OECI

Organisation of European Cancer Institutes

Accreditation and Designation User Manual

EurocanPlatform

Organisation of European
Cancer Institutes

Accreditation and Designation

User Manual

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OECI Accreditation and Designation User Manual

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Introduction to the Accreditation and Designation User Manual

Dear Colleagues,

In recent years the treatment of cancer has developed into a multidisciplinary approach in which specialties from many disciplines, supported by wide array of technical facilities in various services, cooperate to provide optimal treatment.

Moreover, in Comprehensive Cancer Centres (CCCs), a close cooperation with various research groups and disciplines is a condition to perform successful translational research.

Individual professional expertise, both in research and treatment, will remain the cornerstone of the work; however a strong organisational structure is necessary.

As the successful organisation of a CCC is an important ingredient for optimal performance, there is a critical need for quality assurance of the Centres and the development of systems establishing the performance of Centres qualifying for international platforms and the success of their programmes.
In this view, the 7 Framework Programme EC funded Network of Excellence EurocanPlatform has selected the OECI Accreditation and Designation (A&D) Group to perform a quality assessment research project for CCCs in work-package 12 (WP12).

The OECI A&D Manual contains all the policies and procedures designed specifically to help all types of cancer Centres fulfil accreditation requirements.
This Manual is the product of the integrated Accreditation Programme and Designation project, which is offered to OECI cancer Centres since September 2010 after approval during the OECI General Assembly in June 2010 (Budapest).
The detailed policies are designed to be easily adaptable for use by Centres of all sizes. Our OECI A&D team is available to assist with adaptation if necessary.

The A&D Manual tells you everything you need to know to prepare for your "accreditation-designation site visit"

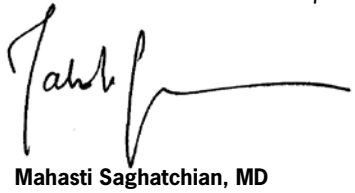
The OECI A&D Manual was written by the OECI A&D team who has the experience of the OECI A&D Programme for several years and over many OECI cancer Centres.

The EurocanPlatform NoE has an extensive communication and dissemination programme targeting the whole European cancer community with the final goal to improve the quality of research and care. This activity is assigned to the WP 14 of the Platform.
The Dissemination of the Platform's outputs includes therefore the Accreditation and Designation activity.
This Manual, as well as the other fundamental outputs coming from the Platform WPs, is distributed to the OECI members and to other European Cancer Institutes potentially interested in the improvement and recognition of their quality.
The electronic version of the Manual is also spread through the OECI website and e-cancermedicalscience, the official journal of the OECI that the Platform chose as official dissemination body.
The Authors thank the OECI in its role of Publisher of this first Edition and for the financial support coming from WP14 of EurocanPlatform managed by the OECI Coordinating Secretariat and Liaison Office headed by Claudio Lombardo.

As a result of these combined efforts, the OECI Accreditation and Designation (A&D) Group is proud to release the First version of the OECI A&D Manual!

We hope this Manual will support Cancer Centres in a successful A&D Programme!

On behalf of the OECI A&D Group



Mahasti Saghatchian, MD
OECI A&D Chair

THE OECI
Accreditation and Designation Programme and Manual

WHAT IS ACCREDITATION?

Accreditation is a process in which an independent organisation evaluates a health care provider and certifies that the provider meets certain quality standards.
The oldest accrediting organisation is the Joint Commission on Accreditation of Healthcare Organisations (JCAHO), but there are several others, in specific areas and various countries.
An accrediting organisation's survey includes an evaluation of the Centre's clinical services, as well as other aspects of the Centre's operations such as administration, personnel management and information management, research and education.
OECI has specialised its A&D programme on multidisciplinary, global and integrated cancer care and research with a major focus on comprehensiveness.

WHO SHOULD BECOME OECI ACCREDITED AND DESIGNATED?

Any OECI cancer centre that provides research, education, care services to cancer patients and that is willing to become a recognised member of our OECI cancer community.

WHY SHOULD A CANCER CENTRE BECOME OECI ACCREDITED AND DESIGNATED?

More than 10 OECI cancer Centres have started the OECI A&D process.
Within the EurocanPlatform Programme 7FP Programme, all participating Centres will be requested to take part in the OECI A&D programme. The OECI offers Cancer Centres who seek quality improvement and recognition within the cancer community (patients, funders, regulatory bodies, governments, cancer health policy planners, research partners) a tool to achieve it and a label of high quality care integrated to research and education.

WHEN MUST A CANCER CENTRE BE ACCREDITED AND DESIGNATED

The accreditation process is likely to take an average of 9 to 12 months, and longer in some cases. The increased need for accreditation will place a heavy demand on the OECI. However the cancer centre should reach a minimum level of quality and organisation in order to fulfil the process and be accepted on board the accreditation programme.
The self-assesment system provides a tool for estimating the readiness of the centre.
The OECI A&D team establishes a precise timeline agreed with each cancer centre applying for the programme in order to allow the necessary time for the preparation and completion of the self-evaluation, peer-review, report and final designation.

HOW DOES THE ACCREDITATION PROCESS WORK?

The cancer Centre that wishes to become OECI accredited should contact the OECI A&D team.
The Cancer centre must be a member of the OECI (or apply to become a member).
The Cancer centre must then review its existing services, practices, and policies and procedures to determine what changes will be required to meet the accreditation standards (self-evaluation). The centre may apply for accreditation after the changes are in place or during implementation. The cancer centre submits an application to the OECI A&D with supporting documentation. The OECI A&D reviews the application and documentation and conducts an on-site survey (peer-review visit). Based on the submitted data and the results of the survey, the organisation will determine whether to accredit the cancer centre and the type of designation awarded. The Cancer centre should then develop a plan, including a detailed timeline, for implementing the necessary changes, developing appropriate policies and procedures and training employees (improvement plan).

The core of our A&D Programme self-assesment, external peer review, designation and follow-up are the OECI Quality Standards and Quantitative Questionnaires that have been established and agreed by the OECI. These can be found in the appendix of the manual and are accessible only to our OECI members.

The full process contains 10 steps (plus the follow-up) which are described in Chapter 5:

- Step 1: Application of a cancer institute in the programme
- Step 2: Payment stage 1 fee
- Step 3: Explanatory visit and preliminary designation result
- Step 4: Self-assesment
- Step 5: Go / no go decision
- Step 6: Payment stage 2 fee
- Step 7: Peer review visit and designation check
- Step 8: Reporting
- Step 9: Formulate improvement plan
- Step 10: OECI A&D Certificate
- Follow-up

An overview of the necessary supporting documents for the institute, auditors and OECI A&D Group are listed in Chapter 6, followed by a summary of the essential obligations and tasks of the Cancer Institute in chapter 7.

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1 Introduction of the OECI A&D Programme

The Organisation of European Cancer Institutes
The mission of the Organisation of European Cancer Institutes (OECI) is to bring together the cancer research and care institutions in the European Union, in order to create a critical mass of expertise and competence. With the view of building and maintaining a consensus on the best models of oncology, developing concrete affordable and realistic solutions to effectively combat cancer and fostering the widest deployment of oncology models and solutions to improve the quality of life for the patients in the EU.

Background of the accreditation programme
The OECI launched the Accreditation Programme in 2002 to fulfil its goals:

– To provide cancer patients within Europe an equal access to high quality of cancer care.
– Helping European cancer institutes to implement a quality system for oncology care using the OECI standards and peer review system.

There have been two rounds of pilot projects in eight different cancer institutes between 2006 and 2008. In the first round four cancer institutes used a tool for self-assesment. In the second round four other cancer institutes were involved to use the improved self-assesment tool and a team of auditors visited three of the institutes for an assessment (peer review) on site. The pilot projects resulted in improvement and development of the accreditation programme, the electronic self-assesment tool, and validation of the quality standards.

The programme has been launched in October 2008.

OECI standards
Standards describe the demands the quality system has to meet and what has to be arranged. The OECI accreditation programme is based upon the OECI standards for high qualitative cancer care. The standards are validated through the pilot projects. The standards are translated in two questionnaires, a qualitative and a quantitative, to assess the current quality in a cancer institute. Both are integrated in an electronic tool (e-tool) for self-assesment.
The content of the questionnaires is accessible on the website: http://oeci.selfassessment.nu/cms/node/53

OECI peer review visit
An OECI peer review is a systematic and independent examination to determine: whether on a level of quality and the coherent results, activities correspond to the planned measures, and whether these measures are suitable and have been effectively implemented to achieve the objectives of the organisation.
The peer review applies to the quality system of the organisation or its elements. The added value of a peer review is that it should lead to improvement of the quality system, working process and products and services of the organisation. It puts the daily routine and its results to the test of quality standards. If differences are found, corrective measures are taken to upgrade the quality system. Though, it is not solely a compulsory activity. On the other hand, a peer review does not aim to assault the quality system of the cancer institute and those responsible.

Scoring system
A scoring system is included in the qualitative questionnaire. The scoring system is based on the Plan-Do-Check-Act-circle or Deming-circle. With the scoring system it is possible to assess the stage of development for each item in the standard. After filling out all the questions, the e-tool generates the results. The results will be used for the content of the peer review as well as input for a quality improvement plan of the institute.

Background of the designation programme
The developments in accreditation have urged the OECI to develop and implement an additional system in which European cancer institutes can also be designated from September 2010 onwards. Such a system creates a platform in which synchronization and benchmarking of cancer activities will be possible on an international scale. Additionally, it is a tool for cancer institutes to ensure and improve their quality level.

By making an effort to gain a designation status, the organisation will be stimulated to disseminate knowledge and to form coalitions with other institutes in Europe that are also designated. This allows cancer institutes to benefit from one another and to reach a critical mass in cancer services.

The keyword in the designation of European cancer institutes is the level of comprehensiveness of both professional infrastructure and performance. The philosophy behind comprehensiveness is:
"If all relevant competences, skills, resources and tools concerning cancer care and research are brought together and integrated, it will lead to an outcome that is larger, on the whole, than the sum of its parts" (Ringborg, 2008). Comprehensiveness, in that sense, can be seen as the new basic principle on how cancer activities institutionally should be organised.

Four different types of cancer institutes/organisations will be distinguished: Cancer Unit, (Specialised) Clinical Cancer Centre, Cancer Research Centre and Comprehensive Cancer Centre (CCC). The definition of each category is given in Table 1. The type of cancer organisation indicates the comprehensiveness of the services and the degree of specialisation.

The objective of designation
A designation system in combination with an exclusive OECI accreditation programme for each designation type of cancer centre will create platforms in which synchronization and benchmarking of cancer institutes will be possible on a European scale.

Definitions of the designation categories are:
– Cancer Units are defined as clinical facilities or hospital departments covering at least radiotherapy and medical or surgical oncology. Additionally they have a formalized collaboration with other hospital specialties.
– The 'Clinical Cancer Centre' is characterised by the clinical capacity covering a sufficient degree of all medical, surgical and radiotherapy services and occasionally a limited degree of clinical research.
– The 'Cancer Research Centre', is characterised by the capacity in cancer research focusing on one or more areas in the field of fundamental and translational oncology.
– The 'Comprehensive Cancer Centre' (CCC) is probably the hardest category to define as many different interpretations on a CCC already exist. Based on available information and many definitions on the concept of a CCC, the following features are considered to be essential for this particular category:
  • A highly innovative character and multidisciplinary approach using the potential of basic, translational and clinical research and clinical facilities and activities, organised in a sufficiently identifiable entity,
  • A direct provision of an extensive variety of cancer care tailored to the individual patient's needs and directed towards learning and improving the professional, organisational and relational quality of care,
  • Broad activities in the area of prevention, education, and external dissemination of knowledge and innovation. In order to accentuate the differences with other cancer centres, a CCC separates itself in the following points:
    • High level of infrastructure, expertise and innovation in the field of oncology research,
    • Maintenance of an extensive network including all aspects of oncology treatment and research,
    • Related to an academic/university centre or is an academic centre.

Glossary
Both questionnaires contain a glossary (doc 42). The intention of the glossary is to provide the user with the meaning of unclear or unknown words; for understanding and interpretation of the questions.

2 Timeline of the OECI A&D process

2.1 In ten steps to A&D certification

It takes ten steps in the OECI A&D Programme towards OECI A&D certification. Figure 1 presents the ten steps preceded by one of the conditions for application, OECI membership. The ten steps include the essential decision moments for continuation of the institute in the programme. And, for monitoring continuous and comprehensive quality improvement in the institute there will be a follow-up of the institute's improvement plan one year after certification. A detailed explanation of all steps is outlined in Chapter 5.

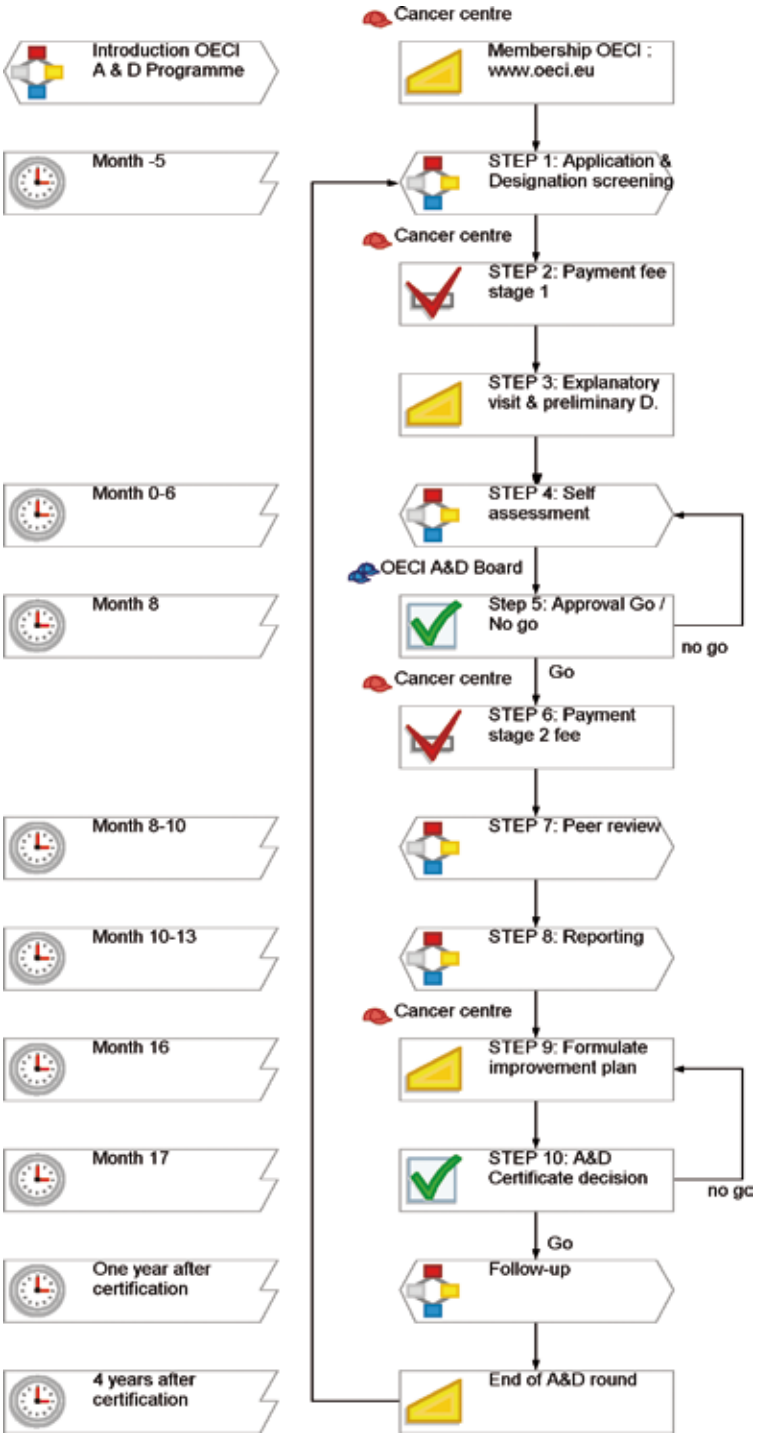


Figure 1: Timeline A&D process

2.1.1 General explanation of the ten steps

The OECI A&D Programme is offered by the OECI, therefore the membership to the OECI is compulsory for those who want to apply to the programme. Information about the OECI membership can be found on the following site: *www.oeci.eu*

STEP 1: Application and designation screening
It takes at least 5 months from the application till the beginning of the self-assessment period. Within this period the institute applies to the programme through the electronic application on the website http//:oeci.selfassessment.nu, including the cancer institute's judgement on the designation type. The application will be examined by the OECI Accreditation and Designation (A&D) Board. After approval, the designation screening takes place to assess the preliminary designation type of the institute. Both the judgement of the institute and the outcome of the designation screening, are the starting point for the next steps.

STEP 2: Payment fee stage one: € 5000
The cancer institute receives the first payment order of € 5000 after the approved application and designation screening, and before the explanatory visit. The total amount of fees (stage one and two) is different according to the designation types. Stage one is equal for all designation types.

STEP 3: Explanatory visit with preliminary designation type result
The explanatory visit takes place when the application of the cancer institute is approved and the designation screening is finished.

STEP 4: Self-assesment according to the quality standards
The accreditation programme for an institute starts at month 0 with the self-assesment. The self-assesment period will take 6 months. The set of quality standards varies for the different designation types.

STEP 5: Approval Go / No go
The final 'go' or 'no go' decision will be taken by the OECI A&D Board within 2 months after finishing the self-assesment with the input of the analysis and proposal of the A&D Committee.

STEP 6: Payment fee stage two: the amount of the fee depends on the designation type
The payment order will be sent after the 'go' decision of the OECI A&D Board.

STEP 7: Peer review
An audit team will have 2 months to prepare the peer review before the peer review visit can take place in month 10.

STEP 8: Reporting
It takes about 3 months to finish the final peer review report including general conclusions, strengths, opportunities and the final designation type in month 13.

STEP 9: Formulate improvement plan
The institute shall present an improvement plan in month 16.

STEP 10: Approval Accreditation and Designation Certificate
The final accreditation decision will be taken by the OECI A&D Board within 1 month after the OECI received the improvement plan of the institute (month 17).

FOLLOW-UP of Accreditation and Designation Programme
One year after the peer review visit the cancer institute provides a written report with the progress of the goals, actions and time-schedule set in the improvement plan.

OECI Accreditation and Designation is valid for four years from the date of issue of the OECI A&D Certificate. The institute should have started a new round of the A&D programme at least 6 months before the expiring date of the certificate.

3 People and parties involved in the A&D programme

This chapter explains the profiles, tasks and obligations of the people and parties involved in the OECI A&D Programme. The chapter is divided in three parts: people and groups within the OECI, OECI auditors and the audit team, and the people involved from the applied cancer institute.

3.1 The OECI

The ultimate objective of the OECI-EEIG (Organisation of European Cancer Institutes-European Economic Interest Grouping) is the development of oncology in Europe for reducing mortality and morbidity due to cancer and increasing survival and quality of life of the patients. Therefore, the model of oncology must be based on a global vision of the cancer problem emphasising the integration of research and education with diagnosis, prevention and care to promote the development of comprehensive and multidisciplinary organisation within the European Cancer Institutes (OECI Statutes).

The structure of the OECI contains the following bodies:
– General Assembly,
– Executive Board,
– The Manager (daily management),
– The Coordination Secretariat,
– The Working Groups.

3.1.1 OECI Executive Board

The Executive Board (OECI Board) is composed of at least the following members (OECI Statutes):
– The President, who presides the meetings of the General Assembly and the Executive Board,
– The Vice-President who shall chair all meetings in the absence of the President,
– The immediate Former President,
– The Executive Secretary,
– Two Elected Members, one of whom serves as Treasurer,
– One Co-opted Member, with no voting rights, designated on the recommendation of the Board.

A list with the names of the current OECI Executive Board members is published on: www.oeci.eu

3.1.2 OECI Accreditation and Designation Working Group

The Executive Board or the General Assembly may assign some tasks to Working Groups, as the Accreditation and Designation Working Group. The Working Groups may include persons not belonging to the Executive Board or who do not represent Members. The Working Groups are accountable to the Executive Board or to the General Assembly for the tasks which have been entrusted to them and shall draw a report of their activities. The rules of procedure of the Working Groups are laid down in the Internal Regulation (OECI Statutes).

The OECI Accreditation and Designation Working Group (A&D Group) includes:
– OECI Accreditation and Designation Board (A&D Board, 3.1.3),
– OECI Accreditation and Designation Management Unit (A&D MU, 3.1.4).

The tasks and responsibilities of the members of the A&D Group is described in the following paragraphs. A list with the names of the current A&D Group members is published on: http://oeci.selfassessment.nu

The OECI A&D Group has monthly meetings by teleconference. Once, during the three months, there will be a face-to-face meeting.

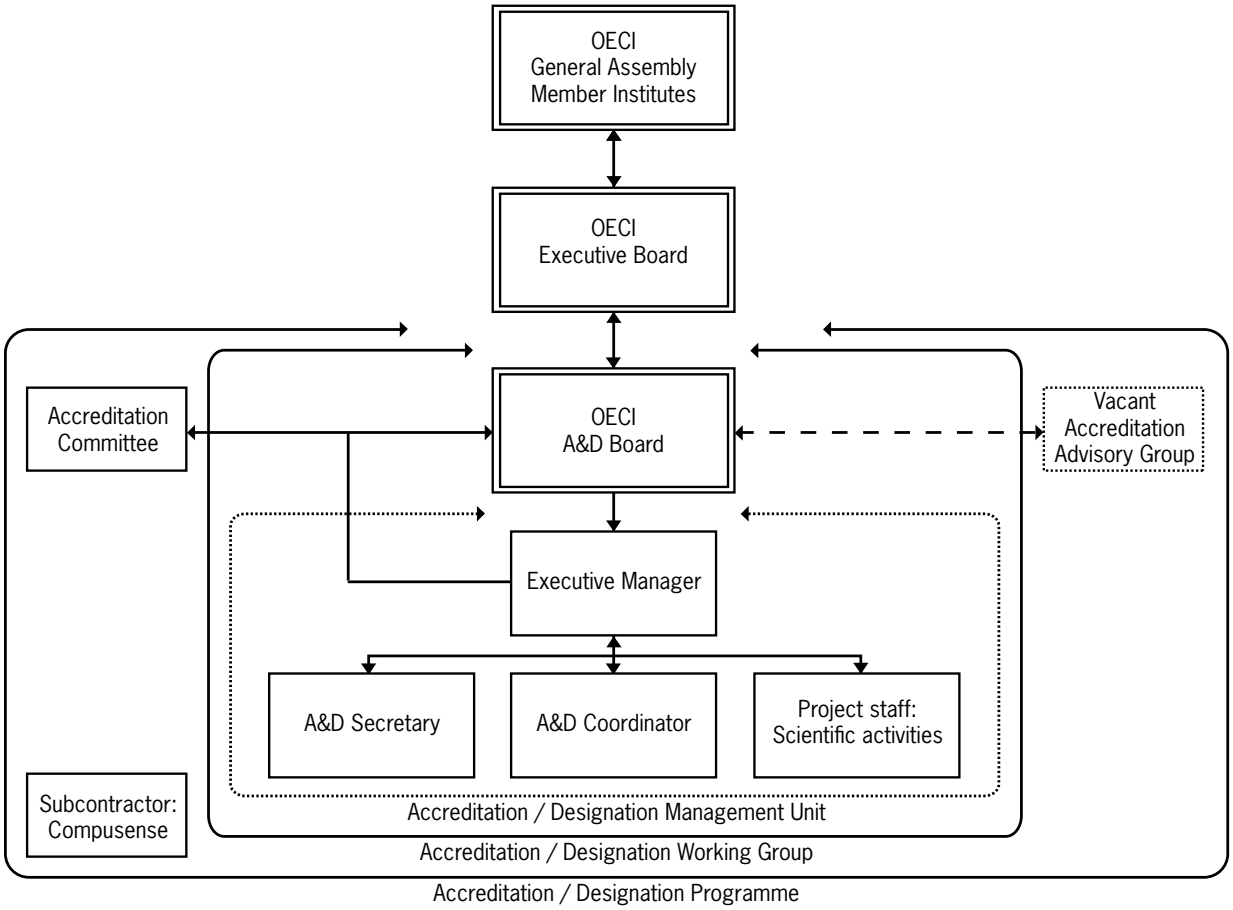


Figure 2: Organisational structure

3.1.3 OECI Accreditation and Designation Board

The requirements for the composition of the A&D Board are:
– The composition of the A&D Board shall be approved by the OECI Board,
– The A&D Board consists of four persons of the OECI member institutes including the chairperson.
– The chairperson is a co-opted member in the OECI Board.
– A&D Board members engage a position within the Board of Directors of an OECI member institute or a position with comparable authority to be decided by the OECI Board.

General and specific tasks

Financial:
– Presenting a quarterly overview of income/expenditure,
– Assessing quarterly the income/expenditure.

Policy/procedures:
– Decision making on accreditation and designation procedures and policy.

Accreditation and Designation Programme:
– Approve/disapprove the application of new cancer institutes in the A&D Programme and preliminary designation type,
– Approve/disapprove the self-assessment results of cancer institute to plan a peer review visit on site ('go'/'no go' decision),
– Approve/ disapprove the final peer review report including designation type,
– Approve/ disapprove the Improvement plan of a cancer institute,
– Dealing with and solving major issues between the A&D Management Unit and cancer institute in case of complaints or other issues.

Decision making

To increase independent examinations in essential steps in the A&D process, the A&D Board will be advised by the OECI A&D Committee (3.1.5). The A&D Committee will propose their conclusions on the essential steps to the OECI A&D Board as input for final approval. The advice of the A&D Committee is not binding.

3.1.3.1 OECI Accreditation and Designation Board Chair

The OECI A&D Chair is leading the activities of the OECI Accreditation and Designation group, chairing the OECI Accreditation Designation Board and representing the group in the OECI Board. The chair is a co-opted member of the OECI board.

– Assessing quarterly income/expenditure compared to provisional budget,
– Reporting the financial status quarterly to the members of the A&D Board and Executive Manager,
– Checking and validating invoices and reimbursement claims with a signature before payment according to the following general rules: Doc 32: OECI A&D Travel policy,
  • In case of prolonged absence or holiday of the A&D Chair, the signature will be delegated to the A&D Secretary. The A&D chair will check and countersign the documents afterwards,
– Providing overview of income/expenditure to the OECI Board Executive Secretary every 6 months,
– Providing the OECI Board Executive Secretary with the original invoices with attached the bank payment receipts once a year or whenever requested,
  • In case of travel by flight also the boarding passes must be added,
– Proposing and reporting annual budget to the OECI Board and OECI A&D Board.

3.1.4 OECI Accreditation and Designation Management Unit

The A&D Management Unit consists of:
– OECI Executive Manager
– OECI A&D Coordinator
– OECI A&D Secretary

Subcontractor Compusense for designation, administration and technical support of the self-assessment e-tool.

3.1.4.1 OECI Executive Manager

General tasks
– Daily management of the A&D Programme,
– Providing a quarterly report for the OECI A&D Board chair: new applications, visited institutes, achieved accreditation etc,
– Supervising the OECI Accreditation and Designation Coordinator,

Financial tasks:
– Sending invoices to the institutes and controlling the payments of the institutes,
– Providing to the A&D Chair and A&D Secretary a copy of invoices sent to the institutes.

Specific tasks and responsibilities of the Executive Manager are described in Doc 43.

3.1.4.2 OECI Accreditation and Designation Coordinator

The OECI A&D Coordinator is supervised by the Executive Manager.

General tasks
– Contact person for all parties involved in A&D Programme,
– Collecting, structuring and making accessible the relevant information and documentation (internal and external) on the website and e-tool,
– Monitoring the ongoing processes and outcomes with regard to the A&D procedures,
– Identifying improvements in the procedures, organisation, e-tool and standards.

Specific tasks
Coaching and advising cancer institutes in all steps of the A&D programme:
– Processing application and designation screening,
– Preparation of explanatory visit,
– Supervision during self-assesment,
– Preparation of the peer review with the cancer institute,
– Supervision in follow-up of the peer review outcomes.

Organizing and performing the peer review:
– Composing the audit team together with the Executive Manager,
– Providing the audit team with documents for preparing the peer review,

– Organizing the auditors' meeting,
– Coordinating the peer review visit on site for accreditation and designation,
– Coordinating the writing of the peer review report in cooperation with the audit team,
– Processing the peer review report towards the final report,
– Coordinating the follow-up of the cancer institute.

Other specific tasks and responsibilities of the A&D Coordinator are described in doc 43.

3.1.4.3 OECI Accreditation Secretary

General tasks
– General secretariat of the OECI Accreditation Programme, under supervision of and following the instructions of the chair,
– Informing the OECI A&D Group about incoming information.

Specific tasks

Organizing meetings and teleconferences:
– Booking the rooms, organising lunches and coffee if necessary, checking availabilities of participants, sending the agendas, writing the minutes and sending it to the group.

Peer review visits:
– Organizing the logistics of the visit: booking hotels for auditors.

A&D Agreements:
– Arranging to complete the signed A&D Agreement from institutes with signatures of the OECI A&D Chair and the OECI President.

Financial:
– Providing quarterly a detailed overview of income/expenditure to the OECI A&D Chair,
– Follow-up of the A&D programme budget,
– Confirming payments of institutes to the institute and Executive Manager,
– Submitting to the A&D Chair all invoices and reimbursement claims for a signature,
– Making the reimbursements of travel expenses of the auditors and A&D Group members through online payment within 10 working days (unless absent), within receipt of all original receipts and reimbursement claims,
– Making the payment of the invoices regarding the A&D Programme through online payment within 10 working days (unless absent), within receipt of all original invoices,
– Coordinating the A&D finances with the OECI Office and providing follow-up (status of the account), sending all the original receipts and invoices on a yearly basis to the OECI Office for the accountant of the OECI.

Other:
– Archiving all the documents of the programme,
– Producing documents and presentations concerning the A&D programme.

3.1.5 OECI Accreditation and Designation Committee

The Accreditation and Designation Committee (A&D Committee) consists of five persons from different institutesand countries, and with different backgrounds related to cancer care. The A&C Committee is coordinated by the Executive Manager.

A list with the names of the current A&D Committee is published on: http://oeci.selfassessment.nu

Profile
– Trained as an auditor and experiences as auditor,
– Accreditation knowledge and affinity,
– Quality improvement attitude,
– The management board of the institute supports the application,
– Working as a professional,
– Helicopter view,
– Capacity to work in a team,
– Good interpersonal properties,
– Capacity to distinguish core issues and side issues, objective,
– Fluent English (spoken as well as written),

– Analytic way of thinking.

Tasks
– To analyze and examine the self-assesment reports for the 'go'/'no go' decision before the peer review visit,
– To analyze the availability of the required proof documents and additional appropriate documents for peer review,
– To advise the A&D Board about a 'go'/'no go' decision with regard to the scores, notes and documents in the self-assesment report,
– To analyse the conclusions, strengths and opportunities that are drafted by the audit team, and to give final advice to the A&D Board about the complete final report, including the designation type,
– To analyze and examine the improvement plan of the institute and advising the A&D Board for final accreditation according to procedures and standards of the institute,
– The A&D Committee will be informed about the final decision of the A&D Board during their meetings.

Meetings
It depend on the workload. At least once a month/six weeks by teleconference or videoconference.

3.1.6 OECI A&D Advisory Group
An advisory group will be developed to advise the OECI A&D Board on major issues in the programme.

3.1.7 Relations and communication between OECI groups
The relations and communication between the OECI groups are described.

3.1.7.1 Relation/communication between the OECI A&D Group and OECI Board
The OECI Board shall take all necessary steps and make all decisions for the achievement of the goals of the OECI A&D Group.

The OECI A&D Board chair represents the group at the OECI Board as co-opted member.

– The OECI Board gives mandate for daily management to OECI A&D Group,
– All standards and procedures have to be approved by the OECI Board and procedures are also signed by the OECI president,
– The A&D Chair will give regular feedback to the OECI Board concerning all accreditation and designation activities. The Executive Manager will provide a quarterly report for the A&D Chair. This report can be used for giving feedback (including new applications, visited institutes, achieved accreditation etc),
– The A&D Board decides if a cancer institute will receive OECI accreditation and will give notice to the OECI Board,
– The A&D Certificate will be signed by the OECI President and the chair of OECI A&D Board.

3.1.7.2 Relation/communication between the OECI A&D Group and OECI General Affairs Manager and OECI Coordinating Secretariat/ liaison office
– Contact about the monthly newsletter, annual programme General Assembly, conferences and brochures, and the annual OECI report,
– Providing overview of the income/expenditure to the OECI Executive Secretary every 6 months,
– Providing the OECI Executive Secretary with the original invoices with attached the bank payment receipts (in case of travelling by flight also the boarding passes must be added) once a year or whenever requested.

3.1.7.3 Relation/communication between the OECI A&D Board and OECI General Assembly
The annual General Assembly has the following powers in relation to OECI A&D Board:
– Adoption of the annual accounts
– Approval of the annual report
– Adoption of the (total) budget and plan of activities for the following year.

3.2 Audit team and auditors

3.2.1 OECI audit team

This part gives explanations about the OECI audit team. More details about the tasks and responsibilities of individual auditors can be find in the part 'OECI auditor'.

Composition of the audit team

The audit team typically consists of four members:

– Chair, who is also one of the auditors,
– Three auditors,
– In case of a preliminary Cancer Unit the audit team possibly includes less than four auditors and the peer review possible takes one day,
– In case of a preliminary CCC one person of the audit team possibly starts half a day earlier to check the designation criteria/checklist in advance.

In an ideal situation the team consists of:

– A chair who is a director of a cancer institute,
– Auditors with different positions/ functions in different fields of oncology, like: medical oncology, care, research, pathology, quality assurance,
– At least one auditor who understands the language of the country where the cancer institute is situated but who is not a resident of that country,
– A mix of experienced and less experienced auditors.

Besides the audit team the OECI Accreditation Coordinator will also be present during the peer review visit to coordinate the peer review activities.

Selecting an audit team

The Executive Manager and A&D Coordinator are responsible for selecting the chair and auditors of an audit team.

Before the audit team members will get access to the self-assesment information of the cancer institute:

– The particular cancer institute has expressed that there is no conflict of interest with any of the audit team members (4.1),
– Each auditor has signed a Confidentiality Agreement (doc 14) and a Conflict of Interest Form (doc 15).

3.2.2 OECI Audit team chair

The chair of the audit team has the same profile, tasks and obligations as the OECI Auditor (3.2.3). However, the chair has some specific additional obligations and tasks.

Profile

– The chair is a Director of a cancer institute (or a position with comparable authority to be decided by the OECI A&D Board),
– The chair has attended the auditors' training,
– The chair has experienced at least one peer review as auditor before chairing a peer review.

Tasks

– The chair opens the peer review visit with a presentation,
– The chair has a leading role in the representation of the team,
– The chair has a leading role in a balanced division of tasks in the team,
– The chair has a leading role in meetings and interviews,
– The chair presents the preliminary results at the end of the peer review visit,
– The chair presents the preliminary designation type at the end of the peer review visit,
– The chair has a leading role in the content of the report and editorial changes.

3.2.3 OECI Auditor

Profile

An OECI auditor:

– Is employed by a cancer institute or hospital and is working in the specific field of oncology, for example:
– Is a (quality) manager, an oncology nurse, a cancer researcher or microbiologist,
– A (quality) manager, an oncology nurse, a cancer researcher or microbiologist,
– Is approved by his/her management to apply as an OECI auditor (engagement letter),
– Has attended the OECI audit training,
– Has the following skills and qualities:
  - speaks and writes fluently in English,
  - has a good overview of the field of oncology in a cancer institute,
  - is a team player,
  - has an objective and analytic way of thinking,
  - has a quality improvement attitude.
  - Is willing to commit time and efforts for peer review, designation screening and report:
    - preparation meeting of the audit team: one day
    - peer review: three days for clinical cancer centres and CCC's, for cancer units possibly one day
    - reporting: two days

Tasks

The auditor:

– Prepares the peer review visit according to the preliminary designation type,
– Prepares the peer review visit by analysing the self-assesment results and documents of a cancer institute,
– Attends the preparation meeting of the audit team one month in advance of the peer review visit,
– Attends the preparation meeting on the evening before the start of the peer review,
– Performs the peer review according to the agenda and designation checklist,
– Writes notes during interviews, presentations and tours,
– Scores the standards as a team during the peer review visit,
– Draws peer review findings as a team for the preliminary results presentation at the end of day two of the peer review: strengths and opportunities,
– Processes notes in e-tool in the first week after the visit and scores the standards that are reviewed,
– Provides a list of strengths and opportunities chapter of the standard,
– Provides a description of the checklist items for confirmation of the designation type,
– Gives written response on the comments and feedbacks on the draft report of the cancer institute, and formulates the final strengths, opportunities and conclusions of the peer review.

3.3 Cancer institute

Obviously all employees of a cancer institute are directly or indirectly involved in the accreditation and designation programme, for example during the self-assesment period delivering data and documents for filling out the questionnaires or during the peer review in the interviews, tours and presentations. It is also advised to involve the employees as much as possible to build commitment to the A&D programme and encourage them to work according to the OECI standards.

Some staff members have a central role in the organisation of the programme which is outlined in this paragraph.

The specific tasks and obligations of the cancer institute are explained step-by-step in the following chapters.

3.3.1 Director cancer institute/Board of Directors

The Director/ Board of Directors of the cancer institute are very important in the accreditation programme for the commitment of the cancer institute with the programme. Although the A&D Coordinator will mainly keep contact with the contact person of the cancer institute, the Director/Board of Directors shall be involved in:
– Signing the application form with designation screening including the own judgement on designation type,
– Discussing the preliminary designation type during the explanatory visit,
– Signing the OECI A&D Programme agreement depending on the preliminary designation type (doc 6),
– Approving the peer review agenda (doc 16),
– Express a potential conflict of interests with the audit team members if necessary (4.2).

During the accreditation process of a cancer institute the Director of the institute will receive the following notifications and documents:
– Approval/disapproval of application and preliminary designation type,
– 'Go'/ 'no go' decision for peer review visit,
– Draft peer review report,
– Final peer review report including final designation type,
– OECI Accreditation and Designation Certificate, with agreed final designation type.

3.3.2 Contact person cancer institute

During the A&D Programme the contact person of the institute communicates with people from the A&D Group concerning several issues.

With the A&D Secretary with regard to:
– A&D Agreement,
– Planning of the explanatory visit,
– Information about accommodation for peer review visit.

With the A&D Coordinator with regard to:
– The application and designation screening
– Information about the programme,
– The content of the explanatory visit,
– Designation screening result and accreditation starting point,
– Periodical contact during the self-assesment period,
– Questions concerning the self-assesment activities or questionnaires,
– Organisation of the peer review,
– Peer review agenda,
– Providing feedback on the draft peer review report,
– Follow-up of the A&D Programme.

With the Executive Manager with regard to:
– Concerning payment of the A&D Programme fee in two stages.

4 Confidentiality and conflict of interest

The OECI A&D Programme and the persons and parties involved, are subject to confidentiality of data, information and knowledge, and potential conflict of interests. There is a policy with regard to this confidentiality which is explained in this chapter.

4.1 Confidentiality

During the A&D programme of a cancer institute different persons will have access to the information and data of the cancer institute. The OECI A&D Programme has developed a policy to guarantee that all persons having access to the information and data will only use it for the purpose it shall be used for: the accreditation of the cancer institute.

In accordance with OECI A&D Group policy, all information related to the accreditation of a cancer institute is strictly confidential. This includes, but is not limited to: reports of evaluation, letters, self-assesment and accreditation materials, interim/annual/biennial reports, correspondence, and the content of any discussion related to the cancer institute and/or its accreditation. All requests for information related to a specific cancer institute and/or programme must be referred to OECI A&D Group, or to the respective cancer institute.

The persons who have to sign the confidentiality agreement (doc 14) are:
- Members of the OECI A&D Board,
- Members of the OECI A&D Management unit
- Members of the OECI A&D Committee,
- All auditors including the chairs.

Freedom of Information Acts which may be applicable in a given state, province, or country do not apply to the OECI A&D Group confidential information related to the accreditation of cancer institutes.

4.2 Conflict of interest

All auditors have to sign the Conflict of Interest form (doc 15) for each peer review they are going to perform.

To ensure that all matters dealing with the accreditation programme of cancer institutes are conducted in an unbiased manner, the OECI A&D Group has adopted a Conflict of Interest Policy.

Criteria that may pose a conflict of interest for a candidate auditor include, but are not limited to:
1. Past or present employment at the cancer institutes being reviewed,
2. Service as a consultant for the cancer institutes being reviewed,
3. Graduation from the cancer institutes being reviewed,
4. Membership on the advisory committee of the cancer institute being reviewed,
5. Other potential conflicts of interest, such as employment of private consultants or subcontracts with private companies etc.

It is expected that the candidate auditor will communicate with the A&D Group staff for clarification on any concern. If conflicts of interest are revealed to the entire team, and if it is agreed that the audit team member will be unbiased in evaluating the programme, it will be acceptable to allow the individual to remain on the audit team.

Expressing conflict of interest by the institute
The composition of the audit team will be sent to the institute to provide the opportunity to express any potential conflict of interest. In case the cancer institute has expressed a potential conflict of interest with one of the auditors in the team, the OECI A&D Board will decide whether the auditor shall be replaced by another auditor.

5 Ten steps A&D process in detail

The following paragraphs describe in detail the ten steps towards the A&D Certificate and the follow-up of continuous and comprehensive quality improvements. It describes the activities and obligations of each of the parties involved in the A&D Programme.

5.1 Step 1: Application of a cancer institute in the programme

Step 1 is the application of the A&D Programme and filling the designation screening list. Figure 3 shows the details of this step.

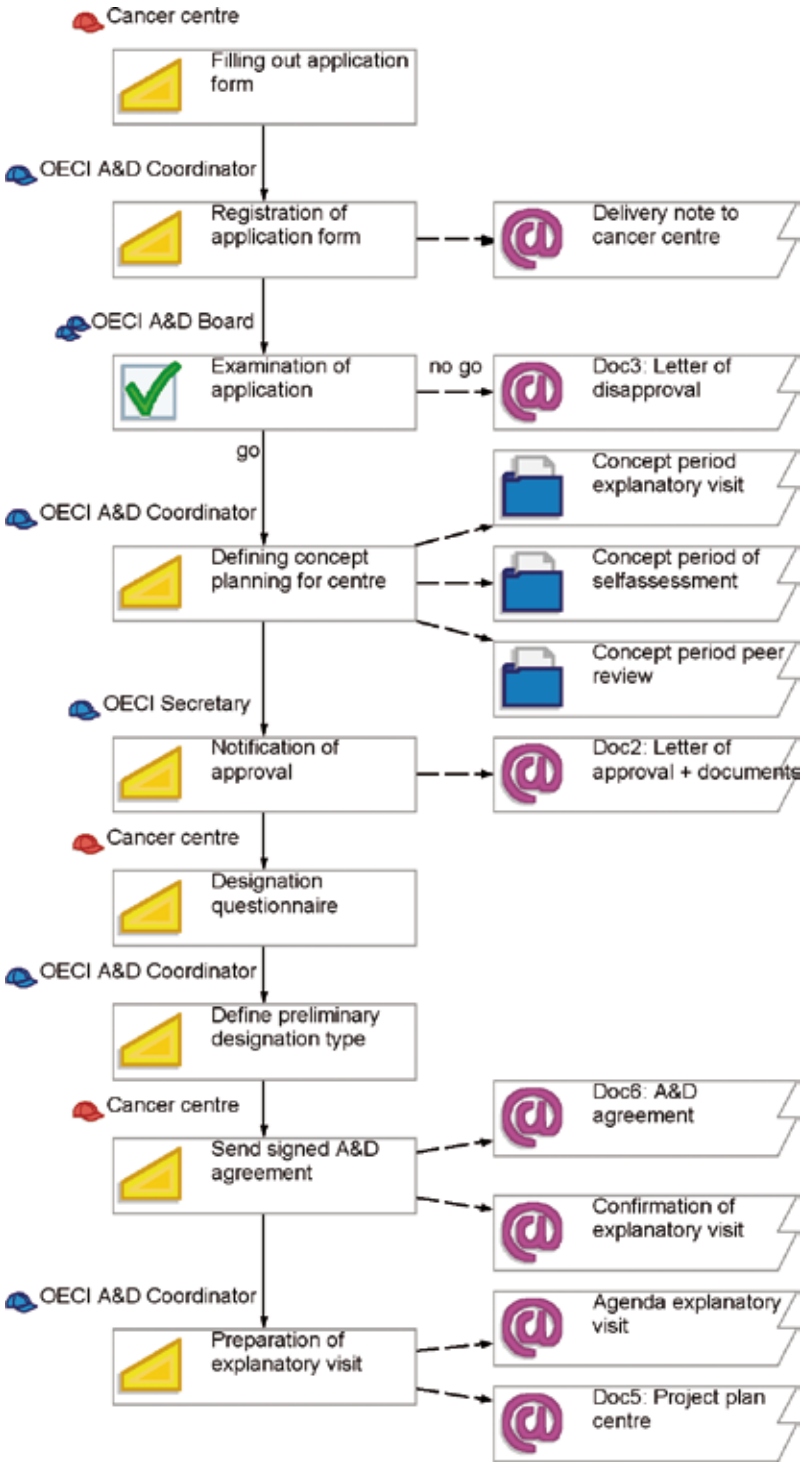


Figure 3: Step 1 Application and designation screening

5.1.1 Step 1: activities and responsibilities of all parties involved (figure 3)

Filling out the application form and designation screening list
Executor: Cancer institute
– The institute can start to fill out the 'Online application form' on the website: *oeci.selfasessment.nu* under the menu 'How to apply?' – The page starts with a general introduction of the programme and by clicking 'Go to the online application form' the application procedure will be explained, – The institute can access the application form by making a username and password as explained on the page. The application contains the judgement of the institute and the designation type. On the last page of the application form the institute can send the application to the OECI A&D Coordinator. The approval/signature of the Director/ Board of Directors is requested for the full commitment to the programme.

Registration of application form
Executor: OECI A&D Coordinator
– The OECI A&D Coordinator receives the application form through the e-tool, – OECI A&D Coordinator sends a delivery note to the applicant's institute.

Examination of the application
Executor: OECI A&D Board
– New applications are discussed in the next teleconference of the OECI A&D Board (every month), – The application is analysed according to the criteria for application as set in the application form, – The institutes' judgement of the designation type should be discussed, – The A&D Board will make the final decision of approving or disapproving the application. Note: The OECI A&D Programme for Cancer Research Centres is not yet developed, this is one of the goals of the OECI A&D Group. **Criteria for application** Applying to the A&D Programme is a voluntary decision of the cancer institute. However, to provide the institute with a qualitative accreditation programme and to meet with the goals for accreditation and designation, there are obligations that each institute involved shall meet to apply to the A&D Programme: – Membership of the OECI, – Strong commitment to quality improvement (signature of Director/ Board of Directors), – Dedicated staff (contact person, project group, all involved employees), – Stable management structure (no interim management on level of board of directors), – No major changes/problems (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 (for Cancer Units the involvement in research programmes is not requested), – Cancer care is performed on an identifiable unit with an identifiable budget, management and organisational structure.

Defining concept planning for institute

Executor: OECI A&D Coordinator

If the OECI A&D Board approves the institute, the A&D Coordinator will draw the planning:
- Designation screening,
- Explanatory visit: planned in cooperation with the institute,
- Self-assesment period,
- Peer review: the final peer review dates are planned in alignment with the availabilities of the cancer institute and the audit team chair.

This will be archived in the accreditation planning (doc 41).

Notification of approval

Executor: OECI A&D Secretary

If an institute is approved to apply to the A&D Programme:
- The A&D Secretary sends the approval letter attached by e-mail (doc 2) to the Board of Directors of the institute and the contact person signed by the A&D Chair,
- The concept planning (designation screening, explanatory visit, self-assesment, peer review) is mentioned in the e-mail,
- The A&D Secretary will plan the explanatory visit date in cooperation with the contact person of the cancer institute and delegates of the A&D Group,
- Attached to the e-mail and letter of approval:
  - A&D Agreement to be signed (doc 6),
  - Accreditation and Designation Manual with timeline (doc 0).

Designation questionnaire

Executor: Cancer institute

- After the approval of the application in the A&D Programme the institute continues with the designation screening that will be accessible through the website: *http://oeci.selfassessment.nu* with the same username and password as for the application,
- All items requested for designation are also requested in the quantitative questionnaire for self-assesment. The institute fills in these items only once. The numbers are automatically copied on the quantitative questionnaire,
- The institute fills out all items in the designation screening questionnaire.

The questionnaire requests the figures of a specific year. The institute can state the year from which the figures derived. The institute should use the figures of the last completed administrative year. An exception to this rule is made when available figures from the last year are asked.

The numbers between brackets are the question numbers in the quantitative questionnaire.

Designation screening items:

- Planned annual budget for health care in € last year available (1.5.4),
- Planned annual budget for research in € last year available, (1.5.5),
- Number of newly registered/diagnosed cancer patients per year (year x). In detail: surgery oncology, medical oncology, radiation therapy, paediatric oncology, haematology, other units and in total for oncology (2.1),
- Number of inpatient beds for overnight stays for: surgery oncology, medical oncology, radiation therapy, paediatric oncology, haematology, other units and in total for oncology in year x (2.1),
- Number of ambulatory day care beds/chairs in year x (2.1),
- FTE physicians dedicated to oncology (2.1),
- Radiology. In detail: number of CT scanners, number of facilities for MRI, number of MRI spectroscopy and number of mammography (2.9),
- Legal number of hours for 1 Full-Time Equivalent (FTE). In detail: Per physician, per nurse day, per nurse night (3.1),
- Number of FTE surgeons. In detail: breast surgery, urologic surgery, thoracic surgery, digestive surgery, neurosurgery, gynaecological surgery, head and neck surgery, soft tissue surgery, orthopaedic surgery, plastic and reconstructive surgery (3.2),
- Number of FTE from medical oncology (3.3),
- Number of studies active (that is open to patient accrual) during year x (4.3.2),
- Number of studies activated in year x. In detail: Phase I, Phase II, Phase III and Phase IV (4.3.3),
- Total research budget of the cancer institute (4.4.1),
- Research funding sources/total amount received in year x. In detail: Number of EU grants running in year x, number of EU grants coordinated in year x, public funding, charities/unrestricted grants and industrial partnership funding (4.4.2),
- Number of peer-reviewed publications per year (year x) national (4.4.4),
- Number of peer-reviewed publications per year (year x) international (4.4.5),
- Number of publications with impact factor > 10 (4.4.7).

Define preliminary designation type

Executor: OECI A&D Coordinator

With the data provided in the designation screening the A&D Coordinator will define the preliminary designation type for the applied institute according to the Designation Decision Schedule (appendix I). The quantitative norms can be found in the Appendix I.

Required criteria for Cancer Research Centre:
- 2.1: Number of beds (year x):
- 2.1: Number of specialists (year x):
- 2.1: Number of new patients (year x):
- 4.4.4 + 4.4.5: Number of scientific papers (year x):
- 1.5.5: Annual budget research (year x):
- 1.5.4: Annual budget care (year x):

If the institute does not meet the required criteria for Cancer Research Centre, the institute can be a Cancer Unit or Clinical Cancer Centre or Comprehensive Cancer Centre (CCC).

Required criteria for Cancer Unit:
- 2.1: Total number of beds + 2.1: ambulatory day care beds:
- 2.1: Or number of new patients (year x):
- 2.1: Or number of specialists (year x):
- 4.4.4+4.4.5: Or number of scientific publications (year x):

And:
- Institute covers radiotherapy and medical oncology or surgical oncology

If the institute does not meet the required criteria for a Cancer Unit, the institute can be a Clinical Cancer Centre or Comprehensive Cancer Centre (CCC).

Required criteria for first selection CCC:
- 1.5.4: Annual budget for care (year x)
- 1.5.5: Annual budget for research (year x):
- 2.1: Total number of beds + 2.1 ambulatory day care beds (year x):
- 4.3.2: Active clinical trials (year x):
- 4.4.4+4.4.5: Number of scientific papers (year x):
- Nr scientific papers with impact factor>10 (year x):

The confirmation and second check takes place during the peer review visit.

If these criteria are not met, the institute can be either a clinical cancer institute or a CCC. The final decision for the designation type will be checked during the peer review visit according to an additional checklist (5.7.1).

Deviation in designation judgement of the institute and the preliminary designation result
The application form for institutes includes the question to classify itself in one of the four designation types. The occurrence of a discrepancy between the judgement of the institute and the designation screening result (preliminary designation) is feasible.
This discrepancy will be discussed during the explanatory visit (step 3).

Send signed accreditation and designation agreement
Executor: Cancer institute
The AD Agreement shall be signed by the Director/Board of Directors of the cancer institute and sent to the A&D Secretary. The A&D Secretary will manage to complete the A&D Agreement with the signatures of the OECI A&D Chair and of the OECI President.

Preparation of explanatory visit
Executor: OECI Accreditation Coordinator
The OECI A&D Coordinator: – Receives the confirmation of the explanatory visit date and the signed A&D agreement from the institute (or OECI Secretary), – Drafts the concept explanatory agenda for the cancer institute (doc 7), – Sends the concept agenda to the (cancer) institute to complete the agenda with the participants (doc. 7), – Sends the template project plan (doc 05) as an example on how to organise the self-assessment period in the institute. Accommodation and transport for the explanatory visit are booked by the delegates of the OECI A&D Group.

5.2 Step 2: Payment stage 1 fee

The institute receives the first payment order after approval of the application and the designation screening, and before the explanatory visit.

Tasks of the Executive Manager:
– Sending invoices to the institutes including the signed A&D Agreement
– Controlling the payments of the institutes,
– Providing the A&D Chair and A&D Secretary with a copy of invoices sent to the institutes.

Tasks of the A&D Secretary:
– Confirming payments of the institutes to the institute and Executive Manager.

The total fee depends on the designation type of the institute:

	Stage 1	Stage 2	Total
Cancer Unit	€ 5.000	€ 15.000	€ 20.000
Clinical Cancer Centre	€ 5.000	€ 25.000	€ 30.000
Comprehensive Cancer Centre (CCC)	€ 5.000	€ 25.000	€ 30.000

The fee of stage one is equal for all types of institutes and covers primarily the costs for application and designation screening, explanatory visit, use of the e-tool during the self-assessment period, the OECI support during the self-assessment period, the organisation of meetings for the A&D Committee and A&D Board for the 'go' decision, and labour costs of the A&D Management Unit.

Difference in fee
– The peer review visit in a Cancer Unit possibly takes one day instead of two full days in clinical cancer centres and CCC's,
– The peer review visit in a Cancer Unit does not include the full set of standards. Standards related to chapter 4 'Research, innovation and development' are not assessed,
– The audit team possibly includes less than four auditors.

Note:
There might be reasons for an institute not being able to continue the A&D programme towards the peer review visit after the self-assessment, such as: delay of the self-assessment period, 'no go' decision, changes in the management of the institutes etc. One year after the payment of stage 1 an institute will be reminded of its participation in the programme. The application of the institute will expire if the institute will not continue the programme within two years after the payment of stage 1. The OECI A&D Group will not return the payment of stage 1.

Note:
If there is a discrepancy between the designation judgement of the institute and the preliminary designation that remains after the explanatory visit, the institute shall pay the fee equal to the designation type applied for. For example: an institute that has classified itself as a clinical cancer centre and is willing to continue the programme as such, shall pay in total € 30.000 although the preliminary designation is a cancer unit.

Note:
If an institute decides to apply for A&D as clinical cancer centre or CCC the full set of standards will be assessed, including the standards related to chapter 4 'Research, innovation and development'.

5.3 Step 3: Explanatory visit and preliminary designation result

During the explanatory visit, two delegates of the OECI A&D Group will meet with delegates of the institute:
– Board of directors,
– Heads of Departments,
– Head of Nurses,
– Quality Managers,
– IT expert (for e-tool),
– All other interested staff in the institute.

Generally, the visit includes three parts:
1. A general presentation for all staff in the institute interested in the OECI Programme,
2. A meeting with the key persons (project group) in the programme to discuss the steps and the template project plan (doc. 5) in detail,
3. A tour in the institute.

During the presentation and meeting the following subject will be explained and discussed:
– The accreditation and designation programme,
– The preliminary designation type according to the designation screening and the judgement of the institute. The designation type is the starting point for accreditation,
– Timelines of the programme,
– Self-assesment period and access to the e-tool,
– Project plan of the institute (doc 5),
– Required documents (doc 9) for peer review,
– Obligations of the cancer institute,
– The OECI's role.

At the end of the explanatory visit the cancer institutes and the OECI delegates agree upon the preliminary designation type of the institute as a starting point for the self-assesment period.

After the explanatory visit the institute:
– Will prepare and plan the self-assesment with the project team,
– Will receive an username and password to enter the e-tool.

Project group and project planning
The OECI A&D Group offers a template project plan (doc 5) containing the following items:
– Who are involved in the project group: professionals and staff from the different departments,
– Planning project group meetings to discuss the progress of the questionnaires,
– Schedule for evaluating the progress and intermediate results to Board of Directors/Management,
– Schedule and methods to inform about the progress to all professionals and staff within the institute,
– Deadline for finishing the questionnaires including notes and (required) documents,
– Moment and method of informing the final results to all professionals and staff.

The OECI A&D Group recommends the value of a project team and project plan to raise commitment , involvement and responsibility of professionals and staff from different departments. This may be useful in all parts of the programme:
– Answering the questions with widely accepted answers during the self-assesment period,
– Sharing the results of the self-assesment,
– Preparing the agenda for the peer review visit, it is not necessary to explain the purpose,
– Giving feedback and comments to the draft peer review report,
– Sharing the results from the peer review visit,
– Formulating and performing actions for the improvement following the peer review results.

5.4 Step 4: Self-assesment

Step 4 of the A&D programme is the six months of self-assesment of the cancer institute (figure 4).

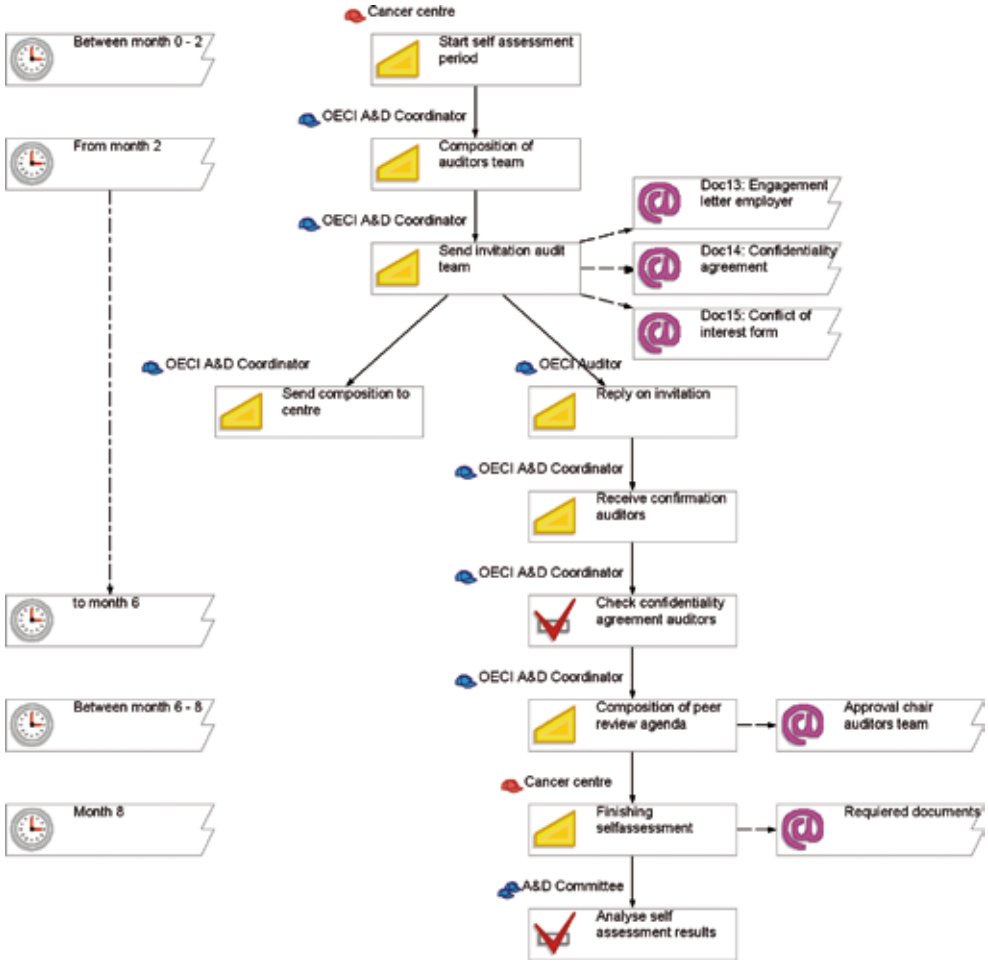


Figure 4: Step 4 Self-assesment

5.4.1 Step 4: activities and responsibilities of all parties involved (figure 4)

Start self-assesment period

Executor: Cancer institute

- Within one month after the explanatory visit the institute has organised a project team and planning to start the self-assessment period,
- The self-assesment takes 6 months,
- The deadline of the self-assesment period is at least 2 weeks before the next TC of the OECI A&D Committee to prepare the go/ no go decision for the OECI A&D Board.

E-tool (see chapter 8)

- The (cancer) institute fills out the quantitative and qualitative questionnaire,
- The (cancer) institute makes notes/remarks at the questions to explain the score/answers,
- The (cancer) institute attaches documents (if available) to questions to support the answers,
- The (cancer) institute attaches minimally the documents required by the OECI,
- The (cancer) institute describes non-compliances/ improvement points in the e-tool that can be used to make an improvement plan.

Progress of the self-assesment

During the self-assesment period, the A&D Coordinator will contact the (cancer) institute regularly to evaluate the progress of the self-assesment.

How to score the standards?

The score is a indicator for the stage of implementation of each item of the standard. The scoring system is based on the Plan-Do-Check-Act-circle or Deming-circle. These four stages of implementation are translated in the following possible answers:

- **Yes** means that the indicator of the standard has been implemented on a wide scale in the cancer institute and the Deming-cycle is completed at least twice (> in third cycle),
- **Mostly** means that the indicator has been implemented in most of the critical places in the cancer institute and the Deming-cycle is completed at least once (> in second cycle),
- **Partially** means that the indicator is implemented on project bases or on a modest scale in the cancer institute or the Deming-cycle has not been completed,
- **No** means that the indicator does not get attention or there are plans to start working on the indicator,
- **Not applicable** means that the indicator is not applicable in the cancer institute.

After filling out all the questions, the e-tool generates the results. The results will be used as input for the peer review as well as input for a quality improvement plan of the institute.

Composition of the audit team

Executor: OECI A&D Coordinator

The OECI Executive Manager and A&D Coordinator compose the audit team for the peer review visit of the institute.

An audit team consists of:

- Chair (is also an auditor),
- Three auditors,
- Coordinator,
- In the case of a Cancer Unit, the audit team includes possibly less than four auditors,
- In the case of a CCC one person of the audit team possibly starts half a day earlier to check the designation criteria in advance.

See criteria for auditors (3.2)

Invitations sent to the audit team

Executor: OECI A&D Coordinator

The auditors will receive an invitation to perform the peer review. The letter will include
- Date for the preparation meeting (under reservation of a 'go' decision),
- Dates peer review (defined in alignment with the cancer institute and chair),
- Introduction of the team members,
- Engagement form for management,
- Explanation about potential conflict of interest from the institute. The institute may express objections against the audit team members. The audit team continues if the institute has agreed with the team.

You can find attached to the letter:
- Confidentiality agreement (doc 14):
  Before the first peer review of an auditor the auditor shall sign a confidentiality agreement,
- Conflict of interest form (doc 15):
  Before every peer review each auditor shall sign a conflict of interest form.
- Engagement form for the management of the auditors (doc 13):
  By signing the engagement form the management board of the auditors provides permission to the auditor to perform the peer review.

Composition sent to the institute

Executor: OECI A&D Coordinator

The composition of the audit team will be sent to the institute to provide the opportunity to express any potential conflict of interest against one/more of the audit team members.

Auditors reply on invitation

Executor: OECI Auditor

Within the timeframe set in the invitation letter, the auditors confirm to the A&D Coordinator:
- Availability on the date of the preparation meeting,
- Availability on the dates of the peer review,
- Doc 14: Confidentiality agreement,
- Doc 15: Conflict of interest form,
- Signed engagement letter from the management of the auditor.

Receive confirmation from auditors

Executor: OECI A&D Coordinator

The OECI Accreditation Coordinator receives the confirmation from the auditors. This shall include:
- Doc 13: Signed engagement letter of management,
- Doc 14: Signed Confidentiality Agreement,
- Doc 15: Signed Conflict of Interest Form.

Check confidentiality agreement auditors

Executor: OECI A&D Coordinator

The OECI Accreditation Coordinator will check if all the auditors have replied and signed doc 13,14 and 15.

Composition of peer review agenda

Executor: OECI A&D Coordinator

- Specify the template peer review agenda for the cancer institute,
- Send concept agenda to the chair of the audit team for approval.

Finishing self-assesment
Executor: Cancer institute
Six months after the beginning of the self-assessment period, the institute has completed the questionnaires and closed the self-assessment in the e-tool: – Quantitative questionnaire, – Qualitative questionnaire, – Notes to support scores, – Requested proof documents and other proof documents attached to questions, – Described non-compliance points/improvement points.

Analyse self-assesment results
Executor: OECI A&D Committee
– To analyze and examine the self-assesment reports before peer review, – To analyze the proof documents for peer review, – To analyse the results of the self-assesment, – To advise the Accreditation Board concerning a 'go'/ 'no go' decision.

5.5 Step 5: Go/no go decision

The final 'go' or 'no go' decision will be taken by the OECI A&D Board. Before the Board takes the decision the A&D Committee will analyse the self-assesment results according to the criteria for self-assesment. The Committee proposes to the A&D Board a 'go' or 'no go' decision.

The 'go' decision is made at least two months in advance of the planned peer review visit.

Meaning of 'go'
A 'go' means that the OECI A&D Board has approved the institute for a 'go' after the OECI A&D Committee has given its independent examination for this approval concerning the criteria:

The institute has provided convenient input of evidence and information to make it possible for an audit team to do a reliable peer review visit on site. The input includes:
1. All items are scored,
2. The questionnaires should be useful for the auditors to prepare the audit, which means that the institute provides transparency in the available evidence (written documents) and explanations (notes):
   - Scores are justified with a note or a document with evidence, unless the score does not need explanation,
   - The relevant documents/procedures/guidelines/cooperation agreements etc, that are requested in the standards are attached,
   - The list of documents requested by the OECI are attached to the e-tool. If the documents are not available in English, an English summary of the documents should be provided,
   - For questions scored as 'partially' or 'no' are described in a non-compliance/ improvement point.

The e-tool manual for institutes explains how to put the evidence in the e-tool (Appendix and doc 10).

Task: Chair of the A&D Group
The Board of Directors of the institute will receive a notification letter of the 'go' decision (doc 36) signed by the chair of the A&D Group.

Task: A&D Coordinator
The contact person of the institute will receive information about the continuation of the programme:
– Concept empty peer review agenda including the audit team (doc 16),
– Explanation on how to fill and complete the agenda,
– Deadline of sending the completed agenda,
– Obligations of the cancer institute for a successful peer review visit:
  - Availability of the staff involved in the peer review visit at the time and location they are expected to be present at according to the agenda,
  - Facilitation of the maintenance of the audit team as agreed in the A&D Programme Agreement,
  - Providing permission to observe activities or procedures in the cancer institute during the peer review visit,
  - On request of the OECI audit team, the institute shall provide access to all relevant locations, files and documents needed for assessment during the on-site peer review,
  - The executed language during the peer review is English. The cancer institute staff involved in interviews need to understand and to speak in English. If not, the OECI requires the presence of an independent person who is able to translate.

Meaning of a 'no go'
Generally, a 'no go' decision means that the peer review visit will be postponed. A possibility for a 'no go' decision is an inconvenient input for the audit team to prepare and perform the peer review in a reliable way. It might be possible that additional information (notes) or evidence (documents) are needed.

5.6 Step 6: Payment stage 2 fee

If the self-assesment of the institute is approved for a 'Go' the institute will receive the invoice for stage two of the A&D fee. The amount of the fee depends on the designation type of the institute.

Tasks of Executive Manager:
– Sending invoices to the institutes, including the signed A&D Agreement
– Controlling the payments of the institutes,
– Providing the A&D Chair and the A&D Secretary a copy of invoices sent to the institutes.

Tasks of the A&D Secretary:
– Confirming payments of institutes to the institute and Executive Manager.

The total fee depends on the designation type of the institute:

	Stage 1	Stage 2	Total
Cancer Unit	€ 5.000	€ 15.000	€ 20.000
Clinical Cancer Centre	€ 5.000	€ 25.000	€ 30.000
Comprehensive Cancer Centre (CCC)	€ 5.000	€ 25.000	€ 30.000

The fee of stage two is not equal for different designation types. The fee covers primarily the costs for: OECI support to the audit team to prepare the peer review visit, organizing the preparation meeting for the audit team, organizing the peer review, OECI support to prepare the institute for the peer review visit, OECI support to the auditors to make the peer review report, organizing A&D Committee meetings and A&D Board meetings, printing and sending the report and the A&D Certificate, follow-up of accreditation one year after certification, and labour costs of the A&D Management unit.

Difference in fee
– The peer review visit in a Cancer Unit possibly takes one day instead of two full days in clinical cancer centres and CCC's,
– The peer review visit in a Cancer Unit does not include the full set of standards. Standards related to chapter 4 'Research, innovation and development' are not assessed,
– The audit team possibly includes less than four auditors.

Note:
If there is a discrepancy between the designation judgement of the institute and the preliminary designation that remains after the explanatory visit, the institute shall pay the fee equal to the designation type they applied for. For example: an institute that has classified itself as clinical cancer centre and is willing to continue the programme as such, they shall pay in total € 30.000 although the preliminary designation is a cancer unit.

Note:
If an institute decides to apply for A&D as clinical cancer centre or CCC the full set of standards will be assessed, including the standards related to chapter 4 'Research, innovation and development'.

5.7 Step 7: Peer review visit and designation check

Figure 5 shows the activities after the 'go' decision. The auditors need 2 months for the audit team to prepare the peer review before the peer review visit can take place in month 10.

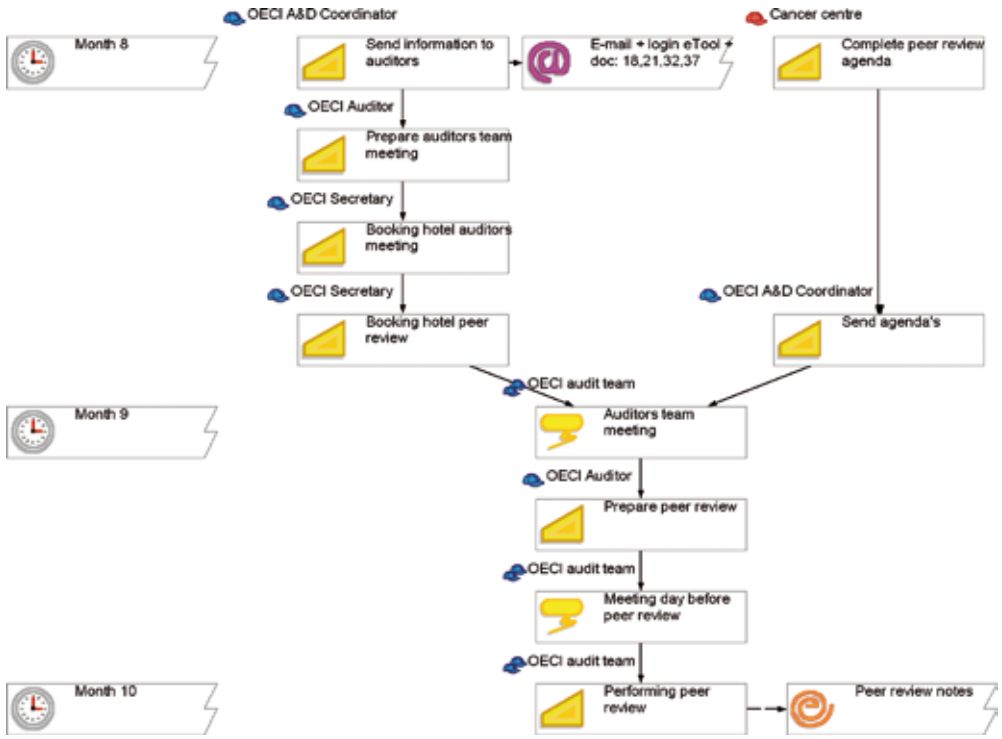


Figure 5: Step 7: Peer review visit and designation check

5.7.1 Step 7: activities and responsibilities of all parties involved (figure 5)

Step 7 starts with parallel activities for A&D Coordinator, the auditors and the institute.

Information sent to the auditors
Executor: OECI A&D Coordinator
The auditors receive an e-mail with a notification of the 'go' decision of the A&D Board including information of the continuation of the accreditation programme. The e-mail contains information about: – Preparation of the peer review, – Access to the information of the cancer institute in the e-tool, – Designation checklist (doc 34), – Login instructions in the user manual (doc 37), – Auditors' meeting and the agenda (doc 18), – Travel and booking instructions for the auditors' meeting and the peer review visit (doc 32 and doc 21).

Preparation of the auditors' team meeting

Executor: OECI Auditor

The individual preparation of the auditors' team meeting includes:
- Analysing the self-assesment reports of the cancer institute:
  - quantitative report including: scores, notes and improvement points,
  - quantitative report,
- Analysing the documents the cancer institute has attached to the e-tool,
- Formulation of main topics for the peer review visit,
- Designation checklist (doc 34).

Booking the hotel for the auditors' meeting

Executor: OECI Secretary

The OECI secretary will book the hotel for the auditors for the auditors' meeting and for the peer review visit.

Complete peer review agenda

Executor: Cancer institute

While the audit team is getting ready for the auditors' meeting, the institute will prepare and complete the peer review visit agenda. The concept agenda will be approved by the auditors' chair during the self-assessment period.

The concept agenda has to be completed by the cancer institute. The auditors will have interviews with employees of the cancer institute. The institute has to plan the persons from the requested departments and the location/room where the interviews will take place.

Completion deadline: 1 week before the auditors' preparation meeting.

Sending the agenda

Executor: OECI A&D Coordinator

The agenda of the preparation meeting will be sent one week before the meeting and will include the concept peer review agenda.

Auditors' team meeting
Executor: OECI audit team
One month before the peer review, the auditors will meet to prepare the peer review. Input: – Result designation screening, – Concept peer review agenda (completed by the cancer institute with interviewees and locations), – Self-assesment reports (qualitative and quantitative), – Attached documents of the cancer institute, – Designation checklist. Content of the meeting: – A general presentation of the accreditation programme, – An explanation of the roles and responsibilities of the auditors, – Report writing procedures, – Planning of interviews, – Content of interviews, – Follow-up of the accreditation programme for the cancer institute. Every auditor will take notes during the peer review visit.

Preparation of the peer review
Executor: OECI Auditor
Individual preparation of the peer review following the appointments made during the auditors' team meeting.

Meeting day before the peer review
Executor: OECI audit team
The evening before the peer review the auditors meet in the hotel for: – Final preparation, – Extra focus on the designation type especially when the institute prefers the CCC level – Group dinner.

Performing the peer review

Executor: OECI audit team

Performing the peer review according to the peer review agenda (doc 16).
During the peer review and in the evenings, the auditors will work on scoring the standards (Yes, Mostly, Partially, No)for the report and drawing the preliminary conclusions, strengths and opportunities.

Designation checklist during the peer review visit:

- Ask the list on scientific publications including an overview of the authors' papers in the hospital (First, second and last author should be clarified)
- Overview is enough, when doubt on the correction of the numbers check impact factor and especially in the impact factor >10
- Ask on site at different wards at least two times the number of beds
  - Cross check, yes or no
- Ask on site at the day care the number of beds/chairs (total)
  - Cross check, yes or no
- Ask in two different interviews the number of physicians from different specialties
- Ask on site the number of active clinical trials
  - Cross check, yes or no
- Check the facilities the availability of the radiotherapy, medical oncology and surgical oncology
  - Check availability, 3 times yes or no

In case the preliminary designation is between a Clinical Cancer Centre and a Comprehensive Cancer Centre, the audit team will have to additionally focus, during the peer review visit, on the following criteria:

- A highly innovative character and multidisciplinary approach using the potential of basic, translational and clinical research and clinical facilities and activities, organised in a sufficiently identifiable entity [Short description]
- A direct provision of an extensive variety of cancer care tailored to the individual patient's needs and directed towards learning and improving the professional, organisational and relational quality of care [Short description]
- Broad activities in the area of prevention, education, and external dissemination of knowledge and innovation. In order to accentuate the differences with other cancer institutes [Short description]
- The level of infrastructure, expertise and innovation in the field of oncology research [Short description]
- Maintenance of an extensive network including all aspects of oncology treatment and research [Short description]

Writing notes during the auditors' peer review

The notes of the interviews, tours and presentation will be processed into the e-tool by the auditors during and after the peer review.
The auditors have **one week** after the peer review visit to process the notes and to provide the descriptions to support the designation type.
The auditors have a personal username and password to enter the e-tool and to go to the peer review report of the institute. Auditors can process their notes in the e-tool at the same time.
The answers need to provide evidence/proof for the scores given to the standard.

The report needs to be:

- Recognisable,
- Concrete,
- Compact,
- Separate minor and major points,
- Strength and weaknesses from appendices in text,
- Objective statements,
- Examples,
- Reasonable arguments for subjective statements,
- Unanimously agreed by the auditors team.

5.8 Step 8: Reporting

After the peer review visit, it will take about 4 months to finish the final peer review report (figure 5).

The reporting period will be split in two phases. In week 1 to 6 the auditors will be working on the draft report. This is outlined and explained in the sub-process: 'Reporting by audit team' (figure 6).

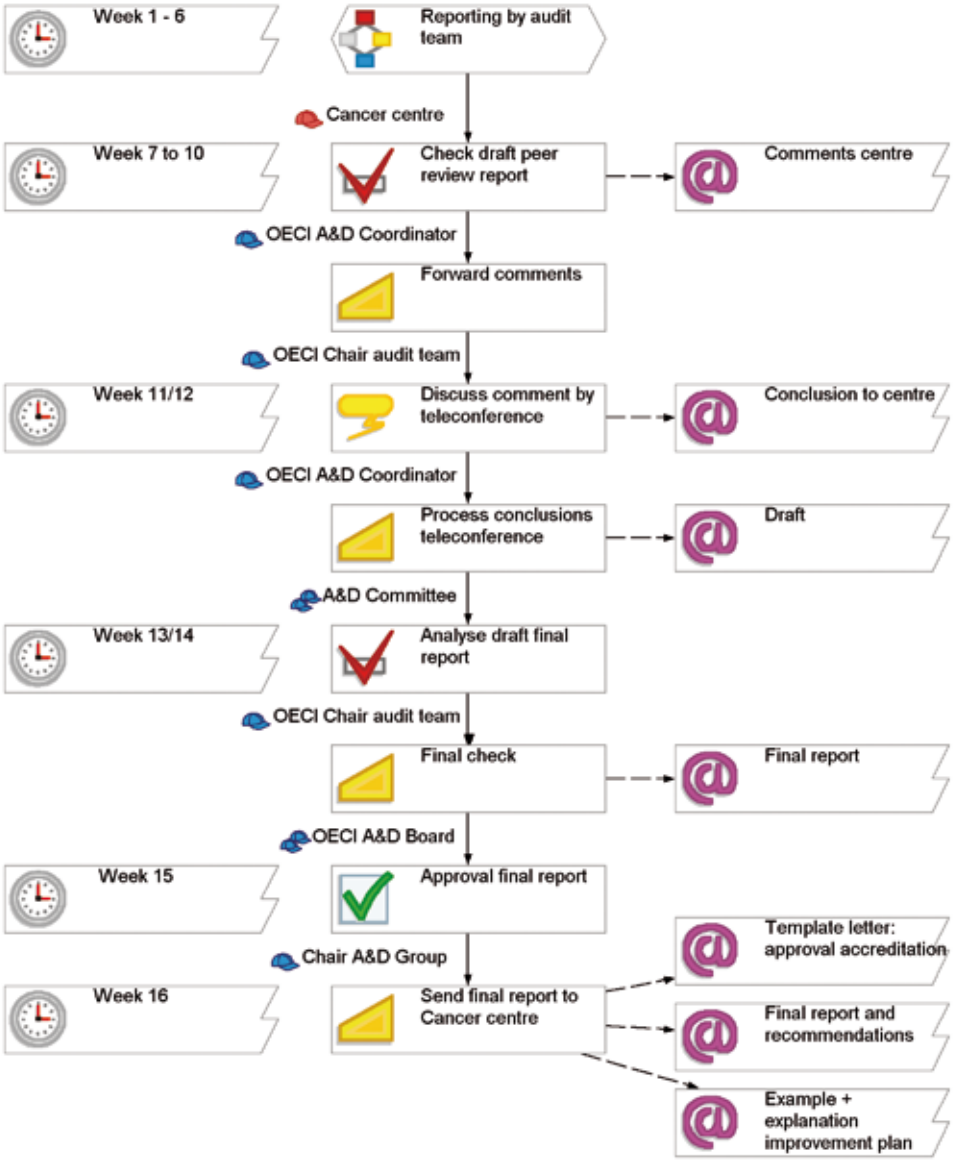


Figure 6: Step 8 Reporting

5.8.1 Week 1-6: Reporting by the auditors (figure 7)

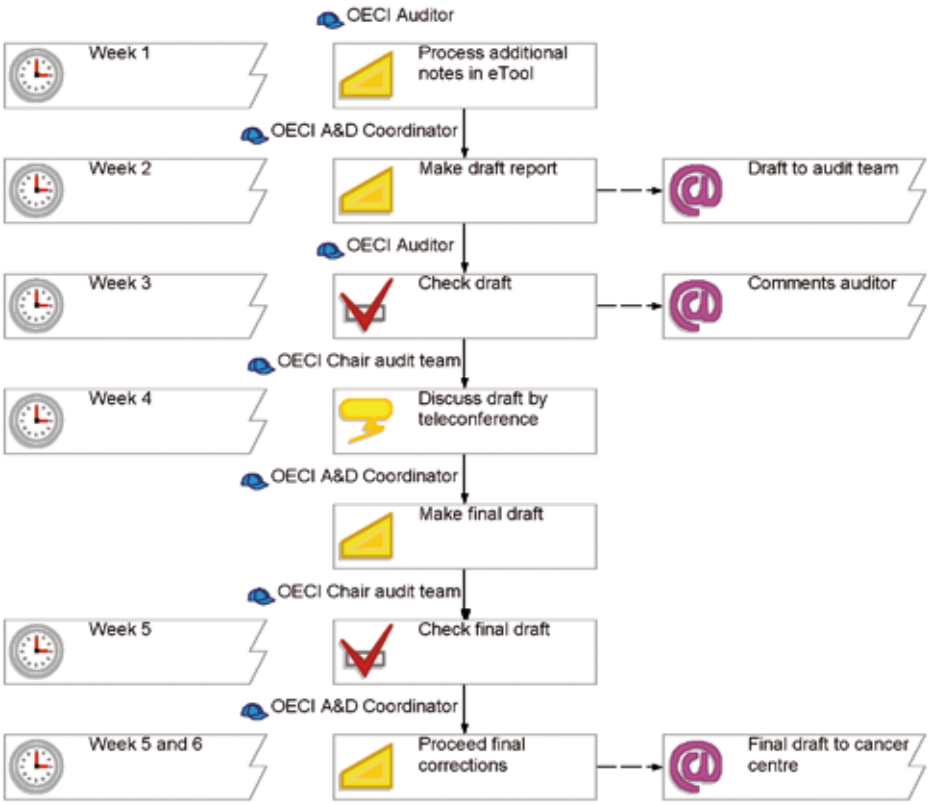


Figure 7: Week 1-6: Reporting by the auditors

Process additional notes in the e-tool
Executor: OECI Auditor
– The auditors have one week after the peer review to deliver additional scores and notes of the peer review interviews, tours and presentation in the e-tool, – Auditors deliver the scores and notes in the e-tool, arranged under the appropriate standard, – Auditors have one week after the peer review to deliver the short descriptions for each designation item and the final designation conclusion, – The OECI Coordinator processes the notes of the peer review in the first draft of the report, – The auditors are also asked to draw a list of strengths and opportunities per chapter of the standard. This list will be discussed together with the feedback and comments of the cancer institute in week 11/12.

Make draft report
Executor: OECI A&D Coordinator
– In week 2 after the peer review the A&D Coordinator will formulate the first draft report. The A&D Coordinator: • Analyses the individual scores of the auditors and make a list of the deviations, • Analyses the notes of the auditors per standard, • Proposes the final text that supports the score of each standard, • Makes a list of the standards that shall be discussed with the audit team. – The A&D Coordinator discusses the first draft with the Executive Manager. – The A&D Coordinator sends the draft to the audit team.

Check draft

Executor: OECI Auditor

The first draft of the report will be send to the audit team to analyse:
- The scores of the auditors,
- The proposed text per standard to support the audit team scores,
- The list of standards with different findings among the auditors in the scores and notes (deviations),
- The proposed designation type with the short descriptions for each item,
- The proposed designation conclusion.

The auditors are requested to give feedback and comments on the draft report.

Discuss draft by teleconference

Executor: OECI Chair audit team

The A&D Coordinator will discuss the draft report and feedback of the auditors with the chair of the audit team by teleconference. The input of the teleconference is a list of deviations sent by the A&D Coordinator.

Make final draft

Executor: OECI A&D Coordinator

The A&D Coordinator:
- Processes the conclusions of the teleconference with the chair of the audit team,
- Discusses the final draft with the Executive Manager,
- Sends the final draft to the cancer institute with a feedback and comments form.

Check final draft

Executor: OECI Chair audit team

The second draft of the report will be sent to the chair to check:
- Final scores as discussed in the teleconference with the audit team,
- Final text per standard that supports the audit team scores,
- Final designation type with the short description for each item,
- Final designation conclusion,
- Editorial changes.

Proceed final corrections

Executor: OECI A&D Coordinator

The A&D Coordinator will proceed the final corrections of the chair and send the final draft report latest in week 6 after the peer review to the Director and accreditation contact person of the cancer institute.

The draft is sent together with:
- Doc 41: Letter presenting the draft report,
- Doc 22: Feedback and comment form.

The final draft will contain:
- The standards reviewed during the peer review visit with the scores of the cancer institute from the self-assessment, the scores of the auditors and the findings of the auditors supporting the scores,
- Description of the designation check findings.

The strengths and opportunities will be presented in the final report.

5.8.2 Step 8: activities and responsibilities of all parties (figure 6)

Check draft peer review report
Executor: Cancer institute
– The Director and the accreditation contact person of the institute will receive the draft peer review report, – The institute will have 4 weeks to distribute the draft report within the cancer institute to whomever is concerned and to collect comments and feedbacks, – After four weeks, the contact person that will have collected the comments within the institute, will have to send the form to the OECI Coordinator. *Note: All feedbacks and comments will be discussed by the audit team but the report will only be revised with reliable arguments and/or new evidence*

Forward comments
Executor: OECI A&D Coordinator
– The comments and feedbacks of the institute on the draft report will be forwarded to the audit team members, – They are requested to give their comments via e-mail, – The institutes comments and response of the audit team members will be discussed with the chair of the audit team.

Discuss comments by teleconference
Executor: OECI Chair audit team
Discuss the feedbacks and comments of the cancer institute: – The comments and response of the auditors will be discussed in a teleconference with the chair of the audit team and the OECI A&D Coordinator, – Conclusions concerning the comments will be inserted in doc 22: Feedback and Comments form. Formulate proposal for conclusions, strengths and opportunities of the cancer institute for the final report.

Process conclusions teleconference
Executor: OECI A&D Coordinator
The A&D Coordinator will process the conclusions of the teleconference, which will include: – Corrections to make, with regard to the comments and feedbacks of the cancer institute, – The formulated general remarks, strengths and opportunities, conclusions. The A&D Coordinator will send the third draft to the chair of the audit team for a final check.

Analyse draft final report
Executor: OECI A&D Committee
The A&D Committee will receive the draft final report with a proposal for the conclusions, strengths and opportunities from the audit team. The A&D Committee will analyse the conclusions, strengths and opportunities that are drafted by the audit team, and give final advice to the Accreditation Board about the complete final report. If the A&D Committee makes major changes in the report, the coordinator of the A&D Committee (the Executive Manager) will send the report for a final check to the chair of the audit team. If there are only minor changes the report will be sent directly to the A&D Board for the final approval.

Final check
Executor: OECI Chair audit team
– If the A&D Committee changes major parts in the report, the report will be sent back to the chair of the audit team, – The chair will have the opportunity to check the report, – If the chair of the audit team agrees with the major changes of the A&D Committee the draft final report will be sent to the A&D Board for approval.

Approval final report
Executor: OECI A&D Board
In week 14 after the peer review the OECI A&D Board will have a teleconference to approve the final report including the strengths, opportunities and conclusions.

Send final report to Cancer institute
Executor: Chair A&D Group
Within 14 to 16 weeks after the peer review the cancer institute will receive: – A letter to present the final report, – The final report including the final designation, – An explanation of the minimum criteria of an improvement action plan.

5.9 Step 9: Formulate improvement plan

The next step for the cancer institute will be the formulation of the improvement plan. The opportunities stated in the final peer review report are an input to write the improvement plan (doc 23: template improvement plan). The plan has to show the willingness to improve the opportunities described in the peer review report as well as a systematic improvement approach.

The plan contains:

Standard	Opportunity	Action	Goal (SMART) desired result	Actions description	Who is involved and responsible for result (Names and department)	Start (date)	Evaluation (date)	Dead line (date)	Priority (high/ medium/ low)
1.1.1									
etc									

A cancer institute may choose a lay-out for an improvement/action plan, such as:
– Lay-out as used in the institute,
– E-tool function for describing improvement points/non-compliances,
– OECI A&D template (doc 23).

The institute will have **three months** to produce the improvement plan.

Based upon the improvement plan the Accreditation and Designation Certificate can be awarded by the OECI A&D Board.

5.10 Step 10: OECI A&D Certificate

Within **1 month** (month 17) after the OECI received the improvement plan from the institute, the OECI A&D Board will take the final A&D decision.

The improvement plan will have to follow some general obligations:
- To show the willingness to improve the main opportunities from the peer review report,
- To show a systematic approach with: opportunities/ goals, actions, persons responsible, start date, evaluation date, end date and priority,
- It is out of the scope of the OECI A&D programme to give advice on how an institute approaches the actions.

The institute will receive the Accreditation and Designation Certificate if the improvement plan of the institute is approved by the OECI A&D Board. The Certificate will also include the final designation. It will receive a letter stating that the institute will be awarded with the certificate. The institute may choose the way of receiving the Certificate, either during the OECI General Assembly or by post mail.

The A&D Certificate will be valid for four years from the date of issue. To maintain the A&D Certificate after these four years the institute will have to start a new round A&D Programme at least six months before the expiring date of the certificate.


OECI
Organisation of European Cancer Institutes
European Economic Interest Grouping
Registered number OECI-EEIG B-001

CERTIFICATE OF ACCREDITATION AND DESIGNATION

OECI

hereby certifies that the

YOUR (cancer) INSTITUTE
Town - Country

meets the quality standards for cancer care and research, and it is therefore designated as:

COMPREHENSIVE CANCER CENTRE

Issued on: 2010-08-15
Validity date: 2012-08-15

Marco Pierotti
OECI President

Mahasti Saghatchian
Chair OECI Accreditation Designation Programme

Figure 8: OECI Accreditation and Designation certificate (Action: add newest version)

5.10.1 Evaluation of the A&D Programme

Evaluation A&D Programme (figure 9 next page)
Executor: OECI A&D Coordinator and Cancer Centre
The A&D Coordinator will send an evaluation form to the institute 3 months after the final A&D Certification approval.

Evaluation by teleconference
Approximately five months after the final A&D Certification approval, the OECI A&D Coordinator and the Executive Manager will plan a teleconference to discuss the evaluation form. Representatives: – Cancer institute contact person, – Chair audit team, – OECI Executive Manager, – OECI A&D Coordinator.

5.11 Follow-up

There is a period of four years from the date of issue of the certification and the expiring date. Within this period the institute will work to achieve the goals of the improvement plan.

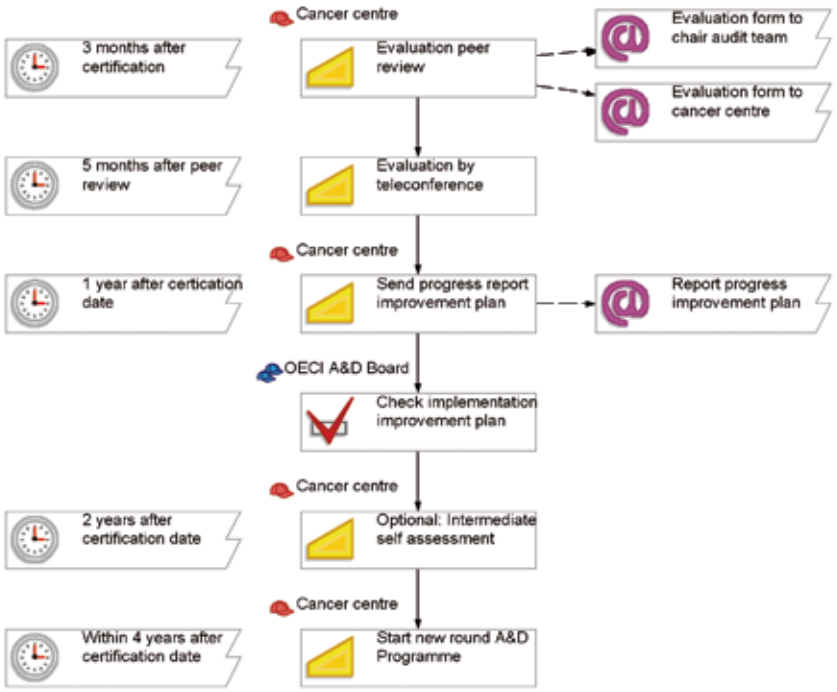


Figure 9: Follow-up of the A&D Programme

Send progress report improvement plan

Executor: Cancer institute

One year after the peer review visit, the institute will report the progress of the goals and activities set in the improvement plan to the to the OECI A&D Board.

The institute can add a column to the improvement plan:

Standard	Opportunity	Action	Goal (SMART) - desired result	Actions description	Who is involved and responsible for result (Names and department)	Start (date)	Evaluation (date)	Dead line (date)	Priority (high/ medium/ low)	**Progress after one year**
1.1.1										

Check implementation improvement plan

The A&D Board will receive a report of the cancer institute with the progress of the implementation of the goals and activities set in the improvement plan.

Intermediate self-assessment (optional)
Executor: Cancer institute
The A&D Programme fee includes four years access to the self-assessment e-tool. The institute has the option to perform an intermediate self-assessment to measure the improvements according to the OECI Quality Standards two years after the peer review visit. *Note:* *This intermediate self-assessment will not be analysed by the OECI. It will be a voluntary exercise of the institute to check the improvements.*

Start new round A&D Programme
Executor: Cancer institute
Four years from the date of issue of the previous OECI A&D Certificate, the A&D Certificate will expire. If the cancer institute wants to keep the accreditation and designation it will be necessary to apply for a new round of the A&D Programme, six months before the certificate expires.

6 Where to find the documents needed in the programme?

The appendix of this manual contains the documents that are useful to start the Accreditation and Designation programme. However, most documents are available when an institute or an auditor logs in the e-tool.

The following table shows the needed and useful documents, and how to access them.

Documents available for the auditors, institutes and the public

Nr.	Name	Auditor	Applicant institutes	Public
Doc 1	Application form and designation screening (electronically)		Website	Website
Doc 5	Template project plan for cancer institute	Appendix IV + E-tool	Appendix IV + E-tool	
Doc 6	Accreditation and Designation Agreement		Send by OECI	
Doc 7	Template agenda explanatory visit		Send by OECI	
Doc 8	Template payment order stage 1		Send by OECI	
Doc 9	List required documents	E-tool	E-tool	Website
Doc 10	E-tool user manual (institute)	Appendix V	Appendix V + E-tool	
Doc 14	Confidentiality agreement	E-tool	E-tool	
Doc 15	Conflict of interest form	E-tool	E-tool	
Doc 16	Template peer review agenda		E-tool	
Doc 19	Template final peer review report	E-tool	E-tool	
Doc 21	Reimbursement form	E-tool	E-tool	
Doc 22	Template Feedback and comments form institute		E-tool	
Doc 23	Template improvement plan		E-tool	
Doc 26	Evaluation form cancer institute		E-tool	
Doc 27	Evaluation form audit team	E-tool		
Doc 31	Application form auditors/ chairs	Website	E-tool	Website
Doc 32	Travel policy rules	E-tool	E-tool	
Doc 37	Auditors e-tool user manual	E-tool		
Doc 42	Glossary	E-tool	E-tool	

Documents for internal use of the OECI A&D Group

Doc 2	Template letter approval application
Doc 3	Template letter disapproval application (not existing yet)
Doc 11	Template letter invitation auditors
Doc 13	Engagement employer auditor
Doc 18	Template auditors meeting agenda
Doc 20	Planning institutes
Doc 24	Template letter approval accreditation
Doc 25	Accreditation Certificate (valid for four years)
Doc 28	Template letter of thanks (to institute) (not existing yet)
Doc 29	List ID-nr institutes
Doc 30	Accountability fact sheet for A&D fee
Doc 33	Complaints form cancer institute (not yet existing)
Doc 35	PPT Explanatory visit
Doc 36	Template letter notification GO
Doc 38	PPT auditors meeting
Doc 39	PPT peer review introduction and preliminary results
Doc 40	Letter presenting draft report
Doc 41	Planning auditors
Doc 43	Financial procedure (included in this user manual)

7 Overview of obligations and tasks of a cancer institute

General obligations:
- Membership of the OECI,
- Strong commitment to quality improvement (signature of Director/ Board of Directors),
- Dedicated staff (contact person, project group, all involved employees),
- Stable management structure (no interim management),
- No major changes/problems (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.
- Cancer care is performed on an identifiable unit with an identifiable budget, management and organisational structure,
- The institute has a preliminary designation as: cancer unit, cancer research centre, clinical cancer centre or Comprehensive Cancer Centre,
- There is an agreement on the designation type between the OECI A&D board and the cancer institute.

Before the explanatory visit
- Signing the A&D agreement,
- Paying accreditation fee stage one (€ 5000 for all types of institute).

Before the beginning of the self-assessment period:
- Organising an internal accreditation project planning and project team.

Before peer review:
- Completed self-assesment questionnaires; results of self-assesment,
- Delivering of requested documents,
- Go-decision of OECI A&D Board,
- Paying A&D fee stage two, The remaining A&D fee for Cancer Units is € 15.000 (total amount € 20.000) and the remaining fee for Clinical Cancer Centres or Comprehensive Cancer Centres is € 25.000 (total amount € 30.000)
- Completing the peer review agenda.

During peer review:
- Facilitating the maintenance of the audit team as agreed in the audit programme,
- Providing permission to observe activities or procedures in the cancer institute during on-site peer review,
- On request of the OECI auditors team, the institute shall provide access to all relevant locations, files and documents needed for assessment during the on-site peer review,
- The participants in the peer review from the institute understand and speak English,
- During tour on departments and wards an independent translator needs to be available to translate the questions of auditors and answers of staff.

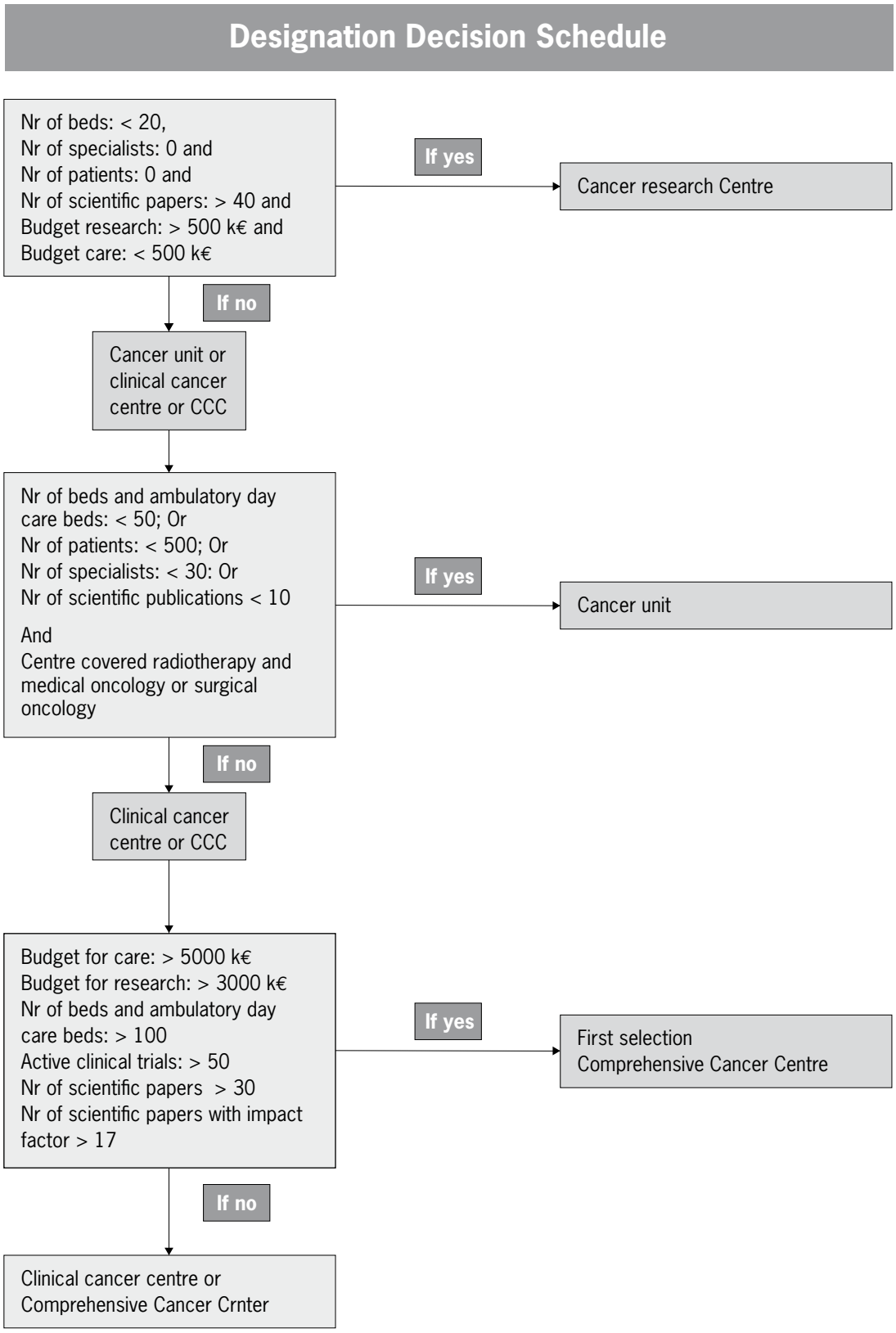
After peer review:
- Providing feedback on the peer review report,
- Delivering an improvement plan,
- Delivering a report with the progress and results of the goals set in the improvement plan,
- Optional: Intermediate self-assesment after two years.

8 Register

Figures

Appendix I. Designation Decision Schedule

(Not for public release).



Appendix II. OECI Quality standards

(This appendix contains a paper version of the OECI quality standards (not for public release).

In clinical cancer centres and Comprehensive Cancer Centres the full set of standards will be assessed during the self-assessment and by the audit team during the peer review visit.

Cancer Unit are excluded for the standards in chapter 4: Research innovation and developments.

The sollowint table shows the chapters and domains with the number of standards and questions. The marked standards are not assessed in Cancer Units.

Chapters	Domains	Nr of standards	Sub standards/ questions Total 264
Chapter 1	General standards, strategic plan and general management	26	121
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All standards and questions are presented on the following pages. Additionally to giving a score to each question, the e-tool gives the opportunity to add notes, proof documents and improvement points.

Qualitative Questionnaire

1. General Standards, Strategic Plan and General Management

1.1. Policy and organisation

1.1.1. Oncological policy plan and general report

1.1.1.1.

		Yes	Mostly	Partially	No	not applicable
1.1.1.1.1.	The board and/or the management of the cancer centre has an official recent plan (not older than five years)					
1.1.1.1.2.	The vision on care in the field of oncology care is explained in the plan					
1.1.1.1.3.	The policy and the goals to be achieved are defined in the plan					
1.1.1.1.4.	The annual plan or multi-year plan contains actions to achieve the goals					
1.1.1.1.5.	The cancer centre has concrete annual or multi-year plans on the level of the main services or clusters					
1.1.1.1.6.	The plan is evaluated in later annual reports					
1.1.1.1.7.	Improvement activities of the cancer centre (logistics, research, education, multidisciplinary teams) are part of the annual report					

1.1.2. Cooperation with universities

1.1.2.1.

The cancer centre has formal cooperation or agreement with at least one university for:

		Yes	Mostly	Partially	No	not applicable
1.1.2.1.1.	care activities					
1.1.2.1.2.	educational activities					
1.1.2.1.3.	research activities					

1.1.3. Cooperation with external partners

Have agreements been reached, about the allocation of tasks, such as a hospital or radio therapeutic institute in the case of referrals?

1.1.3.1.

		Yes	Mostly	Partially	No	not applicable
1.1.3.1.1.	Cooperation arrangements with other cancer centres are clearly documented in (written) agreements covering the goals of the cooperation, tasks, responsibilities and competences of the cancer centre and the cooperating partners					
1.1.3.1.2.	There are (written) agreements with home care organisations					
1.1.3.1.3.	There are (written) defined and documented cooperation arrangements with general practitioners.					
1.1.3.1.4.	There are (written) agreements with nursing home, rest house, palliative care institutions, etc.					
1.1.3.1.5.	There are (written) agreements with special cancer care service providers such as radiotherapy centre, pathology laboratory, specialised surgery unit etc.					

1.1.4. Cancer data registration (institutional level)

Are the data on the patients' types of cancers recorded in an institutional cancer database?

1.1.4.1.

		Yes	Mostly	Partially	No	not applicable
1.1.4.1.1.	The number of new oncology patients is known at an institutional level					
1.1.4.1.2.	The number of new cases for each type of cancer is known at an institutional level					
1.1.4.1.3.	There are diagnostic, treatment and outcome data on patients with cancer available annually at an institutional level					
1.1.4.1.4.	The data are reported and analysed by a multidisciplinary group with recommendations for improvement of care					

1.1.5. Complications registry

Have agreements been reached concerning keeping and discussing a complications registry?

1.1.5.1.

		Yes	Mostly	Partially	No	not applicable
1.1.5.1.1.	There are specific protocols for reporting and recording of complications					
1.1.5.1.2.	The data are analysed at an institutional level					
1.1.5.1.3.	After analysis, improvement measures are developed and action plans implemented in agreement with the departments concerned					

1.3. Resources and materials

1.3.1. Cytostatic drugs, prescription, preparation and distribution

Have agreements been reached concerning the prescription, preparation and distribution of cytostatic drugs?

1.3.1.1.

		Yes	Mostly	Partially	No	not applicable
1.3.1.1.1.	A written procedure concerning prescription of anti-cancer drugs is available					
1.3.1.1.2.	A written procedure concerning preparation of anti-cancer drugs is available					
1.3.1.1.3.	A written procedure concerning distribution of anti-cancer drugs is available					
1.3.1.1.4.	The anti-cancer drugs are prepared in a centralised unit					
1.3.1.1.5.	The anti-cancer drugs are prepared under the direct supervision of a pharmacist					

1.3.2. Administration of cytostatic drugs

Are there protocols for the administration of cytostatic drugs?

1.3.2.1.

		Yes	Mostly	Partially	No	not applicable
1.3.2.1.1.	The cancer centre has described procedures or guidelines on the administration of anti-cancer drugs					
1.3.2.1.2.	The anti-cancer drugs are as much as possible administrated in specialised wards (e.g., administration of anti-cancer drugs takes place only in some well-defined wards (medical oncology ward…)					
1.3.2.1.3.	There is a dedicated day-care unit for the administration of anti-cancer drugs					

1.4. Process control

1.4.1. Continuity of care within the cancer centre

Have agreements been reached concerning the continuity of care, and replacement of nursing, medical, paramedical, and support staff associated with oncology? Is the care covered 7 days a week by specialised staff?

1.4.1.1.

		Yes	Mostly	Partially	No	not applicable
1.4.1.1.1.	Continuity of specialised care is warranted 24 hours a day on the medical, paramedical, nursing and supportive levels. This can, among other things, be achieved by planning continuity of care during nights, week-ends, holidays, illness, attendance at conferences or other reasons for absence, within each discipline					
1.4.1.1.2.	Patients are informed about all the aspects of the continuity of care and eventually referred to another hospital					
1.4.1.1.3.	The patient receives information about the contact person for medical and nursing oncological matters					

1.4.2. Waiting and throughput times

Have norms, standards been defined concerning the maximum waiting and throughput times for oncological patients with regard to first outpatients' visit, admission, and tests/treatment?

1.4.2.1.

There are guidelines (for different types of tumours) for the (maximum) waiting times between:

		Yes	Mostly	Partially	No	not applicable
1.4.2.1.1.	referral by the general practitioner or referring specialist and the first visit to the outpatient's clinic or the admission into the cancer centre					
1.4.2.1.2.	first visit and the time of definitive diagnosis					
1.4.2.1.3.	definitive diagnosis and first treatment					
1.4.2.1.4.	There is a record of those waiting times					
1.4.2.1.5.	There is continuous measurement and analysis of those waiting times leading to improvements when needed					
1.4.2.1.6.	There is a clear definition of the roles of each category of staff on those issues					

1.4.3. Compliance with guidelines

Have agreements been reached concerning the use of guidelines relating to diagnosis, treatment, follow up and research?

1.4.3.1.

		Yes	Mostly	Partially	No	not applicable
1.4.3.1.1.	The medical specialists and the employees of the cancer centre apply the (local/regional/national/ international) guidelines on diagnostics, treatment, follow up and research					
1.4.3.1.2.	The guidelines are easily accessible					
1.4.3.1.3.	The guidelines are updated on a regular basis depending on medical developments					
1.4.3.1.4.	Each decision that differs from the guidelines is recorded in the file of the patient					

1.4.4. Compliance with guidelines

Do you report the compliance with multidisciplinary guidelines?

1.4.4.1.

		Yes	Mostly	Partially	No	not applicable
1.4.4.1.1.	Compliance with guidelines is measured through the registration of the patients' cancer data					
1.4.4.1.2.	Deviations from guidelines are analysed					
1.4.4.1.3.	Deviations from guidelines are discussed					
1.4.4.1.4.	Deviations from guidelines are reported annually					

1.4.5. Tasks and responsibilities of the (oncology) nurses

Have agreements been reached concerning the tasks and responsibilities of nurses working at the oncology department?

1.4.5.1.

		Yes	Mostly	Partially	No	not applicable
1.4.5.1.1.	For each technical, clinical or outpatient's department where patients with cancer are treated, there are nurses trained in oncology					
1.4.5.1.2.	Anti-cancer drugs are administered by specially educated (oncology) nurses					
1.4.5.1.3.	The cancer centre has nurses with expertise with regard to the tumours treated (e.g.: breast, colo-rectal, head and neck, gynaecological cancer)					
1.4.5.1.4.	There are procedures describing the tasks and responsibilities of (oncology) nurses					
1.4.5.1.5.	Roles and responsibilities of nurses with different expertises (oncology, palliative care,…) are described regarding special involvement in oncology care					
1.4.5.1.6.	The nursing discipline has one staff member as contact person for oncology care					

1.4.6. Roles and tasks of the members of the supportive care staff

Have agreements been reached concerning the roles and tasks of the supportive care staff?

1.4.6.1.

		Yes	Mostly	Partially	No	not applicable
1.4.6.1.1.	Roles and responsibilities for each of the paramedical disciplines are described regarding the involvement in oncology care					
1.4.6.1.2.	Roles and responsibilities for each of the supportive disciplines are described regarding the involvement in oncology care					
1.4.6.1.3.	Each of the paramedical discipline has one staff-member as contact person (referent) for oncology care					
1.4.6.1.4.	Each of the supportive disciplines has one staff-member as contact person (referent) for oncology care					

1.4.7. Communication between the members of the supportive care staff

What is the focus of the communication between nursing, paramedic and supportive disciplines?

1.4.7.1.

Communication amongst members of the supportive care staff (nursing, paramedical and supportive disciplines) occurs through:

		Yes	Mostly	Partially	No	not applicable
1.4.7.1.1.	Consultation					
1.4.7.1.2.	Data transmission					
1.4.7.1.3.	Transfer of knowledge					
1.4.7.1.4.	Information and implementation of guidelines					

Have agreements been reached within the cancer centre concerning who is authorised to refer patients to paramedical and/ or support disciplines, and under what circumstances?

1.4.8.1.

		Yes	Mostly	Partially	No	not applicable
1.4.8.1.1.	It is made clear for which problems related to cancer and at which moment paramedical disciplines should be consulted					
1.4.8.1.2.	It is made clear for which problems related to cancer and at which moment supportive disciplines should be consulted					
1.4.8.1.3.	There are written procedures on the circumstances for calling on and referral to paramedical disciplines					
1.4.8.1.4.	There are written procedures on the circumstances for calling on and referral to supportive disciplines					

1.4.9. Multidisciplinary harmonisation / integrated care

Have agreements been reached on the harmonisation of integrated care, between the various disciplines involved in the diagnosis, treatment and counselling of oncology patients?

1.4.9.1.

		Yes	Mostly	Partially	No	not applicable
1.4.9.1.1.	The responsibilities of the different disciplines involved in the diagnosis of the patient in the cancer centre are described					
1.4.9.1.2.	The responsibilities of the different disciplines involved in the treatment of the patient in the cancer centre are described					
1.4.9.1.3.	The responsibilities of the different disciplines involved in the follow-up of the patient in the cancer centre are described					
1.4.9.1.4.	The multidisciplinary team advises on the inclusion of patients in clinical trials					
1.4.9.1.5.	The name of the physician responsible for the coordination of the care of the patient is defined and communicated to the patient					

1.4.10. Selection criteria for the oncology team meeting

Are the selection criteria concerning which patient should be discussed in the multidisciplinary setting clear and documented?

1.4.10.1.

		Yes	Mostly	Partially	No	not applicable
1.4.10.1.1.	Criteria are defined for the selection of patients to be discussed in the multidisciplinary team meetings					
1.4.10.1.2.	These selection criteria are clear, documented and based on a consensus between the different disciplines					

1.4.11. Procedure for the oncological multidisciplinary team meetings

Is there a procedure for the oncological multidisciplinary team meetings?

1.4.11.1.

There are procedures describing how the regular multidisciplinary team meetings apply following criteria:

		Yes	*Mostly*	*Partially*	*No*	*not applicable*
1.4.11.1.1.	One of the specialist in charge of the care of the patient is present during the discussion of the patient					
1.4.11.1.2.	During the presentation of patients, diagnostic results and examination results are available					
1.4.11.1.3.	The necessary facilities to show diagnostic and examination results are available					
1.4.11.1.4.	Conclusions and advice resulting from the multidisciplinary team meeting are documented in the patient's medical record					
1.4.11.1.5.	There is a clear description of the way to inform all the members of the multidisciplinary team about which patients will be discussed					
1.4.11.1.6.	There is a clear description of the communication of the advice resulting from the discussion to all the physicians and other disciplines involved in the care of the given patients					
1.4.11.1.7.	There is a clear description of the communication of the advice resulting from the discussion to the concerned patients					
1.4.11.1.8.	Each final decision about care of the patient that differs from the advice and conclusions of the multidisciplinary team is documented and recorded in the patient's medical record					
1.4.11.1.9.	There is a procedure describing how the conclusions and advice from the multidisciplinary meeting will be evaluated and by whom					

1.4.12. Registration and evaluation of the recommendations of the multidisciplinary team meeting

Have agreements been reached concerning the registration and evaluation of recommendations that emerge from the multidisciplinary team meeting?

1.4.12.1.

		Yes	Mostly	Partially	No	not applicable
1.4.12.1.1.	Conclusions and advice resulting from the multidisciplinary team meeting are documented in the patient's medical record					
1.4.12.1.2.	Deviations from conclusions and advice are documented and motivated in the patient's medical record					
1.4.12.1.3.	There is a procedure described on how the conclusions and advice from the multidisciplinary meeting will be evaluated and by whom.					

1.5. Safeguarding the quality system

1.5.1. Quality and risk management and safety requirements

Does the cancer centre have a global policy for quality and risk management and safety requirements?

1.5.1.1.

		Yes	Mostly	Partially	No	not applicable
1.5.1.1.1.	There is an identified Quality and Risk Management Direction					
1.5.1.1.2.	The quality Director participates in the executive direction of the cancer centre					
1.5.1.1.3.	There is a written global programme describing the policy for: Quality management, including continuous quality improvement (CQI) certification processes and individual accreditation of physicians					
1.5.1.1.4.	There is a written global programme describing the policy for: Risk management, including a programme for the centralised reporting of undesirable events by health care workers					
1.5.1.1.5.	There is a written global programme describing the policy for: Safety management of the cancer centre and its users					
1.5.1.1.6.	There is a written global programme describing the policy for: Patient safety management, including a systematic centralised reporting of side effects of drugs (current practice)					
1.5.1.1.7.	There is a programme for the systemic analysis of major adverse or undesirable events (e.g.: morbidity and mortality reviews), in each clinical and technical department					
1.5.1.1.8.	Patients or patients' relatives should be part of these organisations					

1.5.2. Quality and risk management and safety requirements

1.5.2.1.

		Yes	Mostly	Partially	No	not applicable
1.5.2.1.1.	There is a patients committee (or association), for consultative advice about quality of care and risk management					
1.5.2.1.2.	There is a preventive maintenance programme for equipment and access to accurate and reliable diagnostic tests					
1.5.2.1.3.	There is a monitoring system for the appropriate use of diagnostic services					
1.5.2.1.4.	There is a monitoring system for the appropriate use of (radio)therapeutic services					
1.5.2.1.5.	There is a regular internal audit system					
1.5.2.1.6.	There is a quality and risk dashboard of the cancer centre, with an annual evaluation of the results and, if necessary, revision of its content					

1.5.3. Accuracy of the diagnostic services

Are the diagnostic services safe, efficient and accurate for workers and patients?

1.5.3.1.

		Yes	Mostly	Partially	No	not applicable
1.5.3.1.1.	Security checking of devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are part of the maintenance contracts.					
1.5.3.1.2.	Latest security checks have been done on time					
1.5.3.1.3.	Calibration of devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are part of the maintenance contracts					
1.5.3.1.4.	Latest calibrations have been done on time					
1.5.3.1.5.	Devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are periodically certified by an authorised company. Expiration date is still valid.					
1.5.3.1.6.	There is a reporting system for near miss accidents during the use of the devices and equipment.					

1.5.4. Quality and risk management of research and new techniques

Are there monitoring systems for quality and risk management associated with the introduction of new techniques / new practice?

1.5.4.1.

		Yes	Mostly	Partially	No	not applicable
1.5.4.1.1.	Identification of any risk associated with the introduction of a new technology or new practice is performed systematically					
1.5.4.1.2.	There is a quality assurance programme for clinical research					
1.5.4.1.3.	There is a procedure for Serious Adverse Events and Sudden Unexpected Serious Adverse Reaction handling and reporting					
1.5.4.1.4.	The SOP's are regularly updated and are accessible					

1.5.5. Quality assurance in all areas

Does the cancer centre promote and develop the practice of quality assurance in all areas?

1.5.5.1.

The quality assurance programmes are included in the global policy for quality and risk management

		Yes	Mostly	Partially	No	not applicable
1.5.5.1.1.	There is one quality assurance programme in each oncology healthcare area (chemotherapy, surgery, radiotherapy) and at risk units (anaesthesiology, critical care, etc)					
1.5.5.1.2.	There is at least one quality assurance programme in areas other than the oncology healthcare area					
1.5.5.1.3.	All activities of cancer centre follow, when applicable, the guidelines of Good clinical Practice, Good laboratory Practice and Good manufacturing Practice					

1.5.6. Quality assurance in all areas (HR)

1.5.6.1.

		Yes	Mostly	Partially	No	not applicable
1.5.6.1.1.	Evaluation of the employees is a part of the human resources(HR) management, from bottom to top, including directors, Chief Officers (heads of departments) and physicians.					
1.5.6.1.2.	The results of evaluation are documented and used for building future strategies of the institution, with alignment of the departments					
1.5.6.1.3.	Relevant training is provided to all staff according to their level of responsibility					
1.5.6.1.4.	HR policy includes a formal individual evaluation at least once or twice a year					
1.5.6.1.5.	Training records of all staff are available					
1.5.6.1.6.	Skills, competences and expertises are assessed in case of recruitment at managerial level					
1.5.6.1.7.	Specific psychological support is available for the cancer centre's employees including physicians.					

1.5.7. Privacy, protection of personal data

Are there procedures for privacy, protection of personal data?

1.5.7.1.

		Yes	Mostly	Partially	No	not applicable
1.5.7.1.1.	There is a Patient Charter: an official set of principles, a document defining the commitments of both the cancer centre AND the patient. In this Charter the cancer centre commits itself to respect and to guarantee the patient's privacy					
1.5.7.1.2.	There is a secure procedure for the storage, preservation, consultation and transmission of personal data according to the national/European regulations					
1.5.7.1.3.	Protocols for clinical trials guarantee the protection of the patient's personal data. This point is checked and validated by an Ethical Committee					

2. Screening and primary prevention and health education

2.4. Process control

2.4.1. Availability of screening programmes

In the setting of private health policy, does the cancer centre organise or participate in screening programmes?

2.4.1.1.

		Yes	Mostly	Partially	No	not applicable
2.4.1.1.1.	The cancer centre participates in structured regional (province/county) screening programmes.					
2.4.1.1.2.	The cancer centre participates in structured national screening programmes.					
2.4.1.1.3.	The cancer centre organises screening programmes.					

2.4.2. Participation in prevention and health education initiatives

Does the cancer centre organise or participate in prevention and health education initiatives that meet the needs of the population?

2.4.2.1.

		Yes	Mostly	Partially	No	not applicable
2.4.2.1.1.	The cancer centre organises prevention programmes.					
2.4.2.1.2.	The cancer centre organises health education initiatives/programmes.					
2.4.2.1.3.	The cancer centre participates in prevention programmes					
2.4.2.1.4.	The cancer centre participates in health education initiatives/programmes.					

2.4.3. Availability of primary prevention clinics

Does the institution have one or more specific primary prevention clinics?

2.4.3.1.

		Yes	Mostly	Partially	No	not applicable
2.4.3.1.1.	The cancer centre has a specific primary prevention clinic or at least one specific primary prevention programme					

2.4.4. Oncogenetic clinic / outpatient department

Does the institution have an oncogenetic clinic?

2.4.4.1.

		Yes	Mostly	Partially	No	not applicable
2.4.4.1.1.	The cancer centre has an oncogenetic clinic for identifying high-risk individuals by molecular genetics. ((e.g. breast cancer, ovarian cancer, colo-rectal cancer, endocrine tumours)					
2.4.4.1.2.	Formal relationships exist between the cancer centre and reference genetic laboratories					

2.4.5. Smoking control in the cancer centre

Is there a policy for non smoking in the cancer centre?

2.4.5.1.

		Yes	Mostly	Partially	No	not applicable
2.4.5.1.1.	a non-smoking policy is clearly documented					
2.4.5.1.2.	support is provided to workers who decide to quit smoking					
2.4.5.1.3.	any public part of the cancer centre is clearly identified as a smoke-free area					
2.4.5.1.4.	explanations about smoking regulation in the institution are available for patients					
2.4.5.1.5.	patients are encouraged to quit smoking					
2.4.5.1.6.	workers are encouraged to quit smoking					
2.4.5.1.7.	appropriate and specific support is provided to patients who want to quit smoking					
2.4.5.1.8.	smoking is prohibited to patients (possibly with the exception of a restricted smoking-room equipped with an appropriate aspiration device)					
2.4.5.1.9.	the cancer centre is labialized “Smoke-Free”					

3. Care

3.4. Process control

3.4.1. Pain service

Does the cancer centre have a protocol/guideline for pain control?

3.4.1.1.

		Yes	Mostly	Partially	No	not applicable
3.4.1.1.1.	The cancer centre applies / uses guidelines regarding pain treatment for patients with cancer					
3.4.1.1.2.	There is regular staff education on pain management					
3.4.1.1.3.	Patients and their families receive oral and written information about any pain management.					
3.4.1.1.4.	There is a pain score card as part of the guidelines.					
3.4.1.1.5.	The use of the pain score card is regularly assessed					

3.4.2. Palliative/Supportive care team

Does the cancer centre have written agreements for composition and tasks of the palliative / supportive care team? NB: palliative AND/OR supportive care

3.4.2.1.

The palliative/supportive care team

		Yes	Mostly	Partially	No	not applicable
3.4.2.1.1.	intervenes in a timely way to request from all inpatients departments					
3.4.2.1.2.	replies to out-patient requests with a help line service or consultation					
3.4.2.1.3.	provides education for different disciplinary specialists, patients and families					

3.4.3. Palliative/Supportive and terminal care (guideline)

Are there guidelines to palliative and terminal care? NB: palliative AND/OR supportive care

3.4.3.1.

		Yes	Mostly	Partially	No	not applicable
3.4.3.1.1.	The cancer centre uses guidelines on palliative, supportive and terminal care					
3.4.3.1.2.	Written procedures exist on referral of patients to palliative/terminal care					

3.4.4. Palliative and terminal care

Is the management of the specific needs of patients at the end of their life considered within and outside the cancer centre. NB: palliative AND/OR supportive care

3.4.4.1.

		Yes	Mostly	Partially	No	not applicable
3.4.4.1.1.	All patient cases referred for palliative terminal care are discussed during scheduled meetings with the palliative care team					
3.4.4.1.2.	Agreements exist with other cancer centre(s) for transferring patients at the end of their life, if necessary					
3.4.4.1.3.	Services provided by the cancer centre after patients are discharged are clearly defined					
3.4.4.1.4.	These services are known by terminal patients and relevant workers					

3.4.5. Psycho-oncology service

Does the cancer centre have a psycho-oncology team or department?

3.4.5.1.

		Yes	Mostly	Partially	No	not applicable
3.4.5.1.1.	There is a psycho-oncology service with competence in (oncological) psychiatry and psychology					
3.4.5.1.2.	The staff are trained to detect patients with psychological suffering or distress.					
3.4.5.1.3.	Structured screening methods are used to refer patients to the psycho-oncology team					
3.4.5.1.4.	Procedures about how to refer the patients to the psycho-oncology service, including patients in psychological distress, are clearly defined					

3.4.6. Social Counselling

Does the cancer centre have a guideline or policy on the psychosocial counselling of oncology patients?

3.4.6.1.

		Yes	Mostly	Partially	No	not applicable
3.4.6.1.1.	Social counselling, including social workers, is available and accessible to all patients					

3.4.7. Family involvement in care

Is care organised for the patient's family during treatment, the end of life and the immediate bereavement period?

3.4.7.1.

		Yes	Mostly	Partially	No	not applicable
3.4.7.1.1.	In agreement with the healthcare team, the family can participate in some personal activities (e.g. meals, washing).					
3.4.7.1.2.	Each ward offering palliative/terminal care has a room for meeting the families.					
3.4.7.1.3.	Visiting time restrictions are lifted and arrangements for relatives to stay/sleep as well as for visiting by children are facilitated					

3.4.8. Family involvement in care (children)

Is there special attention paid to children with a parent who is dying?

3.4.8.1.

		Yes	Mostly	Partially	No	not applicable
3.4.8.1.1.	Specific support exists for families with children whose parent is dying (trained staff, guidelines…)					
3.4.8.1.2.	Families are proactively informed on the available support					

3.4.9. Rehabilitation

Is there access to a rehabilitation unit with mono- and multidisciplinary interventions?

3.4.9.1.

		Yes	Mostly	Partially	No	not applicable
3.4.9.1.1.	There is access to a functional rehabilitation department focused on cancer patients.					
3.4.9.1.2.	The rehabilitation unit manages the psychosocial and physical rehabilitation of the patient, starting at an early stage of the treatment, and continuing during the post therapeutic care period					

3.4.10. Prosthetic surgery

Do patients receive information and advice about the possibilities of prosthetic surgery?

3.4.10.1.

		Yes	Mostly	Partially	No	not applicable
3.4.10.1.1.	The person/s in charge of providing information on prosthetic surgery is/are clearly identified					
3.4.10.1.2.	The patient is informed about how to get information					
3.4.10.1.3.	This information includes the potential risks					
3.4.10.1.4.	Prosthetic and reconstructive surgery is available and accessible to all appropriate patients					

4. Research, innovation and development

Note: ***Cancer Units are excluded for the questions in this chapter 4.***

4.1. Policy and organisation

4.1.1. Organisational and hierarchical structure

Is there a description of the organisational and hierarchical structure of the RID organisation?

4.1.1.1.

		Yes	Mostly	Partially	No	not applicable
4.1.1.1.1.	There is an organisational and hierarchical structure specifically for research, innovation and development					
4.1.1.1.2.	A Scientific Advisory Board meets on a regular basis and advice the board of the cancer centre on its research activities					
4.1.1.1.3.	The Scientific Advisory Board verifies the quality of the research activities					
4.1.1.1.4.	The Scientific Advisory Board verifies the coherence of the objectives of the different research programmes and the cancer centres' objectives and strategy at least annually					

4.1.2. Research collaboration

4.1.2.1.

		Yes	Mostly	Partially	No	not applicable
4.1.2.1.1.	The cancer centre has a strategy on collaboration and networking					
4.1.2.1.2.	The cancer centre participates in national and international research projects					

4.1.3. Organisation of clinical research

4.1.3.1.

		Yes	Mostly	Partially	No	not applicable
4.1.3.1.1.	There is a dedicated clinical research management unit					
4.1.3.1.2.	It is the task of the unit to have a strategy for promoting the conduct of clinical trials					
4.1.3.1.3.	It is the task of the unit to ensure the management that the conduct of clinical trials is according to the clinical trials protocols					
4.1.3.1.4.	It is the task of the unit to ensure administrative, scientific and ethical/legal review and approval of new clinical trials					
4.1.3.1.5.	It is the task of the unit to coordinate the clinical research activities as well as their funding					
4.1.3.1.6.	It is the task of the unit centralise the collection of the information about the trials and patients included					
4.1.3.1.7.	It is the task of the unit to provide and update information about the trials to all departments and external partners					
4.1.3.1.8.	It is the task of the unit to assist in the conduct and monitoring of clinical trial activities					
4.1.3.1.9.	It is the task of the unit to provide an annual report on clinical trial activities					

4.1.4. Periodical policy review

Is there a periodical research policy review?

4.1.4.1.

		Yes	Mostly	Partially	No	not applicable
4.1.4.1.1.	There is a periodically defined research policy and research strategy plan					
4.1.4.1.2.	The research policy and research strategy plan are integrated into the general activities of the cancer centre					

4.1.5. Scientific interaction and integration

Is there a structure for integrating and stimulating the scientific interaction?

4.1.5.1.

The cancer centre promotes co-operation between researchers and clinicians through:

		Yes	Mostly	Partially	No	not applicable
4.1.5.1.1.	Organised and formalised activities					
4.1.5.1.2.	Regular information and meetings about research activities					
4.1.5.1.3.	Regular information and meetings about research results					
4.1.5.1.4.	Promotion of integration of research activities into clinical activities					
4.1.5.1.5.	Organisation of integration of research activities into clinical activities					

4.1.6. Internal review and evaluation of grant proposals

Is there a procedure in place for internal review of grant proposals before submissions?

4.1.6.1.

		Yes	Mostly	Partially	No	not applicable
4.1.6.1.1.	There is an internal review of grant proposals before submission to the funding organisation					
4.1.6.1.2.	There is an internal evaluation of the success of the grant proposals					

4.1.7. (suspected) scientific misconduct

Is there a procedure in case of (suspected) scientific misconduct?

4.1.7.1.

		Yes	Mostly	Partially	No	not applicable
4.1.7.1.1.	There is a procedure for dealing with scientific misconduct					

4.3. Resources and materials

4.3.1. Means for conducting research activities

Does the cancer centre have the means for conducting its research activities?

4.3.1.1.

		Yes	Mostly	Partially	No	not applicable
4.3.1.1.1.	The budget for cancer research is clearly and yearly defined					
4.3.1.1.2.	The cancer centre provides access to facilities for research activities					
4.3.1.1.3.	The cancer centre provides resources and means for research activities					
4.3.1.1.4.	Funding of research activities follows clearly defined procedures					
4.3.1.1.5.	The use of financial resources and accounting of research activities is controlled, monitored and reported according to rules					

4.3.2. Intellectual property and innovation

Is there a policy for the protection of intellectual property?

4.3.2.1.

		Yes	Mostly	Partially	No	not applicable
4.3.2.1.1.	There is a strategy for innovation					
4.3.2.1.2.	There is support for protection and exploitation of intellectual property					
4.3.2.1.3.	There is support for business development of research projects					
4.3.2.1.4.	There is a technology transfer service available					

4.3.3. Biobank

4.3.3.1.

		Yes	Mostly	Partially	No	not applicable
4.3.3.1.1.	The cancer centre has a policy for biobanking patient related samples					
4.3.3.1.2.	There is a SOP defining the collection, the storage, the registration and the use of the biological samples					
4.3.3.1.3.	There is a centralised registration of the data related to the biological material					

4.4. Process control

4.4.1. Structured scientific programme

Is there a structured scientific exchange programme in the cancer centre? (colloquia, seminars, theme-specific conferences).

4.4.1.1.

		Yes	Mostly	Partially	No	not applicable
4.4.1.1.1.	There is a structured, documented and up to date scientific programme in the cancer centre through colloquia, seminars or theme-specific conferences.					
4.4.1.1.2.	Scientific programmes are used to guarantee that results from research will be translated into daily practice timely; (e.g.) diagnostic tools, treatment or prevention					

4.4.2. Teaching programme for PhD students

Is there a teaching programme for PhD students ?

4.4.2.1.

		Yes	Mostly	Partially	No	not applicable
4.4.2.1.1.	There is a teaching programme for PhD students					

4.4.3. Transfer of new scientific information to clinical practice

Is there a procedure for the transfer of new scientific information to clinical practice?

4.4.3.1.

		Yes	Mostly	Partially	No	not applicable
4.4.3.1.1.	There is a procedure that guarantees that results from research will be translated into daily practice timely.(e.g.) diagnostic tools, treatment or prevention)					

4.5. Safeguarding the quality system

4.5.1. Periodical site visit/review. Is there a periodical site visit/review of the total research organisation?

4.5.1.1.

There is a periodical review and/or site visit, with external reviewers, of:

		Yes	Mostly	Partially	No	not applicable
4.5.1.1.1.	the total research organisation					
4.5.1.1.2.	each research group/team activities					
4.5.1.1.3.	clinical/translational research					
4.5.1.1.4.	research support facilities					

5. Teaching and continuing education

5.1. Policy and organisation

Does the cancer centre analyse the training needs to define an annual or multi-annual programme?

5.1.1. Analyse training needs

5.1.1.1.

		Yes	Mostly	Partially	No	not applicable
5.1.1.1.1.	The cancer centre analyses the training needs regularly					
5.1.1.1.2.	Based on the analysis, the institution defines an annual or multi-annual training / educational programme for physicians					
5.1.1.1.3.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for researchers					
5.1.1.1.4.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for nurses					
5.1.1.1.5.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for paramedics					
5.1.1.1.6.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for supportive disciplines (psychologists etc.)					
5.1.1.1.7.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for other disciplines (please specify in the note)					

5.4. Process control

5.4.1. Participation in teaching oncology

Do the physicians, researchers, nurses and psychologists in the cancer centre participate in the teaching of undergraduate theoretical courses in oncology?

5.4.1.1.

Does the cancer centre provide teaching to:

		Yes	Mostly	Partially	No	not applicable
5.4.1.1.1.	physicians					
5.4.1.1.2.	researchers					
5.4.1.1.3.	nurses					
5.4.1.1.4.	psychologists					
5.4.1.1.5.	supportive disciplines (psychologists etc.)					
5.4.1.1.6.	other disciplines (please specify in the note)					

5.4.2. Types of teaching programmes provided

Does the cancer centre participate in teaching for PhD/BSc/MSc degree(s) in oncology nursing?

5.4.2.1.

Does the cancer centre provide

		Yes	Mostly	Partially	No	not applicable
5.4.2.1.1.	academic teaching in oncology					
5.4.2.1.2.	continuous medical education (CME)					
5.4.2.1.3.	BSc, MSc and PhD programmes related to cancer research					

5.4.3. Types of teaching programmes organised

Does the cancer centre participate in organising for PhD/BSc/MSc degree(s) in oncology nursing?

5.4.3.1.

Does the cancer centre organise/coordinate:

		Yes	Mostly	Partially	No	not applicable
5.4.3.1.1.	academic teaching in oncology					
5.4.3.1.2.	continuous medical education (CME)					
5.4.3.1.3.	BSc, MSc and PhD programmes related to cancer research					

6. Patient related

6.4. Process control

6.4.1. Educational material

Has policy been defined concerning the production, distribution and administration of educational material relating to oncology?

6.4.1.1.

The cancer centre delivers:

		Yes	Mostly	Partially	No	not applicable
6.4.1.1.1.	written information on relevant aspects of oncology to the patients					
6.4.1.1.2.	written information on relevant aspects of oncology to general practitioners					
6.4.1.1.3.	The written information includes information about diagnostic examinations and methods of treatment					
6.4.1.1.4.	The written information includes information about clinical trials					
6.4.1.1.5.	The written information includes information about supportive care, complementary care and palliative care					

6.4.2. Inform patients on admission

Have procedures been established on informing cancer patients about cancer centre admission procedures?

6.4.2.1.

		Yes	Mostly	Partially	No	not applicable
6.4.2.1.1.	There is detailed information about the admission procedure					
6.4.2.1.2.	This information is available and communicated to the patient					
6.4.2.1.3.	The admission procedure is regularly assessed for efficiency					
6.4.2.1.4.	The cancer centre can accept patients during day and night in the event of an emergency, admit them if necessary, or refer them to another institute					

6.4.3. Informing patients about results, treatment and counselling

Have agreements been reached on informing oncology patients about the results of diagnostic tests, about treatment (and follow up treatment), and about counselling (in terms of how it is done and what it means)?

6.4.3.1.

		Yes	Mostly	Partially	No	not applicable
6.4.3.1.1.	The cancer centre has procedures or guidelines regarding information transfer on diagnostics, treatment, follow-up and supervision of the patient.					
6.4.3.1.2.	Policies are defined about who is informing the patient, relatives and close friends about the result of an examination, further treatment or supervision					
6.4.3.1.3.	Policies are defined about when this information is delivered					
6.4.3.1.4.	Policies are defined about how the transmission of information to the people involved in treatment and patient care is organised					
6.4.3.1.5.	Policies are defined about how the relevant information transferred to the patient is described in the patient's file, such as information about the further treatment that can be expected, the plan of treatment, about requesting a consultation of another medical specialist, the consequence of potential side effects					

6.4.4. Discharge procedure

Does the cancer centre have a discharge procedure?

6.4.4.1.

		Yes	Mostly	Partially	No	not applicable
6.4.4.1.1.	There is a written discharge procedure					
6.4.4.1.2.	This procedure is regularly assessed					
6.4.4.1.3.	At discharge, information is provided to the patients about patients' associations					
6.4.4.1.4.	At discharge, information is provided to the patients about self-helping groups					
6.4.4.1.5.	At discharge, information is provided to the patients about home care					
6.4.4.1.6.	At discharge, information is provided to the patients about treatment and follow-up plans					
6.4.4.1.7.	At discharge, information is provided to the patients about contact details with cancer centre					

6.5. Safeguarding the quality system

6.5.1. Patient satisfaction / experiences

Does the cancer centre evaluate the patient's satisfaction / experiences related to cancer care?

6.5.1.1.

		Yes	Mostly	Partially	No	not applicable
6.5.1.1.1.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during consultation					
6.5.1.1.2.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during day care					
6.5.1.1.3.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during hospitalisation					
6.5.1.1.4.	The survey is regularly analysed and corrective measures are planned					
6.5.1.1.5.	There is a group of patients representing patients and serving as a link between the cancer centre and the patients for advisory and consultation					

6.5.2. Conciliatory commission for complaints

Does the cancer centre have an identified conciliator (or a conciliatory commission), for complaints related to cancer care?

6.5.2.1.

		Yes	Mostly	Partially	No	not applicable
6.5.2.1.1.	The cancer centre has a clearly identified conciliator or a conciliatory commission (sometimes known as a mediator or mediation service, or as the complaints officer or complaints department)					
6.5.2.1.2.	The role of the conciliator or the conciliatory commission is to reply to any request for information or complaints from the patients or their families.					
6.5.2.1.3.	The actions undertaken by the conciliator are recorded in a file that is used to produce an annual report					
6.5.2.1.4.	The conciliator gives feedback on his/her findings to the professional who is the subject of the complaint.					

Appendix III. OECI Quantitative questionnaire

Please fill in the following OECI quantitative questionnaire (not for public release). The italic items are already filled out in the application form. And the underlined items are filled out for the designation screening. Chapter 4 'Research' outside the scope of the OECI Accreditation of Cancer Units.

1. General Questions

1.1. Cancer centre

1.1.1. Project: OECI Quality Improvement Project/Working Group Accreditation (WGA)

1.1.2. Name of the cancer centre _____

1.1.3. Address _____

1.1.4. Telephone _____

1.1.5. Fax _____

1.1.6. Internet site _____

1.2. Management

1.2.1. Administrative Director _____

1.2.2. E-mail Administrative Director _____

1.2.3. Medical Director _____

1.2.4. E-mail Medical Director _____

1.2.5. Scientific Director _____

1.2.6. E-mail Scientific Director _____

1.3. Survey

1.3.1. Name of the Contact person for the survey at the cancer centre _____

1.3.2. Position of the Contact person for the survey _____

1.3.3. E-mail address of the Contact person for the survey _____

1.4. Cancer centre structure

1.4.1.

		Cancer Unit	Clinical Cancer Centre	CCC (Comprehensive cancer centre)	Cancer research Centre
1.4.1.1.	In which category would you classify your cancer centre				

1.4.6.

		academic	public/non profit	private
1.4.6.1.	What is the administrative status of your cancer centre.			

1.4.7.

		at national level	at regional level	Presence of European or International Affairs Collaboration	General accreditation by National Accreditation Organisation or other organisation
1.4.7.1.	Is your cancer centre part of a formalised network of institutions				

1.4.8. Year of accreditation

1.5. Distribution areas and budget

1.5.1. % of patients regional

1.5.2. % of patients national

1.5.3. % of patients international

1.5.4. Planned annual budget for health care (in € last year available) X

1.5.5. Planned annual budget for research (in € last year available) X

2. Infrastructures

2.1. Infrastructures with a focus on cancer care (1 of 7)

2.1.1. per year = x

	surgery oncology	medical oncology	radiation therapy	paediatric oncology	Other units	Haematology	Total (oncology)
Number of newly registered/diagnosed cancer patients (any type)	X	X	X	X	X	X	X
Number of inpatient beds for overnight stays	X	X	X	X	X	X	X
Number inpatient visits for overnight stays							
Mean duration of stay for inpatients							
Number of outpatient visits in consultation							
Waiting time before 1st visit (mean)							
Waiting time treatment decision-first treatment-(mean)							
Number of ambulatory day care beds/chairs							X
Number of ambulatory/day hospital patient visits							
FTE physicians dedicated to oncology(into human resources)							X
% FTE vacant positions							
FTE board certified nurses dedicated to oncology							
% FTE vacant positions							

2.2. Infrastructures with a focus on cancer care (2 of 7)

2.2.1. per year = x

	New patients (total number of newly admitted and referred)	Number of surgical procedures	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
breast cancer C50								
lung cancer C34								
urological cancer: bladder C67								
urological cancer: kidney C64H								
urological cancer: Others								
Male genital organs cancer: prostate C61H								
Male genital organs cancer: testis C62								
Male genital organs cancer: Others								

2.3. Infrastructures with a focus on cancer care (3 of 7)

2.3.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
gastrointestinal cancer: oesophagus C15								
gastrointestinal cancer: stomach C16								
gastrointestinal cancer: colon C18								
gastrointestinal cancer: rectum C20H								
gastrointestinal cancer: liver C22								
gastrointestinal cancer: pancreas C25								
gastrointestinal cancer: Others								

2.4. Infrastructures with a focus on cancer care (4 of 7)

2.4.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
gynaecological cancer: ovary C56H								
gynaecological cancer: cervix C53								
gynaecological cancer: endometrial C54								
gynaecological cancer: Others								

2.5. Infrastructures with a focus on cancer care (5 of 7)

2.5.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
head and neck cancer: larynx C32								
head and neck cancer: hypopharynx C13								
head and neck cancer: oropharynx C10								
head and neck cancer: nasapharynx C11								
head and neck cancer: thyreoid C73H								
head and neck cancer: others								

2.6. Infrastructures with a focus on cancer care (6 of 7)

2.6.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
haematological malignancies: Hodgkin Lymphoma C81								
haematological malignancies: Non Hodgkin Lymphoma C82								
haematological malignancies: Myeloma C90								
haematological malignancies: All leukaemia								
neuro-oncological: Central nervous system C71-C72								
neuro-oncological: others								

2.7. Infrastructures with a focus on cancer care (7 of 7)

2.7.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
paediatric malignancies: all cancers (age 0<15)								
bone and soft tissue tumours: primary bone C40								
bone and soft tissue tumours: Soft tissue C49								
bone and soft tissue tumours: melanoma of the skin C43								
skin cancer: Others C44								

2.8. Radiotherapy

2.8.1. Number of accelerators for radiation therapy _____

2.8.2. Number of cobolt units _____

2.8.3. Resources for proton therapy

	Yes	No
2.8.3.1. Do you have resources for proton therapy?		

2.8.4. Number of conventional RT (patients per year) _____

2.8.5. Number of bracytherapy (patients per year) _____

2.8.6. Number of IMRT (patients per year) _____

2.8.7. Number of IORT (patients per year) _____

2.8.8. Number of stereo tactic RT (single and fractionated) (patients per year) _____

2.9. Radiology

2.9.1. Number of CT scanners X _____

2.9.2. Number of facilities for MRI X _____

2.9.3. Number of MRI spectroscopy X _____

2.9.4. Number of mammography X _____

2.9.5. Waiting time for CT scanners _____

2.9.6. Waiting time for MRI _____

2.9.7. Waiting time for mammography _____

2.9.8. Do you have digitalised imaging (PACS)?

	Yes	No
2.9.8.1.		

2.9.9. Do you have resources for interventional techniques?

	On site	Access to	Not Available
2.9.9.1.			

2.10. Nuclear medicine unit

2.10.1. Number of cameras _____

2.10.2.

		On site	Access to	Not available	not applicable
2.10.2.1.	Pet scan facilities				
2.10.2.2.	pet CT facilities				
2.10.2.3.	Radio nucleotide treatment facilities				

2.11. Laboratory

2.11.1.

		On site	Access to	Not available
2.11.1.1.	Do you have a cytology laboratory?			
2.11.1.2.	Do you have a histopathology laboratory?			

2.11.2. If on site

		Yes	No
2.11.2.1.	immunofluorescence techniques		
2.11.2.2.	Histochemistry		
2.11.2.3.	flow cytomitry		
2.11.2.4.	Techniques for molecular biology and genetics		

2.11.3.

	by cytology	by biopsyon	large pieces of excision
Please specify the number of samples for tumour pathological diagnosis per year at your cancer centre			

2.12. Haematology unit

2.12.1.

		On site	Access to	Not available
2.12.1.1.	Do you have a transfusion centre?			
2.12.1.2.	Do you have a bone marrow bank?			

2.12.2. Number of laminar flow rooms

2.12.3.

	Allogenic stem cell	Autologous bone marrow	Autologous stem cell
Please specify the number of bone marrow/stem cell transplants per year			

2.13. Oncology Multidisciplinary team:

2.13.1. Members are:

		Yes	No
2.13.1.1.	Medical oncologist (or equivalent)		
2.13.1.2.	Surgical Oncologist		
2.13.1.3.	Radiotherapist		
2.13.1.4.	Radiologist		
2.13.1.5.	Pathologist		
2.13.1.6.	Nurses		
2.13.1.7.	Others		

2.14. Palliative care team:

2.14.1. Members are:

		Yes	No	not applicable
2.14.1.1.	Anaesthetist/Physician specialising in pain treatment			
2.14.1.2.	Medical specialists (including psychiatrist and medical oncologist)			
2.14.1.3.	Nurses			
2.14.1.4.	Psychologist			
2.14.1.5.	Anaesthesist			
2.14.1.6.	Physiotherapist			
2.14.1.7.	General practitioner			
2.14.1.8.	Social worker			
2.14.1.9.	Dietician			

2.15. Facilities

2.15.1.

		On site	Access to	Not available
2.15.1.1.	Do you have a tumour bank facility?			
2.15.1.2.	Do you have a central pharmacy?			

2.15.2. Number of operating rooms excluding ambulatory services (specific to oncology): _____

2.15.3. Number of IC beds (specific to oncology): _____

2.15.4.

		On site	Access to	Not available
2.15.4.1.	Do you have other specialised techniques on site			

2.15.5. Do you have other specialised techniques on site?

		Yes	No
2.15.5.1.	laser therapy		
2.15.5.2.	Laparoscopy		
2.15.5.3.	sentinel node?		
2.15.5.4.	Intra Operative Chemo Therapy		
2.15.5.5.	hyperthermia?		
2.15.5.6.	isolated limb perfusion?		
2.15.5.7.	radio frequency ablation		
2.15.5.8.	Others		

3. Human resources

3.1. Human resources (1)

3.1.1.

	Per doctor	Per nurse day	Per nurse night
Legal number of hours for 1 Full-Time Equivalent (FTE)	X	X	X

3.1.2. Total FTE of employees in the cancer centre _____

3.1.3. Total FTE of employees dedicated to cancer patients _____

3.2. Human resources (2)

3.2.1.

	breast surgery	urologic surgery	thoracic surgery	digestive surgery	neurosurgery	gynaecological surgery	head and neck surgery	soft tissue surgery	orthopaedic surgery	plastic and econstructive surgery
Please specify the number of FTE surgeons	X	X	X	X	X	X	X	X	X	X

3.3. Human resources (3)

3.3.1.

	Please specify the number of FTE
gastro enterologists	
pneumonologists/respiratory physicians	
gynaecologists	
haematologists	
paediatricians	
psychiatrists	
anaesthesiologists	
infectious disease specialists	
geneticians	
dermatologists	
pharmacist	
pharmacologists	
geriatricians	
neurologists	
intensive care specialists	
medical oncologists	X
cardiologists	
endocrinologists	
urologists	
plastic surgeons	

3.4. Human resources (4)

3.4.1. Pathology

	Technicians	Pathologists
Please specify the number of FTE		

3.4.2. Nuclear medicine

	technicians in nuclear medicine	physicians in nuclear medicine	physicists/engineers	nurses in nuclear medicine
Please specify the number of FTE				

3.4.3. Radiology

	Radiologists	technicians in radiology	nurses in radiology
Please specify the number of FTE			

3.4.4. Radiotherapy

	radiation therapists	dosimetrists	radiation technicians in radiotherapy
Please specify the number of FTE			

3.4.5. Supportive care

	Dieticians	psychologists	nutricians	speech therapists	physiotherapists	stoma therapists	social workers
Please specify the number of FTE							

4. Research (Outside scope of Cancer Units)

4.1. Research domains

4.1.1.

	Present	FTE dedicated researcher (Phd, MD)	Phd students and fellows	Number of technicians
carcinogenesis				
immunology				
cell biology				
drug development				
Bioinformatics				
Biostatistics				
Tumour progression				
Angiogenesis				
Epidemiology				
Psycho-oncology				
Nursing				
Radiobiology				
Public health				
Health economy				
Clincal trials				

4.1.2.

	Present	FTE dedicated researcher (Phd, MD)	Phd students and fellows technicians	Number of
Pharmacogenomic				
pharmacokinetics/dynamics				
gene therapy				
(onco)genomics				
(onco)proteomics				
Functional imaging				
Toxicology				
Others				

4.2. Structures

4.2.1. Research facilities

❑ Animal House
❑ Transgenic facility
❑ Micro-array facility
❑ Biochemical analysis
❑ Radio labelling (cyclotron)
❑ High Throughput screening
❑ (Bio)Statistics
❑ Cytogenetics
❑ Flowcytometry
❑ Massaspectrometry
❑ Electon microscopy or electron?
❑ Animal pathology/histology
❑ Proteomics facility
❑ DNA sequence facility
❑ Protein analyses facility
❑ Others namely

4.3. Structures

4.3.1.

		Yes	No	not applicable
4.3.1.1.	Do you have a private partnership with companies related to research and innovation			
4.3.1.2.	Do you have a Unit of epidemiology?			
4.3.1.3.	Do you have a biostatistic unit?			
4.3.1.4.	Do you have a Unit of health economy?			
4.3.1.5.	Do you have a data management unit/trial bureau?			
4.3.1.6.	Do you have a local cancer registry?			

4.3.2. Number of studies active (that is open to patient accrual) during year x: X _____

4.3.3. Number of studies activated in year x:

	Phase I	Phase II	Phase III	Phase IV
#	X	X	X	X

4.3.4. Number of new investigator initiated local trials

(Percentage of new investigator initiated local trials %) _____

4.3.5. Number of new investigator initiated national trials

(Percentage) _____

4.3.6. Number of new investigator initiated international trials

(Percentage) _____

4.3.7. Number of new clinical trials with external industrial sponsor

(Percentage) _____

4.3.8. Number of new patients in clinical trials

(indicator: number of new patients included in clinical trials /Number of new patients in the institute) _____

4.3.9.

Does your cancer centre have research collaboration with other cancer centres

		Yes	No
4.3.9.1.	at national level		
4.3.9.2.	at international level		

4.4. Research budget including basic/clinical/translational

4.4.1. Total research budget cancer centre X

4.4.2.

	Nr of EU grants running in year x	Nr of EU grants coordinated in year x	Public funding	Charities/unrestricted grants	Industrial partnership funding
Research funding sources/total amounts received (2008)	X	X	X	X	X

4.4.3. Number of patents over the last 5 years:

4.4.4. Number of peer-reviewed publications per year (year x) national X

4.4.5. Number of peer-reviewed publications per year (year x) international X

4.4.6. Impactfactor cumulative

4.4.7. Number of publications with impactfactor > 10 X

5. Education

5.1. Education

5.1.1. Planned annual budget for education year x (Euros) _____

5.1.2.

		On site	Access to	Not available	not applicable
5.1.2.1.	An information centre for cancer patients				
5.1.2.2.	Medical library				
5.1.2.3.	Online access via internet				

5.1.3.

		Yes	No	not applicable
5.1.3.1.	Educational courses organised by the cancer centre on site			
5.1.3.2.	with local audience			
5.1.3.3.	with national audience			
5.1.3.4.	with international audience			

5.1.4. Number of medical students per year _____

5.1.5. Number of graduate/postgraduate students _____

5.1.6. Number of physicians under specialist training per year _____

5.1.7. Number of nurses under specialist training per year _____

5.1.8. Number of nurses students per year _____

5.1.9. Number PhD students _____

5.1.10. Number of PhD theses per year (average last 5 years) _____

5.1.11. Number of University - Faculty associate Professors _____

5.1.12.

		Yes	No
5.1.12.1.	Do you have formalised exchange programmes		
5.1.12.2.	national		
5.1.12.3.	international		
5.1.12.4.	Do you have formalised patient education programmes		
5.1.12.5.	Do you have formalised education programmes for decision makers		
5.1.12.6.	Do you have formalised continuous medical education (CME) programme		

5.2. Analysis

5.2.1.

Based on the analysis, do you have an annual or multi-annual training / educational programmes for:

		Yes	No
5.2.1.1.	physicians		
5.2.1.2.	researchers		
5.2.1.3.	nurses		
5.2.1.4.	paramedics		
5.2.1.5.	supportive disciplines (psychologists etc.)		
5.2.1.6.	other disciplines (please specify in the note)		

Appendix IV: Project plan

Project plan (doc. 5) for cancer institute to organise self-assessment

General	
Name of the project	"OECI Accreditation Programme"
Institute name	*Name of the (cancer) institute*
Place and country	*Place and country of residence*
Division/department	*Part of the hospital that is involved or whole hospital*
Owner of the project	Board of Directors of the institute: *name person in specific*
Project leader in the institute	*Name of OECI contact person in the institute and position/function in the institute*
OECI Accreditation Coordinator	Femke Boomsma
Start date OECI accreditation	*Date*
What is (are) the motive(s) for starting the project?	*Motives/ Arguments*
Which goal(s) would you like to achieve? (Try to define according to the SMART-method: *Specific, Measurable, Achievable, Realistic, Time-related)*	*To achieve a…….*

Steering committee	
Is there a steering committee present?	*Names of participants and functions*

Composition of the project team

One/two persons from each sub project group.

The sub project groups are small teams of people who are together responsible for a part of the questionnaires. One/two of the group also participate in the project team.

	Name	**Position/function**	**Responsibilities**
Project leader in the institute	*Name + e-mail*	*Position/function*	
Secretary:	*Name + e-mail*	*Position function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	

Planning of the project	
Start	
Explanatory visit	29 June 2010
Number of planned internal meetings	*When periodically meetings?*
Self-assessment period	September 2010 (as proposed)
	February 2011
1st evaluation with OECI Coordinator	*Date and with whom?*
2nd evaluation with OECI Coordinator	*Date and with whom?*
3rd evaluation with OECI Coordinator	*Date and with whom?*
Go/ no-go decision	Early March 2011
Planned peer review	Early May 2011
Planned end date	

Communication: reporting method		
To:	**When/time**	**Method**
Owner		
Board of the institute		*e-mail/written form/ meeting*
Steering committee		*e-mail/written form/ meeting*
Project team		*e-mail/written form/ meeting*
Quality committee		*e-mail/written form/ meeting*
Others: – Staff – Patients –		 Intranet Institutional information media

Communication of the final self-assessment results		
To:	**When/time**	**Method**
Participants?	*Date; at end of self assessment period*	*How?*

Which extra means are necessary? Time considered needed	
Project leader (in the institute)	
OECI Accreditation Coordinator	
Time project members (for each person)	
Time blanks exercise for participants	*Pending further assessment, according to identified needs*
Financial means	*Pending further assessment, according to identified needs* *Planning payment of fee stage 1 and 2*
Other resources (e.g. (training) education, meeting costs	*Pending further assessment, according to identified needs*

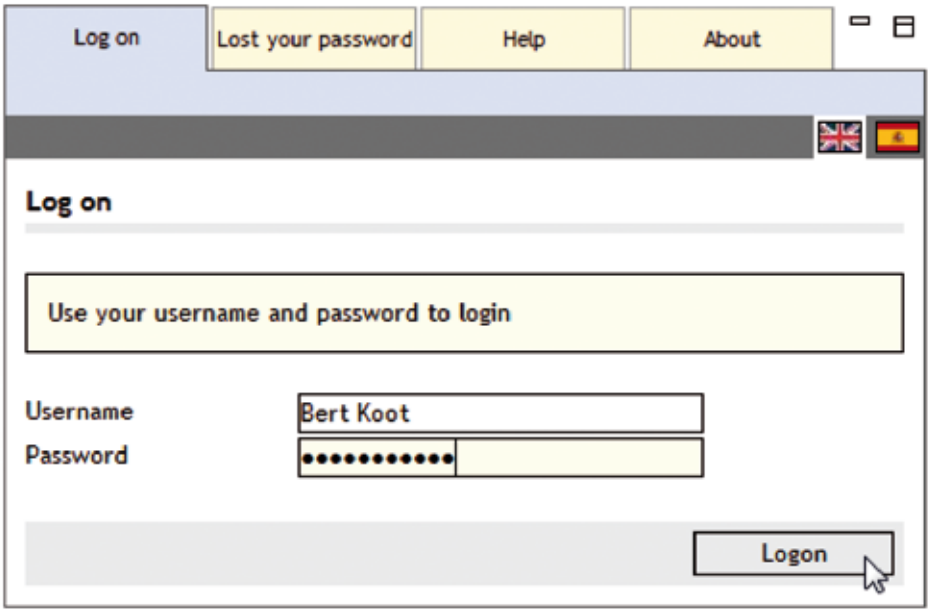
Appendix V. Self-assessment user manual for institutes

1. Log in

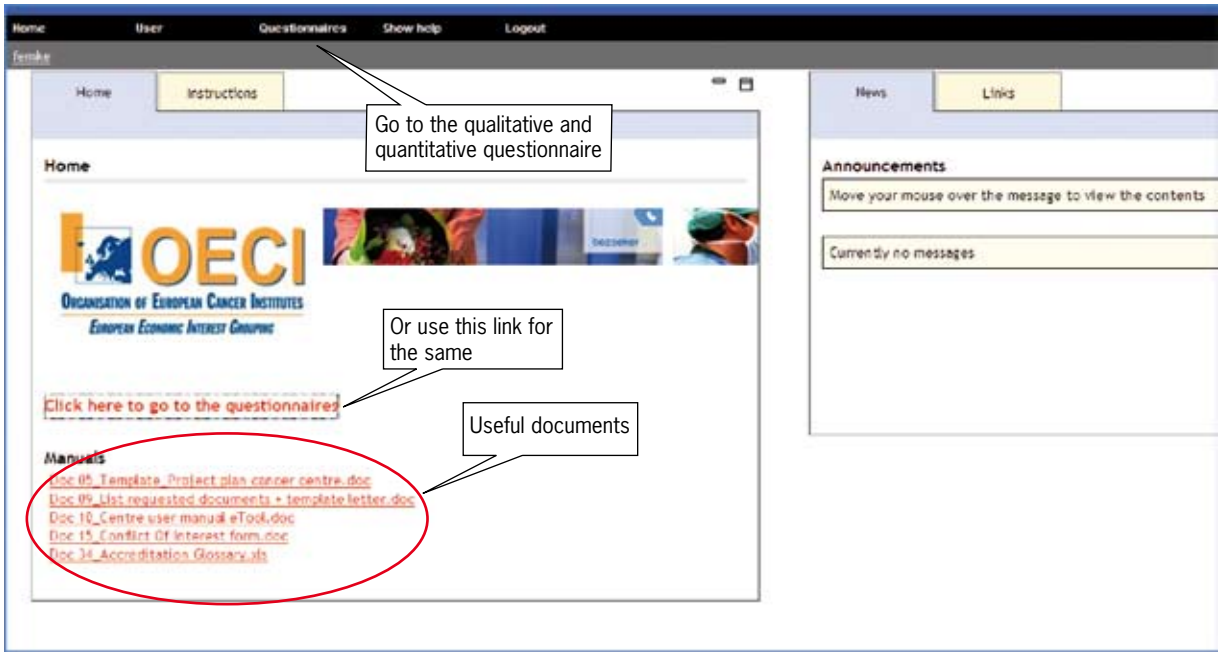
Go to: http://oeci.selfassessment.nu

You can also go directly to the e-tool log-in screen, as it is illustrated underneath, via *http://oeci.selfassessment.nu/compass/user*

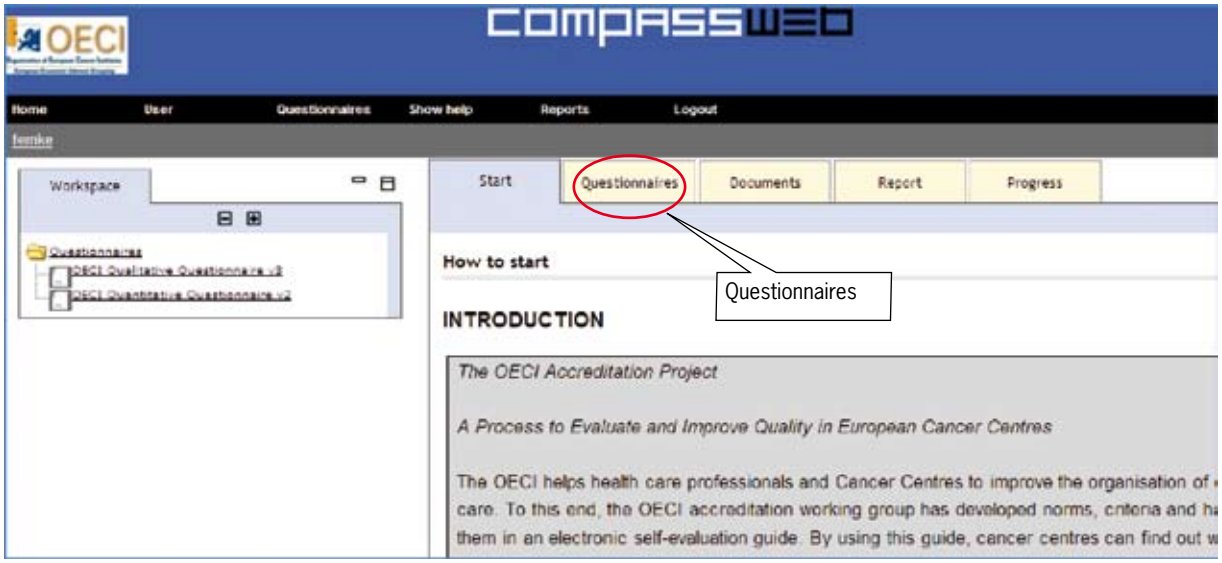
In the log in screen you can use your username and password to enter the e-tool application.

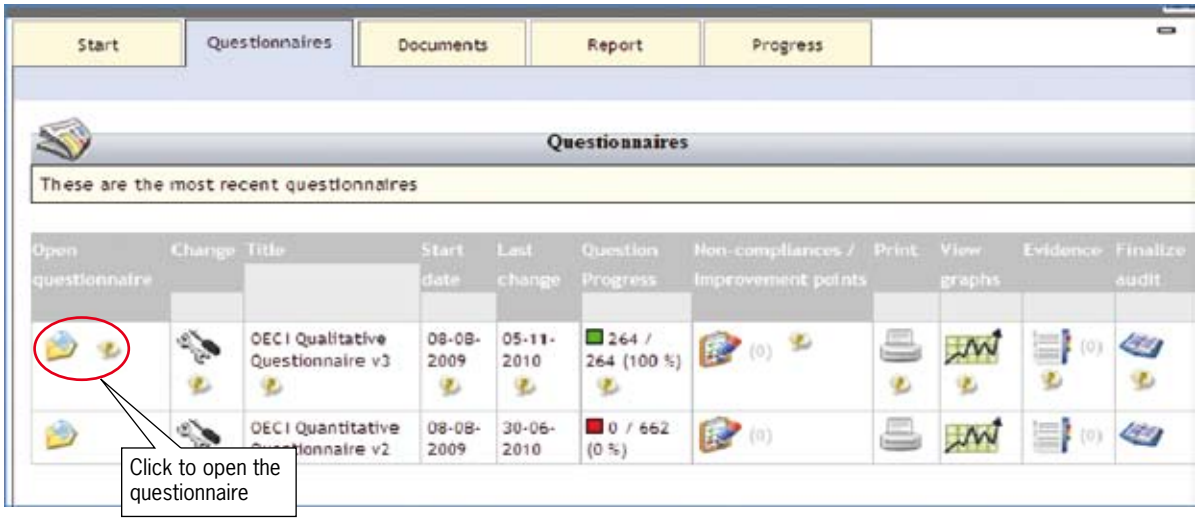


When logged in you can enter the e-tool in the following screen.



If you go to the questionnaires the following screen appears.



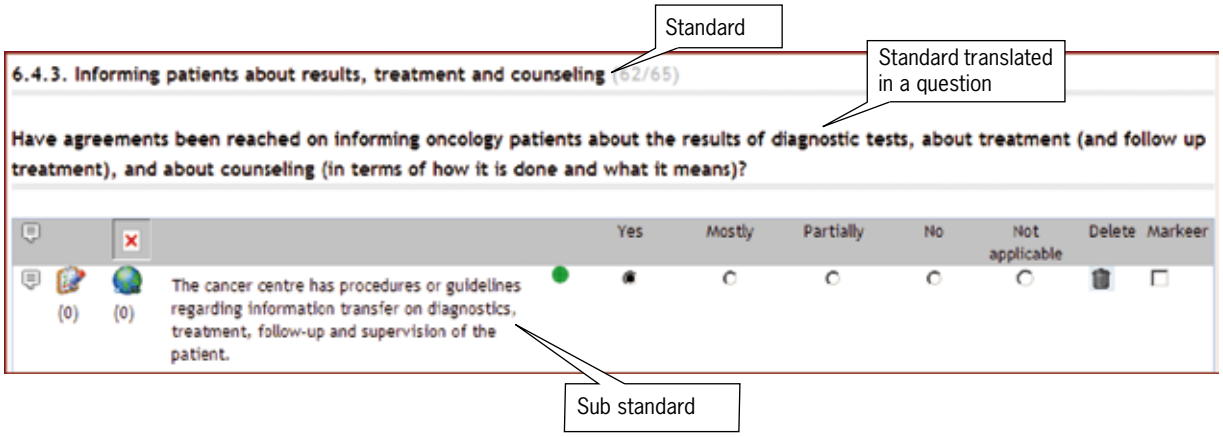


2. Three steps to fill out the qualitative questionnaire

• Step 1: Give a score to all items in the questionnaire

The quality questionnaire consists of:

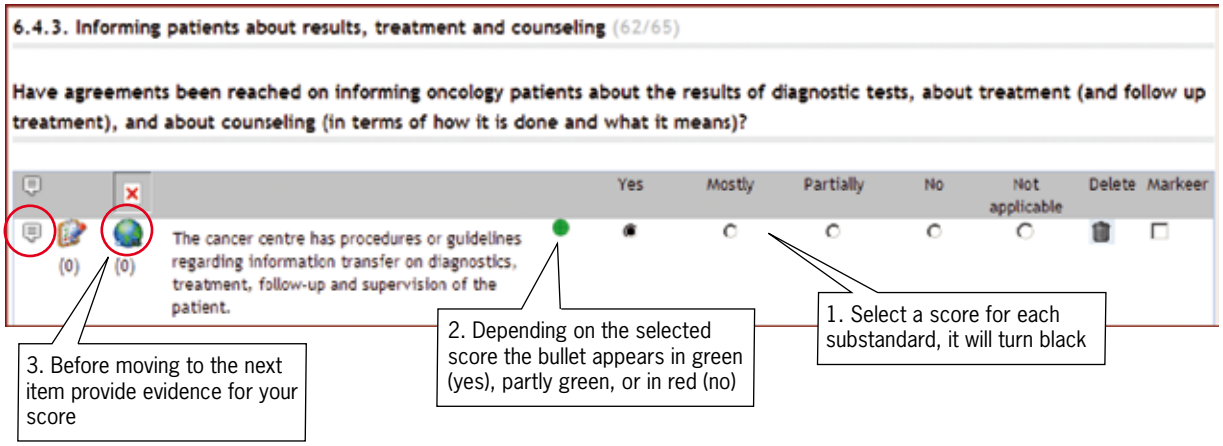
Chapters	Domains	Standards	Sub standards/questions, Total 264 (100%)
Chapter 1	General standards, strategic plan and general management	26	121 (47%)
1.1	Policy and organisation	5	22
1.3	Resources and materials	2	8
1.4	Process control	12	54
1.5	Safeguarding the quality system	7	37
Chapter 2	Screening and primary prevention and health education	5	19 (7%)
2.4	Process control	5	19
Chapter 3	Care	10	30 (11%)
3.4	Process control	10	30
Chapter 4	Research innovation and developments	14	45 (17%)
4.1	Policy and organisation	7	25
4.3	Resources and materials	3	12
4.4	Process control	3	4
4.5	Safeguarding the quality system	1	4
Chapter 5	Education and teaching	4	19 (7%)
5.1	Policy and organisation	1	7
5.4	Process control	3	12
Chapter 6	Patient related	6	30 (11%)
6.4	Process control	4	21
6.5	Safeguarding the quality system	2	9



Possible scores

The score is an indicator for the stage of implementation of each item of the standard. The scoring system is based on the Plan-Do-Check-Act-circle or Deming-circle. These four stages of implementation are translated in the following possible answers:

- **Yes** means that the indicator of the standard has been implemented on a wide scale in the cancer institute and the Deming-cycle is completed at least twice (> in third cycle),
- **Mostly** means that the indicator has been implemented in most of the critical places in the cancer institute and the Deming-cycle is completed at least once (> in second cycle),
- **Partially** means that the indicator is implemented on project bases or on a modest scale in the cancer institute or the Deming-cycle has not been completed,
- **No** means that the indicator does not get attention or there are plans to start working on the indicator,
- **Not applicable** means that the indicator is not applicable in the cancer institute.

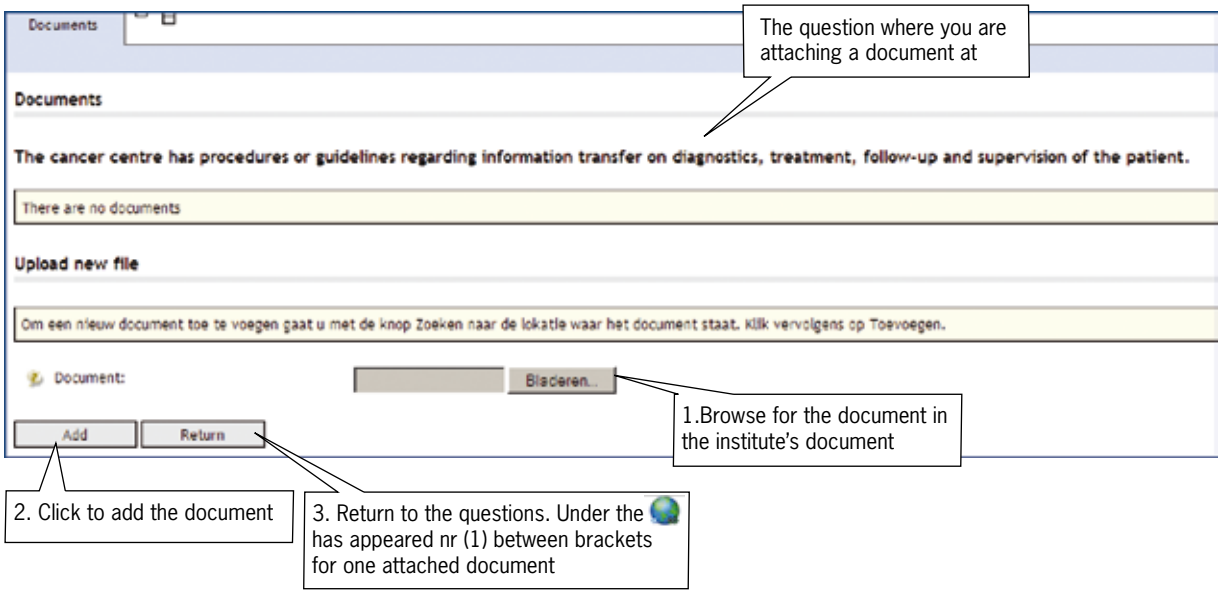


- **Step 2: Provide evidence for the given score, through:**

- Attaching a document to a specific question in the e-tool that provides the evidence OR
- Referring to a document that is already attached in an earlier item OR
- Adding a note to justify the score if there is no document available AND
- Adding the requested documents.

How to attach a document to a specific question?

Click on the globe icon and the following screen appears:

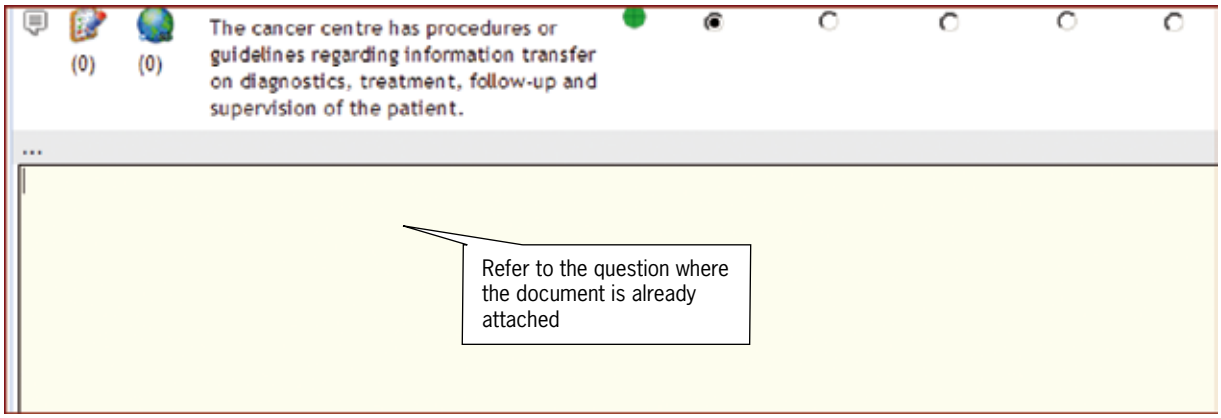


To get an overview of the specific questions that contain a document you can close the questionnaire and click on the icon in the table under evidence.

How to refer to a document that is already attached?

Click on the note box icon. A note box appears under the specific question.
To close the box: just click with your mouse somewhere on the page.

Now there is a note in the note box the icon will be changed with bold lines:

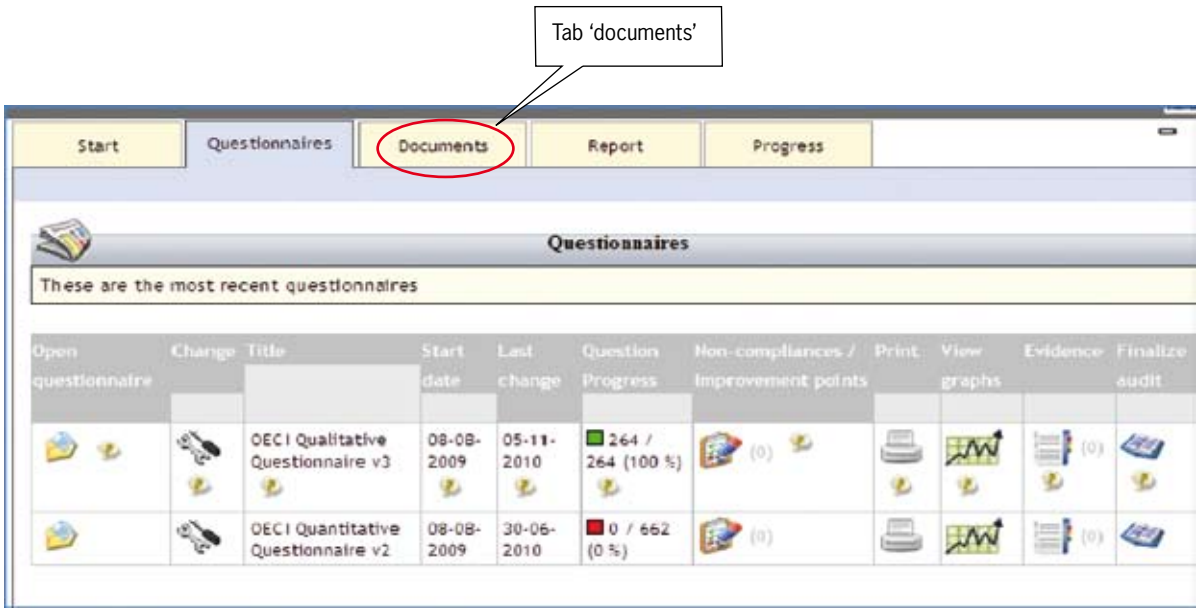


How to add a note to justify the score?

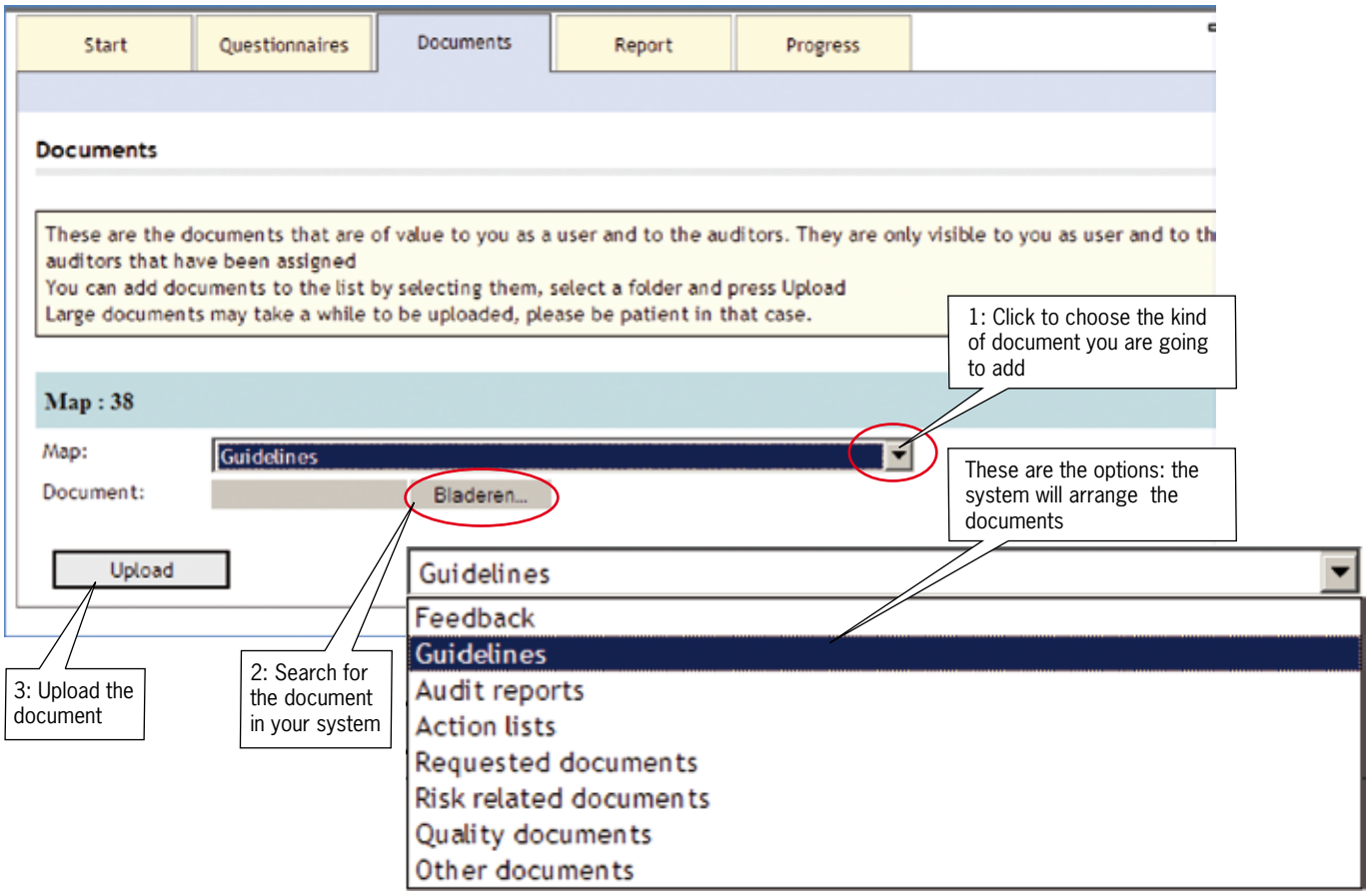
If there is no document that can provide evidence for the given score or the document/policy/procedure is not available, please justify the given score by putting a note in the note box (as explained above).
It is also possible that the institute cannot answer the question literally, for example because the institute is not responsible for the standard questioned, please also use the note box to explain this issue.

How to add the documents requested by the OECI?

When you log in to the e-tool you will see the following screen with some tabs above the two questionnaires. In the underneath figure the tab that is blue: 'Questionnaires' is open.
Go to the tab documents.



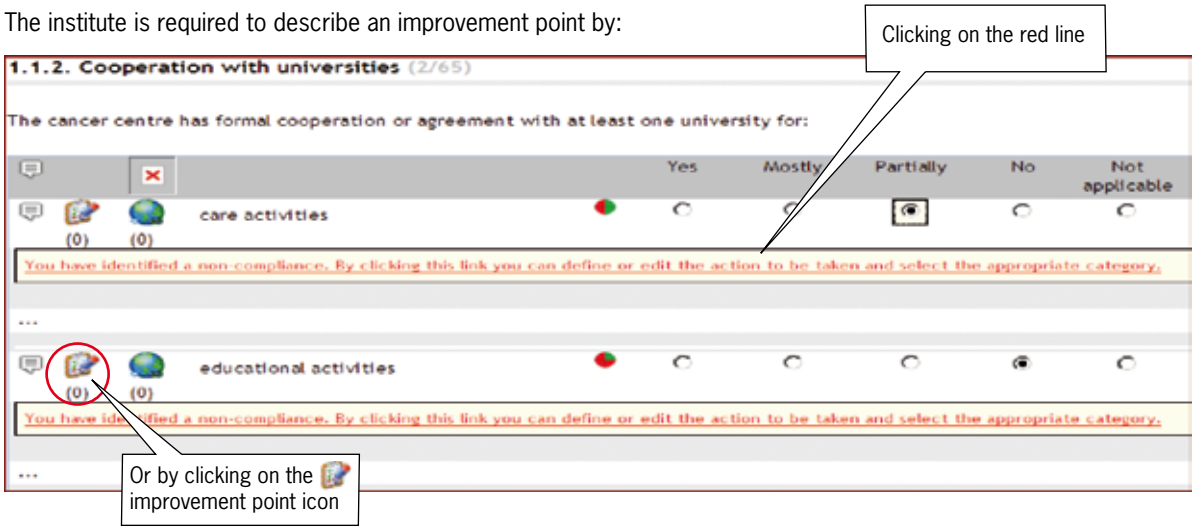
The following screen will appear. Follow step 1, 2 and 3.



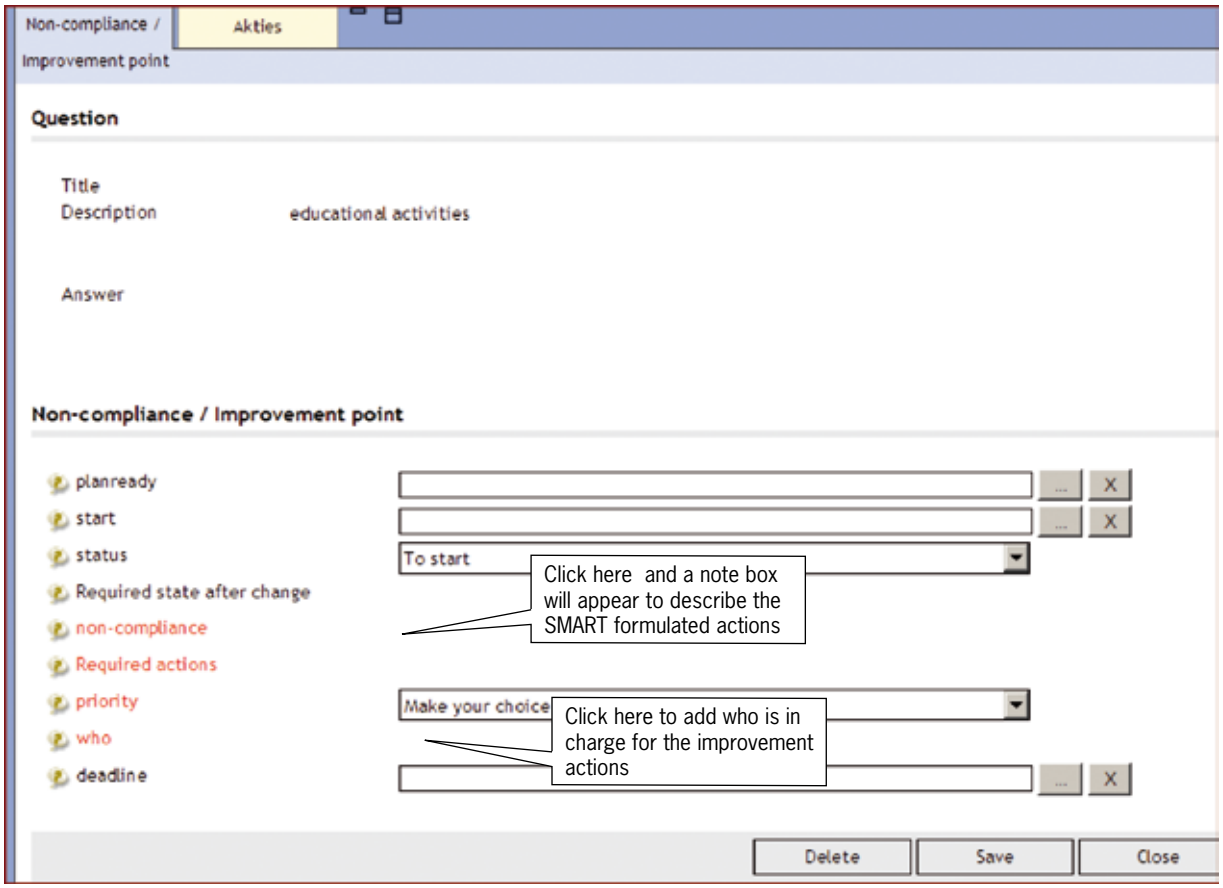
- **Step 3: Add a non-compliance/improvement point**

If you have scored a question with 'partially' or 'no' a red sentence appears under the question that a non-compliance point has been identified. This means that (quality) improvement can be made regarding this substandard by the institute.

The institute is required to describe an improvement point by:

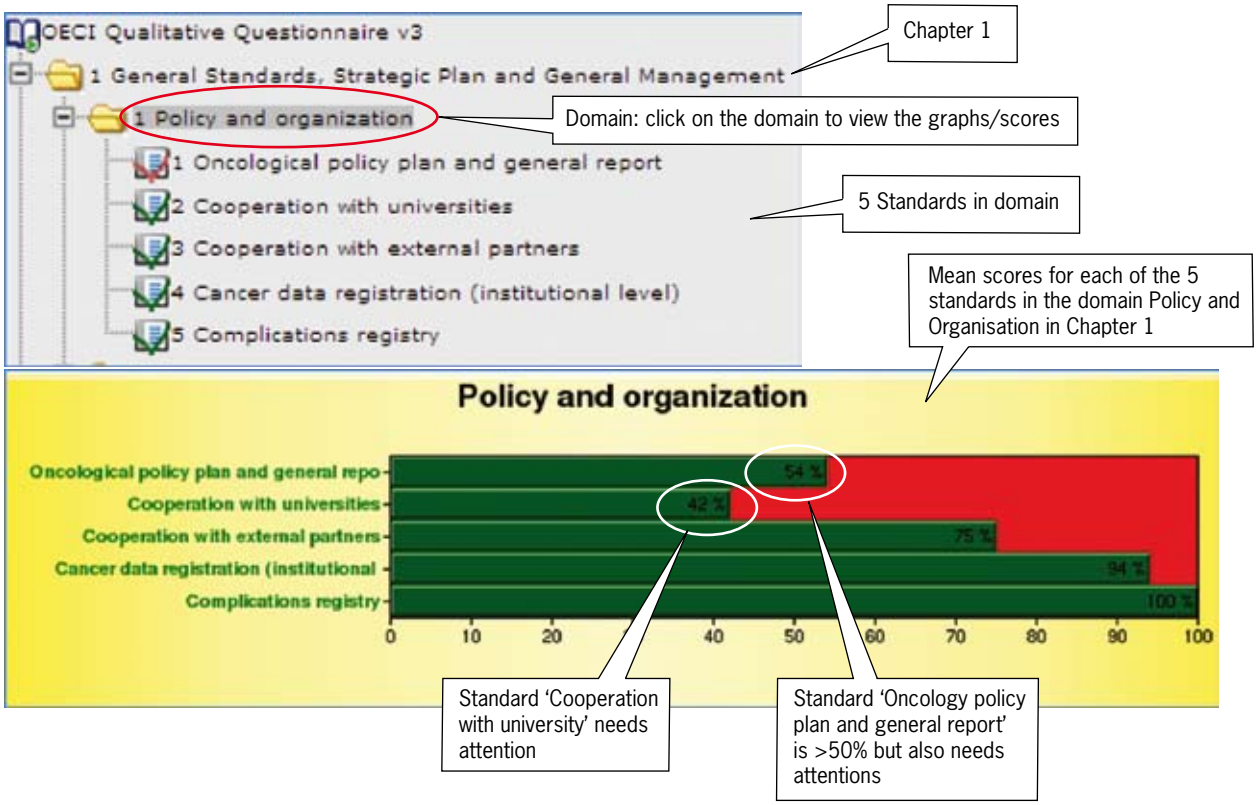


Click on 'Save and new entry' in the screen that appears and fill in the items for the improvement:

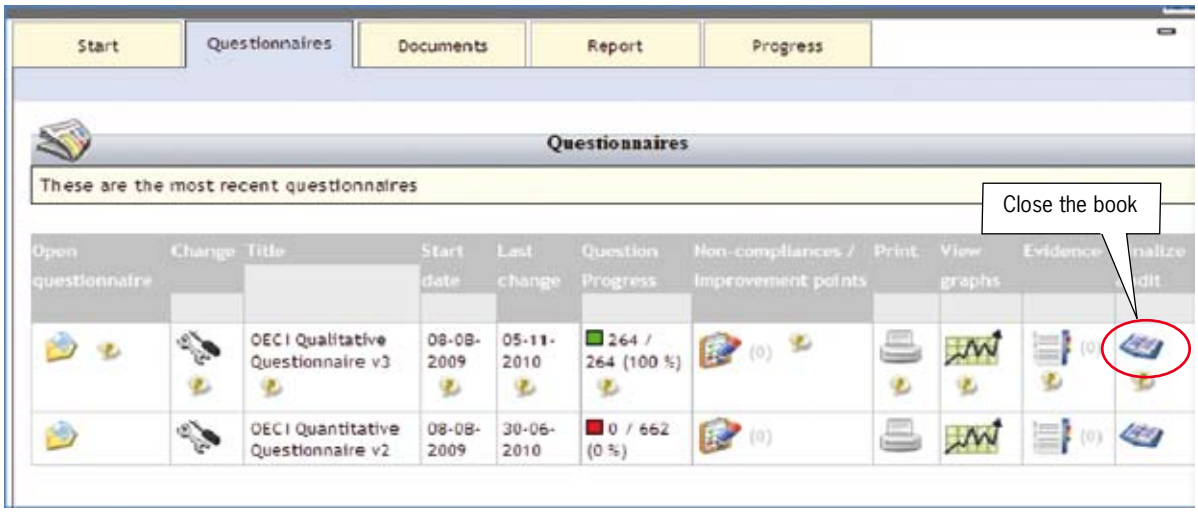


- **Check the level of quality the institute has achieved per standard**

– Open the qualitative questionnaire
– Open the show tree

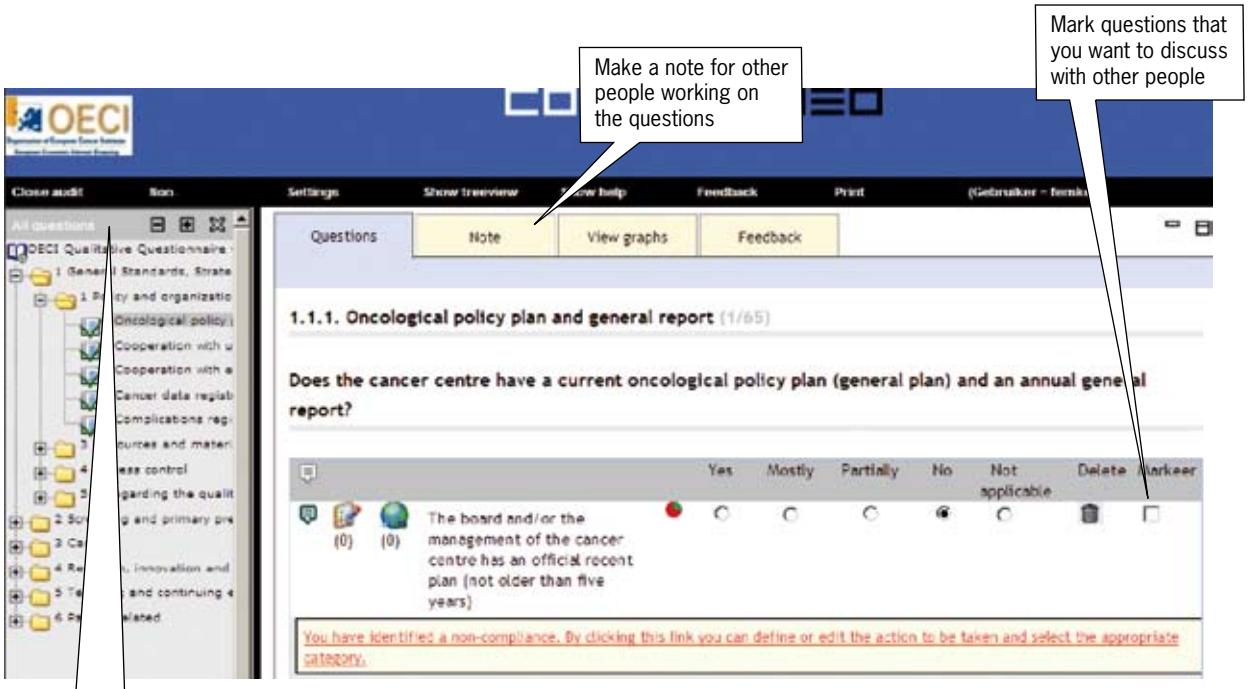


- **Close the questionnaire if you will not change or add anything else**

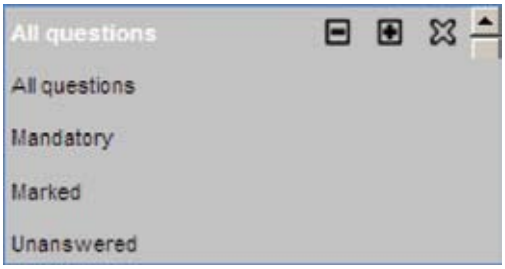


- **Other options**

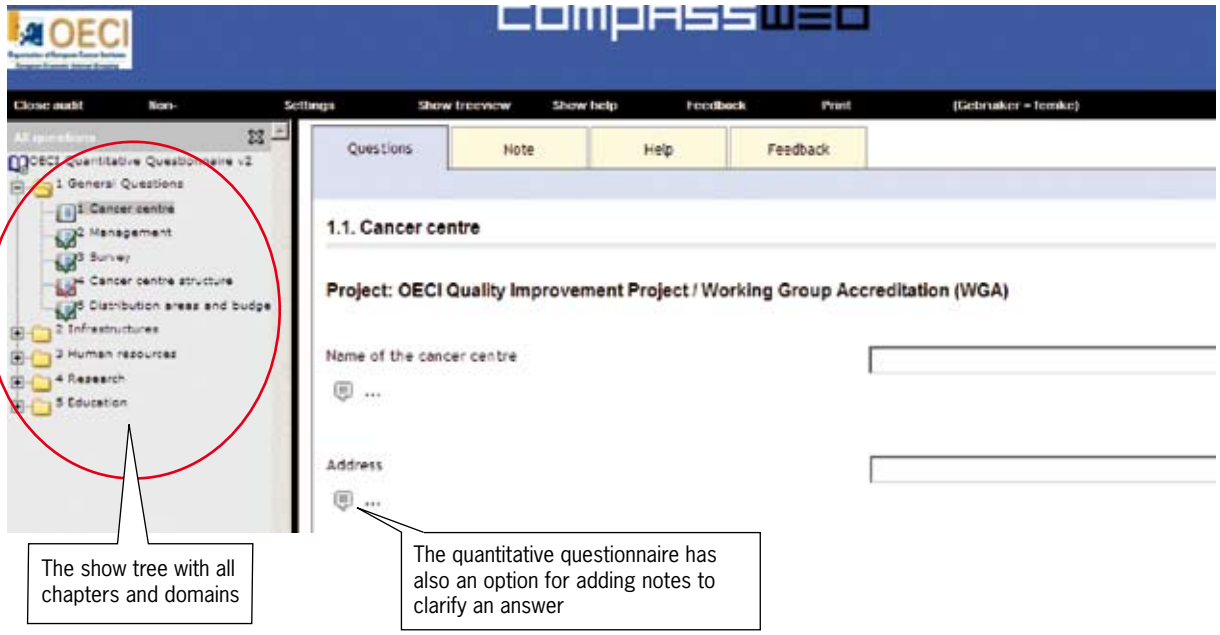
– Mark questions to discuss in project group meetings
– Make a note for other people working in the questionnaire
– Show only the marked or unanswered questions



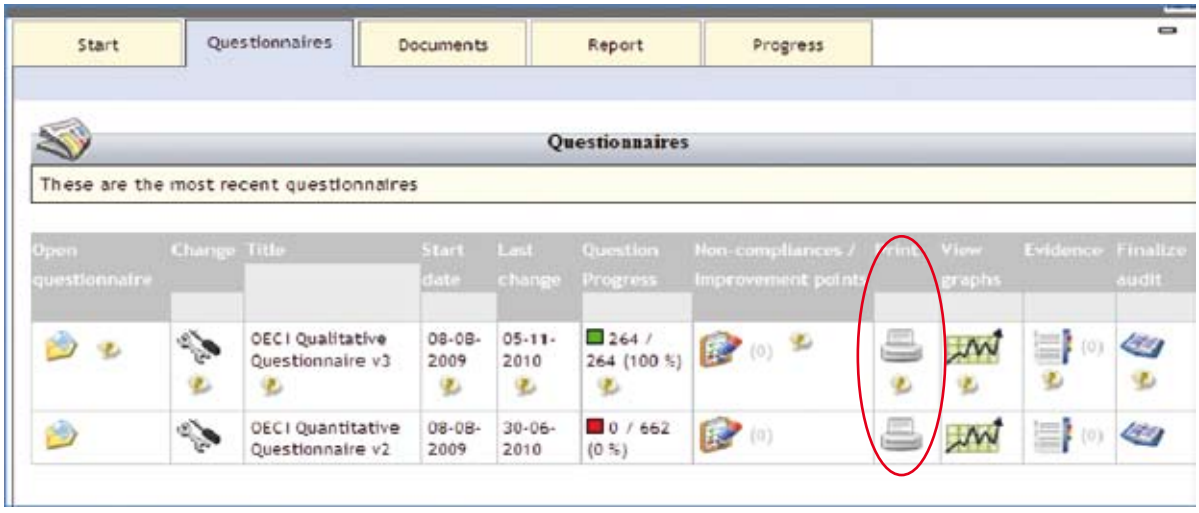
Click on “all questions’ for this list.
Choose one of the options and the show tree will only show the “marked” or “unanswered”



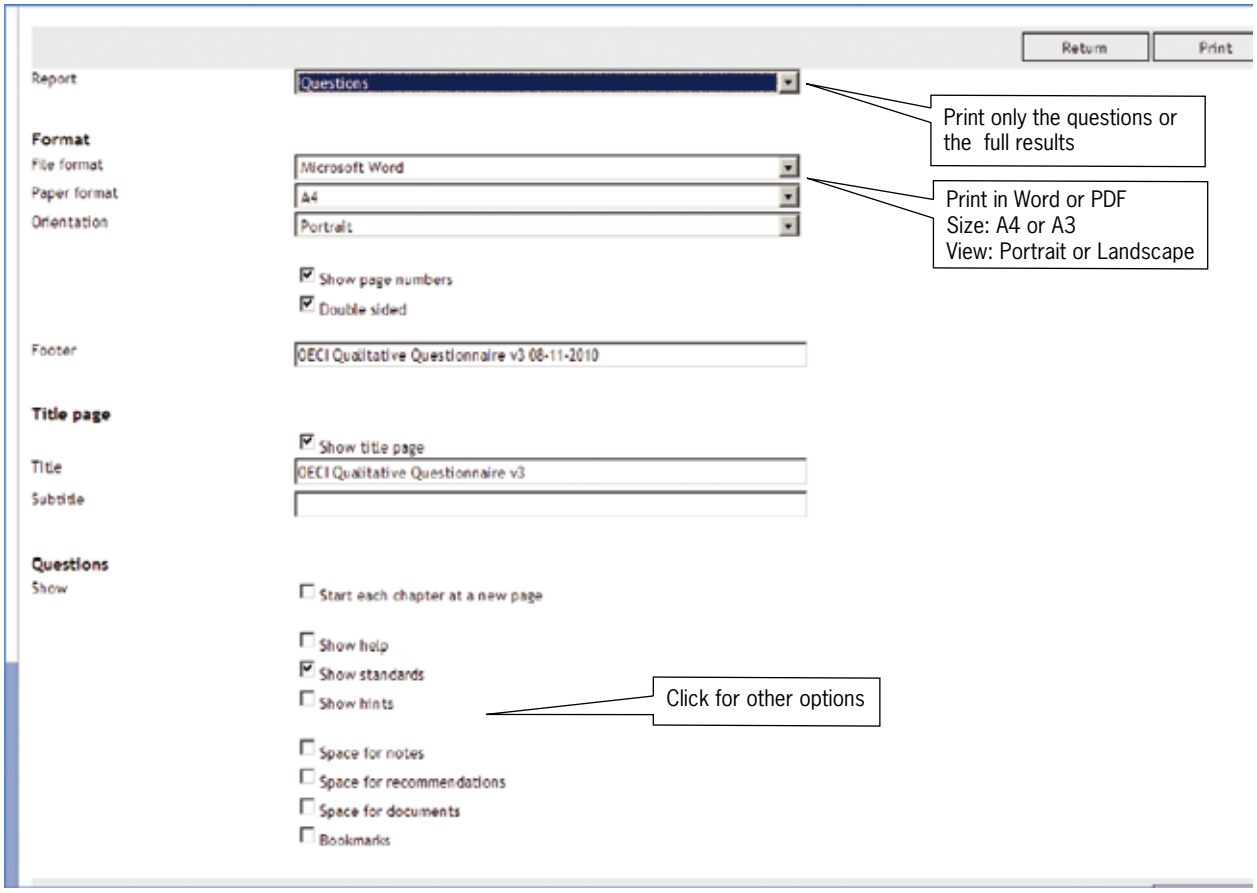
3. Quantitative questionnaire



4. Print the questions and/or the results in a report



The following screen appears with several options.


Return
Print
Report
Questions
Print only the questions or the full results
Format
File format
Microsoft Word
Paper format
A4
Orientation
Portrait
Print in Word or PDF
Size: A4 or A3
View: Portrait or Landscape
Show page numbers
Double sided
Footer
OECI Qualitative Questionnaire v3 08-11-2010
Title page
Show title page
Title
OECI Qualitative Questionnaire v3
Subtitle
Questions
Show
Start each chapter at a new page
Show help
Show standards
Show hints
Click for other options
Space for notes
Space for recommendations
Space for documents
Bookmarks

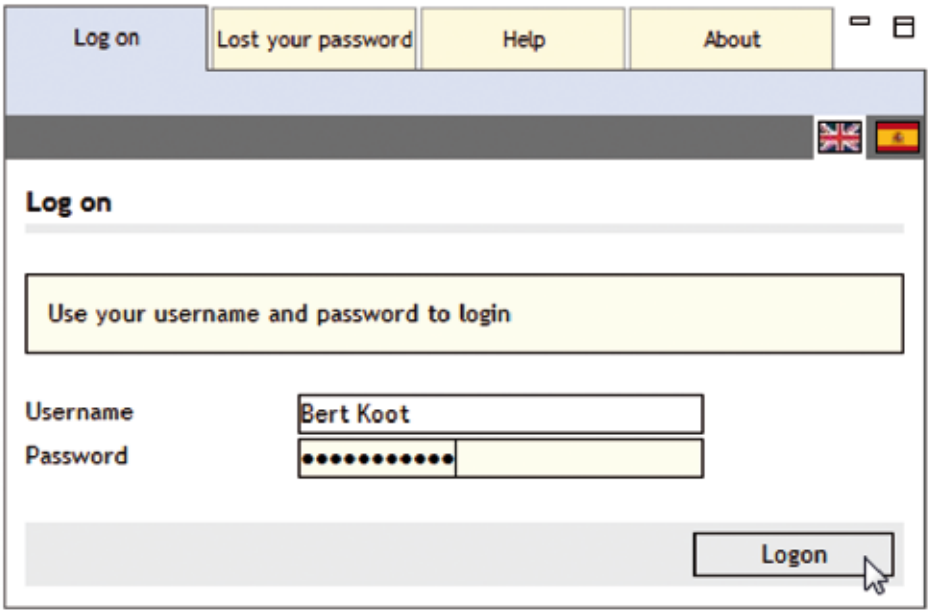
Appendix VI. User manual e-tool for auditors

This user manual gives an explanation of how OECI auditors can use the OECI electronic tool. The great advantage of the tool is that the auditors of a team can communicate with each other regardless of their physical location. An auditor can prepare a peer review individually by analysing the questionnaires and documents, and an auditor can add notes to questions which are unclear or which the auditor would like to discuss with the audit team.

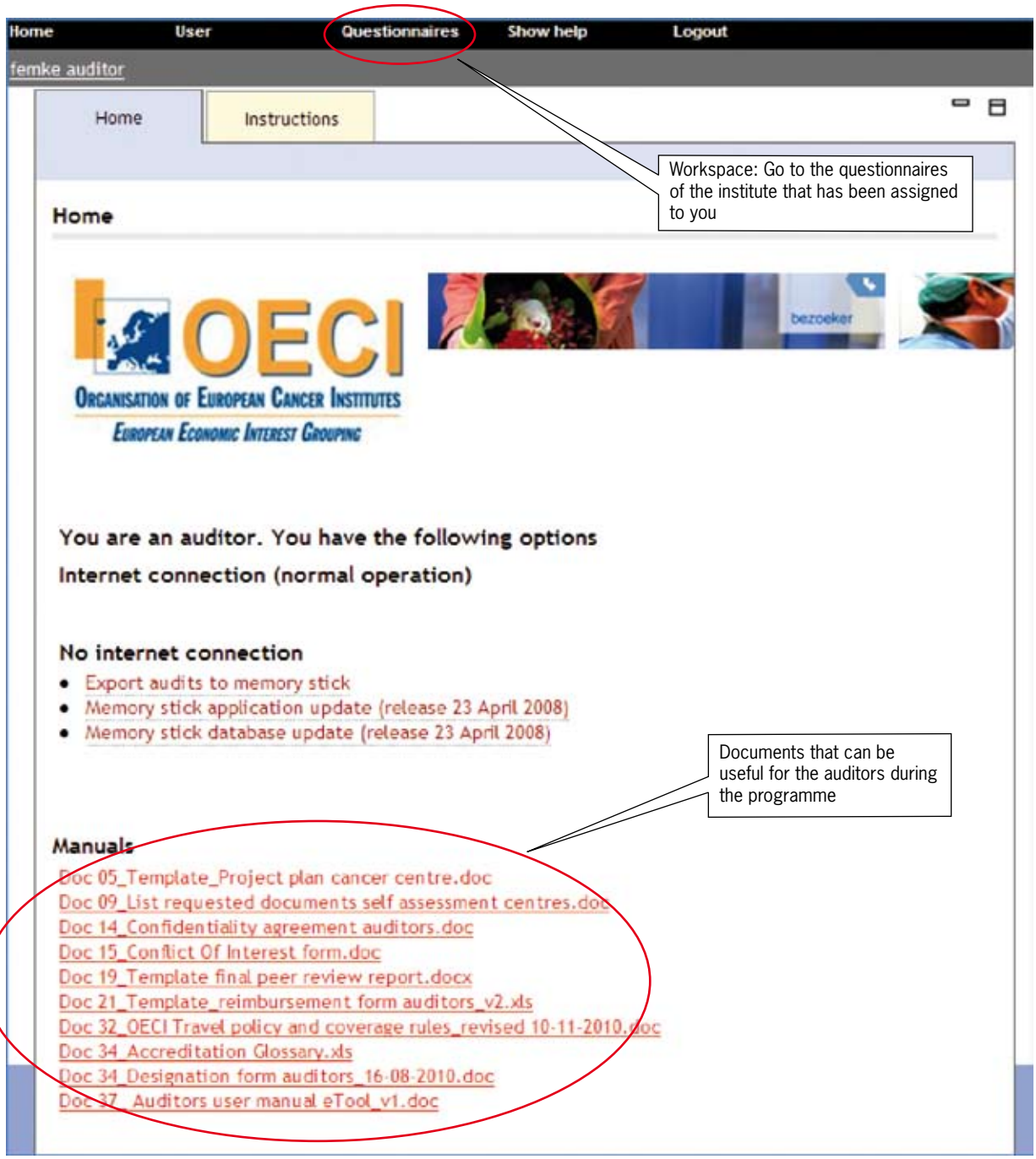
1. Log on

Go to: http://oeci.selfassessment.nu/compass/user or through the website http://oeci.selfassessment.nu.

An Auditor's username has been supplied with a password, use this to log in to the application.



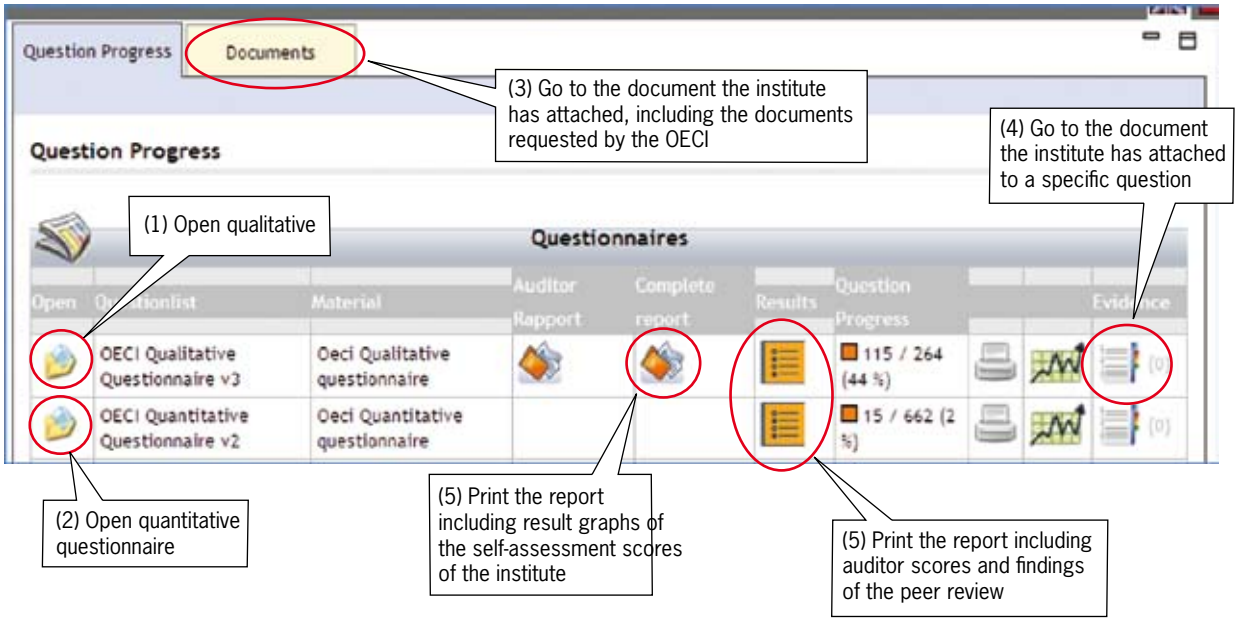
When successfully logged in you will find the following screen:



In the **'Workspace'** you can go to the questionnaires of the institutes that have been assigned to you by the OECI Accreditation Coordinator.

Click on the institute of your choice, the table with the qualitative AND quantitative questionnaire of that institute will appear.

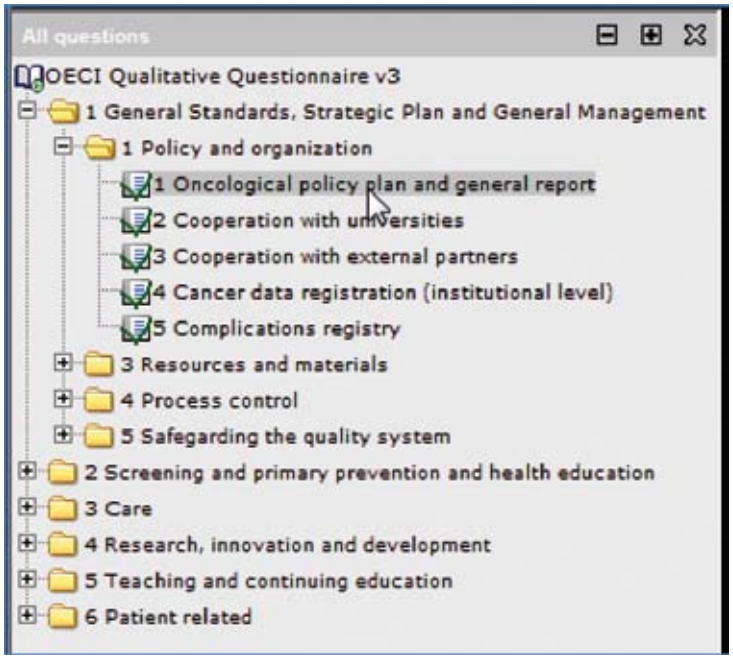
From this window there are several options for the auditor:



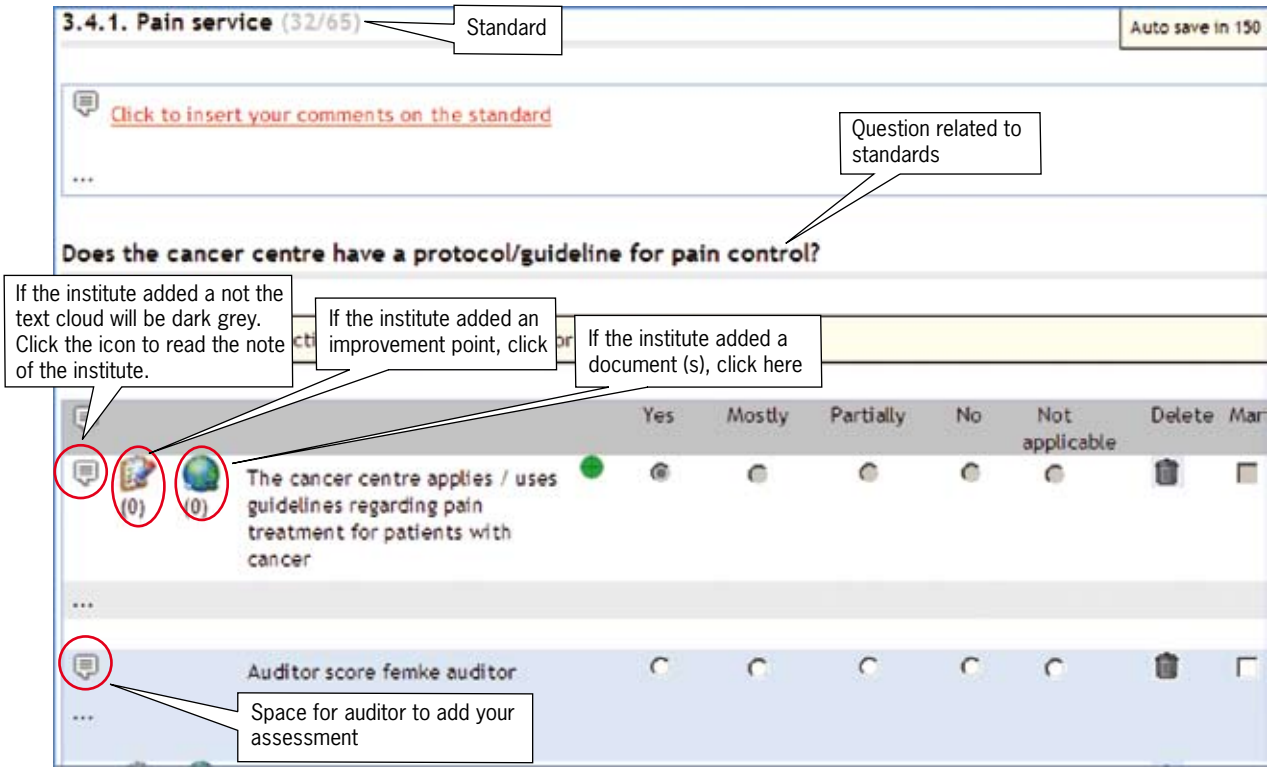
Options in the e-tool:
1. Go into qualitative questionnaire of the cancer institute
2. Go into quantitative questionnaire of the cancer institute
3. Go to the requested documents
4. Go to the documents attached to specific questions
5. Print the reports

2. Preparing a peer review

Open a questionnaire and use the treeview to navigate through the chapters / domains and standards.

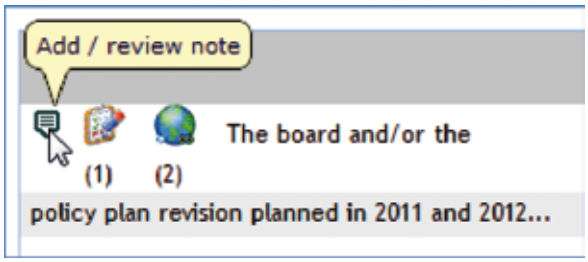


The first line shows the standard and the answer given by the centre, you can read the complete standard by clicking the text of the question.



Beneath the score of the centre, the space for the auditor can be found to add an assessment of the topic. You can score the question by clicking on the appropriate answer. You can **add notes** notes in the same way as reviewing the institutes remark and you can place items on the discussion list by ticking the box.

If an institute added a note to the standard to support the answer you can read the first line of the note underneath the standard. To view the full text, click the little text icon



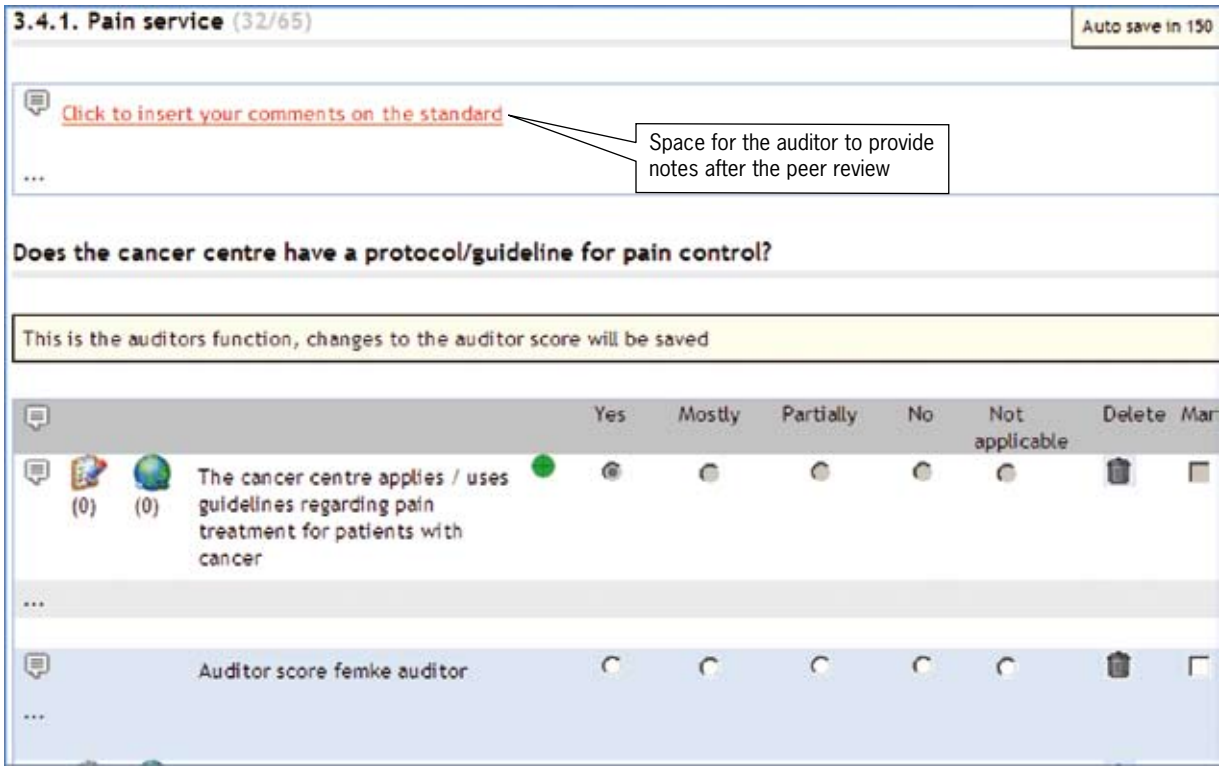
The full text of the note will be shown but can not be changed. Clicking the little icon once more will close the note.
The second icon shows the (number of) improvement points that the institute descibes regarding to this standard.
The third icon showd the number of proof documents that the institute uploaded to support this standard.

3. Report findings and scores after peer review

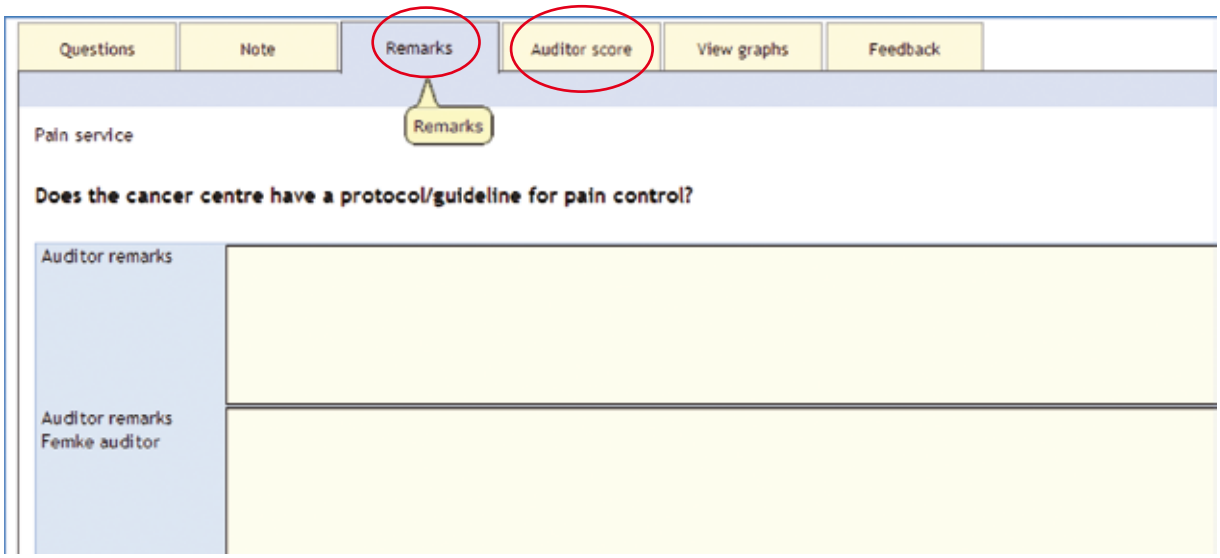
After the peer review the auditors provide their notes and scores to the Accreditation Coordinator through the e-tool:

- Note: On standard level in the questionnaire: for each standard,
- Score: On Sub-question level: for each sub-question,
- Strengths and opportunities: if a standard is a strengths or an opportunity the auditor will also make a not on standard level to explain.

The coordinator will make a draft report with the notes of the auditors.



To view the remarks and the score of the other auditors:

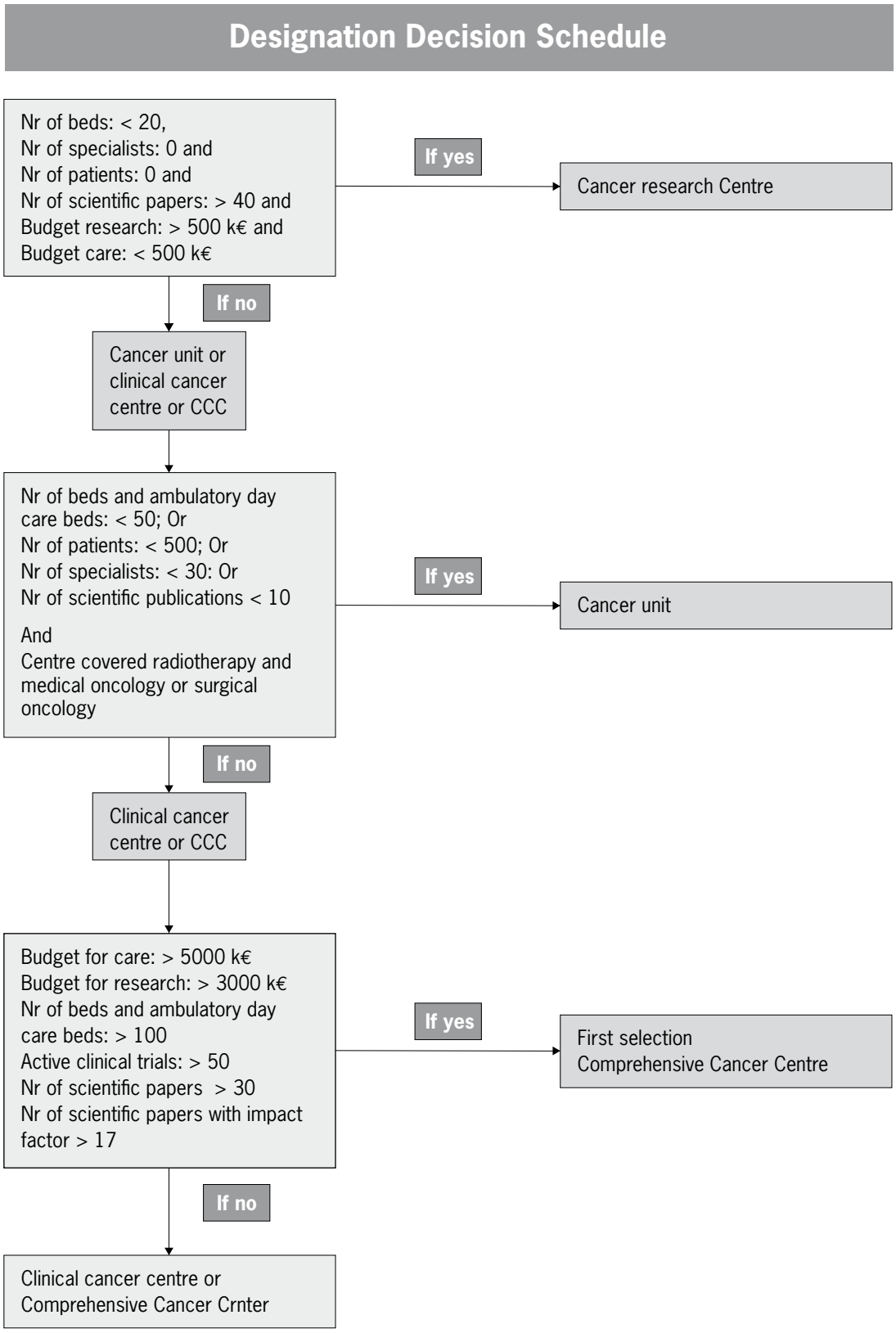


4. The final draft report

The Accreditation Coordinator makes a draft report of all the notes/ remarks, scores and strengths and opportunities.
The auditor will give his/her comments and feedback on the draft before it will be send to the institute as explained in the procedures.

Appendix I. Designation Decision Schedule

(Not for public release).



Appendix II. OECI Quality standards

(This appendix contains a paper version of the OECI quality standards (not for public release).

In clinical cancer centres and Comprehensive Cancer Centres the full set of standards will be assessed during the self-assessment and by the audit team during the peer review visit.

Cancer Unit are excluded for the standards in chapter 4: Research innovation and developments.

The sollowint table shows the chapters and domains with the number of standards and questions. The marked standards are not assessed in Cancer Units.

Chapters	Domains	Nr of standards	Sub standards/ questions Total 264
Chapter 1	General standards, strategic plan and general management	26	121
1.1	Policy and organisation	5	22
1.3	Resources and materials	2	8
1.4	Process control	12	54
1.5	Safeguarding the quality system	7	37
Chapter 2	Screening and primary prevention and health education	5	19
2.4	Process control	5	19
Chapter 3	Care	10	30
3.4	Process control	10	30
Chapter 4	Research innovation and developments	14	45
4.1	Policy and organisation	7	25
4.3	Resources and materials	3	12
4.4	Process control	3	4
4.5	Safeguarding the quality system	1	4
Chapter 5	Education and teaching	4	19
5.1	Policy and organisation	1	7
5.4	Process control	3	12
Chapter 6	Patient related	6	30
6.4	Process control	4	21
6.5	Safeguarding the quality system	2	9

All standards and questions are presented on the following pages. Additionally to giving a score to each question, the e-tool gives the opportunity to add notes, proof documents and improvement points.

Qualitative Questionnaire

1. General Standards, Strategic Plan and General Management

1.1. Policy and organisation

1.1.1. Oncological policy plan and general report

1.1.1.1.

		Yes	Mostly	Partially	No	not applicable
1.1.1.1.1.	The board and/or the management of the cancer centre has an official recent plan (not older than five years)					
1.1.1.1.2.	The vision on care in the field of oncology care is explained in the plan					
1.1.1.1.3.	The policy and the goals to be achieved are defined in the plan					
1.1.1.1.4.	The annual plan or multi-year plan contains actions to achieve the goals					
1.1.1.1.5.	The cancer centre has concrete annual or multi-year plans on the level of the main services or clusters					
1.1.1.1.6.	The plan is evaluated in later annual reports					
1.1.1.1.7.	Improvement activities of the cancer centre (logistics, research, education, multidisciplinary teams) are part of the annual report					

1.1.2. Cooperation with universities

1.1.2.1.

The cancer centre has formal cooperation or agreement with at least one university for:

		Yes	Mostly	Partially	No	not applicable
1.1.2.1.1.	care activities					
1.1.2.1.2.	educational activities					
1.1.2.1.3.	research activities					

1.1.3. Cooperation with external partners

Have agreements been reached, about the allocation of tasks, such as a hospital or radio therapeutic institute in the case of referrals?

1.1.3.1.

		Yes	Mostly	Partially	No	not applicable
1.1.3.1.1.	Cooperation arrangements with other cancer centres are clearly documented in (written) agreements covering the goals of the cooperation, tasks, responsibilities and competences of the cancer centre and the cooperating partners					
1.1.3.1.2.	There are (written) agreements with home care organisations					
1.1.3.1.3.	There are (written) defined and documented cooperation arrangements with general practitioners.					
1.1.3.1.4.	There are (written) agreements with nursing home, rest house, palliative care institutions, etc.					
1.1.3.1.5.	There are (written) agreements with special cancer care service providers such as radiotherapy centre, pathology laboratory, specialised surgery unit etc.					

1.1.4. Cancer data registration (institutional level)

Are the data on the patients' types of cancers recorded in an institutional cancer database?

1.1.4.1.

		Yes	Mostly	Partially	No	not applicable
1.1.4.1.1.	The number of new oncology patients is known at an institutional level					
1.1.4.1.2.	The number of new cases for each type of cancer is known at an institutional level					
1.1.4.1.3.	There are diagnostic, treatment and outcome data on patients with cancer available annually at an institutional level					
1.1.4.1.4.	The data are reported and analysed by a multidisciplinary group with recommendations for improvement of care					

1.1.5. Complications registry

Have agreements been reached concerning keeping and discussing a complications registry?

1.1.5.1.

		Yes	Mostly	Partially	No	not applicable
1.1.5.1.1.	There are specific protocols for reporting and recording of complications					
1.1.5.1.2.	The data are analysed at an institutional level					
1.1.5.1.3.	After analysis, improvement measures are developed and action plans implemented in agreement with the departments concerned					

1.3. Resources and materials

1.3.1. Cytostatic drugs, prescription, preparation and distribution

Have agreements been reached concerning the prescription, preparation and distribution of cytostatic drugs?

1.3.1.1.

		Yes	Mostly	Partially	No	not applicable
1.3.1.1.1.	A written procedure concerning prescription of anti-cancer drugs is available					
1.3.1.1.2.	A written procedure concerning preparation of anti-cancer drugs is available					
1.3.1.1.3.	A written procedure concerning distribution of anti-cancer drugs is available					
1.3.1.1.4.	The anti-cancer drugs are prepared in a centralised unit					
1.3.1.1.5.	The anti-cancer drugs are prepared under the direct supervision of a pharmacist					

1.3.2. Administration of cytostatic drugs

Are there protocols for the administration of cytostatic drugs?

1.3.2.1.

		Yes	Mostly	Partially	No	not applicable
1.3.2.1.1.	The cancer centre has described procedures or guidelines on the administration of anti-cancer drugs					
1.3.2.1.2.	The anti-cancer drugs are as much as possible administrated in specialised wards (e.g., administration of anti-cancer drugs takes place only in some well-defined wards (medical oncology ward…)					
1.3.2.1.3.	There is a dedicated day-care unit for the administration of anti-cancer drugs					

1.4. Process control

1.4.1. Continuity of care within the cancer centre

Have agreements been reached concerning the continuity of care, and replacement of nursing, medical, paramedical, and support staff associated with oncology? Is the care covered 7 days a week by specialised staff?

1.4.1.1.

		Yes	Mostly	Partially	No	not applicable
1.4.1.1.1.	Continuity of specialised care is warranted 24 hours a day on the medical, paramedical, nursing and supportive levels. This can, among other things, be achieved by planning continuity of care during nights, week-ends, holidays, illness, attendance at conferences or other reasons for absence, within each discipline					
1.4.1.1.2.	Patients are informed about all the aspects of the continuity of care and eventually referred to another hospital					
1.4.1.1.3.	The patient receives information about the contact person for medical and nursing oncological matters					

1.4.2. Waiting and throughput times

Have norms, standards been defined concerning the maximum waiting and throughput times for oncological patients with regard to first outpatients' visit, admission, and tests/treatment?

1.4.2.1.

There are guidelines (for different types of tumours) for the (maximum) waiting times between:

		Yes	Mostly	Partially	No	not applicable
1.4.2.1.1.	referral by the general practitioner or referring specialist and the first visit to the outpatient's clinic or the admission into the cancer centre					
1.4.2.1.2.	first visit and the time of definitive diagnosis					
1.4.2.1.3.	definitive diagnosis and first treatment					
1.4.2.1.4.	There is a record of those waiting times					
1.4.2.1.5.	There is continuous measurement and analysis of those waiting times leading to improvements when needed					
1.4.2.1.6.	There is a clear definition of the roles of each category of staff on those issues					

1.4.3. Compliance with guidelines

Have agreements been reached concerning the use of guidelines relating to diagnosis, treatment, follow up and research?

1.4.3.1.

		Yes	Mostly	Partially	No	not applicable
1.4.3.1.1.	The medical specialists and the employees of the cancer centre apply the (local/regional/national/ international) guidelines on diagnostics, treatment, follow up and research					
1.4.3.1.2.	The guidelines are easily accessible					
1.4.3.1.3.	The guidelines are updated on a regular basis depending on medical developments					
1.4.3.1.4.	Each decision that differs from the guidelines is recorded in the file of the patient					

1.4.4. Compliance with guidelines

Do you report the compliance with multidisciplinary guidelines?

1.4.4.1.

		Yes	Mostly	Partially	No	not applicable
1.4.4.1.1.	Compliance with guidelines is measured through the registration of the patients' cancer data					
1.4.4.1.2.	Deviations from guidelines are analysed					
1.4.4.1.3.	Deviations from guidelines are discussed					
1.4.4.1.4.	Deviations from guidelines are reported annually					

1.4.5. Tasks and responsibilities of the (oncology) nurses

Have agreements been reached concerning the tasks and responsibilities of nurses working at the oncology department?

1.4.5.1.

		Yes	Mostly	Partially	No	not applicable
1.4.5.1.1.	For each technical, clinical or outpatient's department where patients with cancer are treated, there are nurses trained in oncology					
1.4.5.1.2.	Anti-cancer drugs are administered by specially educated (oncology) nurses					
1.4.5.1.3.	The cancer centre has nurses with expertise with regard to the tumours treated (e.g.: breast, colo-rectal, head and neck, gynaecological cancer)					
1.4.5.1.4.	There are procedures describing the tasks and responsibilities of (oncology) nurses					
1.4.5.1.5.	Roles and responsibilities of nurses with different expertises (oncology, palliative care,…) are described regarding special involvement in oncology care					
1.4.5.1.6.	The nursing discipline has one staff member as contact person for oncology care					

1.4.6. Roles and tasks of the members of the supportive care staff

Have agreements been reached concerning the roles and tasks of the supportive care staff?

1.4.6.1.

		Yes	Mostly	Partially	No	not applicable
1.4.6.1.1.	Roles and responsibilities for each of the paramedical disciplines are described regarding the involvement in oncology care					
1.4.6.1.2.	Roles and responsibilities for each of the supportive disciplines are described regarding the involvement in oncology care					
1.4.6.1.3.	Each of the paramedical discipline has one staff-member as contact person (referent) for oncology care					
1.4.6.1.4.	Each of the supportive disciplines has one staff-member as contact person (referent) for oncology care					

1.4.7. Communication between the members of the supportive care staff

What is the focus of the communication between nursing, paramedic and supportive disciplines?

1.4.7.1.

Communication amongst members of the supportive care staff (nursing, paramedical and supportive disciplines) occurs through:

		Yes	Mostly	Partially	No	not applicable
1.4.7.1.1.	Consultation					
1.4.7.1.2.	Data transmission					
1.4.7.1.3.	Transfer of knowledge					
1.4.7.1.4.	Information and implementation of guidelines					

Have agreements been reached within the cancer centre concerning who is authorised to refer patients to paramedical and/ or support disciplines, and under what circumstances?

1.4.8.1.

		Yes	Mostly	Partially	No	not applicable
1.4.8.1.1.	It is made clear for which problems related to cancer and at which moment paramedical disciplines should be consulted					
1.4.8.1.2.	It is made clear for which problems related to cancer and at which moment supportive disciplines should be consulted					
1.4.8.1.3.	There are written procedures on the circumstances for calling on and referral to paramedical disciplines					
1.4.8.1.4.	There are written procedures on the circumstances for calling on and referral to supportive disciplines					

1.4.9. Multidisciplinary harmonisation / integrated care

Have agreements been reached on the harmonisation of integrated care, between the various disciplines involved in the diagnosis, treatment and counselling of oncology patients?

1.4.9.1.

		Yes	Mostly	Partially	No	not applicable
1.4.9.1.1.	The responsibilities of the different disciplines involved in the diagnosis of the patient in the cancer centre are described					
1.4.9.1.2.	The responsibilities of the different disciplines involved in the treatment of the patient in the cancer centre are described					
1.4.9.1.3.	The responsibilities of the different disciplines involved in the follow-up of the patient in the cancer centre are described					
1.4.9.1.4.	The multidisciplinary team advises on the inclusion of patients in clinical trials					
1.4.9.1.5.	The name of the physician responsible for the coordination of the care of the patient is defined and communicated to the patient					

1.4.10. Selection criteria for the oncology team meeting

Are the selection criteria concerning which patient should be discussed in the multidisciplinary setting clear and documented?

1.4.10.1.

		Yes	Mostly	Partially	No	not applicable
1.4.10.1.1.	Criteria are defined for the selection of patients to be discussed in the multidisciplinary team meetings					
1.4.10.1.2.	These selection criteria are clear, documented and based on a consensus between the different disciplines					

1.4.11. Procedure for the oncological multidisciplinary team meetings

Is there a procedure for the oncological multidisciplinary team meetings?

1.4.11.1.

There are procedures describing how the regular multidisciplinary team meetings apply following criteria:

		Yes	*Mostly*	*Partially*	*No*	*not applicable*
1.4.11.1.1.	One of the specialist in charge of the care of the patient is present during the discussion of the patient					
1.4.11.1.2.	During the presentation of patients, diagnostic results and examination results are available					
1.4.11.1.3.	The necessary facilities to show diagnostic and examination results are available					
1.4.11.1.4.	Conclusions and advice resulting from the multidisciplinary team meeting are documented in the patient's medical record					
1.4.11.1.5.	There is a clear description of the way to inform all the members of the multidisciplinary team about which patients will be discussed					
1.4.11.1.6.	There is a clear description of the communication of the advice resulting from the discussion to all the physicians and other disciplines involved in the care of the given patients					
1.4.11.1.7.	There is a clear description of the communication of the advice resulting from the discussion to the concerned patients					
1.4.11.1.8.	Each final decision about care of the patient that differs from the advice and conclusions of the multidisciplinary team is documented and recorded in the patient's medical record					
1.4.11.1.9.	There is a procedure describing how the conclusions and advice from the multidisciplinary meeting will be evaluated and by whom					

1.4.12. Registration and evaluation of the recommendations of the multidisciplinary team meeting

Have agreements been reached concerning the registration and evaluation of recommendations that emerge from the multidisciplinary team meeting?

1.4.12.1.

		Yes	Mostly	Partially	No	not applicable
1.4.12.1.1.	Conclusions and advice resulting from the multidisciplinary team meeting are documented in the patient's medical record					
1.4.12.1.2.	Deviations from conclusions and advice are documented and motivated in the patient's medical record					
1.4.12.1.3.	There is a procedure described on how the conclusions and advice from the multidisciplinary meeting will be evaluated and by whom.					

1.5. Safeguarding the quality system

1.5.1. Quality and risk management and safety requirements

Does the cancer centre have a global policy for quality and risk management and safety requirements?

1.5.1.1.

		Yes	Mostly	Partially	No	not applicable
1.5.1.1.1.	There is an identified Quality and Risk Management Direction					
1.5.1.1.2.	The quality Director participates in the executive direction of the cancer centre					
1.5.1.1.3.	There is a written global programme describing the policy for: Quality management, including continuous quality improvement (CQI) certification processes and individual accreditation of physicians					
1.5.1.1.4.	There is a written global programme describing the policy for: Risk management, including a programme for the centralised reporting of undesirable events by health care workers					
1.5.1.1.5.	There is a written global programme describing the policy for: Safety management of the cancer centre and its users					
1.5.1.1.6.	There is a written global programme describing the policy for: Patient safety management, including a systematic centralised reporting of side effects of drugs (current practice)					
1.5.1.1.7.	There is a programme for the systemic analysis of major adverse or undesirable events (e.g.: morbidity and mortality reviews), in each clinical and technical department					
1.5.1.1.8.	Patients or patients' relatives should be part of these organisations					

1.5.2. Quality and risk management and safety requirements

1.5.2.1.

		Yes	Mostly	Partially	No	not applicable
1.5.2.1.1.	There is a patients committee (or association), for consultative advice about quality of care and risk management					
1.5.2.1.2.	There is a preventive maintenance programme for equipment and access to accurate and reliable diagnostic tests					
1.5.2.1.3.	There is a monitoring system for the appropriate use of diagnostic services					
1.5.2.1.4.	There is a monitoring system for the appropriate use of (radio)therapeutic services					
1.5.2.1.5.	There is a regular internal audit system					
1.5.2.1.6.	There is a quality and risk dashboard of the cancer centre, with an annual evaluation of the results and, if necessary, revision of its content					

1.5.3. Accuracy of the diagnostic services

Are the diagnostic services safe, efficient and accurate for workers and patients?

1.5.3.1.

		Yes	Mostly	Partially	No	not applicable
1.5.3.1.1.	Security checking of devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are part of the maintenance contracts.					
1.5.3.1.2.	Latest security checks have been done on time					
1.5.3.1.3.	Calibration of devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are part of the maintenance contracts					
1.5.3.1.4.	Latest calibrations have been done on time					
1.5.3.1.5.	Devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are periodically certified by an authorised company. Expiration date is still valid.					
1.5.3.1.6.	There is a reporting system for near miss accidents during the use of the devices and equipment.					

1.5.4. Quality and risk management of research and new techniques

Are there monitoring systems for quality and risk management associated with the introduction of new techniques / new practice?

1.5.4.1.

		Yes	Mostly	Partially	No	not applicable
1.5.4.1.1.	Identification of any risk associated with the introduction of a new technology or new practice is performed systematically					
1.5.4.1.2.	There is a quality assurance programme for clinical research					
1.5.4.1.3.	There is a procedure for Serious Adverse Events and Sudden Unexpected Serious Adverse Reaction handling and reporting					
1.5.4.1.4.	The SOP's are regularly updated and are accessible					

1.5.5. Quality assurance in all areas

Does the cancer centre promote and develop the practice of quality assurance in all areas?

1.5.5.1.

The quality assurance programmes are included in the global policy for quality and risk management

		Yes	Mostly	Partially	No	not applicable
1.5.5.1.1.	There is one quality assurance programme in each oncology healthcare area (chemotherapy, surgery, radiotherapy) and at risk units (anaesthesiology, critical care, etc)					
1.5.5.1.2.	There is at least one quality assurance programme in areas other than the oncology healthcare area					
1.5.5.1.3.	All activities of cancer centre follow, when applicable, the guidelines of Good clinical Practice, Good laboratory Practice and Good manufacturing Practice					

1.5.6. Quality assurance in all areas (HR)

1.5.6.1.

		Yes	Mostly	Partially	No	not applicable
1.5.6.1.1.	Evaluation of the employees is a part of the human resources(HR) management, from bottom to top, including directors, Chief Officers (heads of departments) and physicians.					
1.5.6.1.2.	The results of evaluation are documented and used for building future strategies of the institution, with alignment of the departments					
1.5.6.1.3.	Relevant training is provided to all staff according to their level of responsibility					
1.5.6.1.4.	HR policy includes a formal individual evaluation at least once or twice a year					
1.5.6.1.5.	Training records of all staff are available					
1.5.6.1.6.	Skills, competences and expertises are assessed in case of recruitment at managerial level					
1.5.6.1.7.	Specific psychological support is available for the cancer centre's employees including physicians.					

1.5.7. Privacy, protection of personal data

Are there procedures for privacy, protection of personal data?

1.5.7.1.

		Yes	Mostly	Partially	No	not applicable
1.5.7.1.1.	There is a Patient Charter: an official set of principles, a document defining the commitments of both the cancer centre AND the patient. In this Charter the cancer centre commits itself to respect and to guarantee the patient's privacy					
1.5.7.1.2.	There is a secure procedure for the storage, preservation, consultation and transmission of personal data according to the national/European regulations					
1.5.7.1.3.	Protocols for clinical trials guarantee the protection of the patient's personal data. This point is checked and validated by an Ethical Committee					

2. Screening and primary prevention and health education

2.4. Process control

2.4.1. Availability of screening programmes

In the setting of private health policy, does the cancer centre organise or participate in screening programmes?

2.4.1.1.

		Yes	Mostly	Partially	No	not applicable
2.4.1.1.1.	The cancer centre participates in structured regional (province/county) screening programmes.					
2.4.1.1.2.	The cancer centre participates in structured national screening programmes.					
2.4.1.1.3.	The cancer centre organises screening programmes.					

2.4.2. Participation in prevention and health education initiatives

Does the cancer centre organise or participate in prevention and health education initiatives that meet the needs of the population?

2.4.2.1.

		Yes	Mostly	Partially	No	not applicable
2.4.2.1.1.	The cancer centre organises prevention programmes.					
2.4.2.1.2.	The cancer centre organises health education initiatives/programmes.					
2.4.2.1.3.	The cancer centre participates in prevention programmes					
2.4.2.1.4.	The cancer centre participates in health education initiatives/programmes.					

2.4.3. Availability of primary prevention clinics

Does the institution have one or more specific primary prevention clinics?

2.4.3.1.

		Yes	Mostly	Partially	No	not applicable
2.4.3.1.1.	The cancer centre has a specific primary prevention clinic or at least one specific primary prevention programme					

2.4.4. Oncogenetic clinic / outpatient department

Does the institution have an oncogenetic clinic?

2.4.4.1.

		Yes	Mostly	Partially	No	not applicable
2.4.4.1.1.	The cancer centre has an oncogenetic clinic for identifying high-risk individuals by molecular genetics. ((e.g. breast cancer, ovarian cancer, colo-rectal cancer, endocrine tumours)					
2.4.4.1.2.	Formal relationships exist between the cancer centre and reference genetic laboratories					

2.4.5. Smoking control in the cancer centre

Is there a policy for non smoking in the cancer centre?

2.4.5.1.

		Yes	Mostly	Partially	No	not applicable
2.4.5.1.1.	a non-smoking policy is clearly documented					
2.4.5.1.2.	support is provided to workers who decide to quit smoking					
2.4.5.1.3.	any public part of the cancer centre is clearly identified as a smoke-free area					
2.4.5.1.4.	explanations about smoking regulation in the institution are available for patients					
2.4.5.1.5.	patients are encouraged to quit smoking					
2.4.5.1.6.	workers are encouraged to quit smoking					
2.4.5.1.7.	appropriate and specific support is provided to patients who want to quit smoking					
2.4.5.1.8.	smoking is prohibited to patients (possibly with the exception of a restricted smoking-room equipped with an appropriate aspiration device)					
2.4.5.1.9.	the cancer centre is labialized “Smoke-Free”					

3. Care

3.4. Process control

3.4.1. Pain service

Does the cancer centre have a protocol/guideline for pain control?

3.4.1.1.

		Yes	Mostly	Partially	No	not applicable
3.4.1.1.1.	The cancer centre applies / uses guidelines regarding pain treatment for patients with cancer					
3.4.1.1.2.	There is regular staff education on pain management					
3.4.1.1.3.	Patients and their families receive oral and written information about any pain management.					
3.4.1.1.4.	There is a pain score card as part of the guidelines.					
3.4.1.1.5.	The use of the pain score card is regularly assessed					

3.4.2. Palliative/Supportive care team

Does the cancer centre have written agreements for composition and tasks of the palliative / supportive care team? NB: palliative AND/OR supportive care

3.4.2.1.

The palliative/supportive care team

		Yes	Mostly	Partially	No	not applicable
3.4.2.1.1.	intervenes in a timely way to request from all inpatients departments					
3.4.2.1.2.	replies to out-patient requests with a help line service or consultation					
3.4.2.1.3.	provides education for different disciplinary specialists, patients and families					

3.4.3. Palliative/Supportive and terminal care (guideline)

Are there guidelines to palliative and terminal care? NB: palliative AND/OR supportive care

3.4.3.1.

		Yes	Mostly	Partially	No	not applicable
3.4.3.1.1.	The cancer centre uses guidelines on palliative, supportive and terminal care					
3.4.3.1.2.	Written procedures exist on referral of patients to palliative/terminal care					

3.4.4. Palliative and terminal care

Is the management of the specific needs of patients at the end of their life considered within and outside the cancer centre. NB: palliative AND/OR supportive care

3.4.4.1.

		Yes	Mostly	Partially	No	not applicable
3.4.4.1.1.	All patient cases referred for palliative terminal care are discussed during scheduled meetings with the palliative care team					
3.4.4.1.2.	Agreements exist with other cancer centre(s) for transferring patients at the end of their life, if necessary					
3.4.4.1.3.	Services provided by the cancer centre after patients are discharged are clearly defined					
3.4.4.1.4.	These services are known by terminal patients and relevant workers					

3.4.5. Psycho-oncology service

Does the cancer centre have a psycho-oncology team or department?

3.4.5.1.

		Yes	Mostly	Partially	No	not applicable
3.4.5.1.1.	There is a psycho-oncology service with competence in (oncological) psychiatry and psychology					
3.4.5.1.2.	The staff are trained to detect patients with psychological suffering or distress.					
3.4.5.1.3.	Structured screening methods are used to refer patients to the psycho-oncology team					
3.4.5.1.4.	Procedures about how to refer the patients to the psycho-oncology service, including patients in psychological distress, are clearly defined					

3.4.6. Social Counselling

Does the cancer centre have a guideline or policy on the psychosocial counselling of oncology patients?

3.4.6.1.

		Yes	Mostly	Partially	No	not applicable
3.4.6.1.1.	Social counselling, including social workers, is available and accessible to all patients					

3.4.7. Family involvement in care

Is care organised for the patient's family during treatment, the end of life and the immediate bereavement period?

3.4.7.1.

		Yes	Mostly	Partially	No	not applicable
3.4.7.1.1.	In agreement with the healthcare team, the family can participate in some personal activities (e.g. meals, washing).					
3.4.7.1.2.	Each ward offering palliative/terminal care has a room for meeting the families.					
3.4.7.1.3.	Visiting time restrictions are lifted and arrangements for relatives to stay/sleep as well as for visiting by children are facilitated					

3.4.8. Family involvement in care (children)

Is there special attention paid to children with a parent who is dying?

3.4.8.1.

		Yes	Mostly	Partially	No	not applicable
3.4.8.1.1.	Specific support exists for families with children whose parent is dying (trained staff, guidelines…)					
3.4.8.1.2.	Families are proactively informed on the available support					

3.4.9. Rehabilitation

Is there access to a rehabilitation unit with mono- and multidisciplinary interventions?

3.4.9.1.

		Yes	Mostly	Partially	No	not applicable
3.4.9.1.1.	There is access to a functional rehabilitation department focused on cancer patients.					
3.4.9.1.2.	The rehabilitation unit manages the psychosocial and physical rehabilitation of the patient, starting at an early stage of the treatment, and continuing during the post therapeutic care period					

3.4.10. Prosthetic surgery

Do patients receive information and advice about the possibilities of prosthetic surgery?

3.4.10.1.

		Yes	Mostly	Partially	No	not applicable
3.4.10.1.1.	The person/s in charge of providing information on prosthetic surgery is/are clearly identified					
3.4.10.1.2.	The patient is informed about how to get information					
3.4.10.1.3.	This information includes the potential risks					
3.4.10.1.4.	Prosthetic and reconstructive surgery is available and accessible to all appropriate patients					

4. Research, innovation and development

Note: ***Cancer Units are excluded for the questions in this chapter 4.***

4.1. Policy and organisation

4.1.1. Organisational and hierarchical structure

Is there a description of the organisational and hierarchical structure of the RID organisation?

4.1.1.1.

		Yes	Mostly	Partially	No	not applicable
4.1.1.1.1.	There is an organisational and hierarchical structure specifically for research, innovation and development					
4.1.1.1.2.	A Scientific Advisory Board meets on a regular basis and advice the board of the cancer centre on its research activities					
4.1.1.1.3.	The Scientific Advisory Board verifies the quality of the research activities					
4.1.1.1.4.	The Scientific Advisory Board verifies the coherence of the objectives of the different research programmes and the cancer centres' objectives and strategy at least annually					

4.1.2. Research collaboration

4.1.2.1.

		Yes	Mostly	Partially	No	not applicable
4.1.2.1.1.	The cancer centre has a strategy on collaboration and networking					
4.1.2.1.2.	The cancer centre participates in national and international research projects					

4.1.3. Organisation of clinical research

4.1.3.1.

		Yes	Mostly	Partially	No	not applicable
4.1.3.1.1.	There is a dedicated clinical research management unit					
4.1.3.1.2.	It is the task of the unit to have a strategy for promoting the conduct of clinical trials					
4.1.3.1.3.	It is the task of the unit to ensure the management that the conduct of clinical trials is according to the clinical trials protocols					
4.1.3.1.4.	It is the task of the unit to ensure administrative, scientific and ethical/legal review and approval of new clinical trials					
4.1.3.1.5.	It is the task of the unit to coordinate the clinical research activities as well as their funding					
4.1.3.1.6.	It is the task of the unit centralise the collection of the information about the trials and patients included					
4.1.3.1.7.	It is the task of the unit to provide and update information about the trials to all departments and external partners					
4.1.3.1.8.	It is the task of the unit to assist in the conduct and monitoring of clinical trial activities					
4.1.3.1.9.	It is the task of the unit to provide an annual report on clinical trial activities					

4.1.4. Periodical policy review

Is there a periodical research policy review?

4.1.4.1.

		Yes	Mostly	Partially	No	not applicable
4.1.4.1.1.	There is a periodically defined research policy and research strategy plan					
4.1.4.1.2.	The research policy and research strategy plan are integrated into the general activities of the cancer centre					

4.1.5. Scientific interaction and integration

Is there a structure for integrating and stimulating the scientific interaction?

4.1.5.1.

The cancer centre promotes co-operation between researchers and clinicians through:

		Yes	Mostly	Partially	No	not applicable
4.1.5.1.1.	Organised and formalised activities					
4.1.5.1.2.	Regular information and meetings about research activities					
4.1.5.1.3.	Regular information and meetings about research results					
4.1.5.1.4.	Promotion of integration of research activities into clinical activities					
4.1.5.1.5.	Organisation of integration of research activities into clinical activities					

4.1.6. Internal review and evaluation of grant proposals

Is there a procedure in place for internal review of grant proposals before submissions?

4.1.6.1.

		Yes	Mostly	Partially	No	not applicable
4.1.6.1.1.	There is an internal review of grant proposals before submission to the funding organisation					
4.1.6.1.2.	There is an internal evaluation of the success of the grant proposals					

4.1.7. (suspected) scientific misconduct

Is there a procedure in case of (suspected) scientific misconduct?

4.1.7.1.

		Yes	Mostly	Partially	No	not applicable
4.1.7.1.1.	There is a procedure for dealing with scientific misconduct					

4.3. Resources and materials

4.3.1. Means for conducting research activities

Does the cancer centre have the means for conducting its research activities?

4.3.1.1.

		Yes	Mostly	Partially	No	not applicable
4.3.1.1.1.	The budget for cancer research is clearly and yearly defined					
4.3.1.1.2.	The cancer centre provides access to facilities for research activities					
4.3.1.1.3.	The cancer centre provides resources and means for research activities					
4.3.1.1.4.	Funding of research activities follows clearly defined procedures					
4.3.1.1.5.	The use of financial resources and accounting of research activities is controlled, monitored and reported according to rules					

4.3.2. Intellectual property and innovation

Is there a policy for the protection of intellectual property?

4.3.2.1.

		Yes	Mostly	Partially	No	not applicable
4.3.2.1.1.	There is a strategy for innovation					
4.3.2.1.2.	There is support for protection and exploitation of intellectual property					
4.3.2.1.3.	There is support for business development of research projects					
4.3.2.1.4.	There is a technology transfer service available					

4.3.3. Biobank

4.3.3.1.

		Yes	Mostly	Partially	No	not applicable
4.3.3.1.1.	The cancer centre has a policy for biobanking patient related samples					
4.3.3.1.2.	There is a SOP defining the collection, the storage, the registration and the use of the biological samples					
4.3.3.1.3.	There is a centralised registration of the data related to the biological material					

4.4. Process control

4.4.1. Structured scientific programme

Is there a structured scientific exchange programme in the cancer centre? (colloquia, seminars, theme-specific conferences).

4.4.1.1.

		Yes	Mostly	Partially	No	not applicable
4.4.1.1.1.	There is a structured, documented and up to date scientific programme in the cancer centre through colloquia, seminars or theme-specific conferences.					
4.4.1.1.2.	Scientific programmes are used to guarantee that results from research will be translated into daily practice timely; (e.g.) diagnostic tools, treatment or prevention					

4.4.2. Teaching programme for PhD students

Is there a teaching programme for PhD students ?

4.4.2.1.

		Yes	Mostly	Partially	No	not applicable
4.4.2.1.1.	There is a teaching programme for PhD students					

4.4.3. Transfer of new scientific information to clinical practice

Is there a procedure for the transfer of new scientific information to clinical practice?

4.4.3.1.

		Yes	Mostly	Partially	No	not applicable
4.4.3.1.1.	There is a procedure that guarantees that results from research will be translated into daily practice timely.(e.g.) diagnostic tools, treatment or prevention)					

4.5. Safeguarding the quality system

4.5.1. Periodical site visit/review. Is there a periodical site visit/review of the total research organisation?

4.5.1.1.

There is a periodical review and/or site visit, with external reviewers, of:

		Yes	Mostly	Partially	No	not applicable
4.5.1.1.1.	the total research organisation					
4.5.1.1.2.	each research group/team activities					
4.5.1.1.3.	clinical/translational research					
4.5.1.1.4.	research support facilities					

5. Teaching and continuing education

5.1. Policy and organisation

Does the cancer centre analyse the training needs to define an annual or multi-annual programme?

5.1.1. Analyse training needs

5.1.1.1.

		Yes	Mostly	Partially	No	not applicable
5.1.1.1.1.	The cancer centre analyses the training needs regularly					
5.1.1.1.2.	Based on the analysis, the institution defines an annual or multi-annual training / educational programme for physicians					
5.1.1.1.3.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for researchers					
5.1.1.1.4.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for nurses					
5.1.1.1.5.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for paramedics					
5.1.1.1.6.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for supportive disciplines (psychologists etc.)					
5.1.1.1.7.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for other disciplines (please specify in the note)					

5.4. Process control

5.4.1. Participation in teaching oncology

Do the physicians, researchers, nurses and psychologists in the cancer centre participate in the teaching of undergraduate theoretical courses in oncology?

5.4.1.1.

Does the cancer centre provide teaching to:

		Yes	Mostly	Partially	No	not applicable
5.4.1.1.1.	physicians					
5.4.1.1.2.	researchers					
5.4.1.1.3.	nurses					
5.4.1.1.4.	psychologists					
5.4.1.1.5.	supportive disciplines (psychologists etc.)					
5.4.1.1.6.	other disciplines (please specify in the note)					

5.4.2. Types of teaching programmes provided

Does the cancer centre participate in teaching for PhD/BSc/MSc degree(s) in oncology nursing?

5.4.2.1.

Does the cancer centre provide

		Yes	Mostly	Partially	No	not applicable
5.4.2.1.1.	academic teaching in oncology					
5.4.2.1.2.	continuous medical education (CME)					
5.4.2.1.3.	BSc, MSc and PhD programmes related to cancer research					

5.4.3. Types of teaching programmes organised

Does the cancer centre participate in organising for PhD/BSc/MSc degree(s) in oncology nursing?

5.4.3.1.

Does the cancer centre organise/coordinate:

		Yes	Mostly	Partially	No	not applicable
5.4.3.1.1.	academic teaching in oncology					
5.4.3.1.2.	continuous medical education (CME)					
5.4.3.1.3.	BSc, MSc and PhD programmes related to cancer research					

6. Patient related

6.4. Process control

6.4.1. Educational material

Has policy been defined concerning the production, distribution and administration of educational material relating to oncology?

6.4.1.1.

The cancer centre delivers:

		Yes	Mostly	Partially	No	not applicable
6.4.1.1.1.	written information on relevant aspects of oncology to the patients					
6.4.1.1.2.	written information on relevant aspects of oncology to general practitioners					
6.4.1.1.3.	The written information includes information about diagnostic examinations and methods of treatment					
6.4.1.1.4.	The written information includes information about clinical trials					
6.4.1.1.5.	The written information includes information about supportive care, complementary care and palliative care					

6.4.2. Inform patients on admission

Have procedures been established on informing cancer patients about cancer centre admission procedures?

6.4.2.1.

		Yes	Mostly	Partially	No	not applicable
6.4.2.1.1.	There is detailed information about the admission procedure					
6.4.2.1.2.	This information is available and communicated to the patient					
6.4.2.1.3.	The admission procedure is regularly assessed for efficiency					
6.4.2.1.4.	The cancer centre can accept patients during day and night in the event of an emergency, admit them if necessary, or refer them to another institute					

6.4.3. Informing patients about results, treatment and counselling

Have agreements been reached on informing oncology patients about the results of diagnostic tests, about treatment (and follow up treatment), and about counselling (in terms of how it is done and what it means)?

6.4.3.1.

		Yes	Mostly	Partially	No	not applicable
6.4.3.1.1.	The cancer centre has procedures or guidelines regarding information transfer on diagnostics, treatment, follow-up and supervision of the patient.					
6.4.3.1.2.	Policies are defined about who is informing the patient, relatives and close friends about the result of an examination, further treatment or supervision					
6.4.3.1.3.	Policies are defined about when this information is delivered					
6.4.3.1.4.	Policies are defined about how the transmission of information to the people involved in treatment and patient care is organised					
6.4.3.1.5.	Policies are defined about how the relevant information transferred to the patient is described in the patient's file, such as information about the further treatment that can be expected, the plan of treatment, about requesting a consultation of another medical specialist, the consequence of potential side effects					

6.4.4. Discharge procedure

Does the cancer centre have a discharge procedure?

6.4.4.1.

		Yes	Mostly	Partially	No	not applicable
6.4.4.1.1.	There is a written discharge procedure					
6.4.4.1.2.	This procedure is regularly assessed					
6.4.4.1.3.	At discharge, information is provided to the patients about patients' associations					
6.4.4.1.4.	At discharge, information is provided to the patients about self-helping groups					
6.4.4.1.5.	At discharge, information is provided to the patients about home care					
6.4.4.1.6.	At discharge, information is provided to the patients about treatment and follow-up plans					
6.4.4.1.7.	At discharge, information is provided to the patients about contact details with cancer centre					

6.5. Safeguarding the quality system

6.5.1. Patient satisfaction / experiences

Does the cancer centre evaluate the patient's satisfaction / experiences related to cancer care?

6.5.1.1.

		Yes	Mostly	Partially	No	not applicable
6.5.1.1.1.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during consultation					
6.5.1.1.2.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during day care					
6.5.1.1.3.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during hospitalisation					
6.5.1.1.4.	The survey is regularly analysed and corrective measures are planned					
6.5.1.1.5.	There is a group of patients representing patients and serving as a link between the cancer centre and the patients for advisory and consultation					

6.5.2. Conciliatory commission for complaints

Does the cancer centre have an identified conciliator (or a conciliatory commission), for complaints related to cancer care?

6.5.2.1.

		Yes	Mostly	Partially	No	not applicable
6.5.2.1.1.	The cancer centre has a clearly identified conciliator or a conciliatory commission (sometimes known as a mediator or mediation service, or as the complaints officer or complaints department)					
6.5.2.1.2.	The role of the conciliator or the conciliatory commission is to reply to any request for information or complaints from the patients or their families.					
6.5.2.1.3.	The actions undertaken by the conciliator are recorded in a file that is used to produce an annual report					
6.5.2.1.4.	The conciliator gives feedback on his/her findings to the professional who is the subject of the complaint.					

Appendix III. OECI Quantitative questionnaire

Please fill in the following OECI quantitative questionnaire (not for public release). The italic items are already filled out in the application form. And the underlined items are filled out for the designation screening. Chapter 4 'Research' outside the scope of the OECI Accreditation of Cancer Units.

1. General Questions

1.1. Cancer centre

1.1.1. Project: OECI Quality Improvement Project/Working Group Accreditation (WGA)

1.1.2. Name of the cancer centre _____

1.1.3. Address _____

1.1.4. Telephone _____

1.1.5. Fax _____

1.1.6. Internet site _____

1.2. Management

1.2.1. Administrative Director _____

1.2.2. E-mail Administrative Director _____

1.2.3. Medical Director _____

1.2.4. E-mail Medical Director _____

1.2.5. Scientific Director _____

1.2.6. E-mail Scientific Director _____

1.3. Survey

1.3.1. Name of the Contact person for the survey at the cancer centre _____

1.3.2. Position of the Contact person for the survey _____

1.3.3. E-mail address of the Contact person for the survey _____

1.4. Cancer centre structure

1.4.1.

		Cancer Unit	Clinical Cancer Centre	CCC (Comprehensive cancer centre)	Cancer research Centre
1.4.1.1.	In which category would you classify your cancer centre				

1.4.6.

		academic	public/non profit	private
1.4.6.1.	What is the administrative status of your cancer centre.			

1.4.7.

		at national level	at regional level	Presence of European or International Affairs Collaboration	General accreditation by National Accreditation Organisation or other organisation
1.4.7.1.	Is your cancer centre part of a formalised network of institutions				

1.4.8. Year of accreditation

1.5. Distribution areas and budget

1.5.1. % of patients regional

1.5.2. % of patients national

1.5.3. % of patients international

1.5.4. Planned annual budget for health care (in € last year available) X

1.5.5. Planned annual budget for research (in € last year available) X

2. Infrastructures

2.1. Infrastructures with a focus on cancer care (1 of 7)

2.1.1. per year = x

	surgery oncology	medical oncology	radiation therapy	paediatric oncology	Other units	Haematology	Total (oncology)
Number of newly registered/diagnosed cancer patients (any type)	X	X	X	X	X	X	X
Number of inpatient beds for overnight stays	X	X	X	X	X	X	X
Number inpatient visits for overnight stays							
Mean duration of stay for inpatients							
Number of outpatient visits in consultation							
Waiting time before 1st visit (mean)							
Waiting time treatment decision-first treatment-(mean)							
Number of ambulatory day care beds/chairs							X
Number of ambulatory/day hospital patient visits							
FTE physicians dedicated to oncology(into human resources)							X
% FTE vacant positions							
FTE board certified nurses dedicated to oncology							
% FTE vacant positions							

2.2. Infrastructures with a focus on cancer care (2 of 7)

2.2.1. per year = x

	New patients (total number of newly admitted and referred)	Number of surgical procedures	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
breast cancer C50								
lung cancer C34								
urological cancer: bladder C67								
urological cancer: kidney C64H								
urological cancer: Others								
Male genital organs cancer: prostate C61H								
Male genital organs cancer: testis C62								
Male genital organs cancer: Others								

2.3. Infrastructures with a focus on cancer care (3 of 7)

2.3.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
gastrointestinal cancer: oesophagus C15								
gastrointestinal cancer: stomach C16								
gastrointestinal cancer: colon C18								
gastrointestinal cancer: rectum C20H								
gastrointestinal cancer: liver C22								
gastrointestinal cancer: pancreas C25								
gastrointestinal cancer: Others								

2.4. Infrastructures with a focus on cancer care (4 of 7)

2.4.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
gynaecological cancer: ovary C56H								
gynaecological cancer: cervix C53								
gynaecological cancer: endometrial C54								
gynaecological cancer: Others								

2.5. Infrastructures with a focus on cancer care (5 of 7)

2.5.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
head and neck cancer: larynx C32								
head and neck cancer: hypopharynx C13								
head and neck cancer: oropharynx C10								
head and neck cancer: nasapharynx C11								
head and neck cancer: thyreoid C73H								
head and neck cancer: others								

2.6. Infrastructures with a focus on cancer care (6 of 7)

2.6.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
haematological malignancies: Hodgkin Lymphoma C81								
haematological malignancies: Non Hodgkin Lymphoma C82								
haematological malignancies: Myeloma C90								
haematological malignancies: All leukaemia								
neuro-oncological: Central nervous system C71-C72								
neuro-oncological: others								

2.7. Infrastructures with a focus on cancer care (7 of 7)

2.7.1. per year = x

	New patients (newly admitted and referred)	Number of surgical procedures (numbers/ patients)	Number of Chemotherapy (numbers/ patients)	Total number of sessions (RT)	Working with guidelines (Y/N)	Multidisciplinary meeting (Y/N)	Clinical pathways (Y/N)	Number of patients (RT)
paediatric malignancies: all cancers (age 0<15)								
bone and soft tissue tumours: primary bone C40								
bone and soft tissue tumours: Soft tissue C49								
bone and soft tissue tumours: melanoma of the skin C43								
skin cancer: Others C44								

2.8. Radiotherapy

2.8.1. Number of accelerators for radiation therapy _____

2.8.2. Number of cobolt units _____

2.8.3. Resources for proton therapy

	Yes	No
2.8.3.1. Do you have resources for proton therapy?		

2.8.4. Number of conventional RT (patients per year) _____

2.8.5. Number of bracytherapy (patients per year) _____

2.8.6. Number of IMRT (patients per year) _____

2.8.7. Number of IORT (patients per year) _____

2.8.8. Number of stereo tactic RT (single and fractionated) (patients per year) _____

2.9. Radiology

2.9.1. Number of CT scanners X _____

2.9.2. Number of facilities for MRI X _____

2.9.3. Number of MRI spectroscopy X _____

2.9.4. Number of mammography X _____

2.9.5. Waiting time for CT scanners _____

2.9.6. Waiting time for MRI _____

2.9.7. Waiting time for mammography _____

2.9.8. Do you have digitalised imaging (PACS)?

	Yes	No
2.9.8.1.		

2.9.9. Do you have resources for interventional techniques?

	On site	Access to	Not Available
2.9.9.1.			

2.10. Nuclear medicine unit

2.10.1. Number of cameras _____

2.10.2.

		On site	Access to	Not available	not applicable
2.10.2.1.	Pet scan facilities				
2.10.2.2.	pet CT facilities				
2.10.2.3.	Radio nucleotide treatment facilities				

2.11. Laboratory

2.11.1.

		On site	Access to	Not available
2.11.1.1.	Do you have a cytology laboratory?			
2.11.1.2.	Do you have a histopathology laboratory?			

2.11.2. If on site

		Yes	No
2.11.2.1.	immunofluorescence techniques		
2.11.2.2.	Histochemistry		
2.11.2.3.	flow cytomitry		
2.11.2.4.	Techniques for molecular biology and genetics		

2.11.3.

	by cytology	by biopsyon	large pieces of excision
Please specify the number of samples for tumour pathological diagnosis per year at your cancer centre			

2.12. Haematology unit

2.12.1.

		On site	Access to	Not available
2.12.1.1.	Do you have a transfusion centre?			
2.12.1.2.	Do you have a bone marrow bank?			

2.12.2. Number of laminar flow rooms

2.12.3.

	Allogenic stem cell	Autologous bone marrow	Autologous stem cell
Please specify the number of bone marrow/stem cell transplants per year			

2.13. Oncology Multidisciplinary team:

2.13.1. Members are:

		Yes	No
2.13.1.1.	Medical oncologist (or equivalent)		
2.13.1.2.	Surgical Oncologist		
2.13.1.3.	Radiotherapist		
2.13.1.4.	Radiologist		
2.13.1.5.	Pathologist		
2.13.1.6.	Nurses		
2.13.1.7.	Others		

2.14. Palliative care team:

2.14.1. Members are:

		Yes	No	not applicable
2.14.1.1.	Anaesthetist/Physician specialising in pain treatment			
2.14.1.2.	Medical specialists (including psychiatrist and medical oncologist)			
2.14.1.3.	Nurses			
2.14.1.4.	Psychologist			
2.14.1.5.	Anaesthesist			
2.14.1.6.	Physiotherapist			
2.14.1.7.	General practitioner			
2.14.1.8.	Social worker			
2.14.1.9.	Dietician			

2.15. Facilities

2.15.1.

		On site	Access to	Not available
2.15.1.1.	Do you have a tumour bank facility?			
2.15.1.2.	Do you have a central pharmacy?			

2.15.2. Number of operating rooms excluding ambulatory services (specific to oncology): _____

2.15.3. Number of IC beds (specific to oncology): _____

2.15.4.

		On site	Access to	Not available
2.15.4.1.	Do you have other specialised techniques on site			

2.15.5. Do you have other specialised techniques on site?

		Yes	No
2.15.5.1.	laser therapy		
2.15.5.2.	Laparoscopy		
2.15.5.3.	sentinel node?		
2.15.5.4.	Intra Operative Chemo Therapy		
2.15.5.5.	hyperthermia?		
2.15.5.6.	isolated limb perfusion?		
2.15.5.7.	radio frequency ablation		
2.15.5.8.	Others		

3. Human resources

3.1. Human resources (1)

3.1.1.

	Per doctor	Per nurse day	Per nurse night
Legal number of hours for 1 Full-Time Equivalent (FTE)	X	X	X

3.1.2. Total FTE of employees in the cancer centre _____

3.1.3. Total FTE of employees dedicated to cancer patients _____

3.2. Human resources (2)

3.2.1.

	breast surgery	urologic surgery	thoracic surgery	digestive surgery	neurosurgery	gynaecological surgery	head and neck surgery	soft tissue surgery	orthopaedic surgery	plastic and econstructive surgery
Please specify the number of FTE surgeons	X	X	X	X	X	X	X	X	X	X

3.3. Human resources (3)

3.3.1.

	Please specify the number of FTE
gastro enterologists	
pneumonologists/respiratory physicians	
gynaecologists	
haematologists	
paediatricians	
psychiatrists	
anaesthesiologists	
infectious disease specialists	
geneticians	
dermatologists	
pharmacist	
pharmacologists	
geriatricians	
neurologists	
intensive care specialists	
medical oncologists	X
cardiologists	
endocrinologists	
urologists	
plastic surgeons	

3.4. Human resources (4)

3.4.1. Pathology

	Technicians	Pathologists
Please specify the number of FTE		

3.4.2. Nuclear medicine

	technicians in nuclear medicine	physicians in nuclear medicine	physicists/engineers	nurses in nuclear medicine
Please specify the number of FTE				

3.4.3. Radiology

	Radiologists	technicians in radiology	nurses in radiology
Please specify the number of FTE			

3.4.4. Radiotherapy

	radiation therapists	dosimetrists	radiation technicians in radiotherapy
Please specify the number of FTE			

3.4.5. Supportive care

	Dieticians	psychologists	nutricians	speech therapists	physiotherapists	stoma therapists	social workers
Please specify the number of FTE							

4. Research (Outside scope of Cancer Units)

4.1. Research domains

4.1.1.

	Present	FTE dedicated researcher (Phd, MD)	Phd students and fellows	Number of technicians
carcinogenesis				
immunology				
cell biology				
drug development				
Bioinformatics				
Biostatistics				
Tumour progression				
Angiogenesis				
Epidemiology				
Psycho-oncology				
Nursing				
Radiobiology				
Public health				
Health economy				
Clincal trials				

4.1.2.

	Present	FTE dedicated researcher (Phd, MD)	Phd students and fellows technicians	Number of
Pharmacogenomic				
pharmacokinetics/dynamics				
gene therapy				
(onco)genomics				
(onco)proteomics				
Functional imaging				
Toxicology				
Others				

4.2. Structures

4.2.1. Research facilities

❑ Animal House
❑ Transgenic facility
❑ Micro-array facility
❑ Biochemical analysis
❑ Radio labelling (cyclotron)
❑ High Throughput screening
❑ (Bio)Statistics
❑ Cytogenetics
❑ Flowcytometry
❑ Massaspectrometry
❑ Electon microscopy or electron?
❑ Animal pathology/histology
❑ Proteomics facility
❑ DNA sequence facility
❑ Protein analyses facility
❑ Others namely

4.3. Structures

4.3.1.

		Yes	No	not applicable
4.3.1.1.	Do you have a private partnership with companies related to research and innovation			
4.3.1.2.	Do you have a Unit of epidemiology?			
4.3.1.3.	Do you have a biostatistic unit?			
4.3.1.4.	Do you have a Unit of health economy?			
4.3.1.5.	Do you have a data management unit/trial bureau?			
4.3.1.6.	Do you have a local cancer registry?			

4.3.2. Number of studies active (that is open to patient accrual) during year x: X _____

4.3.3. Number of studies activated in year x:

	Phase I	Phase II	Phase III	Phase IV
#	X	X	X	X

4.3.4. Number of new investigator initiated local trials

(Percentage of new investigator initiated local trials %) _____

4.3.5. Number of new investigator initiated national trials

(Percentage) _____

4.3.6. Number of new investigator initiated international trials

(Percentage) _____

4.3.7. Number of new clinical trials with external industrial sponsor

(Percentage) _____

4.3.8. Number of new patients in clinical trials

(indicator: number of new patients included in clinical trials /Number of new patients in the institute) _____

4.3.9.

Does your cancer centre have research collaboration with other cancer centres

		Yes	No
4.3.9.1.	at national level		
4.3.9.2.	at international level		

4.4. Research budget including basic/clinical/translational

4.4.1. Total research budget cancer centre X

4.4.2.

	Nr of EU grants running in year x	Nr of EU grants coordinated in year x	Public funding	Charities/unrestricted grants	Industrial partnership funding
Research funding sources/total amounts received (2008)	X	X	X	X	X

4.4.3. Number of patents over the last 5 years:

4.4.4. Number of peer-reviewed publications per year (year x) national X

4.4.5. Number of peer-reviewed publications per year (year x) international X

4.4.6. Impactfactor cumulative

4.4.7. Number of publications with impactfactor > 10 X

5. Education

5.1. Education

5.1.1. Planned annual budget for education year x (Euros) _____

5.1.2.

		On site	Access to	Not available	not applicable
5.1.2.1.	An information centre for cancer patients				
5.1.2.2.	Medical library				
5.1.2.3.	Online access via internet				

5.1.3.

		Yes	No	not applicable
5.1.3.1.	Educational courses organised by the cancer centre on site			
5.1.3.2.	with local audience			
5.1.3.3.	with national audience			
5.1.3.4.	with international audience			

5.1.4. Number of medical students per year _____

5.1.5. Number of graduate/postgraduate students _____

5.1.6. Number of physicians under specialist training per year _____

5.1.7. Number of nurses under specialist training per year _____

5.1.8. Number of nurses students per year _____

5.1.9. Number PhD students _____

5.1.10. Number of PhD theses per year (average last 5 years) _____

5.1.11. Number of University - Faculty associate Professors _____

5.1.12.

		Yes	No
5.1.12.1.	Do you have formalised exchange programmes		
5.1.12.2.	national		
5.1.12.3.	international		
5.1.12.4.	Do you have formalised patient education programmes		
5.1.12.5.	Do you have formalised education programmes for decision makers		
5.1.12.6.	Do you have formalised continuous medical education (CME) programme		

5.2. Analysis

5.2.1.

Based on the analysis, do you have an annual or multi-annual training / educational programmes for:

		Yes	No
5.2.1.1.	physicians		
5.2.1.2.	researchers		
5.2.1.3.	nurses		
5.2.1.4.	paramedics		
5.2.1.5.	supportive disciplines (psychologists etc.)		
5.2.1.6.	other disciplines (please specify in the note)		

Appendix IV: Project plan

Project plan (doc. 5) for cancer institute to organise self-assessment

General	
Name of the project	"OECI Accreditation Programme"
Institute name	*Name of the (cancer) institute*
Place and country	*Place and country of residence*
Division/department	*Part of the hospital that is involved or whole hospital*
Owner of the project	Board of Directors of the institute: *name person in specific*
Project leader in the institute	*Name of OECI contact person in the institute and position/function in the institute*
OECI Accreditation Coordinator	Femke Boomsma
Start date OECI accreditation	*Date*
What is (are) the motive(s) for starting the project?	*Motives/ Arguments*
Which goal(s) would you like to achieve? (Try to define according to the SMART-method: *Specific, Measurable, Achievable, Realistic, Time-related)*	*To achieve a…….*

Steering committee	
Is there a steering committee present?	*Names of participants and functions*

Composition of the project team

One/two persons from each sub project group.

The sub project groups are small teams of people who are together responsible for a part of the questionnaires. One/two of the group also participate in the project team.

	Name	**Position/function**	**Responsibilities**
Project leader in the institute	*Name + e-mail*	*Position/function*	
Secretary:	*Name + e-mail*	*Position function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	
Member:	*Name*	*Position/function*	

Planning of the project	
Start	
Explanatory visit	29 June 2010
Number of planned internal meetings	*When periodically meetings?*
Self-assessment period	September 2010 (as proposed)
	February 2011
1st evaluation with OECI Coordinator	*Date and with whom?*
2nd evaluation with OECI Coordinator	*Date and with whom?*
3rd evaluation with OECI Coordinator	*Date and with whom?*
Go/ no-go decision	Early March 2011
Planned peer review	Early May 2011
Planned end date	

Communication: reporting method		
To:	**When/time**	**Method**
Owner		
Board of the institute		*e-mail/written form/ meeting*
Steering committee		*e-mail/written form/ meeting*
Project team		*e-mail/written form/ meeting*
Quality committee		*e-mail/written form/ meeting*
Others: – Staff – Patients –		 Intranet Institutional information media

Communication of the final self-assessment results		
To:	**When/time**	**Method**
Participants?	*Date; at end of self assessment period*	*How?*

Which extra means are necessary? Time considered needed	
Project leader (in the institute)	
OECI Accreditation Coordinator	
Time project members (for each person)	
Time blanks exercise for participants	*Pending further assessment, according to identified needs*
Financial means	*Pending further assessment, according to identified needs* *Planning payment of fee stage 1 and 2*
Other resources (e.g. (training) education, meeting costs	*Pending further assessment, according to identified needs*

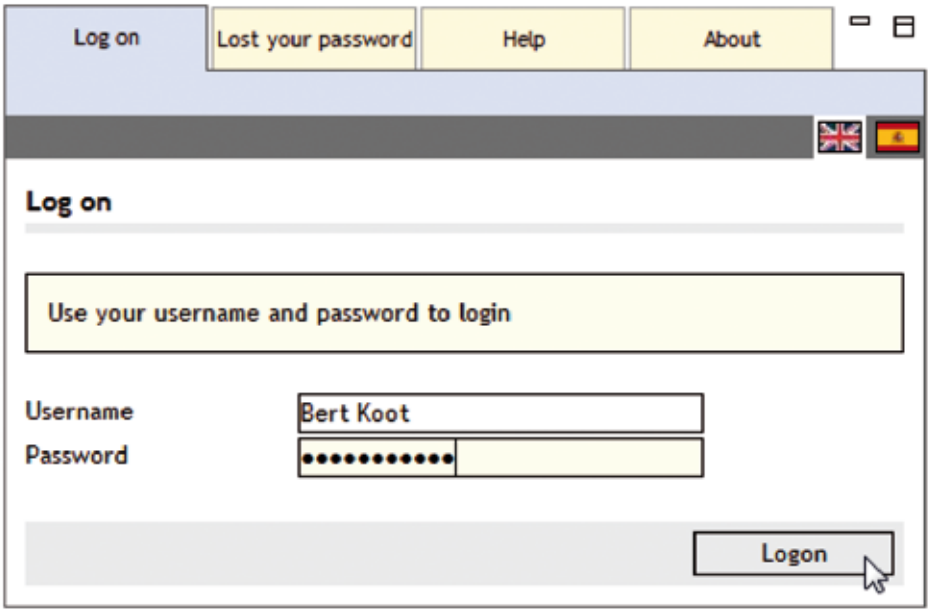
Appendix V. Self-assessment user manual for institutes

1. Log in

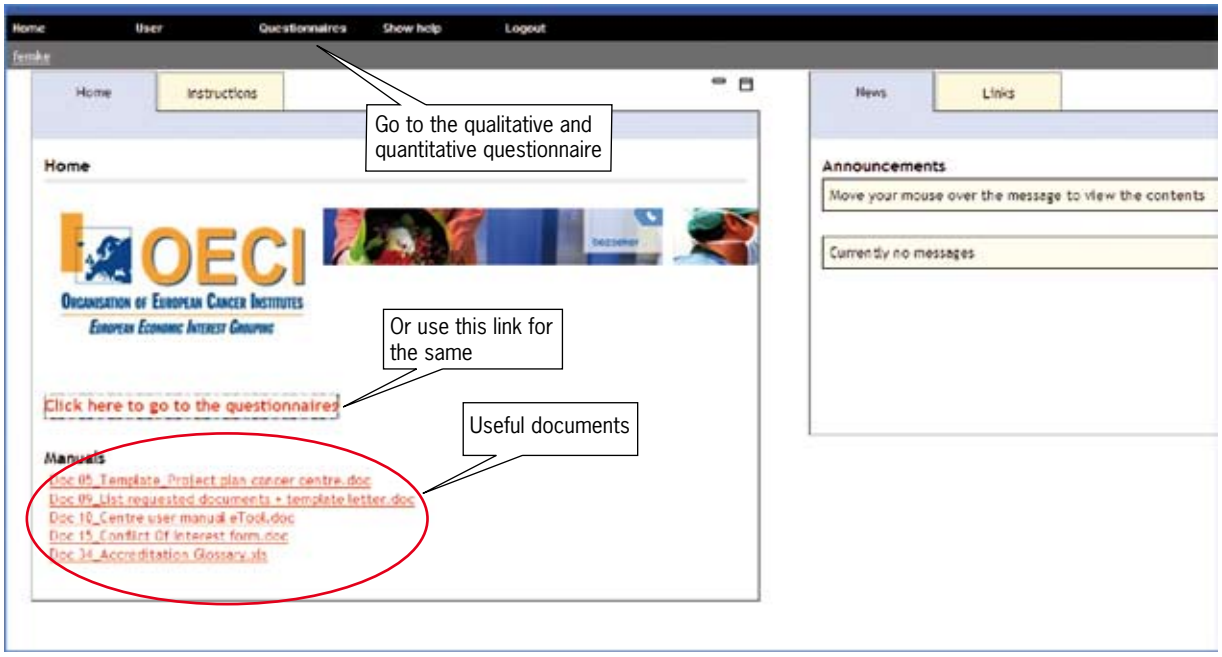
Go to: http://oeci.selfassessment.nu

You can also go directly to the e-tool log-in screen, as it is illustrated underneath, via *http://oeci.selfassessment.nu/compass/user*

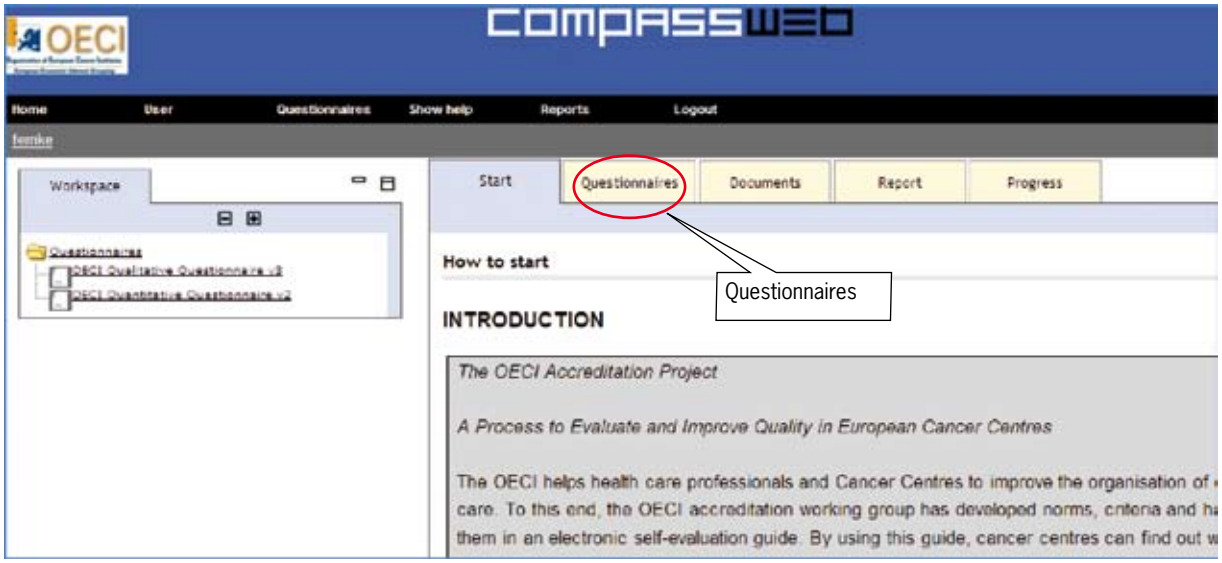
In the log in screen you can use your username and password to enter the e-tool application.

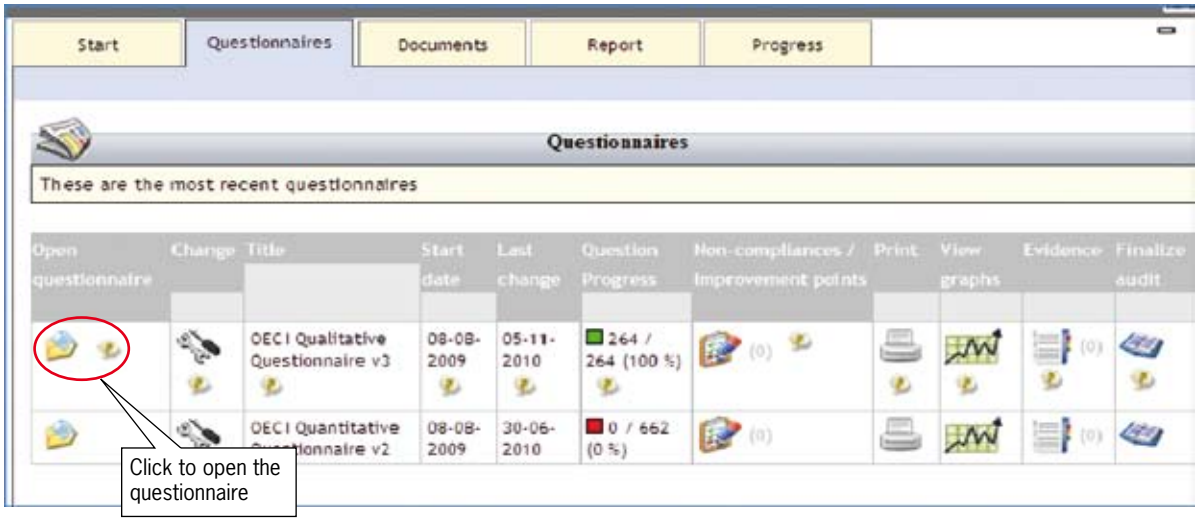


When logged in you can enter the e-tool in the following screen.



If you go to the questionnaires the following screen appears.



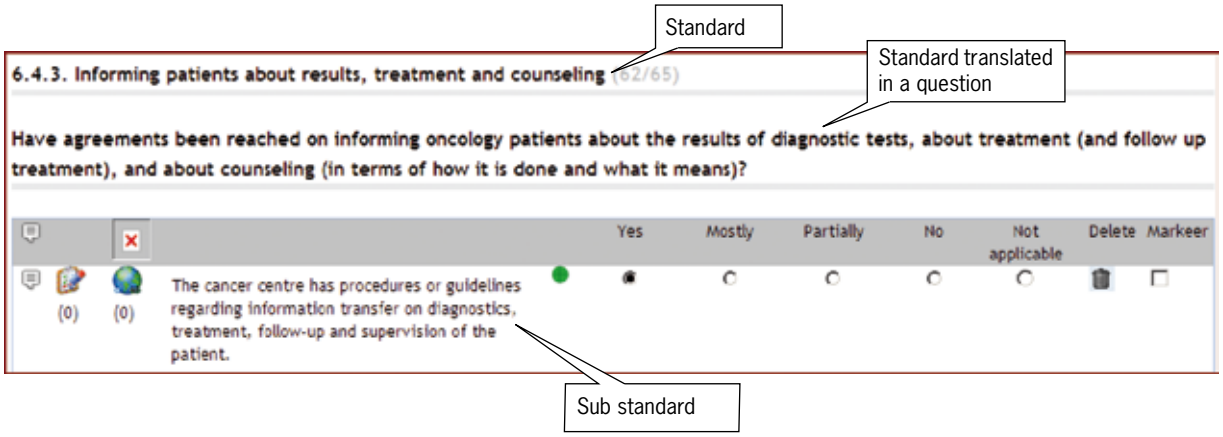


2. Three steps to fill out the qualitative questionnaire

• Step 1: Give a score to all items in the questionnaire

The quality questionnaire consists of:

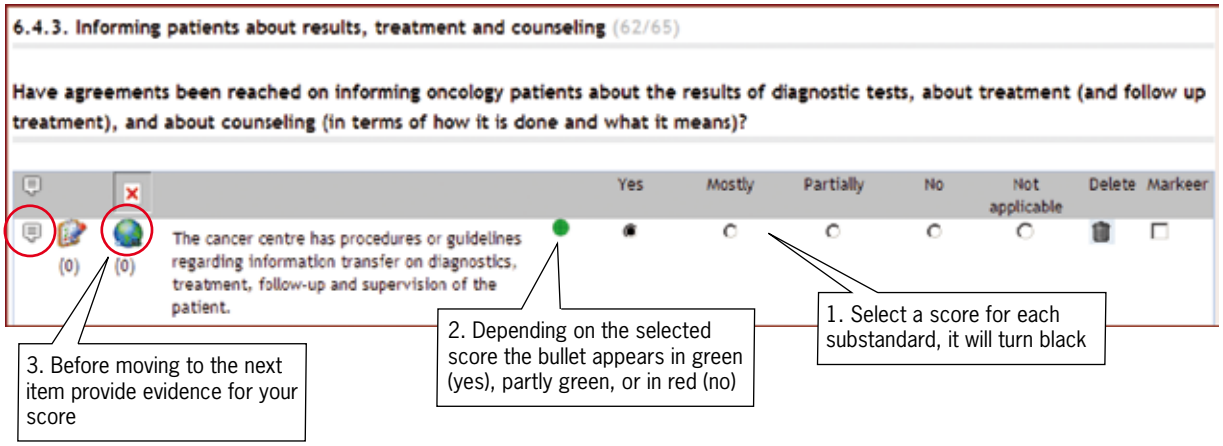
Chapters	Domains	Standards	Sub standards/questions, Total 264 (100%)
Chapter 1	General standards, strategic plan and general management	26	121 (47%)
1.1	Policy and organisation	5	22
1.3	Resources and materials	2	8
1.4	Process control	12	54
1.5	Safeguarding the quality system	7	37
Chapter 2	Screening and primary prevention and health education	5	19 (7%)
2.4	Process control	5	19
Chapter 3	Care	10	30 (11%)
3.4	Process control	10	30
Chapter 4	Research innovation and developments	14	45 (17%)
4.1	Policy and organisation	7	25
4.3	Resources and materials	3	12
4.4	Process control	3	4
4.5	Safeguarding the quality system	1	4
Chapter 5	Education and teaching	4	19 (7%)
5.1	Policy and organisation	1	7
5.4	Process control	3	12
Chapter 6	Patient related	6	30 (11%)
6.4	Process control	4	21
6.5	Safeguarding the quality system	2	9



Possible scores

The score is an indicator for the stage of implementation of each item of the standard. The scoring system is based on the Plan-Do-Check-Act-circle or Deming-circle. These four stages of implementation are translated in the following possible answers:

- **Yes** means that the indicator of the standard has been implemented on a wide scale in the cancer institute and the Deming-cycle is completed at least twice (> in third cycle),
- **Mostly** means that the indicator has been implemented in most of the critical places in the cancer institute and the Deming-cycle is completed at least once (> in second cycle),
- **Partially** means that the indicator is implemented on project bases or on a modest scale in the cancer institute or the Deming-cycle has not been completed,
- **No** means that the indicator does not get attention or there are plans to start working on the indicator,
- **Not applicable** means that the indicator is not applicable in the cancer institute.

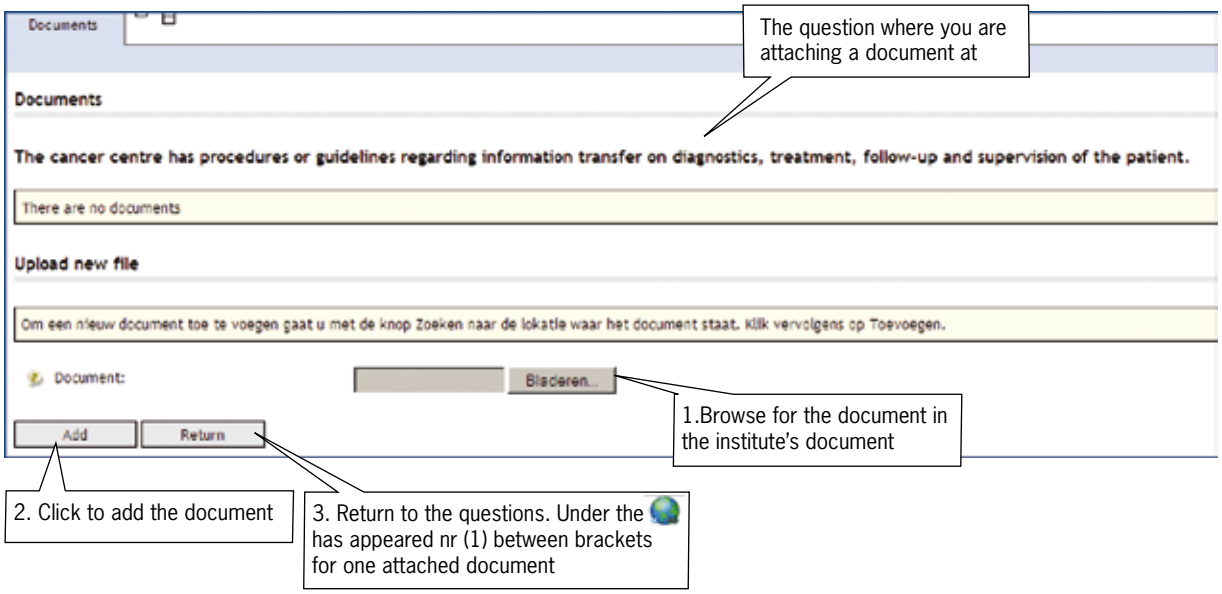


- **Step 2: Provide evidence for the given score, through:**

- Attaching a document to a specific question in the e-tool that provides the evidence OR
- Referring to a document that is already attached in an earlier item OR
- Adding a note to justify the score if there is no document available AND
- Adding the requested documents.

How to attach a document to a specific question?

Click on the globe icon and the following screen appears:

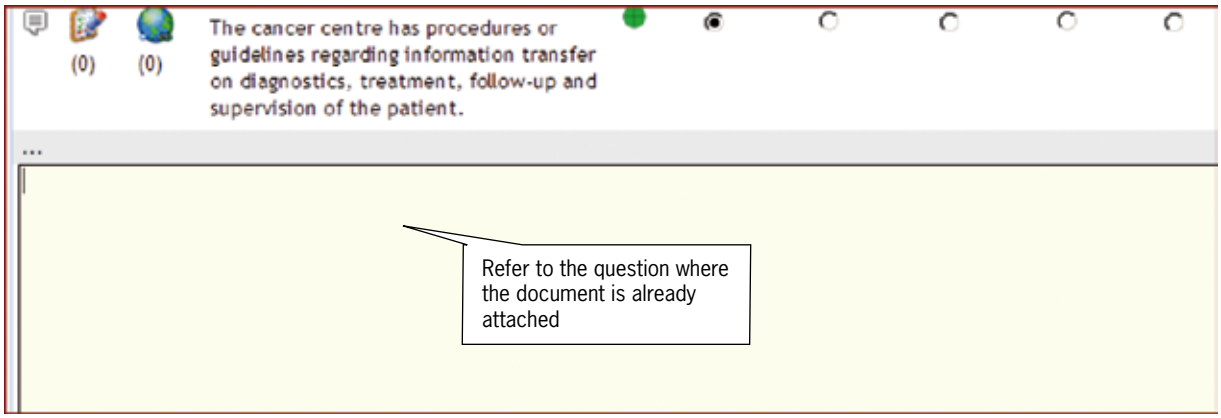


To get an overview of the specific questions that contain a document you can close the questionnaire and click on the icon in the table under evidence.

How to refer to a document that is already attached?

Click on the note box icon. A note box appears under the specific question.
To close the box: just click with your mouse somewhere on the page.

Now there is a note in the note box the icon will be changed with bold lines:

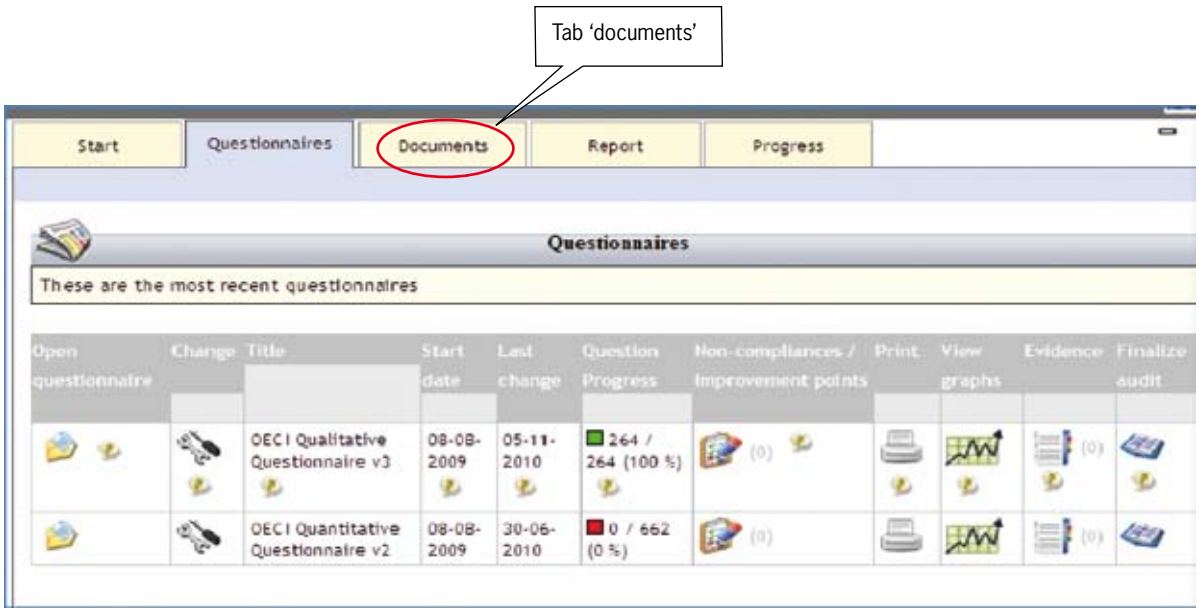


How to add a note to justify the score?

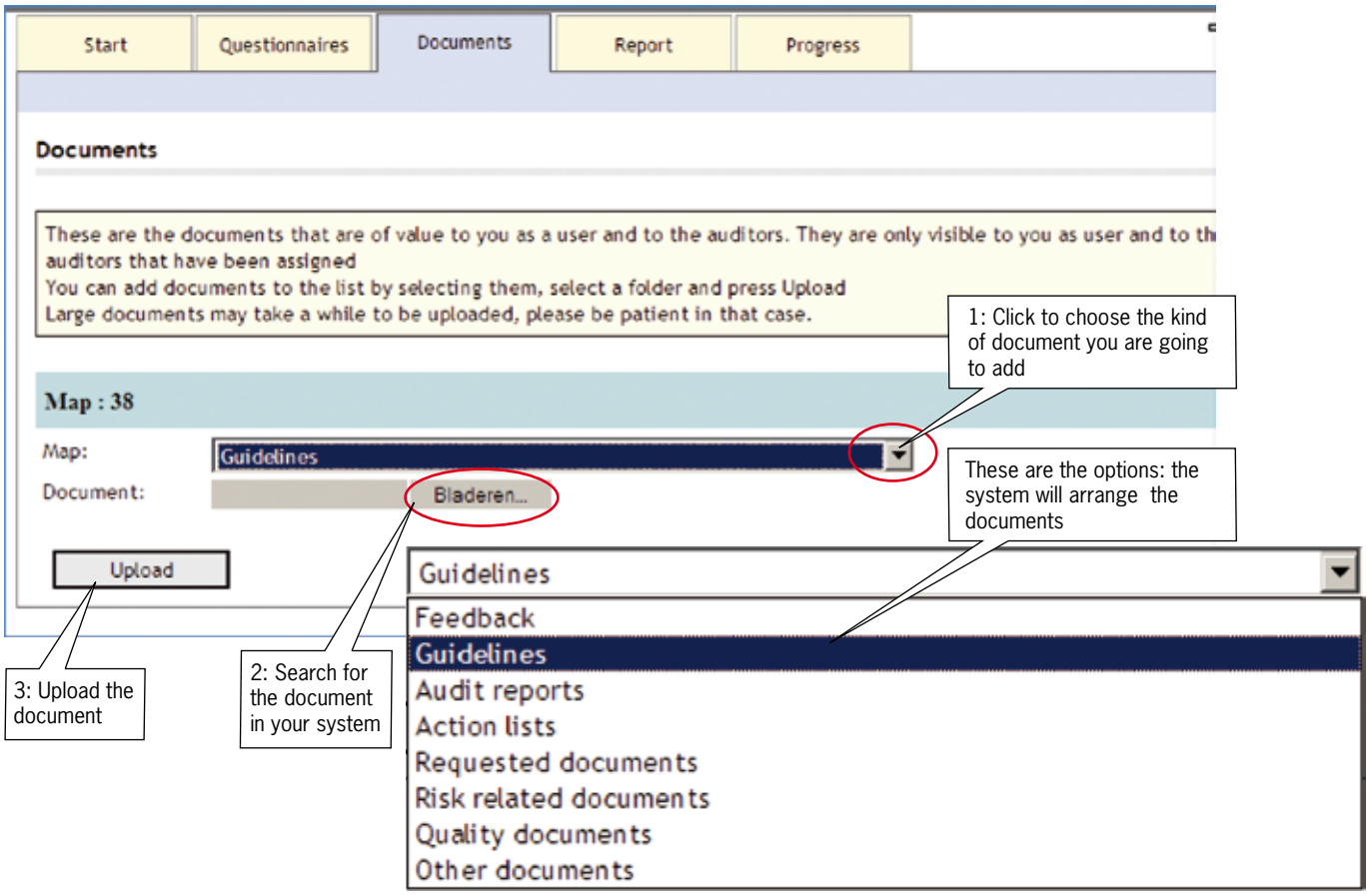
If there is no document that can provide evidence for the given score or the document/policy/procedure is not available, please justify the given score by putting a note in the note box (as explained above).
It is also possible that the institute cannot answer the question literally, for example because the institute is not responsible for the standard questioned, please also use the note box to explain this issue.

How to add the documents requested by the OECI?

When you log in to the e-tool you will see the following screen with some tabs above the two questionnaires. In the underneath figure the tab that is blue: 'Questionnaires' is open.
Go to the tab documents.



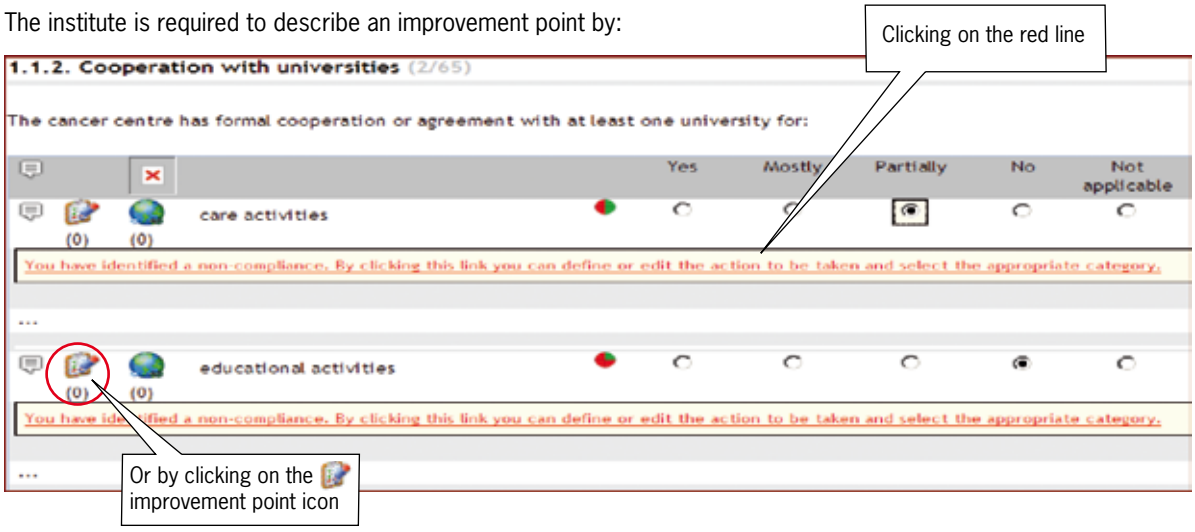
The following screen will appear. Follow step 1, 2 and 3.



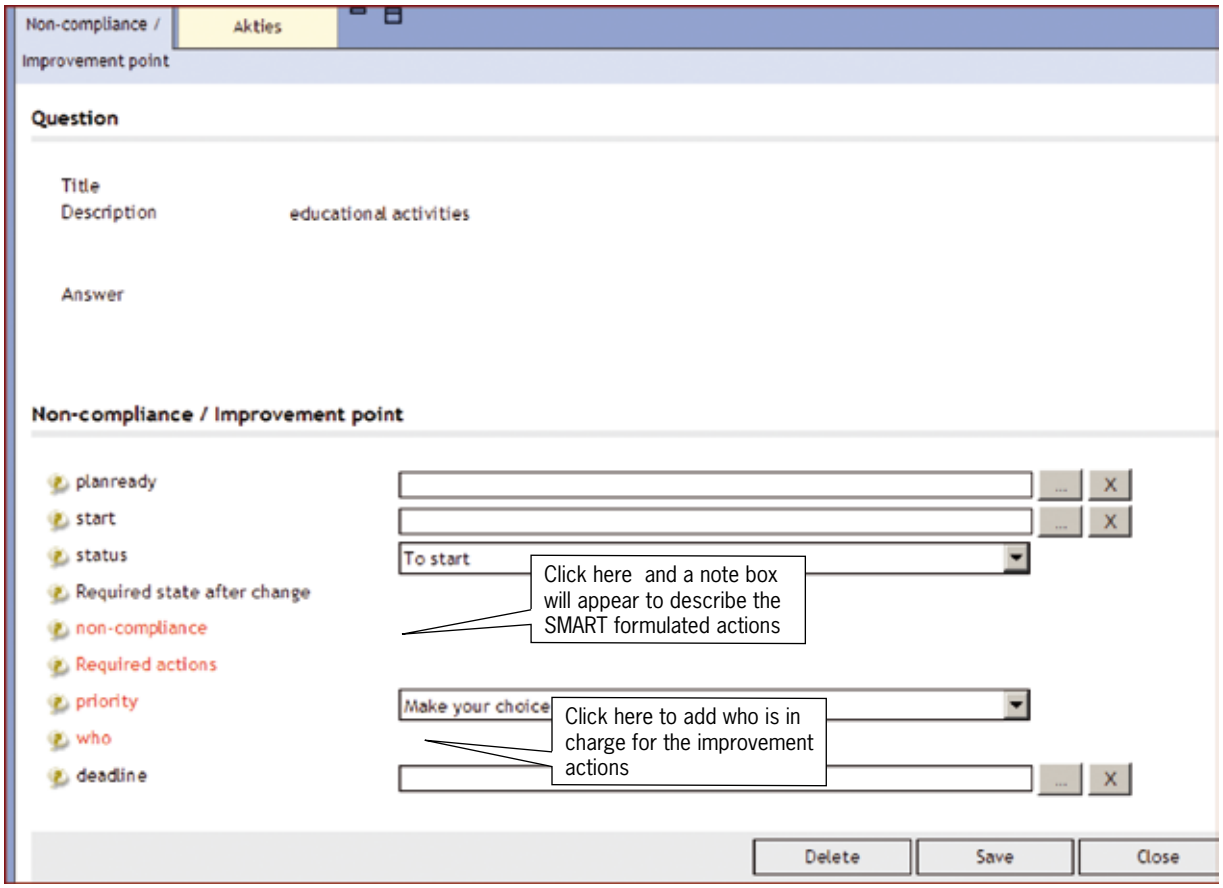
- **Step 3: Add a non-compliance/improvement point**

If you have scored a question with 'partially' or 'no' a red sentence appears under the question that a non-compliance point has been identified. This means that (quality) improvement can be made regarding this substandard by the institute.

The institute is required to describe an improvement point by:

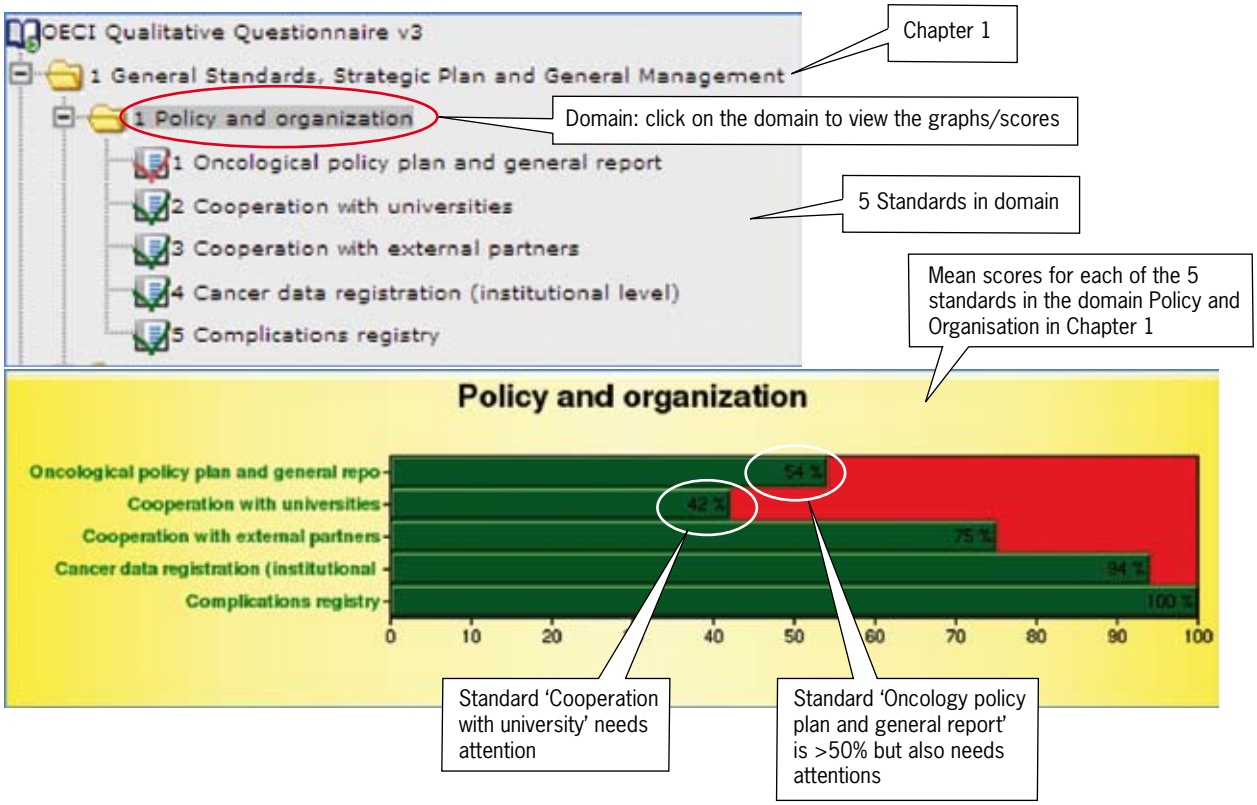


Click on 'Save and new entry' in the screen that appears and fill in the items for the improvement:

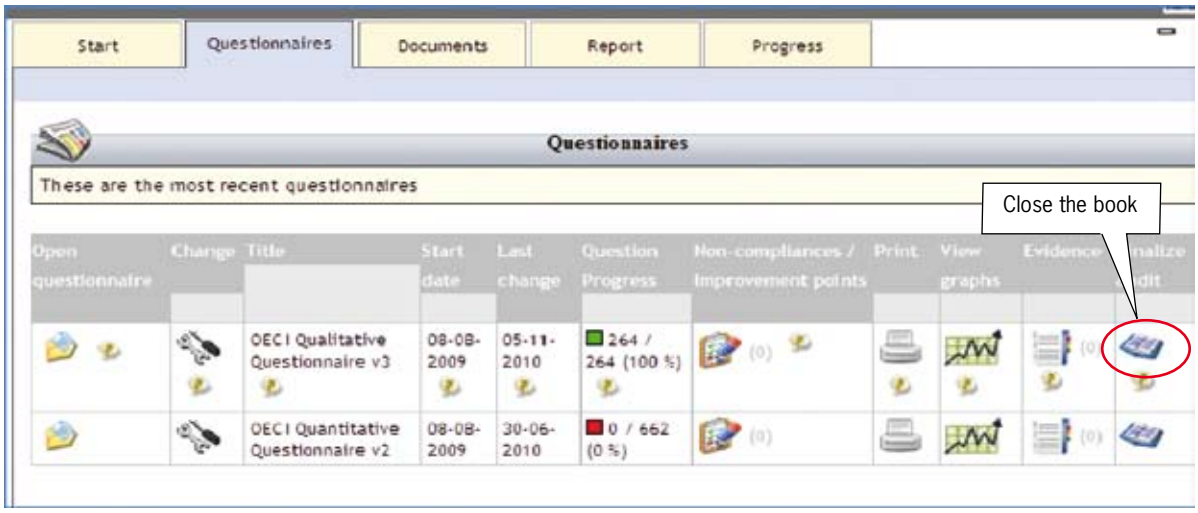


- **Check the level of quality the institute has achieved per standard**

– Open the qualitative questionnaire
– Open the show tree

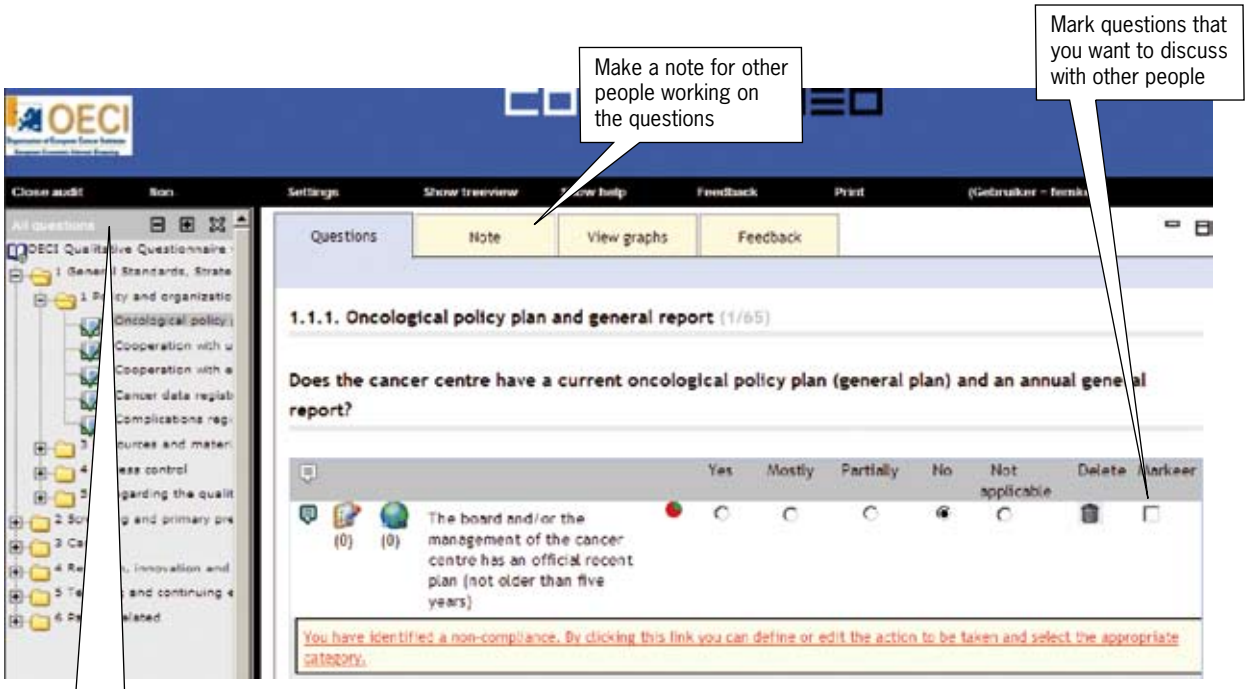


- **Close the questionnaire if you will not change or add anything else**

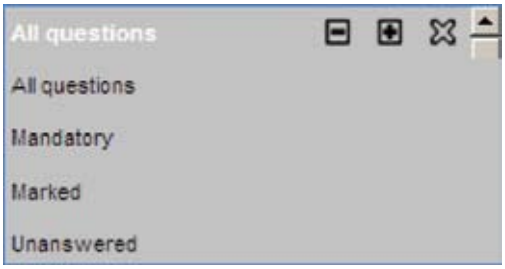


- **Other options**

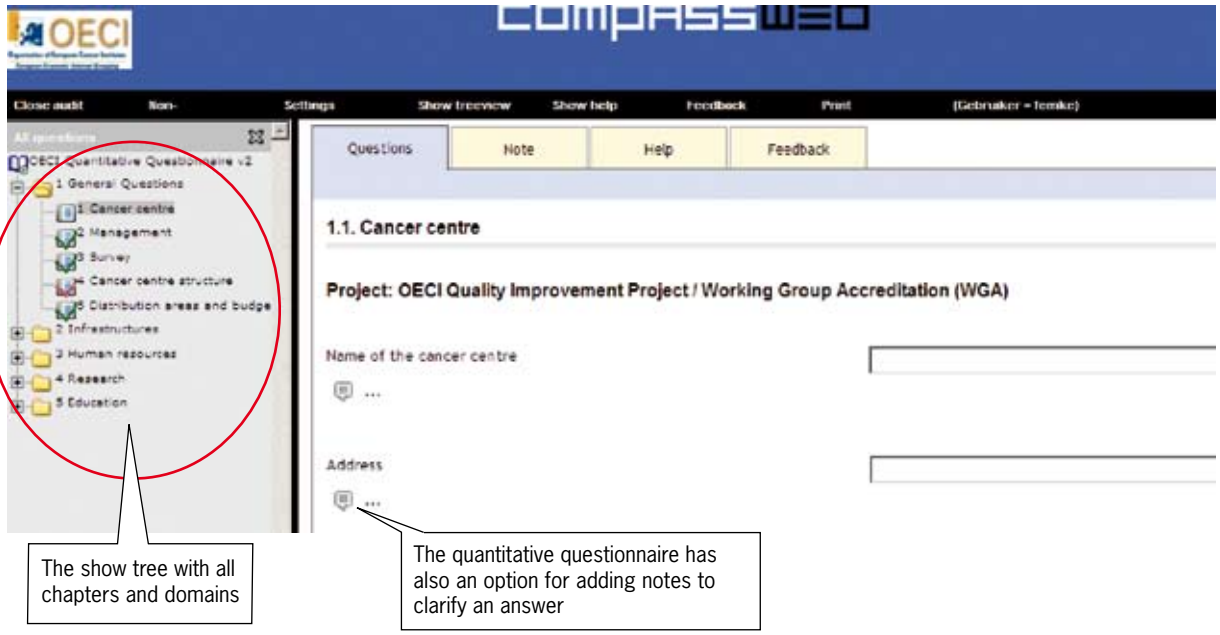
– Mark questions to discuss in project group meetings
– Make a note for other people working in the questionnaire
– Show only the marked or unanswered questions



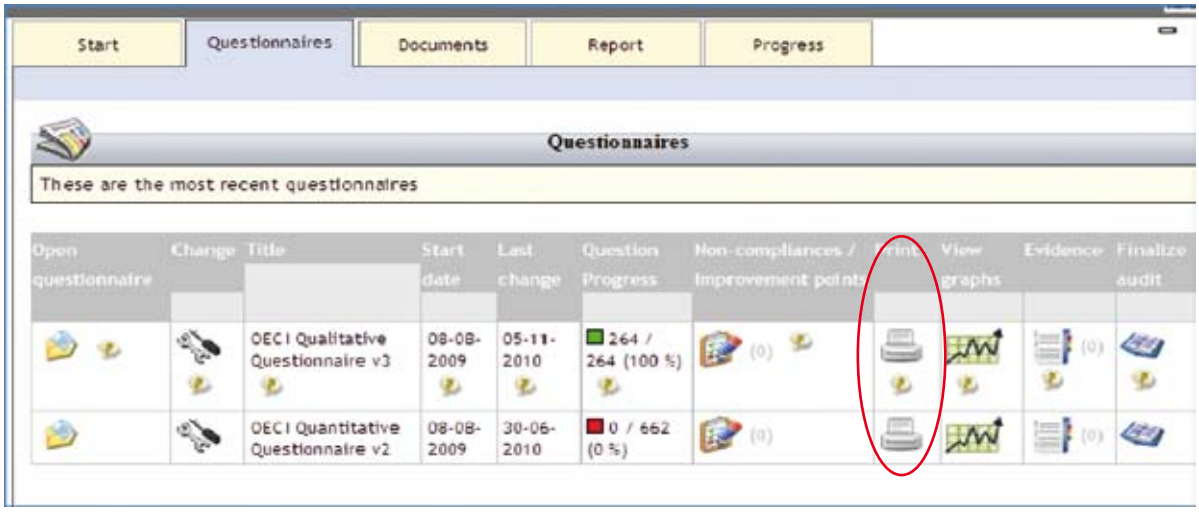
Click on “all questions’ for this list.
Choose one of the options and the show tree will only show the “marked” or “unanswered”



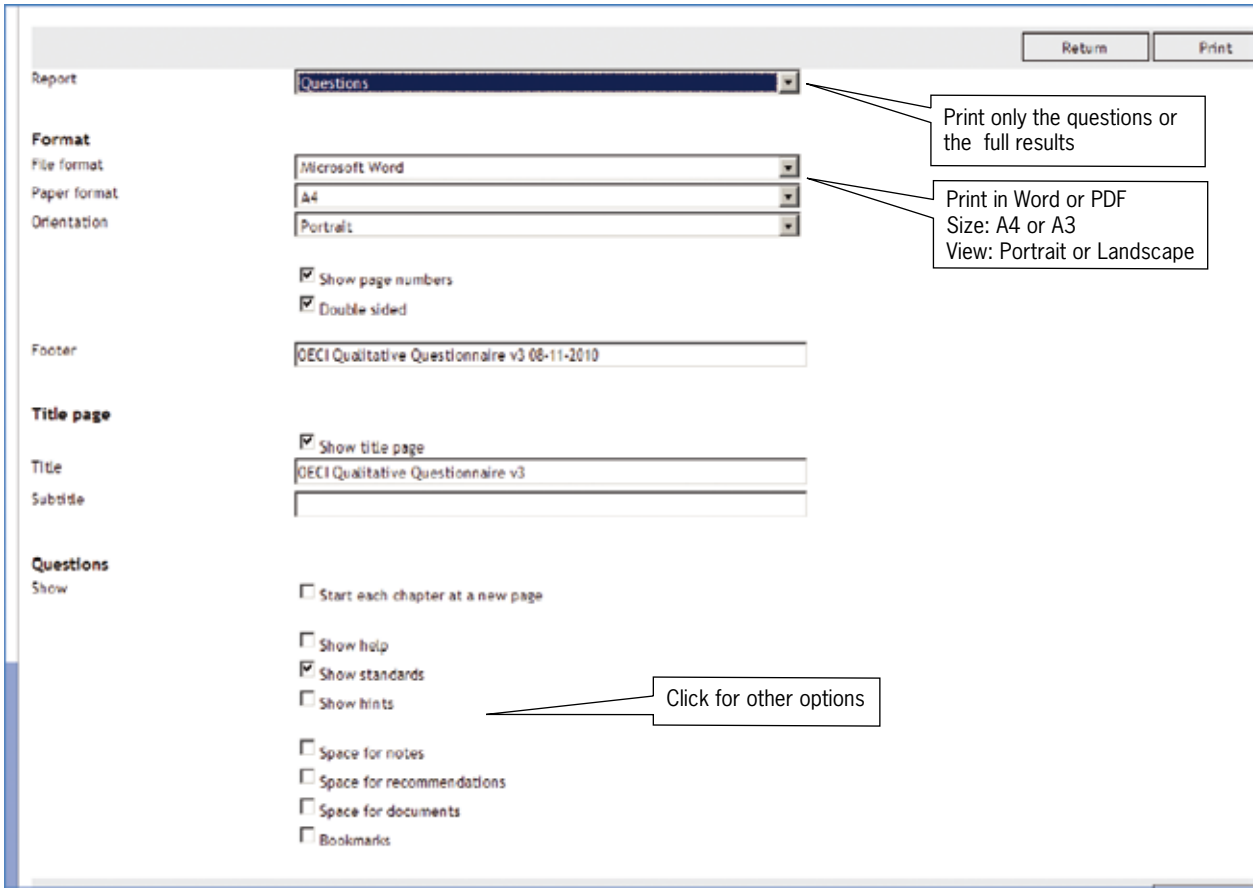
3. Quantitative questionnaire



4. Print the questions and/or the results in a report



The following screen appears with several options.


Return
Print
Report
Questions
Print only the questions or the full results
Format
File format
Microsoft Word
Paper format
A4
Orientation
Portrait
Print in Word or PDF
Size: A4 or A3
View: Portrait or Landscape
Show page numbers
Double sided
Footer
OECI Qualitative Questionnaire v3 08-11-2010
Title page
Show title page
Title
OECI Qualitative Questionnaire v3
Subtitle
Questions
Show
Start each chapter at a new page
Show help
Show standards
Show hints
Click for other options
Space for notes
Space for recommendations
Space for documents
Bookmarks

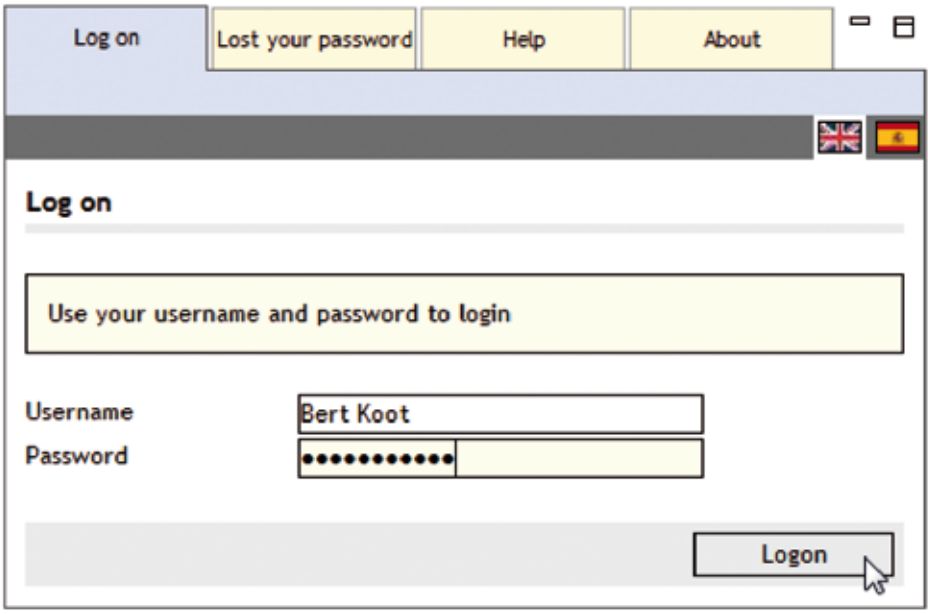
Appendix VI. User manual e-tool for auditors

This user manual gives an explanation of how OECI auditors can use the OECI electronic tool. The great advantage of the tool is that the auditors of a team can communicate with each other regardless of their physical location. An auditor can prepare a peer review individually by analysing the questionnaires and documents, and an auditor can add notes to questions which are unclear or which the auditor would like to discuss with the audit team.

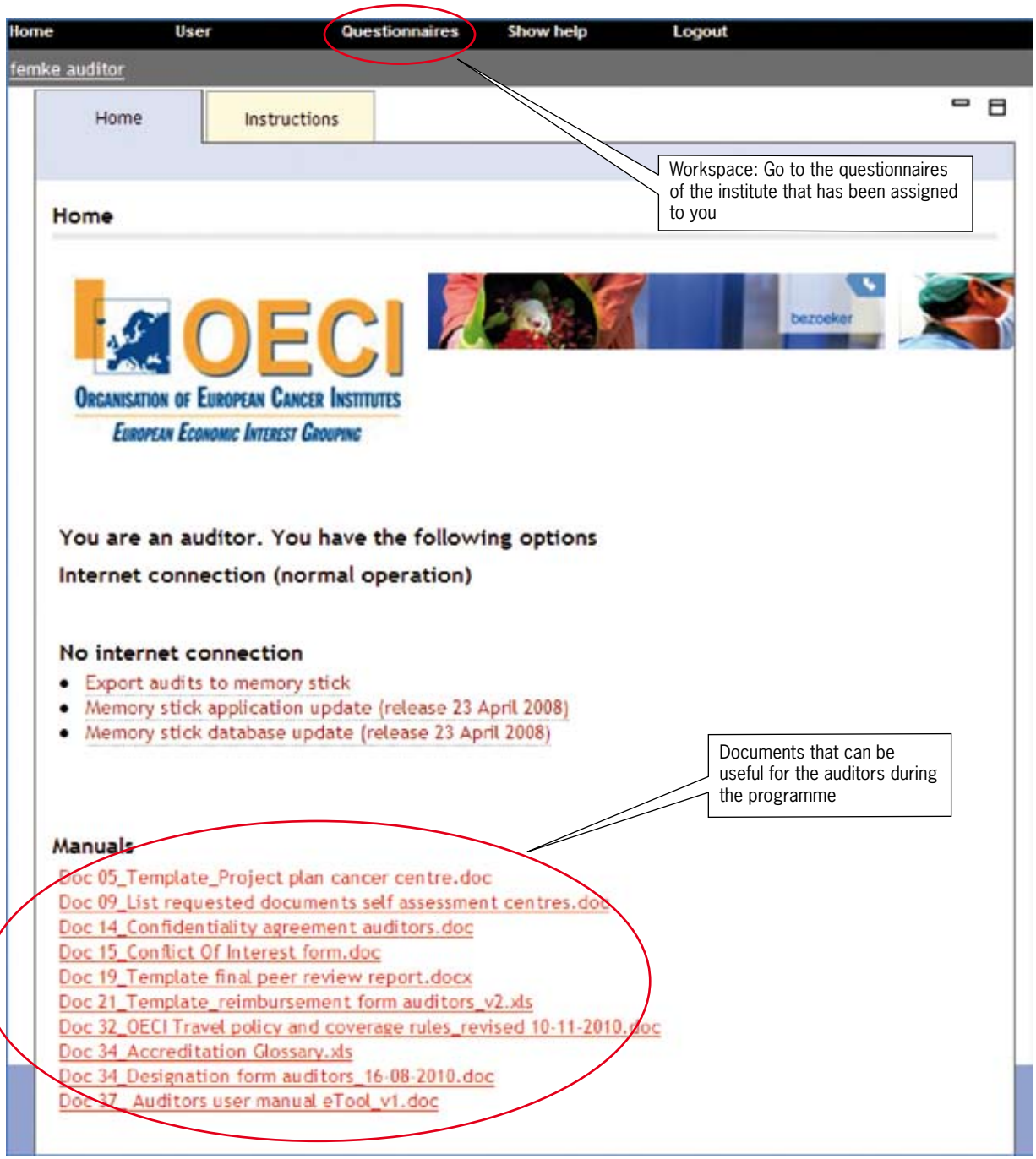
1. Log on

Go to: http://oeci.selfassessment.nu/compass/user or through the website http://oeci.selfassessment.nu.

An Auditor's username has been supplied with a password, use this to log in to the application.



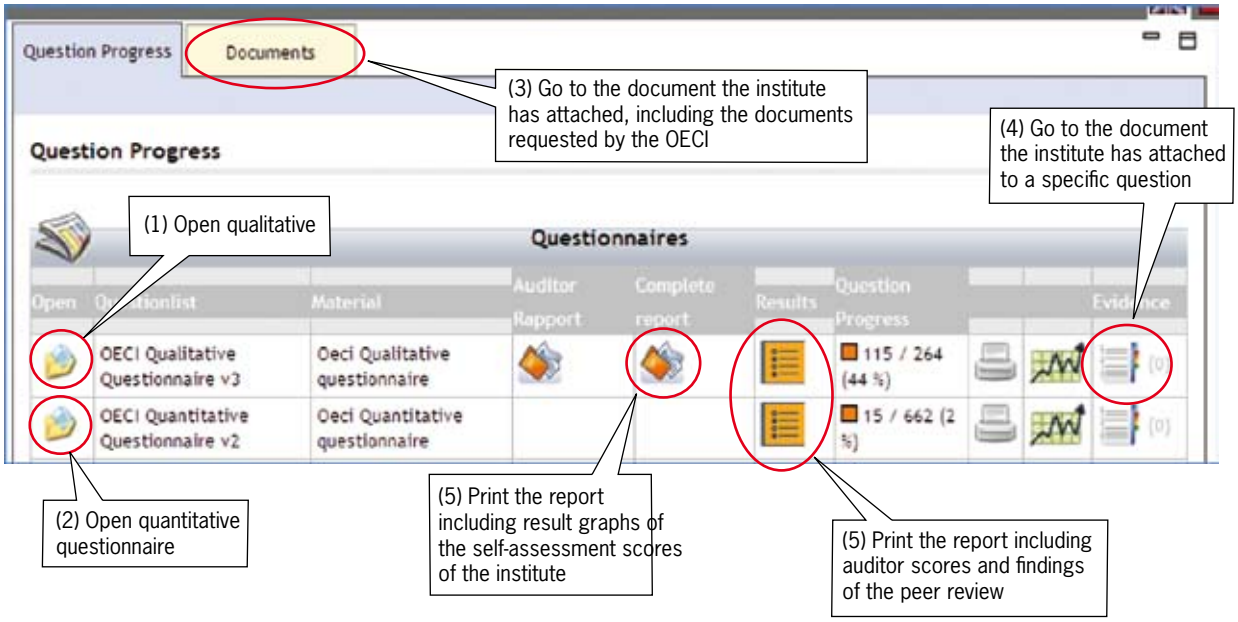
When successfully logged in you will find the following screen:



In the **'Workspace'** you can go to the questionnaires of the institutes that have been assigned to you by the OECI Accreditation Coordinator.

Click on the institute of your choice, the table with the qualitative AND quantitative questionnaire of that institute will appear.

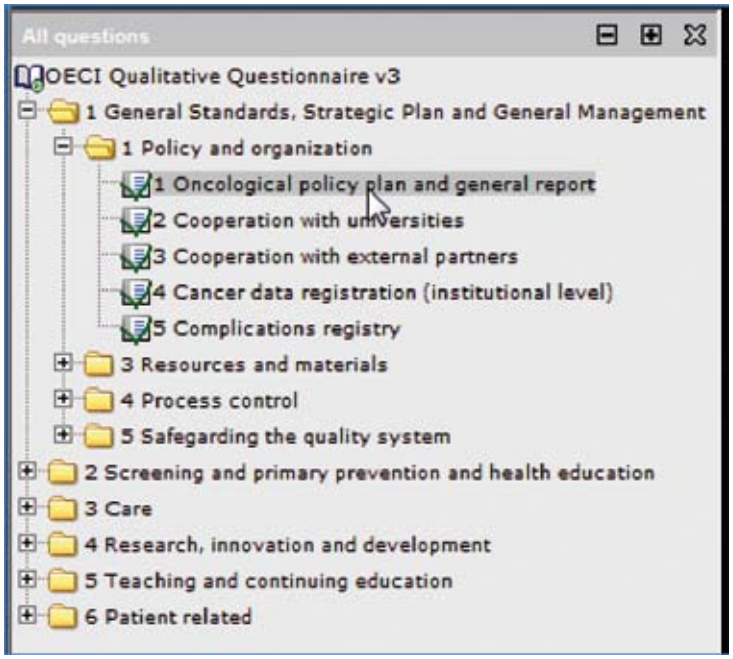
From this window there are several options for the auditor:



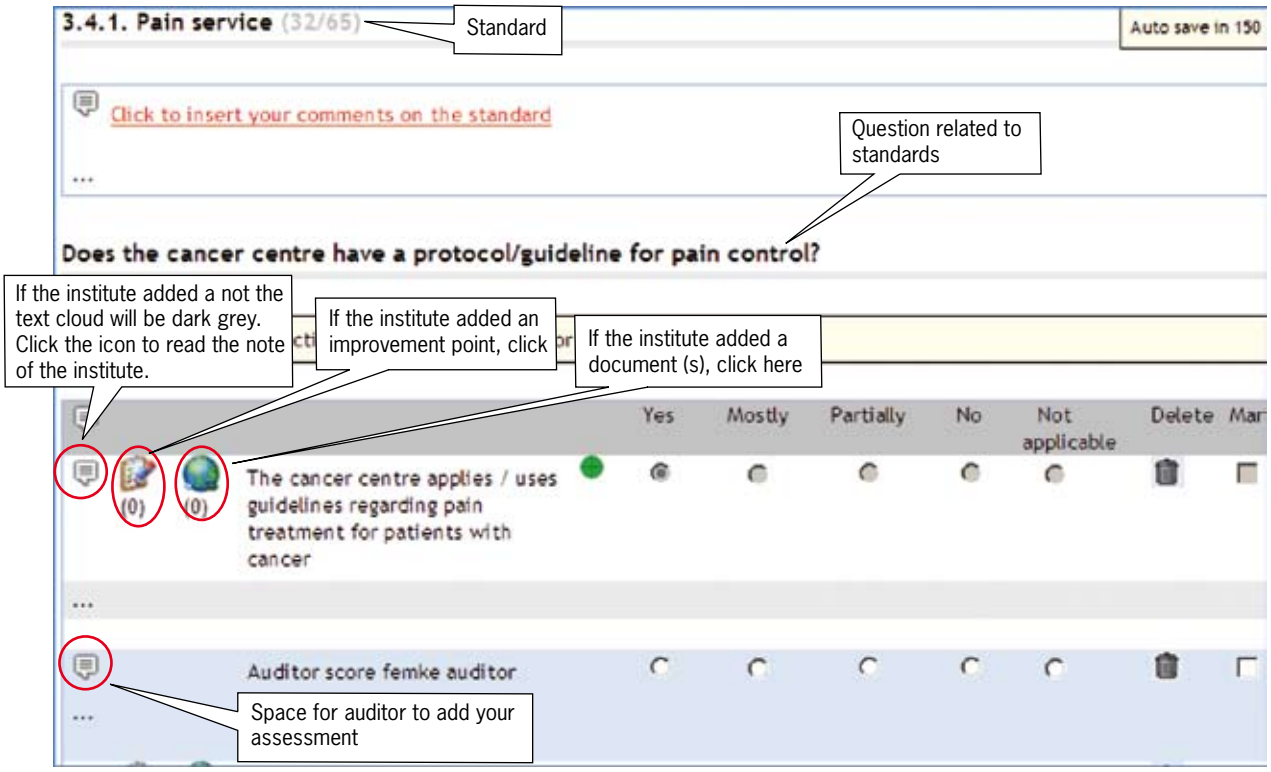
Options in the e-tool:
1. Go into qualitative questionnaire of the cancer institute
2. Go into quantitative questionnaire of the cancer institute
3. Go to the requested documents
4. Go to the documents attached to specific questions
5. Print the reports

2. Preparing a peer review

Open a questionnaire and use the treeview to navigate through the chapters / domains and standards.

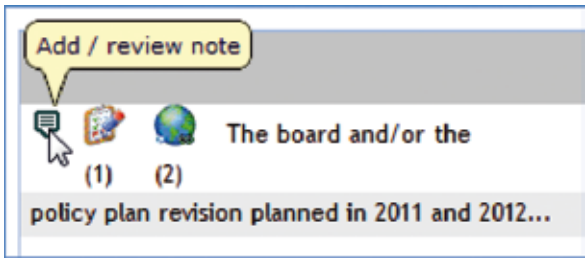


The first line shows the standard and the answer given by the centre, you can read the complete standard by clicking the text of the question.



Beneath the score of the centre, the space for the auditor can be found to add an assessment of the topic. You can score the question by clicking on the appropriate answer. You can **add notes** notes in the same way as reviewing the institutes remark and you can place items on the discussion list by ticking the box.

If an institute added a note to the standard to support the answer you can read the first line of the note underneath the standard. To view the full text, click the little text icon



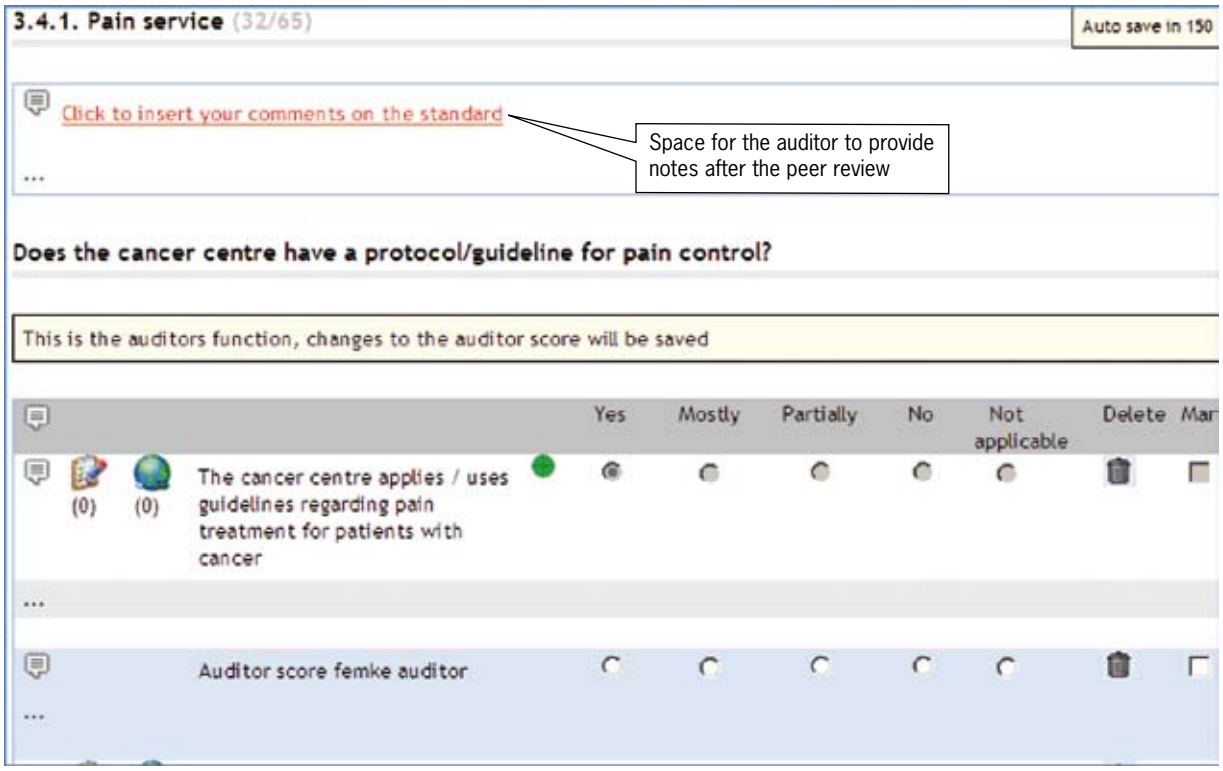
The full text of the note will be shown but can not be changed. Clicking the little icon once more will close the note.
The second icon shows the (number of) improvement points that the institute descibes regarding to this standard.
The third icon showd the number of proof documents that the institute uploaded to support this standard.

3. Report findings and scores after peer review

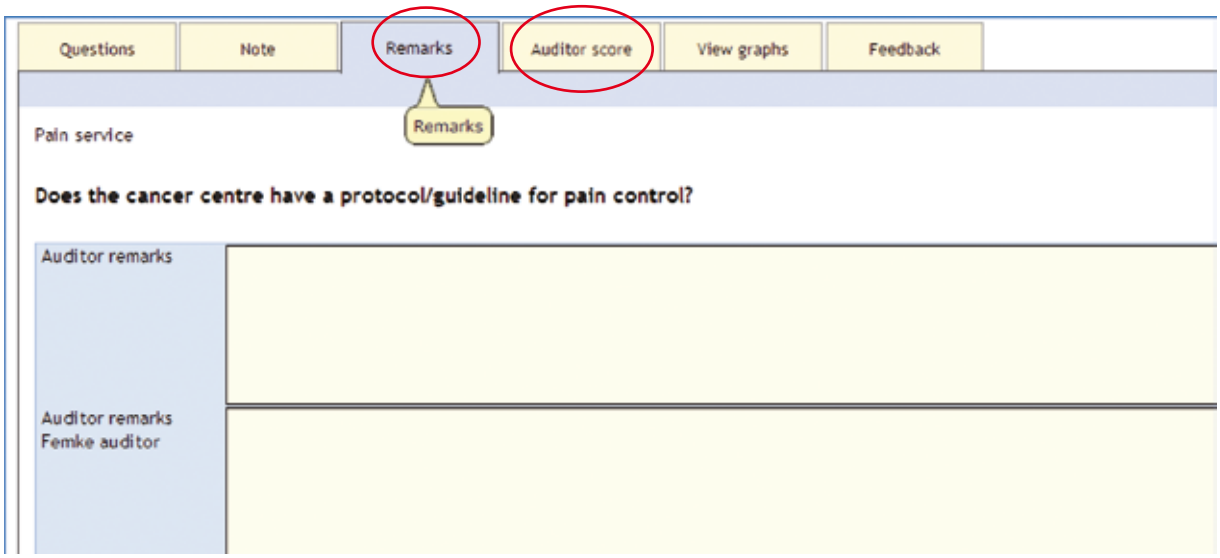
After the peer review the auditors provide their notes and scores to the Accreditation Coordinator through the e-tool:

- Note: On standard level in the questionnaire: for each standard,
- Score: On Sub-question level: for each sub-question,
- Strengths and opportunities: if a standard is a strengths or an opportunity the auditor will also make a not on standard level to explain.

The coordinator will make a draft report with the notes of the auditors.



To view the remarks and the score of the other auditors:



4. The final draft report

The Accreditation Coordinator makes a draft report of all the notes/ remarks, scores and strengths and opportunities.
The auditor will give his/her comments and feedback on the draft before it will be send to the institute as explained in the procedures.

CERTIFY THE FUTURE

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