment duration, prompting a need to rethink the clinical pathway in cancer care.
- A significant proportion of Emergency Department (ED) admissions for oncology patients are due to uncontrolled pain, disease- or treatment-related toxicities. These represent a failure in the continuum of care and expose gaps in current service models. Many of these acute presentations can be managed/prevented upstream in an outpatient/ambulatory setting, reducing the economic impact of unplanned oncology care, as well as enhancing patients' quality of life.

### Solution

- Supportive oncology is the management of chronic and emergent problems in people living with and beyond the disease. It encompasses the entire cancer spectrum and has developed in response to the changing patient demographic.
- Optimal supportive oncology requires input from a myriad of medical and non-medical specialties – a "pyramid of provision"– with supporting services working in an integrated way.
- It is delivered through daily open-access multiprofessional Enhanced Supportive Care (ESC) clinics (so patients have rapid on-site or remote access to expertise in management of disease- and treatment-related toxicities), a weekly supportive oncology MDT, onco-endocrinology, psycho-oncology and senior adult oncology clinics, and a unique dedicated supportive oncology directorate within the hospital management structure which houses all medical and non-medical supportive cancer services.
- The clinical services are underpinned by a nationally recognised supportive oncology clinical fellows training scheme and a programme of supportive oncology research.

### Impact

- Supportive oncology has been shown to improve symptom burden, reduce chemotherapy deferrals, reduce secondary care use, and provide a financial saving to the NHS, which proves this model to be sustainable in achieving superior outcomes for patients with cancer. Whilst ESC clinics have traditionally catered for the needs of patients with treatable but not curable cancer, the cost saving from the reduced end-of-life year costs in one study was large enough to pay for the care of all patients, including those not in the last year of life.
- A multicentre study examining the economic impact of supportive oncology services in UK cancer centres found that Enhanced Supportive Care (ESC) significantly reduced costs in patients with treatable but incurable disease. Across a 12-month period between 2021 and 2022, £1.6 million was spent delivering ESC across eight UK centres. Reductions in secondary care usage for 1,061 patients saved £ 8.5 million.

### Critical success factors

- The concept of supportive oncology in the UK originated from specialists at The Christie, who developed the model of Enhanced Supportive Care (ESC). Support from the Trust board, from its inception, was crucial to its success.
- The model was subsequently adopted and funded by NHS England and tested in a further 20 cancer centres.
- In 2025, both the Royal College of Physicians and The Royal College of Radiologists released press statements calling for the development of standardised clinical pathways in supportive oncology, supported by an expanded workforce, closer integration with oncology, and the development of outcome metrics. This recognition of the core value that supportive oncology brings to cancer care has represented a significant milestone. The report also identified rising complex need, coupled with medical training that is falling behind, supportive oncology not yet embedded in training curricula, a need to strengthen workforce training, and standardisation and improvements in clinical practice.

### Next steps

- Specialists from The Christie have been working with government to help define the steps required to ensure that supportive oncology becomes standard practice across all UK cancer centres over the next 10 years. This work will form part of the new UK cancer plan (due to be released in early 2026).
- Work is also underway to identify key effective components and optimal models of care. This will, in turn, help simplify business case planning and provide clarity in terms of service commissioning.

# The Christie NHS Foundation Trust

## Acute Oncology – Acute Assessment Unit and Acute Emergency Ambulatory Cancer Care

**Tim Cooksley**
Consultant in Acute Medicine
E-mail: tim.cooksley@nhs.net

The Christie NHS
NHS Foundation Trust

### Challenge addressed by the practice

Emergency care systems around the world frequently experience capacity, resource, and staffing constraints. This is epitomised in NHS urgent and emergency care (UEC) settings. Emergency Department overcrowding can lead to worse patient outcomes due to delays in therapy. Cancer patients seeking emergency care can be vulnerable in this setting and timely delivery of care is often aspirational rather than reality in many acute care systems.

The increased range of cancer therapies, such as immune checkpoint inhibitors, indications for their use and delivery in an increasingly co-morbid population means that acute cancer complications will continue to place a growing and significant burden on emergency and inpatient hospital services. This requires novel and innovative models of acute cancer delivery to facilitate safe and sustainable care.

### Solution

Acute medicine is at the heart of finding opportunities to mitigate the current crisis and deliver future innovative, adaptive, high-quality, and sustainable urgent and emergency care. The fundamental components of the specialty—well-functioning, evidence-driven Acute Medical Units (AMUs) and Ambulatory Emergency Care—alongside enhanced care areas are essential for high-quality emergency care.

Ambulatory care delivers acute care to patients without the need for an inpatient bed. Its implementation is founded on the evidence that patients presenting with acute illnesses can be stratified as low risk for developing complications and therefore do not require traditional inpatient care. This schema can logically be extended to the emergency oncology setting. Ambulatory outpatient management of low-risk febrile neutropenia using the MASCC score exemplifies this approach. The Christie has developed an acute medical model with an AAU and AACU to adopt this approach to acute cancer care.

### Impact

AAU and AACU services have delivered nationally and internationally leading personalised acute cancer care. The units are managing 70–100 acute cancer patients a day, reducing pressure on local EDs and meaning many cancer patients avoid the indignity and harm of corridor care.

The expertise of the model has facilitated improved outcomes in acute cancer presentations, particularly life-threatening toxicities such as immune checkpoint inhibitor-related myasthenia gravis and overlap syndrome, and haemophagocytic lymphohistiocytosis (HLH).

The service has already led the delivery and development of several acute ambulatory cancer pathways including immune checkpoint inhibitor related hypophysitis and hepatitis, platinum related acute kidney injury, incidental pulmonary embolism and led national work on low febrile neutropenia based on The Christie pathway. More nuanced risk stratification of currently perceived high-risk toxicities has afforded the opportunity to personalise acute management.

Acute cancer and toxicity research is widely published through the unit. These innovative approaches are increasingly used as national and international exemplar models.

### Critical success factors

- An organisational passion for the delivery of high-quality acute cancer care.
- Centralisation of acute cancer care has facilitated the knowledge and expertise to develop novel models, enabled greater skills and knowledge in the management of toxicities, and translated that to the daily delivery of high-quality acute care for patients.
- Adopting the principles of acute medicine to acute cancer care through the models of the AAU and AACU.
- Training and developing a highly skilled acute oncology workforce, including acute oncology nurse practitioners, pharmacists, physiotherapists, occupational therapists, dieticians, nurses, and doctors.
- Using quality improvement and research to drive innovative models to deliver acute cancer care.
- Collaborative working with oncology and specialty colleagues.
- Multiple peer-reviewed publications, poster presentations and invited lectures to showcase achievements and facilitate further innovation and learning to develop services.

### Next steps

- As cancer therapies continue to evolve, the service will continue to innovate to deliver modern and novel models for the management of their toxicities to ensure continued improved outcomes.
- Continue to lead and participate in acute cancer research work to drive both acute cancer outcomes and personalised toxicity management.
- Begin delivering acute cancer care in the patient's home, utilising digital technologies and patient-reported measures, supported by diagnostic interventions at the bedside, with point-of-care intravenous treatments and blood tests, and point-of-care ultrasound with administration of intravenous therapies. This will also offer the opportunity to integrate with palliative and supportive care at home when required.

# Vall d'Hebron University Hospital
## Palliative Care through the Patient Pathway

### Challenge addressed by the practice

One of the principal challenges currently faced is the provision of care across multiple healthcare settings, driven by the growing population of oncology patients. Care is, delivered in different contexts, including HVH inpatient units, Pere Virgili inpatient care, outpatient clinics, and through coordination with home-based care services.

Another important challenge involves caring for patients from diverse nationalities and cultural backgrounds. This requires intercultural sensitivity, adapted communication strategies, and an understanding of differing values, beliefs, and expectations related to illness and care.

Additionally, continuous social changes have increased the diversity of family structures, personal circumstances, and socioeconomic contexts. As a result, healthcare professionals face highly heterogeneous situations that demand flexible and responsive care models, avoiding standardised approaches and promoting person-centred care within each patient's social environment.

### Solution

To address the need for care across different healthcare settings, a transversal and coordinated care model has been implemented to ensure continuity throughout the disease trajectory. Clear communication pathways have been established among HVH and Pere Virgili inpatient units, outpatient services, and home care teams, supported by procedures and protocols designed to prevent fragmentation of care.

To meet the needs of patients from diverse cultural and national backgrounds, intercultural care strategies have been introduced, including cultural mediation and coordination with spiritual care support. These measures facilitate effective communication and ensure respect for patients' values, beliefs, and expectations.

In response to ongoing social changes and increasing family and socioeconomic diversity, a flexible, person-centred approach has been adopted. Comprehensive assessments covering clinical, social, emotional, and family dimensions enable the development of individualised care plans tailored to complex and evolving needs.

### Impact

A Multidisciplinary Team Involvement discuss the patient's situation, ensuring that each team member contributes with his or her expertise to create a holistic understanding of the patient's needs.

The goal is to develop an individualised care plan based on the assessment findings.

There is patient and family engagement in the treatment planning process, with family meetings when needed.

The goal would be:

- Earlier referral to palliative care
- Reduced use of futile interventions
- Improved anticipatory care planning

### Critical success factors

- Symptom manage assessment and daily addressed
- Management approach to refractory symptoms at the end of life
- Adequacy of comfort well monitored and documented
- Management approach to dying patients who are unable to be managed at home; they are admitted with priority for single rooms to ensure their privacy and intimacy during this difficult time

**Key factors**:

- Staff training
- Integration of screening tools into the medical record
- Periodic review of results

### Next steps

The center needs to have a continuity of education programmes that include:

- Expanding early integration of palliative services throughout the cancer trajectory
- Enhancing interdisciplinary collaboration
- Strengthening communication with patients and families

Future developments may focus on personalised symptom-management plans, improved psychological and spiritual support, and wider use of telehealth to ensure continuity of care.

Ongoing evaluation will prioritise patient-reported outcomes, quality-of-life measures, and caregiver support. Future research needs to be done.

# Karolinska Comprehensive Cancer Center

## Research

**Thuy Tran**
Head of TTC and Resercher at KI
E-mail: thuy.tran@regionstockholm.se

Karolinska Comprehensive Cancer Center

### Challenge addressed by the practice

Theranostics Trial Center (TTC) tackles the complexity of combining diagnostic imaging and the therapeutic use of radiolabelled drugs (theranostics) within a single, streamlined clinical framework—bridging two traditionally separate domains for precise, image guided treatment.

### Solution

The center focuses on early-phase clinical trials to evaluate new radiopharmaceuticals. This involves:

- Assessing safety, biodistribution, pharmacokinetics (how the radiopharmaceutical is distributed in the body)
- Performing dosimetry (how much radiation the body receives), target engagement, and imaging feasibility

Theranostics requires close collaboration across specialties, including nuclear medicine, medical physics, oncology, radiopharmacy, and clinical research. TTC brings these diverse teams together to facilitate translation from early drug development to the clinic.

By identifying and targeting only those tumours that express the chosen molecular target, theranostics helps avoid the risks and side effects of non-beneficial treatments, ultimately improving patients' quality of life.

The center relies on cutting-edge facilities, including cyclotrons, radiochemistry labs, and imaging infrastructure, to support complex tracer development and enable rigorous clinical trials.

### Impact

- Theranostics helps address the challenge of selecting the right patients, based on biomarkers revealed through diagnostic imaging, ensuring therapies are targeted and effective.
- Acts as the hub for Theranostics Trial Alliance (TTA) Sweden, a national network in Sweden.
- Coordinates multicenter trials and partnerships with academia and industry.

TTC has catalysed foundational infrastructure, networks, and translational workflows. These efforts indicate a meaningful shift in Swedish/Scandinavian cancer research, emphasising precision theranostic trials, efficient patient stratification, and health-economic evaluation.

### Critical success factors

Bringing together diverse expertise—nuclear medicine, medical physics, radiopharmacy, oncology, imaging, molecular biology, and clinical trial specialists—has enabled seamless integration of diagnostics and therapy under one umbrella.

Building state-of-the-art facilities, including radiochemistry labs and nuclear medicine imaging systems, has been essential for developing and validating novel radiopharmaceuticals.

Investment in workforce development—training nuclear medicine staff, radiochemists, and clinical trial experts—ensures sustainability and addresses a global bottleneck in theranostics implementation.

Factors like expert collaboration, robust infrastructure, policy-aligned funding, standardised processes, networked trials, economic justification, leadership, training, as well as close collaboration with patient organisation, have collectively underpinned the rapid and successful establishment of theranostic capabilities at Karolinska and across Sweden.

### Next steps

**Expansion of Clinical Trials**

- Broader research on other targets, and inclusion of other tumour types with high unmet clinical need, beyond neuroendocrine and prostate cancers (e.g., breast, lung, and pancreatic), as well more effective radionuclide therapies such as alpha emitters and combination therapy
- Collect and publish real-world evidence on survival, quality of life, and toxicity profiles
- Benchmark against standard-of-care treatments and build health economics foundation for implementing these new treatments in clinical routines

Thuy Tran

# Trinity St James's Comprehenesive Cancer Centre

## Cancer Clincial Trials

**Ingrid Kiernan**
Manager, Cancer Clinical Trials Unit
E-mail: ikiernan@stjames.ie

Trinity College Dublin
The University of Dublin

Institiúid Ailse Choláiste na Tríonóide/San Séamas
Trinity St James's Cancer Institute

### Challenge addressed by the practice

We encountered several challenges on the journey to achieving Comprehensive Cancer Centre status. The two principal challenges were: (a) increasing the number of actively recruiting clinical trials and (b) increasing patient enrolment into interventional cancer studies to meet OECI standards. In parallel, it was essential to fully embed clinical trials within routine clinical services. Although we had an experienced team of research nurses and trial coordinators, it quickly became apparent that additional staffing and new roles within the unit would be required to support this expansion. Modern oncology trials are increasingly complex, involving stringent eligibility criteria, biomarker testing, advanced imaging, and intensive safety monitoring. As a result, it was crucial to carefully select trials that were both scientifically relevant and operationally feasible, while maximising access for our patient population.

### Solution

The response to these challenges was multifactorial. We introduced several new roles within the unit, including a dedicated research nurse team leader to oversee the research nursing workforce, a start-up specialist and clinical trial assistant focused exclusively on the trial start-up pathway, and a research assistant role. In parallel, a revised research nursing structure was implemented to strengthen the team and provide a career path for the nursing team. A comprehensive review of the existing trial portfolio was undertaken to identify gaps and opportunities for expansion. This highlighted the need to diversify beyond an exclusive focus on IMP trials. Consequently, we developed stronger links with on-site cancer surgical teams and have since successfully opened and recruited patients to surgical oncology trials. To enhance visibility and accessibility of clinical research, a Clinical Trials page was developed on the hospital website, providing up-to-date information on actively recruiting studies and clear contact details for the public. In addition, an outreach programme was initiated with academic collaborators and pharmaceutical partners to identify new opportunities and support the strategic expansion of the clinical trial portfolio.

### Impact

The implementation of these initiatives has had a significant and sustained impact on the unit's clinical research capability. The introduction of the new roles, together with a revised research nursing structure, strengthened workforce capacity and created clear career progression pathways. This enabled the unit to support a higher volume of studies while maintaining quality, governance, and staff retention. Streamlining the trial start-up pathway resulted in improved efficiency and faster study activation, allowing the unit to respond more effectively to new opportunities and reduce delays to first patient recruitment. The structured portfolio review and subsequent diversification beyond IMP-only trials has led to a sustained increase in trial activity and patient enrolment. Enhancing the visibility of clinical research through a dedicated Clinical Trials webpage improved awareness among patients, clinicians, and referring teams. The outreach programme with academic and industry partners strengthened external relationships, increased the attractiveness of the site for new studies, and supported the strategic and sustainable growth of the trial portfolio.

### Critical success factors

The success of this initiative was underpinned by a committed group of Principal Investigators, a skilled and motivated research team, strong collaboration across hospital departments, and sustained support from hospital leadership. Engaged PIs are central to this success. These clinicians play a central role in identifying suitable patients in routine clinical practice, engaging proactively with current and potential sponsors, and continuously seeking innovative treatment options for their patients. The role of the Clinical Trials Unit is to translate this clinical leadership and scientific vision into operational delivery, ensuring that studies are activated efficiently, conducted to the highest standards, and fully integrated into patient care. Diversifying beyond IMP trials proved critical, delivering increased recruitment and providing new learning opportunities that enhanced the skills and capability of the research team.

### Next steps

We are focused on sustaining momentum and further expanding activity. Over the medium term, a key priority is the optimal use of technology, including the implementation of an electronic clinical trial patient chart and the development of a fully electronic site file. These initiatives will enhance efficiency, data quality, and regulatory compliance. In parallel, we will continue to diversify the trial portfolio, including the activation of a medical device study, and will maintain proactive outreach to industry partners through our Principal Investigators to support ongoing portfolio growth.

# Vall d'Hebron University Hospital (HUVH) and Vall d'Hebron Institute of Oncology (VHIO)

## Research Unit for Molecular Therapy of Cancer (UITM) – CaixaResearch

**Elena Garralda**
Director, Research Unit for Molecular Therapy of Cancer (UITM) – CaixaResearch
E-mail: egarralda@vhio.net

## Challenge addressed by the practice

- To establish our unit as one of Europe's foremost comprehensive facilities with the best-in-class translational, collaborative, and multidisciplinary framework to rapidly transform the latest scientific discoveries into actionable insights to benefit patients.
- Maintain the reputation of the UITM – CaixaResearch as a reference centre in precision oncology by developing novel therapies based on tumour profiles and optimising treatment strategies through innovative clinical trial designs, including multi-modular basket studies and umbrella trials.
- Expand a broad portfolio of promising novel anticancer therapies across a balanced spectrum of early-phase clinical studies to drive progress in discovering new cancer medicines and harness these advances to bring innovative drugs, including first-in-class treatments and new combinations, to people with cancer.

## Solution

Inaugurated in 2010, our unit is located within the general area of the Vall d'Hebron University Hospital. This privileged environment provides direct access to patients and promotes tight connectivity between oncology care and research, facilitating the implementation of novel treatment modalities with selective drugs and the generation of insights to guide the individualised treatment of patients.

Optimal patient treatment and care, and pioneering translational research at our unit, are made possible through the essential collaboration with many other teams of oncology professionals, as well as other healthcare specialists, including dermatologists, cardiologists, and ophthalmologists.

Through VHIO's translational model, research at our unit is linked to several research lines led by investigators of our institute's Biomedical Research Division, driven through collaboration with many other programs and groups including our Molecular Prescreening Program. These collaborations enable us to connect molecular biology and optimal tumour models with pharmacology and innovative clinical research. VHIO scientists collaborate in our unit's trials to facilitate biomarker development, achieve a deep understanding of the mechanism of action of anti-cancer agents, and increase our understanding of the mechanisms of cancer drug resistance.

They also enable us to advance other promising and transformative treatment modalities in oncology, including cancer immunotherapy. As part of our Comprehensive Program of Cancer Immunotherapy and Immunology Program, we focus on the early drug development of immunotherapies including novel cytokines, bispecifics, immunomodulatory agents, and treatment combinations, and participate in translational research in immuno-oncology.

## Impact

Studies conducted at UITM play a pivotal role in advancing precision medicine in oncology by tailoring cancer treatments to individual patients based on their unique genetic makeup and molecular profiles. Each year, around 600 patients are treated in over 300 Phase 1 clinical trials at our unit. Around 80 new Phase 1 clinical trials and basket trials are opened each year within the unit, bringing access to innovative drugs to patients. Since VHIO was established in 2006, our research and clinical teams have contributed to more than 70 new drug indications.

Our unit is also devoted to the training of physicians in early clinical drug development and fostering expertise in translational science, dynamic trial designs, and novel trial methodologies. We host around 12 students througout the year from local universities and from abroad, collaborating with other universities, schools, and sites.

## Critical success factors

Our Molecular Prescreening Program was established in 2010 as a strategic program for the detection of cancer biomarkers to guide clinicians in selecting both standard-of-care and investigational anticancer treatments. This program facilitates the clinical implementation of emerging cancer biomarkers that help to optimise the selection of therapies for patients being considered for enrolment in early-phase clinical trials. Diagnostic tests are developed and validated in-house for cost-effective and streamlined identification of tumour molecular alterations of major interest in drug development.

Our Advanced Oncology Research Program enables us to design and conduct an expanding portfolio of Phase 1–2 clinical trials against novel targets. This unit is advancing the development of targeted anti-cancer therapies and accelerating transformative research focused on unravelling the complexities of clinical resistance mechanisms.

We foster strong collaborative partnerships to advance targeted therapies against cancer. For example, we participate in Cancer Core Europe (CCE), an alliance between seven outstanding cancer centres to spur the development of innovative cancer therapies through collaborative clinical research. Additionally, as a member of CCE's Clinical Trials and Translational Research Pillar, we lead innovative trial design through our participation in pioneering studies, including CCE's Basket of Baskets and CCE-DART.

## Next steps

We will continue to bring the best therapies and personalised treatments into the clinic to improve patient outcomes, with a particular interest in cell therapies for solid tumours.

We also prioritise empowerment and participation of patients, ensuring that their perspectives and needs are heard and respected throughout. We will continue to enhance patient-centredness in clinical trials by involving patients and cancer survivors in the design of clinical trial protocols and increasing their involvement and representation in projects and on committees.

# Karolinska Comprehensive Cancer Center

## Academical Education and Talent Development

**Liselotte Bäckdahl**
Research Coordinator Cancer Research KI
E-mail: liselotte.backdahl@ki.se

Karolinska Comprehensive Cancer Center

### Challenge addressed by the practice

- Shortage of highly specialised oncologists and need to manage increasingly complex cancer treatments
- Continuous professional development for nurses and researchers in oncology
- Integration of clinical practice with research and innovation to strengthen cancer care centers

### Solution

- Karolinska CCC  emphasises staff education: internal training and paid advanced education for nurses to become oncology and surgical care specialists.
- Oncology residency (ST training) for physicians at Karolinska University Hospital (Solna and Huddinge), including structured supervision, mandatory courses, and research opportunities.
- Karolinska Institutet (KI) offers formal specialist programs at master's level in both oncology and surgical nursing.
- KI invests heavily in research talent development: PhD programs in tumour biology, postdoctoral programs (SciLifeLab Clinical Translational), and national research schools (e.g., NatiOn), as well as 300 PhD and post-doc courses in all research areas. A specific career support office to guide the staff and students, with for example, mentor programs, funding, innovation support, entrepreneurship courses and networking possibilities, as well as industry internships for PhD sudents and post-docs who would like to investigate an industry career. KI also has focus organisations such as WISE – Women In Science and Education, a network for female scientists and teachers, and Junior Faculty, an interest organisation for young scientists and aspiring PIs.

### Impact

- Improves patient care through evidence-based methods and multidisciplinary collaboration.
- Enhances skills of nurses and physicians in advanced cancer care.
- Strengthens research capacity and innovation in oncology.
- Positions Karolinska CCC as an internationally leading cancer centre.

### Critical success factors

- Clear structure and national guidelines (National Board of Health and Welfare) for specialist training
- Strong integration between clinical practice and academia (Karolinska Institutet)
- Funding and incentives for research involvement (e.g., Research-ST, seed grants)
- Qualified supervisors with pedagogical training and structured feedback
- Support from professional networks such as the Swedish Oncology Society (SOF)

### Next steps

- Expand research tracks within oncology residency (e.g., translational oncology)
- Increase international collaborations and exchange programs
- Build infrastructure and partnerships, advance AI in diagnostics and prognostics, expand global access to screening, and develop next-generation tumour analytics tailored for precision oncology
- Strengthen recruitment and outreach to attract more oncology specialists and researchers

Liselotte Bäckdahl


# Leuven Cancer Institute

## Education

LEUVEN CANCER INSTITUTE LKI

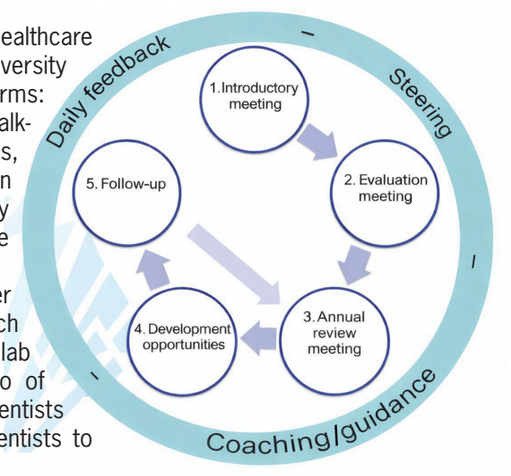
**Johan Van Lint**
Director of Research of the Leuven Cancer Institute (LKI)
E-mail: johan.vanlint@kuleuven.be

## Challenge addressed by the practice

- To provide a comprehensive training programme, tailored to different professionals, throughout their entire career (from student to advanced professional)
- To remain aware of the training needs of the various types of prosessionals (doctors, researchers, nurses, social workers, and allied health professionals)
- To continuously receive feedback about the quality of the training, in order to ensure continuous improvement
- To respond to a rapidly changing world with scientific advances, technical innovations, and increased skill requirements
- To ensure talent development for all employees (including top talents)
- To ensure efficient dissemination of knowledge and skills amongst the workforce
- To ensure that the higher education that we provide, matches the requirements and expectations of the care sector, also outside our own university (hospital) environment

## Solution

- The main development of this solution was carried out by the university and university hospital, where the Leuven Cancer Institute (LKI) is fully integrated and contributes complementary elements. LKI members play an active role in university/hospital policies, as “enablers” on the workfloor, and providers of input for continuous optimisations, and as members of relevant education boards (who follow up programme needs and design improvements).
- The entire career trajectory of each type of healthcare professional is immersed in continuous education.
- At the start, detailed onboarding takes place for each type of professional (e.g. a mandatory 2-day incoming oncology nurse schooling). For each onboarding, content is defined in great detail.
- Mentorship is a widespread practice within our organisation, and every employee has an annual discussion with their supervisor about training needs.
- The set of topics on which a particular type of professional should be continuously trained is defined in detail and followed up in a portfolio that must be kept up to date and is regularly reviewed for progress. Some nurses are trained as expert nurses and consultant nurses with advanced knowledge on a particular topic. They are embedded in the wards and spread best practices amongst their colleagues.
- Continuous education training for our healthcare professionals is integrated/managed by the University Hospital Leuven learning center. It takes many forms: short seminars, dedicated training days/weeks, walk-in events for nurses and allied health professionals, and a wide range of e-learning modules that can be followed at one’s own pace (with mandatory completion, with content depending on the profession).
- Our Oncology Doctoral School trains future cancer researchers through a dedicated cancer research course, journal clubs, seminars, interdisciplinary lab visits, meet-the-patient sessions, and a portfolio of coursework and skills development. Clinician scientists often work in close collaboration with basic scientists to ensure cross-pollination.




- Patients are also educated through tailor training materials on how to live with cancer (brochures, videos).
- Any type of training receive feedback from trainees to ensure continuous improvement and adaptation to changing needs.

## Impact

- Our attention to education creates a workforce that is fully up to date with international best practices.
- This also contributes strongly to our quality culture. For example, it reduces risks for patients, e.g. even simple education on hand hygiene strongly reduces infection risks.
- Continuous feedback ensures the relevance and applicability of training content.
- Continuous education and training also promote rapid dissemination of scientific advances and practice innovations through the workforce at all professional levels.
- Importantly, increased workforce satisfaction through a sense of continuous growth contributes to staff retention (particularly important in the context of workforce shortages in the healthcare sector).
- Training and education of patients contributes to better coping with the disease and to improved quality of life.
- The breadth of skills acquired by our PhD students (not narrowly limited to their own research subject) increases their success in various post-PhD trajectories (academia, industry, government).
- Co-promotorship of physicians and basic scientists for many PhD students increases the clinical relevance and applicability of many findings.

## Critical success factors

- Good communication between training providers and the professionals for whom the education is tailored is crucial (continuous information on training needs and feedback on the quality of training provided).
- The e-learning system creates flexibility in when to follow a course, while its mandatory nature ensures that everyone has the required knowledge on a particular topic.
- The clear definition of mandatory knowledge/skills and the follow-up in a portfolio ensures that every professional is automatically involved in lifelong learning.
- A quality culture for education: all training is continuously evaluated by participants to ensure ongoing improvement.
- Organisation: courses and training are not just offered but are part of a broader vision and embedded in enabling structures (e.g. the Learning Centre of our University Hospital).
- Infrastructure: the IT environment for e-learning and the physical environment of the STEPS skills centre contribute strongly to the quality and efficiency of training.
- Attention to the skills of the trainers themselves (“train-the-trainer” sessions).
- The large majority of our teaching are actively involved in scientific research, thereby transmitting an enquiring scientific attitude to trainees (beyond pure knowledge or skills).

## Next steps

- Training programmes require continuous monitoring for quality and improvement.
- Sharing of best practices with other networks to which LKI belongs (e.g. OECI) or to which KU Leuven and UZ Leuven (University Hospital Leuven) belong (e.g. EUHA, U21).
- Early detection of top talents and specific guidance along their trajectory to enable their growth.
- Strengthening of care education (nursing, social workers, etc.) by better coordination amongst different trainings, increased coordination with care “actors” to further increase professionalisation of (and recruitment into) the care professions, and interdisciplinary modular trainings via distance education.
- Providing high-quality internships in the hospital (for all possible roles, including supportive ones).
- Increased use of simulation trainings, immersive systems, and extended reality applications for skills training.
- Exploration of the possible applications (but also complications) of AI in education.
- Expansion of lifelong learning based on novel trends, research results, and developments in teaching and care.

# The Christie NHS Foundation Trust

## Developing an International, Inclusive and Integrated Programme of Cancer Education

**Rikki Goddard-Fuller**
Director, Christie Institute for Cancer Education
E-mail: R.Goddard-Fuller@nhs.net

The Christie NHS
NHS Foundation Trust

### Challenge addressed by the practice

Ensuring high-quality continuing education for professionals that enables excellent care and the best outcomes for patients through five key criteria:

**Multiprofessional**: Within and across primary, secondary and specialist clinical/non-clinical professional teams

**Inclusive**: Enabling all learners to access support and learning to benefit better patient care

**Collaborative**: Designing education with patients for both patients and professionals

**Relevant**: To scope of practice and stage of career (undergraduate to senior professional)

**Accessible**: Online and in-person education for UK, European and international professionals

### Solution

Creation and evolution of specialist cancer education into a dedicated Christie Institute for Cancer Education. The institute supports over 20,000 learner episodes per year, providing education to:

- Christie staff across all grades and professions
- Undergraduate students from 10 different healthcare disciplines and 10 universities
- Postgraduate, research and professional external colleagues via credentialed programmes and vocational CME/CPD
- International learners from >50 countries, online and in-person, via dedicated observership and fellowship schemes

Using authentic, expert education across a broad range of cancer care domains:

- Precision oncology (including proton and immunotherapy), advanced surgical and diagnostic cancer care
- Supportive cancer care, physics, engineering, and primary care/family medicine oncology
- Leadership, communication, and organisational improvement

This is led by a specialist education and clinical team, supporting wider educational scholarship, research, and leadership in cancer education nationally and internationally.

### Impact

Progressive growth in learning and transformation in practice:

- Greater accessibility to cancer care education through our Digital Clinical Placement programme
- Vocational and advanced degree pathways for all clinical staff, supporting career development, advanced practice roles, and innovation in practice (e.g. neighbourhood and outreach oncology, senior adult care, and acute oncology)
- Global education citizenship: support for all staff to achieve and benefit from knowledge exchange with other cancer centres, alongside a dedicated programme of online events and observerships for professional visitors learning with The Christie
- Scholarship-informed education practice: underpinned by an active programme of faculty development and recognition schemes for staff
- Patient and community engagement: through an Experts by Experience programme, with a focus on inclusion and accessible care and expert patient co-design of education (e.g. https://alknowledge.org/)

### Critical success factors

The Christie focuses on providing real world educational support, connecting evidenced based education and clinical research and enabling best patient outcomes through:

- Dedicated body of clinical and educational expertise in an inter-disciplinary, collaborative culture
- Expert clinical academic, and educational leadership
- Alignment with, influence on, and contribution to wider Christie innovation goals
- Investment in, access to, and recognition of education in a wider inclusive Christie culture
- Benefit from a mixed model of education provision, areas of expert practice, and commitment to access and inclusion for all learners
- Regular horizon scanning to ensure both innovation in cancer care and education practice integrate to keep learning authentic, relevant, and impactful
- A learn together philosophy

### Next steps

Our education culture and philosophy are one of continuous improvement, supporting The Christie's innovation in future cancer care:

- Enabling digitally transformed practices for patients, and staff
- Data driven, care closer to patients' homes
- Personalised care linked to primary, secondary, and tertiary prevention

More widely:

- Launch of a new innovative series of Future Cancer Care postgraduate programmes for international and UK cancer professionals
- With the OECI, developing an active educational network of cancer care resources and centres

# The OECI Accreditation Map

Algeria
- ★ **Anti-Cancer Center Blida Algeria Specialized Hospital Control Against Cancer**, Blida

Austria
- ★ **Comprehensive Cancer Center Vienna**, Vienna

Belgium
- ★ **Institut Jules Bordet (IJB)**, Brussels
- ★ **Leuven Kankerinstituut (LKI)**, Leuven
- ★ **Kortrijk Kankercentrum az groeninge**, Kortrijk

Brazil
- ★ **A.C. Camargo Cancer Centre**, Sao Paulo

Chile
- ★ **Instituto Oncológico Fundación Arturo López Pérez (FALP)**, Santiago

Colombia
- ★ **Instituto Nacional de Cancerología ESE**, Bogota

Cyprus
- ★ **German Oncology Center (GOC)**, Limassol

Czech Republic
- ★ **Masarykův onkologický ústav**, Brno

Denmark
- ★ **Aarhus Universitetshospital**, Aarhus
- ★ **Vejle Sygehus, Patienternes Kræftsygehus en del af Sygehus Lillebælt**, Vejle
- ★ **Copenhagen Comprehensive Cancer Center (CCCC) Departement of oncology Rigshospitalet**, Copenhagen
- ★ **Copenhagen Comprehensive Cancer Center (CCCC) Departement for cancer treatment, Herlev and Gentofte Hospital**, Helrev

Estonia
- ★ **Sihtasutus Tartu Ülikooli Kliinikum**, Tartu

Finland
- ★ **HUS Syöpäkeskus Helsingin Yliopistollinen Sairaala**, Helsinki
- ★ **TYKS Syöpäkeskus Turun Yliopistollinen Sairaala**, Turku
- ★ **TAYS Syöpäkeskus Tampereen Yliopistollinen Sairaala**, Tampere
- ★ **KYS Syövänhoitokeskus Kuopion Yliopistollinen Sairaala**, Kuopio
- ★ **OYS Oulun Yliopistollinen Sairaala**, Oulu

France
- ★ **Centre Léon Bérard**, Lyon
- ★ **Gustave Roussy**, Villejuif
- ★ **Institut Curie**, Paris
- ★ **Centre Jean Perrin**, Clermont-Ferrand
- ★ **Institut Paoli – Calmettes**, Marseille
- ★ **Institut du Cancer de Montpellier (ICM)**, Montpellier
- ★ **Institut Universitaire du Cancer de Toulouse-Oncopole**, Toulouse
- ★ **Assistance Publique - Hôpitaux de Paris Institut Universitaire de Cancérologie APHP. Sorbonne Université**, Paris
- ★ **Cancer Institute AP-HP. Nord - Université Paris Cité**, Paris
- ★ **Institut du cancer Paris CARPEM AP-HP.Centre-Université Paris Cité**, Paris
- ★ **Centre François Baclesse**, Caen
- ★ **Institut de Cancérologie de l'Ouest (ICO)**, Angers - Saint Herblain
- ★ **Centre de lutte contre le cancer Eugène Marquis**, Rennes
- ★ **Centre Oscar Lambret**, Lille
- ★ **Institut Bergonié**, Bordeaux
- ★ **Centre Henri Becquerel**, Rouen
- ★ **Centre Antoine Lacassagne**, Nice
- ★ **Institut Godinot**, Reims
- ★ **Centre de Lutte Contre le Cancer Georges-François Leclerc**, Dijon
- ★ **Institut de Cancérologie de Lorraine**, Vandoeuvre-les-Nancy
- ★ **Institut du Cancer – AP-HP. Université Paris-Saclay**, Villejuif
- ★ **Institut Sainte Catherine**, Avignon

Greece
- ★ **General Oncology Hospital of Athens "Saint Savvas"**, Athens
- ● **General Oncology Hospital of Pireaus Metaxa**, Piraeus
- ● **Hellenic Cancer Federation -ELLOK**, Athens

Hungary
- ★ **Országos Onkológiai Intézet**, Budapest

Iceland
- ★ **Landspítali**, Reykjavík

Ireland
- ★ **Trinity St. James's Cancer Institute**, Dublin
- ★ **Beaumont RCSI Cancer Centre**, Dublin
- ★ **HSE West North West, University of Galway Cancer Centre**, Galway
- ★ **Cork University Hospital/University College Cork**, Cork
- ★ **St Vincent's UCD Cancer Centre**, Dublin
- ★ **Mater Private Network**, Dublin
- ★ **The Mater Misericordiae University Hospital**, Dublin

Italy
- ★ **Centro di Riferimento Oncologico di Aviano (CRO), IRCCS**, Aviano
- ★ **IRCCS Ospedale Policlinico San Martino**,Genoa
- ★ **Istituto Europeo di Oncologia**, Milan
- ★ **Fondazione IRCCS - Istituto Nazionale dei Tumori**, Milan
- ★ **Istituto Nazionale Tumori IRCCS "Fondazione G.Pascale" (INT-Pascale)**, Naples
- ★ **Istituto Nazionale Tumori Regina Elena**, Rome
- ★ **IRCCS Ospedale San Raffaele (OSR)**, Milan
- ★ **Istituto Oncologico Veneto IRCCS-IOV**, Padua
- ★ **Azienda Unità Sanitaria Locale di Reggio Emilia - IRCCS Istituto in Tecnologie Avanzate e Modelli Assistenziali in Oncologia**, Reggio Emilia
- ★ **IRCCS Istituto Clinico Humanitas**, Rozzano (Milan)
- ★ **Istituto di Candiolo FPO-IRCCS**, Candiolo (Turin)
- ★ **ASST Spedali Civili di Brescia (SCH)**, Brescia
- ★ **Istituto Tumori Giovanni Paolo II, Istituto di Ricovero e Cura a Carattere Scientifico**, Bari
- ★ **IRCCS, Centro di Riferimento Oncologico della Basilicata (CROB)**, Rionero in Vulture (Potenza)
- ★ **IRCCS Ospedale Sacro Cuore Don Calabria**, Negrar di Valpolicella (Verona)
- ★ **Istituto Oncologico del Mediterraneo s.p.a. (IOM)**, Viagrande (Catania)
- ★ **Fondazione Poliambulanza**, Brescia
- ★ **Fondazione IRCCS Policlinico San Matteo**, Pavia

Jordan
- ★ **King Hussein Cancer Center**, Amman

Latvia
- ★ **Rīgas Austrumu klīniskā universitātes slimnīca**, Riga
- ★ **Paula Stradiņa Klīniskā universitātes slimnīca**, Riga

Lithuania
- ★ **National Cancer Institute**, Vilnius
- ★ **Vilnius University Hospital Santaros Klinikos**, Vilnius

Norway
- ★ **Oslo Universitetssykehus (OUS)**, Oslo
- ★ **Helse Bergen HF (Haukeland University Hospital)**, Bergen
- ★ **Akershus University Hospital Trust**, Lørenskog

Poland
- ★ **Narodowy Instytut Onkologii im. Marii Skłodowskiej-Curie Państwowy Instytut Badawczy**, Warsaw

Portugal
- ★ **Instituto Português de Oncologia do Porto Francisco Gentil, E.P.E. (IPO-Porto)**, Porto
- ★ **Instituto Português de Oncologia de Lisboa Francisco Gentil, E.P.E. (IPO-Lisboa)**, Lisbon
- ★ **Instituto Português de Oncologia de Coimbra Francisco Gentil, E.P.E. (IPO-Coimbra)**, Coimbra

Slovenia
- ★ **Onkološki Inštitut Ljubljana**, Ljubljana

Spain
- ★ **Institut Català d'Oncologia ICO**, L'Hospitalet de Llobregat (Barcelona)
- ★ **Vall d'Hebron Barcelona Campus Hospitalari**, Barcelona
- ★ **Cancer Center Clinica Universidad de Navarra**, Pamplona
- ★ **Fundación Jiménez Díaz University Hospital**, Madrid
- ★ **Clínic Barcelona Comprehensive Cancer Centre**, Barcelona
- ★ **Fundación Instituto Valenciano de Oncología IVO**, Valencia
- ★ **Institut d'Oncologia de la Catalunya Sud Hospital Universitari Sant Joan de Reus**, Reus
- ★ **Centro Integral Oncológico Clara Campal**, Madrid
- ★ **Hospital Universitario 12 de Octubre**, Madrid
- ★ **Hospital Universitario La Paz**, Madrid
- ★ **Hospital Universitario Ramon Y Cajal**, Madrid
- ★ **Hospital Universitario Clínico San Carlos**, Madrid
- ★ **Hospital Clínico Universitario de Valencia (Departamento de Salud Clínico-Malvarrosa)**, Valencia
- ★ **Hospital General Universitario Gregorio Marañón**, Madrid
- ★ **Hospital Universitario Puerta de Hierro Majadahonda**, Majadahonda
- ★ **Fundació de Gestió Sanitària de l'Hospital de La Santa Creu i Sant Pau - Campus Sant Pau – Puigvert**, Barcelona

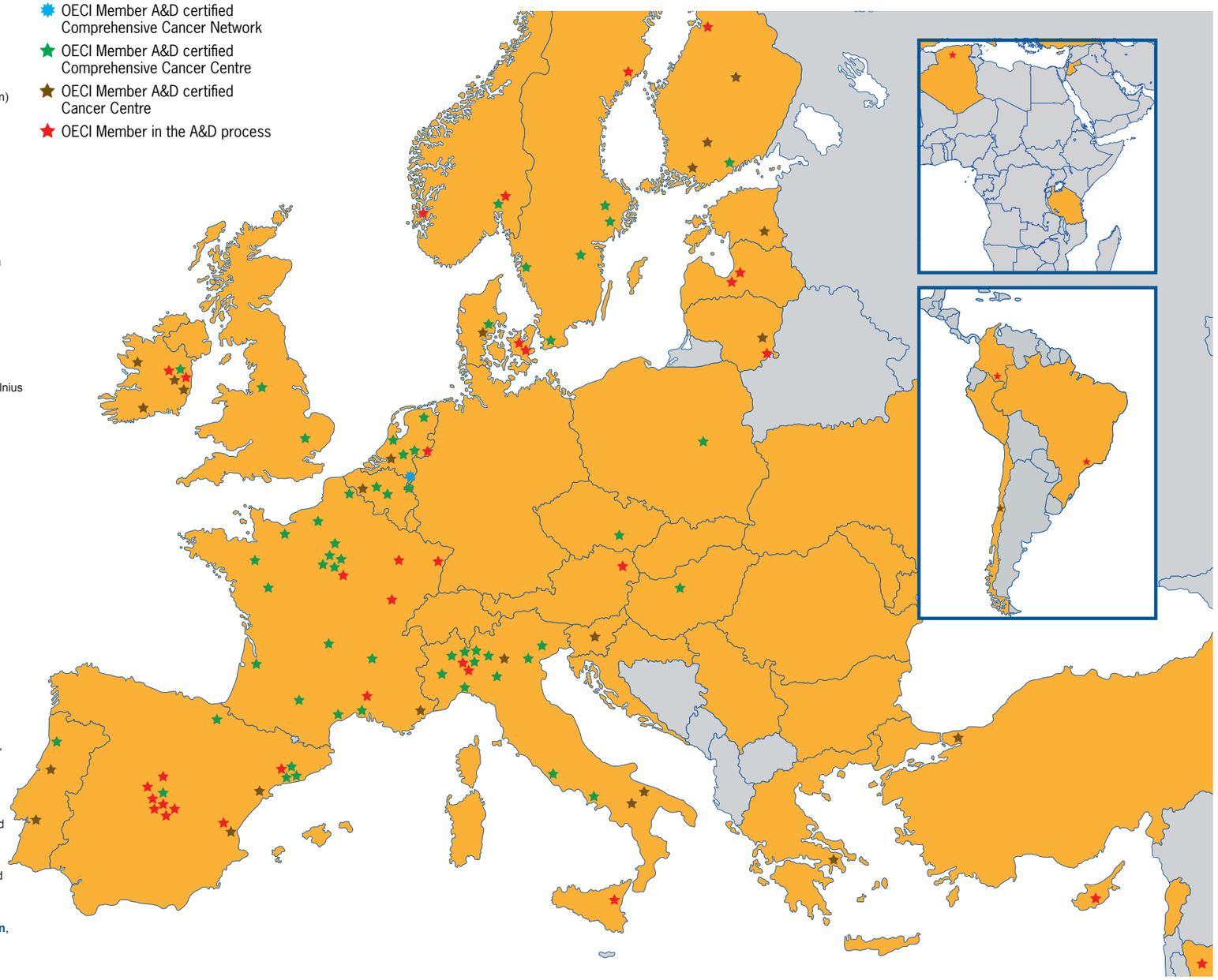
Sweden
- ★ **Karolinska Institute and University Hospital**, Stockholm
- ★ **Skånes Universitetssjukhus**, Lund
- ★ **Uppsala University Hospital**, Uppsala
- ★ **Sahlgrenska University Hospital**, Göteborg
- ★ **Linköping Comprehensive Cancer Center**, Linköping
- ★ **Norrlands Universitetssjukhus**, Umeå

The Netherlands
- ● **OncoZON Cancer Network**, Maastricht
- ★ **Netherlands Cancer Institute**, Amsterdam
- ★ **Erasmus MC Cancer Institute**, Rotterdam
- ★ **Maastricht University Medical Centre+**, Maastricht
- ★ **University Medical Center Groningen Comprehensive Cancer Center (UMCG-CCC)**, Groningen
- ★ **Rijnstate**, Arnhem
- ★ **Radboudumc Centrum voor Oncologie**, Nijmegen

Turkey
- ★ **Anadolu Sağlık Merkezi**, Kocaeli

United Kingdom
- ★ **The Christie NHS Foundation Trust**, Manchester
- ★ **Cancer Research UK Cambridge Centre**, Cambridge

- OECI Member A&D certified Comprehensive Cancer Network
- OECI Member A&D certified Comprehensive Cancer Centre
- OECI Member A&D certified Cancer Centre
- OECI Member in the A&D process



Appendix 1

# The A&D Board

The A&D Board is responsible for the decision-making on Accreditation and Designation procedures and policies. Furthermore, the A&D Board decides on the important steps in the programme, e.g. application approval, preliminary designation, decision go / no go peer review, certification and designation.

**Mef Nilbert**
**Chair of the A&D Board**
Lund University, Skane University Hospital Cancer Center
Lund, Sweden

**Hisam Alahdab**
**Executive Director**
Cedars Sinai International
Doha, Qatar

**Paulina Bravo**
**Director of Patient Education and Involvement | Patient Expert**
Fundación Arturo López Pérez
Providencia, Chile

**Jorrit Enserink**
**Professor and Research Group Leader**
Oslo University Hospital CCC
Oslo, Norway

**Vanesa Gregorc**
**Deputy Scientific Director**
Candiolo Cancer Institute FPO-IRCCS
Candiolo, Italy

**Eva Jolly-Gustafsson**
**Head of Patient Care Unit Radiotherapy, Theme Cancer**
Karolinska University Hospital
Stockholm, Sweden

**Evy Lobbestael**
**Institute Manager**
KU Leuven Cancer Institute
Leuven, Belgium

**József Lövey**
**Chair of the OECI Accreditation Committee**
Oslo University Hospital CCC
Oslo, Norway

**Claire Noonan**
**Cancer Accreditation Lead**
Beaumont RCSI Cancer Centre
Dublin, Ireland

**John V. Reynolds**
**Professor and Head of Department, Surgery**
Trinity College Dublin
Dublin, Ireland

**David Verger**
**Quality and Risk Director**
Institute Universitaire du Cancer Toulouse Oncopole
Toulouse, France



Appendix 2

# The Accreditation Committee

**József Lövey**
**Chair of the Accreditation Committee**
Oslo University Hospital
Oslo, Norway

**Miguel Areia**
**Quality Manager**
IPO Coimbra
Coimbra, Portugal

**Mario de Bellis**
**Attending Physician, Gastroenterology and Endoscopy**
National Cancer Institute "Foundation G. Pascale"
Naples, Italy

**Patricia Doherty**
**Senior Cancer Programme Manager**
Trinity St. James's Cancer Institute, Trinity College
Dublin, Ireland

**Silke Engelholm**
**Medical Director**
Skåne University Hospital Comprehensive Cancer Centre
Region Skåne, Sweden

**Mary Fogarty**
**Quality Manager**
St. James's Hospital, Dublin
Dublin, Ireland

**Stefania Grisanti**
**Assistant Director of Nursing**
European Institute of Oncology
Milan, Italy

**Fiona Harris**
**Consultant Clinical Oncologist**
Cambridge University Hospitals NHS Foundation Trust
Cambridge, The UK

**Helen O'Reilly**
**Clinical Nurse Manager, OECI Coordinator**
HSE West North West, University of Galway, Cancer Centre
Galway, Ireland

**Outi Nikunen**
**Senior Planning Officer Coordinator**
Finnish Cancer Center FICAN
Helsinki, Finland

**Louise Svanström**
**Quality Developer**
Karolinska Comprehensive Cancer Center
Stockholm, Sweden

**Marek Svoboda**
**Director**
Masaryk Memorial Cancer Institute
Brno, Czech Republic

**Appendix 3**

# The Extended Board

The Extended A&D Board meets four times a year to discuss the strategy of the A&D programme and advise on development and growth.

**Jean-Benoît Burrion**
**Head of Preventive and Screening**
Institute Jules Bordet
Brussels, Belgium

**Rui Henrique**
**Director of the Pathology**
IPO Porto
Porto, Portugal

**Bernd Kremer**
**Head of Head & Neck Department**
ErasmusMC
Rotterdam, The Netherlands

**Jacqueline Stouthard**
**Board Member**
Netherlands Cancer Institute
Amsterdam, The Netherlands

**Claudia Valverde**
**Consulting Physician**
Vall d'Hebron
Barcelona, Spain

**Wim H. van Harten**
**Research Group Leader NKI**
Netherlands Cancer Institute
Amsterdam, The Netherlands

**Appendix 4**

# The A&D Management Unit

The A&D Coordinators play an important role throughout the entire A&D programme, from the centre's application to the approval of the final report and improvement action plan by the OECI A&D Board, including the one-year follow-up.

**Simon Oberst**
**Director of Quality and Accreditation**
Organisation of European Cancer Institutes
Brussels, Belgium

**Harriët Blaauwgeers**
**A&D Coordination Manager**
Organisation of European Cancer Institutes
The Netherlands

**Willien Westerhuis**
**Coordinator**
Netherlands Comprehensive Cancer Organisation, IKNL
The Netherlands

**Jolanda van Hoeve**
**Coordinator**
Netherlands Comprehensive Cancer Organisation, IKNL
The Netherlands

**Wendy Dontje**
**Coordinator**
Netherlands Comprehensive Cancer Organisation, IKNL
The Netherlands

**Marjet Doctor**
**Coordinator**
Netherlands Comprehensive Cancer Organisation, IKNL
The Netherlands

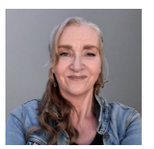
**Roxana Plesoianu**
**OECI Operations Manager**
Organisation of European Cancer Institutes
Brussels, Belgium

**Claudio Lombardo**
**General Manager**
Organisation of European Cancer Institutes
Genoa, Italy

**Janneke Verloop**
**Coordinator**
Netherlands Comprehensive Cancer Organisation, IKNL
The Netherlands

**Diana Kochegarova**
**Graphic Designer & Content Manager**
Organisation of European Cancer Institutes
Genoa, Italy

**Alex White**
**Secretary**
Organisation of European Cancer Institutes
Genoa, Italy



**Sylvia Blommestein**
**Secretary**
Netherlands Comprehensive Cancer Organisation, IKNL
The Netherlands

**Appendix 4**

# How to Participate to the OECI A&D Programme

## General conditions

Applying to the OECI A&D Programme is a voluntary decision of a cancer centre. However, there are a number of criteria that a centre should meet:

- The cancer centre/institute should be an OECI Member or in process of becoming one
- Strong commitment to quality improvement
- Dedicated staff (contact person, project group, all involved employees)
- Stable management structure (no interim management)
- No major changes/issues (expected management change, merger, housing movements, financial crisis)
- Following the steps of the A&D programme with care and within the required timeline
- Involvement in oncology research and education programmes
- Provision of oncology surgery, radiation therapy and medical oncology
- Cancer care is performed in an identifiable unit with an identifiable budget, management, and organisational structure.

## 10 Steps to get accredited with us

A cancer centre/institute that wishes to become OECI accredited should contact the OECI A&D team, which will assist in the process.

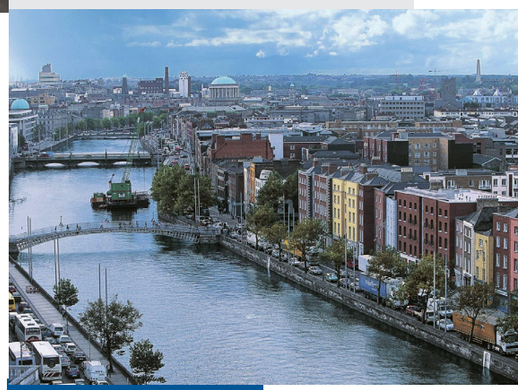
**STEP 1**: The cancer centre/institute completes an application form in the e-tool (oeci.exata.nl), where all questionnaires are available in a secured environment.
**STEP 2**: Application approval and payment fee – Stage 1.
**STEP 3**: Preliminary designation screening process.
**STEP 4**: Self-assessment according to Quality Standards and Quantitative Questionnaire in the e-tool (~6 months).
**STEP 5**: A&D Board and A&D Committee review the self-assessment. A Go-decision is made when the centre/institute is ready for a 2-day on-site peer review.
**STEP 6**: Payment fee Stage 2.
**STEP 7**: Peer review and designation assessment (3 months after finishing the self-assessment).
**STEP 8**: Reporting with strengths and recommendations (1 month after the peer review); improvement plan (2 months after the peer review).
**STEP 9**: Accreditation and Designation Certificate.
**STEP 10**: Follow-up (1 year).

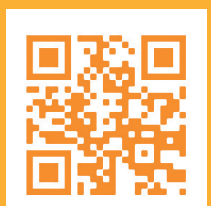
The whole process from Application to Certification lasts about 18 months. The certificate is valid for 5 years.

For more information on how to become an OECI Full or Associate Member, please contact the ***OECI Liaison Office*** at ***oeci@oeci.eu***

For enquiries relating to the A&D Certification Programme, please contact **Harriet Blaauwgeers** at **oeci@iknl.nl**







**OECI-EEIG**
c/o Fondation Universitaire
11, Rue d'Egmont
B-1000, Brussels, Belgium
Phone: +32 2 512 0146

**www.oeci.eu**
**For membership contact:**
**oeci@oeci.eu**