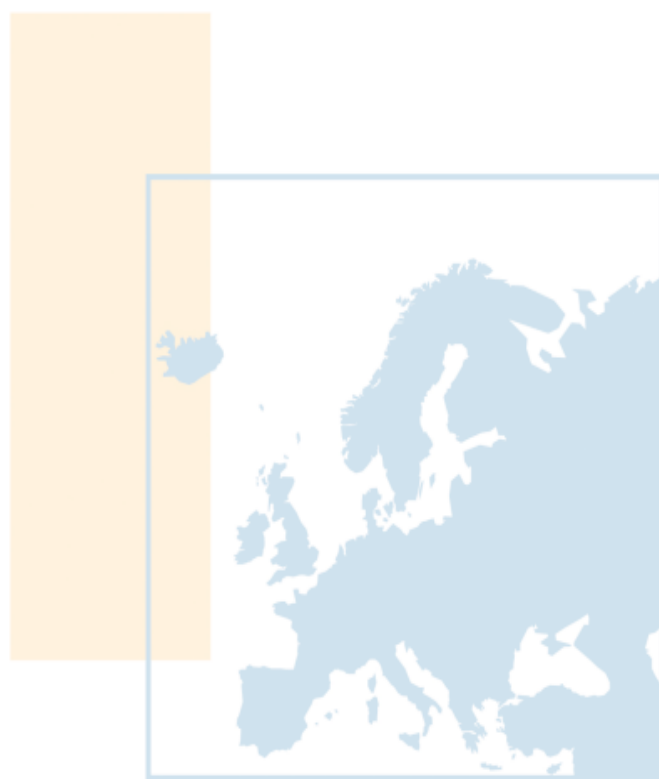


OECD peer review report

OECD A&D Programme, Manual 3.2

CONFIDENTIAL

Copenhagen Comprehensive Cancer Center (CCCC)



Year of peer review	2026
Dates of peer review	22 and 23 April
Date approval final report	
Approved by	

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The OECI

The mission of the Organisation of European Cancer Institutes (OECI) is to serve as a linking organisation, coordinating interdisciplinary cancer treatment and improving the quality of cancer care. This can be achieved by integrating cancer prevention, cancer care, research and development and cancer education.

The A&D programme for OECI members focuses on the key issues for quality comprehensive cancer care, such as: organisation and planning of integrated care, multidisciplinary working, integration and translation of results from research into daily practice, integration of education, patient satisfaction and involvement, and structures for continuous quality improvement.

Audit team

The team auditors who performed the peer review of the cancer centre were:

Chair	Jean-Benoît Burrión	Head of Preventive and Screening Clinic, Institute Jules Bordet, Brussels	Belgium
Auditor	John Reynolds	Professor of Surgery and Clinical Lead, Trinity St. James's Cancer Institute, Dublin	Ireland
Auditor	Silvia Basso	Director of quality improvement and risk management, Fundación Arturo López Pérez, Santiago de Chile	Chile
Auditor	Cherry May Sanchez	Programme Lead for the Nursing and Allied Health Professional Programme, CRUK Cambridge Centre	UK
Auditor	Patricia Doherty	Senior Cancer Programme Manager, Trinity St. James's Cancer Institute, Trinity College, Dublin	Ireland
Auditor	Alicia Diaz Redondo	Head of Quality Department; Senior Doctor of Preventive Medicine and Public Health; Head of Patient Safety Commission, Hospital Gregorio Marañón, Madrid	Spain
OECI Co-ordinator	Jolanda van Hoeve	OECI Co-ordinator and advisor at the Netherlands Comprehensive Cancer Organisation	the Netherlands

The auditors in the team made it possible to provide this peer review report.

Objectives of Copenhagen Comprehensive Cancer Center (CCCC)

To achieve its ambitions, the CCCC will focus on 4 core areas:

- A. Treatment and care**, which is CCCC's most important task.
- B. Research** that is the prerequisite for optimal treatment and care and ensures that CCCC rethinks the efforts made towards cancer patients and their relatives.
- C. Education**, because hospitals play a major role in the training of professionals. CCCC functions both as a) educational institution, b) employer of graduates and c) partner to universities and university colleges for development of the educational programmes. In addition, the CCCC has a major obligation in relation to continuing the education of the staff of the Centre.
- D. Quality development**, as strengthened focus on quality development contributes to CCCC always delivering treatment and care of the highest quality.

The peer review report: scores and remarks

The report contains the list of the standards and sub-standards. Each sub-standard is scored by the Centre during the self-assessment and by the audit team after the peer review visit. To support the scores of the auditors' score, auditors formulate a remark for each standard, where applicable. The score is an indicator for the implementation degree of each item of the standard. The scoring system is based on the Plan-Do-Check-Act-circle (Deming-circle). These four stages of implementation are translated into the following possible scores:

Yes: the indicator of the standard has been implemented on a wide scale in the Centre and the Deming-cycle has been completed at least twice (> third cycle),

Mostly: the indicator has been implemented in most of the critical places in the Centre and the Deming-cycle has been completed at least once (> second cycle),

Partially: the indicator has been implemented on project bases or on a modest scale in the Centre or the Deming-cycle has not been completed (Do-Check),

No: the indicator has not yet been considered or there are plans to start working on the indicator (Plan),

Not applicable: the indicator is not applicable in the Centre.

The overview of documents that have been uploaded as evidence can be found in the centre's self assessment environment the e-tool.

Final accreditation, decision and follow-up

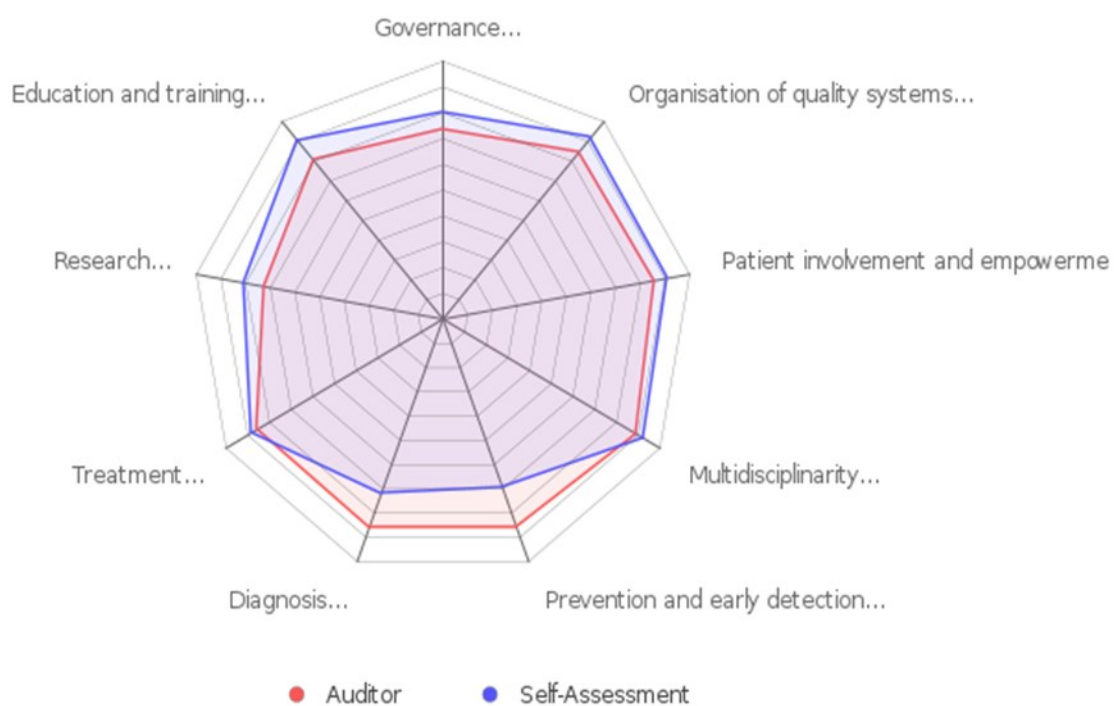
The auditors' review - related to the OECI Quality Standards - described in this report, is a snapshot of the institute. Throughout the complete Accreditation and Designation programme, the institute will develop and improve the quality of care. Therefore, to be eligible for an OECI A&D Certificate, the institute should draw up an Improvement Action Plan based on the peer review results described in this report.

The improvement plan must be sent to the OECI Accreditation Coordinator Jolanda van Hoeve, j.vanhoeve@iknl.nl within 8 weeks, after the draft report has been sent. The improvement plan should include a description of how the intends to meet the standards listed in the opportunities for improvement of this report. The centre will be given a manual and template for the improvement plan.

After the Accreditation and Designation Board has approved the final report and improvement plan of your institute, the certificate will be handed over.

Part 1: Findings of the audit team regarding the OECl quality standards

This part of the peer review report contains the nine chapters of the OECl quality standards. With the input of the peer review visit the audit team has scored the standards as the centre did during the self-assessment period. For each standard the audit team has reviewed, the team provided a general remark considering to what level the centre has met the standard.



1. Governance

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 1														
Score audit team	5	45.5	2	18.2	4	36.4	0	0.0	0	0.0	0	0.0	11	100.0
Score centre	5	45.5	5	45.5	1	9.1	0	0.0	0	0.0	0	0.0	11	100.0

Standard 1: Structure of the cancer centre – identifiable entity

Auditors findings

The Copenhagen Comprehensive Cancer Center (CCCC) brings together the Departments of Cancer Treatment at Herlev-Gentofte Hospital (HGH) and Rigshospitalet (RH), including coordinated radiotherapy services across both sites. Surgical oncology is delivered by designated surgical departments within partner hospitals and is therefore not formally embedded within the CCCC organisational structure. Nevertheless, surgical care is closely integrated through multidisciplinary team meetings and collaborative clinical projects. The centre is overseen by a 13-member Board with responsibility for strategic direction, prioritisation, and quality oversight in cancer care. The Board includes leadership from both hospitals, representatives from oncology, haematology, surgery, paediatric oncology, regional health advisory councils, and external stakeholders including the Danish Cancer Society, the University of Copenhagen, and the Technical University of Denmark. Its terms of reference, composition, and meeting records confirm a clear strategic mandate across care, research, and quality. The governance structure was set up in 2023. Day-to-day management is undertaken by the CCCC Leadership Group, composed of the Chief Medical Officers and Chief Nurse Officers from both hospitals. The strategic vision has been outlined in broad terms but has not yet been fully translated into a formal operational plan, particularly in research. Financial stewardship remains limited within the Board, in part due a highly regulated national healthcare framework.

The cancer centre has an identifiable governing entity (board of directors / executive committee).

#	Standard	Score	Auditor score
1	CORE The cancer centre has an identifiable governing entity (board of directors / executive committee with accountability for: - Strategic plan for cancer care - Plan for research - Quality and safety - Budget.	Mostly	Mostly

Standard 2: Structure of the cancer centre - Quality Management

Auditors findings	
The Chief Medical Officer from HGH, who is a member of both the CCCC Board and the CCCC Leadership Group, holds responsibility for quality management within the CCCC.	

The administrative/ board level of the cancer centre includes quality management.

#	Standard	Score	Auditor score
1	CORE There is an identifiable Director who has quality and risk management as his / her responsibility.	Mostly	Mostly
2	The director who has quality and risk management as his/her responsibility is a member of the board of directors or senior management team of the cancer centre.	Mostly	Yes

Standard 3: Strategy and quality cycle of the cancer centre

Auditors findings	
The CCCC has developed an initial strategic framework outlining its ambitions across the four core domains of care, research, education, and quality. While this document provides useful orientation, it remains relatively high level and is not yet translated into a comprehensive operational plan with clearly defined SMART objectives, timelines, and measurable outcomes covering the full scope of the CCCC's activities. At the regional level, a broader health development strategy for the Capital Region of Denmark (2023) has been established, identifying five strategic priority areas. In alignment with this framework, the HGH Department of Cancer Treatment has produced an annual agreement describing its strategic development priorities for the period 2022-2023. However, no equivalent document was identified for RH. The CCCC has published an annual report highlighting several important initiatives and developments. Nevertheless, the report does not yet provide a comprehensive overview of the CCCC's overall activities, performance indicators, and achievements during the reporting period.	

A periodical planning and control cycle concerning oncology policy and strategy is present.

#	Standard	Score	Auditor score
1	CORE There is a written strategic plan for the cancer centre which covers at least 3 years, and which is formally endorsed by the board.	Mostly	Partially
2	Each main service or department of the centre has an annual or multi-year plan which is consistent with the centre's overall strategy plan for cancer.	Mostly	Partially
3	CORE According to the planning and control cycle the centre produces a (multi-)annual report which results in a quality improvement plan.	Partially	Partially

Standard 4:

Auditors findings	
Thanks to Denmark's highly centralised and detailed healthcare funding structure, the CCCC is in a position to present a breakdown of annual costs for both HGH and RH. However, the CCCC investment and depreciation plans are not substantiated: financial management is limited and constrained by detailed national healthcare planning.	

The centre has processes for ensuring financial sustainability.

#	Standard	Score	Auditor score
1	The cancer centre defines a multi-annual budget for its activities, which ensures sustainability as far as practicable.	Yes	Partially

Standard 5: Cooperation with universities

Auditors findings	
Denmark has a well-established legislative and regulatory framework that governs the organisation of healthcare and institutional collaboration. As a result, many partnerships operate within these formal structures rather than through separate bilateral agreements. Within this framework, the university hospitals of the Capital Region - HGH and RH - maintain structured collaborations with both the University of Copenhagen and the Technical University of Denmark, particularly in the areas of education, research, and innovation. Part of these collaborations are coordinated through the Copenhagen University Hospital (FCA), which serves as the organisational platform linking the Faculty of Health and Medical Sciences at the University of Copenhagen with the healthcare services of the Capital Region and Zealand Region. This structure provides a formal framework to support integrated academic and clinical activities across the partner institutions.	

Written cooperation agreements concerning educational and research activities with at least one university are present and periodically evaluated.

#	Standard	Score	Auditor score
1	CORE For training and postgraduate education activities.	Yes	Yes
2	CORE For research activities.	Yes	Yes

Standard 6: Cooperation with external partners

Auditors findings

In Denmark, cooperation between departments and hospitals is generally not formalised through bilateral agreements. Instead, healthcare providers operate within a nationally defined regulatory framework, notably the Specialty Plan, which establishes the organisation of hospital services, centralisation of certain highly specialised services, and enables collaboration across institutions, including in cancer care. This national framework specifies how hospitals, centres, and departments coordinate their activities and distribute specialised functions. While a limited number of operational agreements may exist at the hospital level, such as for shared services like pharmacy, most inter-institutional collaboration is structured and governed through this Specialty Plan for the hospital sector.

There are written agreements concerning the allocation of responsibilities and tasks for referrals of patients.

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

2. Organisation of quality systems

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 2														
Score audit team	37	71.2	7	13.5	7	13.5	1	1.9	0	0.0	0	0.0	52	100.0
Score centre	46	88.5	5	9.6	0	0.0	1	1.9	0	0.0	0	0.0	52	100.0

Standard 7: Integrated quality, risk and safety management

Auditors findings

Management systems are being implemented at national level. The Danish Patient Safety Authority (DPSA) plays a key role in this regard. In the Capital Region, the Oncology Health Advisory Council (SFR) assesses and monitors quality and ensures consistency across the various oncology departments. A regional quality management system (VIP) is in place. The CCCC also operates its own quality management system, described in the manual 'CCCC Quality Management Programme'. The reporting and handling of adverse events are organised in accordance with a national tool and a standard operating procedure (the Danish URH system), which is implemented at regional level. Not everyone is entirely familiar with the procedure and aggregated data on adverse events do not appear to be routinely compiled or analysed at a global level, which may hinder the identification of broader patterns. Similarly, the reporting of near-miss events does not seem to be systematically integrated into the current process, although such information could provide valuable insights for prevention. While a document management system is in place, its implementation is not uniform across all areas of the organisation. Some departments operate their own document management systems in parallel, which may limit the standardisation and centralised oversight of SOPs. The Centre for IT, Medicine and Telecommunications in the Capital Region (CIMT) manages data storage and processing. A comprehensive prospective risk management system is not clearly in place. Although a quality manager is represented at board level, quality management responsibilities are largely decentralised across the individual units. This decentralisation limits the integration of the various quality systems at CCCC level, making it difficult to ensure a coherent and organisation-wide approach to quality oversight. All in all, while quality systems are in place based upon national/regional tools, there is a need for these systems to be more integrated systematically across the CCCC.

The cancer centre has a structured policy for quality, risk and safety management.

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

Standard 8: Quality analysis and improvement

Auditors findings
The Danish Cancer Treatment Groups (DMCG) and the regional clinical databases (RKKP) provide outcome data for each cancer subtype, as well as key performance indicators (KPIs) covering the full care pathway, from diagnosis to supportive and palliative care. The national patient experience survey (LUP) aims to improve quality as perceived by patients across 5 regions. In the Capital Region, the survey is managed by the Centre for Patient Involvement (CPI). The Danish Health Authority may conduct inspections to assess the quality of services. Within the electronic patient record EPIC and at regional level, several dashboards summarise quality data for use by senior management, executive management and quality units. These dashboards are reviewed regularly (every 1 to 3 months) by the central management of the hospital/centre. Relevant follow-up measures are communicated to the CCCC management to ensure that actions are taken.

The cancer centre has an integrated quality, risk and safety requirement system.

#	Standard	Score	Auditor score
1	CORE There is a quality, risk and safety dashboard with standardised indicators (including overall survival, patient satisfaction, patient quality of life, MDTs' activities).	Yes	Yes
2	This dashboard is analysed on a regular basis by senior management and acted upon.	Yes	Yes
3	CORE The line management of the centre are responsible for implementing improvements after analysing results of quality and risk and safety factors.	Yes	Yes

Standard 9: Quality reporting

Auditors findings
Reports from inspections and accreditations are not published on the website.

The centre publishes summary reports or grades from inspections and accreditations.

#	Standard	Score	Auditor score
1	The centre systematically publishes on its website summary information on feedback from external quality inspections and accreditations.	No	No

Standard 10:

Auditors findings
Although several examples were given, a comprehensive prospective risk management system is not clearly in place. This was confirmed during the quality management interview, where it was acknowledged that risk assessments are carried out on an ad hoc basis rather than through a systematic and structured approach.

There is a standard process for the introduction of new practices.

#	Standard	Score	Auditor score
1	Systematic risk assessment is performed before the introduction of a new technology or a new intervention.	Yes	Partially

Standard 11: Quality assurance

Auditors findings
The quality assurance programme is primarily led by the Danish Multidisciplinary Cancer Groups (DMCG) and the Danish Clinical Quality Programme - National Clinical Registries (RKKP). Since 1 January 2025, the Danish Healthcare Quality Institute (Sundhedsvæsenets Kvalitetsinstitut, DHQI) has been established, replacing the Health Technology Council (Behandlingsrådet) and the Regions' Clinical Quality Development Programme (RKKP). A programme of systematic internal audits is not fully in place. No annual audit plan was provided, and audits have not been uniformly conducted across all units of the CCCC.

Quality assurance programmes (QAPs) are in place.

#	Standard	Score	Auditor score
1	Quality assurance programmes are part of the policy for quality and risk management covering all departments.	Yes	Yes
2	There is a QAP for clinical research.	Yes	Yes
3	CORE There is an internal audit system following an annual plan covering all departments.	Mostly	Partially
4	There is a programme for infection control.	Yes	Yes
5	Infection rates are monitored.	Yes	Yes
6	Results of the infection control programme are reported and analysed.	Yes	Yes

Standard 12: Cancer data registration

Auditors findings
Cancer-related data are available from the Joint Municipal Management Information System (FLIS). Specific reports can be generated from the EPIC system, and these are monitored by the CCCC Leadership. The trends in new diagnoses, treatments and outcome data are reviewed by the DMCG working groups. All cases are reported to the National Patient Register. However, a patient receiving multiple treatments, such as surgery, chemotherapy and radiotherapy, is counted separately for each modality, which may result in an overestimation of the actual number of new patients.

Cancer patient data are used for developing strategic planning and quality improvement of care processes.

#	Standard	Score	Auditor score
1	CORE The number of new patients, newly diagnosed patients and treated patients by tumour type in the cancer centre are available annually at the cancer centre level.	Yes	Mostly
2	The diagnostic trends of cancer patients by tumour type / stage are known at an institutional level and reported annually to the board of the cancer centre for future planning.	Yes	Yes
3	The centre reports all new cancer patients to the regional or national cancer registry.	Yes	Yes
4	The treatment trends of cancer patients by tumour type are known at the cancer centre level and MDT level and reported annually to the board for future planning.	Yes	Yes
5	CORE The outcome data of cancer patients by tumour type are known at the cancer centre level and MDT level and are used by management for strategic planning / or policy decisions.	Yes	Yes

Standard 13: Waiting and throughput times

Auditors findings
Waiting times are the primary national indicator used to monitor the quality of care. The CCCC complies with the standard across all aspects.

For critical stages in the care process the maximum waiting times are defined.

#	Standard	Score	Auditor score
1	There are standards for the maximum waiting times between referral and first visit to outpatients' clinic or admission to the cancer centre.	Yes	Yes
2	There are standards for the maximum waiting time between first visit and the time of definitive diagnosis.	Yes	Yes
3	There are standards for the maximum waiting times between definitive diagnosis and first treatment.	Yes	Yes
4	There is a record and continuous monitoring of the actual waiting times against the standards.	Yes	Yes
5	CORE If maximum waiting times are exceeded improvement actions are defined promptly.	Yes	Yes

Standard 14:

Auditors findings			
Denmark has a national system, managed by the Danish Patient Safety Authority, which allows for the anonymous reporting of serious adverse events. At the time of the peer review visit, a global complications registry report, documented improvement actions agreed across all relevant departments, and evidence of annual measurement of their effectiveness were not available for review.			

The board of the cancer centre gets standardised reports on complications and Serious Adverse Events at regular intervals for future evaluations.

#	Standard	Score	Auditor score
1	CORE The cancer centre has a comprehensive system for reporting, registration and assessing complications and Serious Adverse Events.	Yes	Mostly
2	The global report of complications registry data is reported to the medical management at least annually.	Yes	Partially
3	Improvement actions are developed and implemented in agreement with all departments and disciplines concerned.	Yes	Partially
4	The effect of improvement actions is measured and reported at least annually.	Yes	Partially

Standard 15: Technical quality of medical equipment

Auditors findings			
The MEDUSA database supports the lifecycle management of medical equipment, while the regional IT and Medico-technical unit (CIMT) ensures operation, maintenance, and procurement of extensive medical and IT infrastructure across hospitals. This includes large-scale device management, data centres, and digital systems. Training covers technical, clinical, and patient care aspects and is delivered across major Danish cancer centres. Within the CCCC, robust processes ensure that only appropriately trained personnel operate specialised equipment.			

Medical equipment is safe, efficient and accurate.

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

Standard 16: HRM – staffing

Auditors findings
Staffing levels are monitored, and competency verification is supported through delegated rights, specialist roles, regional training platforms, and documented certification within personnel records.

Staffing levels are planned.

#	Standard	Score	Auditor score
1	Staffing levels of key disciplines are planned in all clinical departments so as to ensure safety and high-quality care and by reference to the guidelines or standards of professional societies or regulators, where applicable.	Yes	Yes

Standard 17: HRM – appraisal policy and support system

Auditors findings
Annual Employee Development Interviews (MUS) are conducted by line managers for all staff, using structured documentation to guide discussions on professional performance, personal development, and future goals. These interviews result in a documented individual development plan, which is reviewed annually. Staff training and competencies are tracked through a digital Course Portal, complemented by additional records in personal files. Healthcare professionals requiring licensure are registered in the national Authorization Register, ensuring regulatory compliance.

The centre has a comprehensive appraisal policy and support system for its staff.

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

Standard 18: Privacy, protection of, and access to personal data

Auditors findings
Patients' personal data are protected under the GDPR, with regional policies and Data Protection Officer (DPO) contact information available online. Patients can access their medical records digitally through national (sundhed.dk) and regional (My SP) platforms, where they can view healthcare data, appointments, and communicate with healthcare providers. Sundhed.dk also provides general health information and access to services. The sharing of personal health data requires regularly updated signed consent forms, and a digital solution is currently being developed to simplify this process. Policies on informed consent follow Danish national legislation, and patients can also create a living and medical will to outline their healthcare preferences.

Written procedures regarding privacy and protection of, and access to personal data are present.

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

3. Patient involvement and empowerment

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 3														
Score audit team	28	73.7	5	13.2	5	13.2	0	0.0	0	0.0	0	0.0	38	100.0
Score centre	31	81.6	7	18.4	0	0.0	0	0.0	0	0.0	0	0.0	38	100.0

Standard 19:

Auditors findings

The **Patient User Advisory Panel** enables patient representatives to support the organisation by providing voluntary advice on the delivery of its services. However, the centre has an opportunity to increase this level of involvement and could benefit from more fully utilising patient participation in the planning and organisation of the comprehensive centre. Currently, when new practices are introduced, patient representatives describe their involvement as minimal. Their contribution is often limited to giving feedback on specific project-based items, rather than being actively engaged in the broader planning and development of new practice changes within the centre.

It is the mission of the centre to encourage patient involvement in services.

#	Standard	Score	Auditor score
1	CORE The cancer centre involves patients and patient's voluntary organisations and support groups in the planning and organisation of services.	Yes	Partially
2	The standard process of introducing new practices in clinical care ensures that patients are involved.	Mostly	Mostly
3	There is a committee representing patients and serving as a link between the cancer centre and the patients for advice and consultation.	Yes	Yes

Standard 20: Patient education programmes

Auditors findings

The centre offers a specific education programme for patients, known as the "patient school". This is an interesting model in which patients receive education 5 days a week, for half a day each time, to accommodate for personal schedules and commitments of patients. The programme provides education tailored to specific medical specialties and involves members of the multidisciplinary team, who lead teaching sessions to help patients understand their illness, diagnosis, treatment options, and related topics. In addition, the Danish Cancer Society is able to visit the hospital to offer support to patients during their stay. At HGH, there is also a dedicated patient support system that provides assistance and guidance to patients.

Patient education programmes are in place.

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

Standard 21: Patients' rights and preferences

Auditors findings
Standard Operating Procedures (SOPs) are in place to ensure that patient preferences are respected, including support for religious, social, and cultural needs.

The centre has a policy on patients' preferences.

#	Standard	Score	Auditor score
1	The centre has a policy on respecting patients' preferences (religious, cultural, social).	Yes	Yes

Standard 22: Patient information

Auditors findings
Patients receive informational materials either as printed documents or through the digital patient-access platform, MyChart. It is also possible to access documents in specific languages upon request. These information materials include information on training, and information on diagnostic options. Patients are also provided with a booklet on potential side effects, which includes information on relevant contact numbers, and follow-up instructions after treatment. Patients cannot self-refer to clinical trials. However, they will have access to information about available trials once these are discussed with clinicians during consultation. Supportive care is primarily accessed at the municipal level, unless patients meet the criteria for referral to the late-effects clinic. Patients feel that the supportive care they receive is insufficient or inconsistent, suggesting an area for improvement. Information on patient rights is available at the regional level and is shared with patients.

Information is provided to patients.

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

Standard 23: Informing patients about their care

Auditors findings
Clear procedures exist for informing patients about diagnosis, treatment and follow-up through MDT-led consultations, documented pathways and digital tools (EPIC/MyChart). Staff receive specific training in patient communication, and all information shared is documented in the patient record. Patients are informed about continuity of care when they are referred to other providers, each patient is given a named contact person (coordination nurse), and all patients receive clear emergency contact details for clinical staff. There is no evidence of an individualised survivorship care plan across all pathways but patients receive information on available support services and can be referred to late-effects clinics and municipal services. Patients perceive municipal supportive care as inconsistent across locations, with services largely focused on general care with limited access to specialised oncology-specific support.

There are procedures for informing patients about the diagnostic results, treatment and follow-up, and survivorship support.

#	Standard	Score	Auditor score
1	CORE There are procedures in place which specify how and by whom patients are informed about their diagnostic results, treatment options, follow-up, and survivorship support, which involve shared decision-making.	Yes	Mostly
2	Expertise and specific training on communicating with patients and their families is available for staff.	Yes	Yes
3	The information communicated to the patient is recorded in the patient's record.	Yes	Yes
4	If patients are referred to another healthcare provider, they are informed about the continuity of their care	Yes	Yes
5	Patients receive information about their contact person for all matters related to their care.	Yes	Yes
6	CORE All patients are given contact information of clinical staff in case of emergency.	Yes	Yes

Standard 24: Informing patients on admission

Auditors findings	
Cancer patients are informed about the cancer centre admission and welcoming procedures, and all patients visiting the centre receive clear general information about the hospital. Detailed information regarding admission processes is readily available and communicated to patients in a timely and understandable manner. Upon admission, patients receive a cancer pack with information about their cancer type. In addition, patients and their caregivers are provided with information about relevant patients' associations, self-help groups, and external support services. This ensures that they have access to peer support and complementary care throughout the cancer pathway.	

Cancer patients are informed about the cancer centre admission and welcoming procedures.

#	Standard	Score	Auditor score
1	All patients visiting the cancer centre receive general information about the hospital.	Yes	Yes
2	Detailed information about the admission procedure is available and communicated to patients.	Yes	Yes
3	Information about patients' associations and about self-help and support groups is given to patients and their caregivers.	Yes	Yes

Standard 25: Discharge procedure, follow-up and survivorship care planning

Auditors findings	
The centre has a defined discharge procedure, including the provision of information to patients on further treatment, follow-up, re-admission and home care, including established processes to inform the patient's general practitioner when care is transferred. This process is supported by the use of electronic medical records. Individual survivorship support is partially met, as patients receive information on available support services and can be referred to late-effects clinics and municipal services. However, a consistently documented, individualised survivorship care plan is not yet in place for all patients. Provision of an individual end-of-life care plan is largely in place, with care options discussed and coordinated by the palliative care team in collaboration with patients and caregivers.	

A discharge procedure and related care plans are defined.

#	Standard	Score	Auditor score
1	CORE There is a defined discharge procedure including giving information on further treatment, follow-up, re-admission and home care.	Yes	Yes
2	The centre has processes to inform the patient's general practitioner of a transfer of care.	Yes	Yes
3	The patient is provided with an individual survivorship plan which is discussed with the patient and includes details of all support services and support groups available.	Mostly	Partially
4	The patient is provided with an individual plan for end-of-life care, which is discussed with the patient and care givers.	Mostly	Mostly

Standard 26: Patient satisfaction / experience

Auditors findings	
Patients' experience of cancer care is embedded within the centre's quality improvement system. The centre regularly gathers patient experience data through national patient satisfaction surveys, adverse event reporting, and feedback channels during both outpatient and inpatient care. Survey results are analysed, reported and discussed through line management structures, MDTs and quality committees, with actions are taken when trends or issues are identified. The use of Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) is partially met. Some PROMs (e.g. quality of life and toxicity assessments such as EORTC and CTCAE) and patient experience feedback are collected and reviewed, but a fully standardised and validated PROM and PREM framework, consistently applied across all pathways in both hospitals to assess health status, functional impact, communication and care processes, has not yet been fully developed or implemented.	

Patients' experience of cancer care is an integrated part of the quality improvement system of the centre.

#	Standard	Score	Auditor score
1	CORE The cancer centre has methods to regularly gather patients' experiences during outpatient and inpatient care.	Yes	Yes
2	CORE Satisfaction surveys are analysed, reported and acted upon through the line management of the centre.	Yes	Yes
3	The centre uses questionnaires to ascertain the perceptions of the patient's health status, level of impairment, disability and health-related quality of life (e.g. Patient-Reported Outcome Measures (PROM)).	Mostly	Partially
4	The centre uses questionnaires to assess the impact of the process of care on the patient's experience, e.g. communication and timelines of assistance (e.g. Patient-Reported Experience Measures (PREM)).	Mostly	Partially

Standard 27: System for receiving and managing complaints

Auditors findings			
The cancer centre has a clearly defined complaints procedure, supported by an identified complaints officer/complaints office. All complaints and related actions are formally recorded and contribute to annual reporting. Complaints data are reviewed through governance structures, including Board discussions where trends or recurring issues are identified, and feedback is provided to staff involved to support learning and quality improvement.			

The cancer centre has a complaints procedure.

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

Standard 28: Collaboration with patient organisations

Auditors findings			
The centre works closely with patient organisations and has established partnerships with existing patient groups, including the Danish Cancer Society. These organisations are involved in monitoring care pathways, patient surveys and benchmarking activities, and provide the patient perspective through advisory committees, ad hoc consultations and committees specific to certain services (e.g. oncogenetics). This collaboration promotes patient-centred care, service improvement and adaptation to patients' needs throughout the cancer care pathway.			

The centre collaborates with patient organisations.

#	Standard	Score	Auditor score
1	The cancer centre identifies and co-operates with existing patient organisations.	Yes	Yes

4. Multidisciplinary

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 4														
Score audit team	24	85.7	1	3.6	3	10.7	0	0.0	0	0.0	0	0.0	28	100.0
Score centre	25	89.3	3	10.7	0	0.0	0	0.0	0	0.0	0	0.0	28	100.0

Standard 29: Patient pathways

Auditors findings

Cancer patient management relies on national detailed "cancer packages" elaborated at the Danish National Board of Health level, and available on its website. There are 24 cancer package pathways that cover approximately 38 cancer types. Noticeably, they detail the waiting times for diagnosis and treatment. These core "cancer packages" are complemented at regional level by more specific pathways according to local organisation and practices. All regional documents are available on the regional document management system "VIP". Additionally, supplementary "Patient pathway descriptions" are available at CCCC level, including the roles of diagnostic and therapeutic disciplines.

Patient pathways are defined for all tumours and sub-types treated in the centre, which chart the process from patient admission up to the end of follow-up of care.

#	Standard	Score	Auditor score
1	CORE There is a written patient pathway for each tumour (sub)type treated in the centre, except for very rare cancers.	Yes	Yes
2	The functions of the different disciplines involved in the diagnosis, treatment and follow-up of the patient are defined and described in the patient pathways.	Yes	Yes
3	Supportive and palliative care is specifically included in the patient pathways.	Yes	Yes

Standard 30: Patient pathways: co-ordination of patients on the pathway

Auditors findings

Patients' care pathways are managed by "course coordinators", whose role is to ensure a smooth transition for patients through the various stages of diagnosis, treatment and follow-up, the implementation of MDT consensus decisions, and in particular to ensure the adherence to the waiting times defined for the main stages of the pathway. A referral system for palliative care is also in place, enabling timely access to specialised support when needed. In addition, procedures have been established to ensure that general practitioners are properly informed about their patients' health status and follow-up plans after discharge from the hospital. Although the system is described, continuity of supportive care between hospitals and local services does not appear to be fully guaranteed.

Patients have co-ordination to ensure their continuity of care on the pathway.

#	Standard	Score	Auditor score
1	CORE For every patient there is an identified co-ordinator or manager (or written process for case management) of their pathway from admission until end of follow-up, including the implementation of MDT recommendations.	Mostly	Yes
2	There are routines in place for referral and feedback amongst nursing, palliative care and supportive disciplines.	Yes	Partially
3	There are procedures in place for informing the patients' General Practitioner about key recommendations, decisions and diagnostic and treatment results in a timely manner.	Yes	Yes

Standard 31: Implementation of guidelines

Auditors findings
Guidelines are developed at national level by the Danish Multidisciplinary Cancer Group (DMCG) using a highly structured approach. The guidelines are updated at least every 3 years or as required via consensus groups (commissions) when new trial data or other breakthroughs becomes available. All guidelines are available on the DMCG website. New clinical and support staff are informed about the relevant guidelines at hospital, regional and national levels. Any decision deviating from clinical guidelines and/or the recommendations of the multidisciplinary team must be discussed with the patient and recorded in the EPIC electronic health record. However, the assessment of deviations from the guidelines within the CCCC is not documented.

For each type of cancer, consensus has been reached among the disciplines involved about the clinical guidelines used for diagnosis, treatment and follow-up.

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

Standard 32: Electronic patient record

Auditors findings

A common Electronic Patient Record for the Capital Region healthcare services is in place (EPIC).

There are electronic patient records to ensure the safety, timelines and continuity of care.

#	Standard	Score	Auditor score
1	CORE Each patient has an Electronic Patient Record which enables all relevant disciplines along the patient pathway to access the full information concerning the patient.	Yes	Yes

Standard 33: Process of multidisciplinary team meetings

Auditors findings

A general guideline on the process of MDT meetings, adapted from the UK model, was published in 2016 and is implemented at national level. Specific SOPs are set out in the DMCG-MDT guidelines for each tumour type. These guidelines provide a useful reference framework, but there was no indication that strict adherence to these guidelines is mandated or audited. Patients eligible for MDT discussion are defined, and all aspects of the MDT conferences are described in detail, including the inclusion of patients in clinical trials. Requirements for the physical setting and infrastructure needed to conduct MDT meetings are also specified. The observed MDTs during the peer review, the Prostate MDT and Breast MDT, were of high quality, and revealed adequate discussion of patients following the guidelines and SOPs. Clinical trial eligibility was discussed in both MDTs. The real time documentation of MDT discussion and decisions in EPIC for the Prostate MDT at HGH is an exemplar of MDT process. In addition, on a visit to the Head and Neck Wards at RH the audit team learned of the inclusion of patients within their MDTs, which is an excellent initiative in particular for patients undergoing complex treatments. Although non-consultant doctors, and specialist nurses, can attend, the attendance for both MDTs appeared low, perhaps limiting the educational and training opportunity within the MDT. For cancer services within the CCCC delivered at both HGH and RH, such as prostate and colorectal cancer, it is not evident that process are aligned across both MDTs, nor is it evident that both MDTs communicate on patient pathways, research, trials, and related activities. As part of quality improvement within the MDT structure, there is a need to harmonise and standardise such structures and processes across the new CCCC organisation and strategy. For other cancer types, for instance pancreas and liver, surgery is performed exclusively at RH, yet "leadership" of the programme within the CCCC organigramme is at HGH. This represents an opportunity for the CCCC to ensure full integration across sites. In contrast, Upper GI cancer, Head and Neck cancer, and Haematology are managed exclusively at RH, meaning no major structural adjustments appear to be required for these pathways within the CCCC.

The centre has MDT groups covering every tumour type which follow a Standard Operating Procedure (SOP).

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

Standard 34: Multidisciplinary team meetings

Auditors findings
All relevant clinical information is made available for multidisciplinary team (MDT) meetings, and the conclusions from these meetings are documented in the EPIC patient record, where they are accessible to all relevant disciplines. The observed MDTs during the peer review revealed adequate recording of the conclusion and recommendations of the MDT in the Electronic Patient Record. For the Prostate MDT, the discussion, staging, and recommendation was recorded simultaneously by one attendee, and all content could be immediately seen in EPIC. For the Breast MDT, some preparation was conducted by the Lead Oncologists prior to the Meeting and provisional treatment plans recommended and signed off on during the Meeting. A formal procedure for communicating information to patients is in place. In addition, a tumour board is available to support case discussions and decision-making.

Information, dissemination and access to expertise in the MDT

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

Standard 35: MDT review

Auditors findings
Guidelines are reviewed and updated at the national level by the Danish Multidisciplinary Cancer Group (DMCG), which meets three times a year and comprises representatives from all regions. Many of the MDT Leads from the RH and the HGH are involved in the DMCG. Patient pathways and key performance indicators are discussed and evaluated at national level.

Multi-disciplinary team (MDT) review

#	Standard	Score	Auditor score
1	CORE Every MDT meets at least twice a year in a learning event to review outcomes, quality of procedures, patient pathways and indicators, for quality improvement.	Mostly	Mostly
2	Patient pathways are updated regularly, based upon the review.	Yes	Yes

Standard 36: Rare cancers

Auditors findings
RH is a member of EUROBLOODNET. The CCCC maintains liaison with specialised designated centres, including the Aarhus Proton Centre and MD Anderson Cancer Centre. Connection within the European Reference Networks (ERNs) were confirmed for NETs, rare gynaecological cancers, and rare sarcomas.

Management of rare cancers.

#	Standard	Score	Auditor score
1	Procedures are in place to consult or to refer patients with rare cancers to a designated reference centre or a European Reference Network.	Yes	Yes

5. Prevention and early detection

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 5														
Score audit team	9	69.2	3	23.1	1	7.7	0	0.0	0	0.0	0	0.0	13	100.0
Score centre	6	46.2	4	30.8	1	7.7	0	0.0	2	15.4	0	0.0	13	100.0

Standard 37: Screening and early detection

Auditors findings

The breast cancer screening programme is coordinated by a central regional screening unit, which has long been led by the Breast Imaging Department at RH, whilst the examinations are carried out at several regional mammography units, notably at HGH. Double-blind readings are performed at both university hospitals, HGH and RH, where follow-up examinations and surgical procedures also take place. For all screening programmes, both hospitals are involved in diagnostic assessment (HGH) and tertiary assessment or complex diagnoses (RH). In addition, both hospitals, and in particular the Department of Clinical Biochemistry at HGH, are involved in several research projects related to early diagnosis (e.g. the Pancreas Knowledge Centre at HGH) and cancer screening strategies with risk stratification. These include studies on the impact of updated multi-gene panel sequencing and attitudes toward risk-stratified breast cancer screening in Denmark.

Involvement in screening and early detection.

#	Standard	Score	Auditor score
1	The cancer centre participates in regional or national screening programmes.	N.a.	Yes
2	The cancer centre participates in specific early detection programmes.	N.a.	Yes
3	The cancer centre participates in research into early detection, risk stratification and/or screening.	Partially	Yes

Standard 38: Oncogenetic service

Auditors findings

RH hosts one of Denmark's major Clinical Genetics departments, playing a central role in hereditary cancer counselling, complex variant interpretation, cascade testing within families, and translational research in inherited cancer risk. National guidelines are provided by the Danish Society of Medical Genetics. No in-house psychological support is available within the department; instead, patients are referred to municipal services, where support is provided by practitioners in either the private or public sector.

Access to an oncogenetic clinic is available.

#	Standard	Score	Auditor score
1	CORE An oncogenetic clinic is available and accessible to all appropriate patients.	Yes	Yes
2	Guidelines for referral to oncogenetic services are available.	Yes	Yes
3	Recommendations for individuals at increased risk are based on guidelines.	Yes	Yes
4	Psychological support is offered in the oncogenetic service.	Mostly	Partially

Standard 39: Cancer risk reducing strategies in the cancer centre

Auditors findings
The CCCC offers a range of resources providing information on primary prevention. Patients receive written and verbal information on healthy living, including diet, exercise, smoking cessation and recognition of signs and symptoms, and are referred to appropriate programmes. A smoking policy is in place at the centre, and the hospital is designated as a smoke-free zone. Support for smoking cessation is available through referral to the primary care sector.

Cancer risk reducing strategies in the cancer centre.

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

6. Diagnosis

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 6														
Score audit team	27	75.0	5	13.9	3	8.3	1	2.8	0	0.0	0	0.0	36	100.0
Score centre	24	66.7	1	2.8	5	13.9	0	0.0	6	16.7	0	0.0	36	100.0

Standard 40: Radiology

Auditors findings

Leadership of the radiology department (RH) ensures sufficient staffing. SOPs are available on the VIP system and reviewed annually, protocols are reviewed every 2 years (or when needed). Radiologist reports are available after 7 days, which is in adherence with the national and local guidelines and laws on maximum waiting times in Denmark. Acute cases are reported on the same day, with non-acute cases reported within 5-10 days. Waiting times are recorded in the EPIC system and the department is alerted if there are deviations from the expected waiting times. The department is equipped with state-of-the-art technology (photon-counting computed tomography). While most equipment meets age requirements, some devices are older than 10 years, with plans in place to secure replacement equipment. The department is engaged in research to a high degree with over 100 publications per year. The Centre for IT, Medical technology and telephony (CIMT) is responsible for procurement and servicing of medical technology equipment. They conduct internal audits and have an annual meeting to review data and improvement projects. There are regular meetings with the radiology department at GHG.

The radiology department is sufficiently staffed, resourced and effectively managed.

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

Standard 41: Nuclear medicine

Auditors findings	
The nuclear medicine department is appropriately staffed and resourced to support safe and high-quality care, with staffing levels planned to meet service demand and safety requirements. The unit operates with up-to-date SOPs describing imaging methods, which are reviewed bi-annually. Nuclear medicine reports are made available to referring clinicians, typically within 7 working days, with the ability to prioritise urgent examinations when clinical urgency is indicated, which is in adherence with the National and local guidelines and Danish legislation. Waiting times are recorded in the EPIC system, measured from the point of physician notification to completion of the examination, supporting monitoring of access and performance. Clinical audits are undertaken in line with national requirements and EU Council Directive 2013/59/EURATOM, and all imaging is stored digitally. The department houses the only two MR-PETs in Copenhagen, and several CT-PETs, including a protected scanner for research. They produce radiolabelled tracers for state-of-the-art PET studies across oncology, including as examples PSMA and DOTA, studies of the tumour microenvironment (FAPI), and studies of inflammation (H2O2). The department also provides imaging for brain tumours and childhood cancers and is a leading centre in Europe in research. Quality control of imaging equipment is routinely performed in accordance with national and European guidelines. While most equipment meets age requirements, some devices are older than 10 years, with plans in place to secure replacement equipment. The departments at RH and HGH communicate with each other but are not joined yet within the CCCC model. There is currently no clear evidence of regular departmental learning events for quality improvement held at least twice per year, representing an area for further development.	

The nuclear medicine department is sufficiently staffed, resourced and effectively managed.

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

Standard 42: Logistics of scheduling diagnostic examinations

Auditors findings	
National cancer pathways outline maximum waiting times for diagnostic appointments. There is no standard policy for keeping slots open for emergencies. Urgent cases marked by referring clinician will receive assessment within 24 hours. The radiology department at RH has a dedicated acute scanner.	

Agreements have been reached about scheduling appointments and giving priority to urgent examinations (CT, MRI, mammography).

#	Standard	Score	Auditor score
1	There is a policy for scheduling diagnostic examinations.	Yes	Yes
2	Arrangements are in place about giving priority to urgent examinations (CT, MRI, mammography).	Yes	Yes
3	There is a Standard Operating Procedure for keeping appointment slots available for emergencies.	Mostly	Mostly

Standard 43: Molecular diagnostics

Auditors findings	
A molecular diagnostics programme is available at RH and HGH, providing a comprehensive suite of molecular testing. National Danish Molecular Diagnostic guidelines are provided by the national Multidisciplinary Cancer Groups. A national Molecular Tumour Board (MTB) meets monthly in Denmark, chaired by RH.	

Arrangements are in place for molecular diagnostics.

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

Standard 44: Pathology

Auditors findings	
The pathology laboratory processes over 60,000 specimens per year. Pathology department leadership is responsible for planning and maintaining adequate staffing levels. The department adheres to national SOPs covering all aspects of the specimen collection, preparation, analyses, reporting and storage. The department participates in external quality assurance processes with 7-8 pathology departments (inter-laboratory) in the region. The biobank has been in operation since 2009 and follows national SOPs. Staff receive competency training, maintain training records and annual appraisals. Training and education opportunities are actively utilised. Staff interested in conducting research projects are encouraged and facilitated in this regard. The pathology department operates in accordance with ISO 15189 standards and they are in the process of formal accreditation by DANAK (expected autumn 2026). The quality management system is supported by QualiWare, which enables structured process documentation, governance, and continuous quality improvement.	

The pathology laboratory / institute is sufficiently staffed, resourced and effectively managed.

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

Standard 45: Pathology reporting

Auditors findings
Turnaround times for frozen sections are recorded, and all reporting times are monitored and comply with national guidelines, but not the OECl standard of 5 working days. The department advised that existing national guidelines no longer adequately reflect the evolving complexity of modern pathology requirements. In some instances, quality reviews between pathology departments in HGH and RH have assigned turnaround times for reporting. The departments meet regularly to review and discuss data for quality purposes.

Arrangements are in place for pathology reporting.

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

7. Treatment

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 7														
Score audit team	70	73.7	14	14.7	9	9.5	2	2.1	0	0.0	0	0.0	95	100.0
Score centre	76	80.0	15	15.8	1	1.1	0	0.0	3	3.2	0	0.0	95	100.0

Standard 46: 24/7 access to specialist care

Auditors findings

An on-call service providing a 24/7 on-site presence and a telephone hotline is in place within the oncology departments of RH and HGH. SOPs have been established. The on-call doctor's main task is to assess and manage emergency situations, such as adverse events and toxic effects. There is no dedicated unit located in a specific geographical area. All specialities are available 24 hours a day, 7 days a week, for consultations or emergency referrals, as part of a regional organisation. Time slots for outpatient appointments are allocated according to patients' needs.

Arrangements are in place for 24/7 care by specialised staff.

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

Standard 47: Surgical oncology

Auditors findings	
The surgical oncology service is adequately staffed and organised, with continuous 24/7 admission, on-call surgical coverage, and appropriate infrastructure, including operating theatres, inpatient beds, and multidisciplinary support from surgeons, dietitians, tube-feeding nurses, speech and language therapists, and rehabilitation staff. Surgical planning is based on MDT recommendations, with tumour cases reviewed weekly, and biopsy results available on the same day to inform treatment decisions. Deviations from the MDT's plans are documented in EPIC. Minimum procedure volumes are defined for tumour type according to the Danish Specialty Plan, and Denmark has a centralized model for complex cancer surgery and for some rarer cancer types. Although key metrics including operative mortality and major morbidity is available nationally, some commonly used KPIs such as unexpected re-admissions within 90 days, and reoperations within 90 days are not collected or analysed at CCCC level. Moreover, although 30-day mortality is available, 90-day mortality is now a more validated benchmark internationally for complex surgeries and should be considered and included. With respect to overall governance, key process and outcome measures from across the range of surgeries at RH and HGH should be embedded within the overall governance model with respect to quality assurance, integration across sites, and strategic planning.	

The surgical oncology department is sufficiently staffed, resourced and effectively managed.

#	Standard	Score	Auditor score
1	CORE Minimum surgical volumes per cancer surgeon are defined for each tumour type.	Yes	Yes
2	CORE There is 24-hour availability of surgical oncologists in all major specialties including at weekends and on public holidays.	Yes	Yes
3	All treatment plans and recommendations of the MDT form the basis for surgery.	Mostly	Mostly
4	If there are any deviations from the surgical treatment plan, they are recorded in the patient record and communicated appropriately to the patient and multidisciplinary team.	Yes	Yes
5	Technical and organisational processes for fresh tissue, frozen sections and biobanking are in place for all surgical procedures.	Yes	Yes
6	30-day mortality after surgery is recorded and evaluated.	N.a.	Mostly
7	Unexpected re-admissions to surgery within 90 days is recorded and evaluated.	N.a.	No
8	The technical quality of surgery is regularly monitored for all procedures.	N.a.	No

Standard 48: Reconstructive surgery

Auditors findings	
Reconstructive surgery is offered for a range of organs and tissues, including reconstruction of breast cancer head and neck cancer, vulva, and soft tissue tumours such as sarcomas. This includes microvascular reconstruction. Information is provided to patients by both the oncology departments and the surgery departments.	

Reconstructive surgery is offered to all appropriate patients.

#	Standard	Score	Auditor score
1	CORE There is a full range of reconstructive surgery, immediate or delayed, including aesthetic and functional restoration surgery for all body regions.	Yes	Yes
2	Patient information about reconstructive surgery is proactively provided in written form and includes benefits and risks.	Mostly	Mostly

Standard 49: Radiotherapy

Auditors findings
The radiotherapy department is sufficiently staffed, resourced and effectively managed to ensure safe, accurate and high-quality care. The centre operates with extensive infrastructure, including multiple linear accelerators, MR-Linac capability, stereotactic and adaptive radiotherapy platforms, supported by physicists and clinical teams across sites, with the ability to provide 24-hour on-call cover when required, except on Sundays. During the peer review the closer integration between HGH and RH regarding radiotherapy was observed, particularly in the management of emergency cases, supported by a formal agreement between the two hospitals. A general contingency plan exists at regional level, and the radiotherapy departments have their own specific contingency plans. Regular quality assurance checks are performed by medical physicists at defined intervals. All patients receive a medical consultation prior to the start of radiotherapy and are provided with information on treatment options, potential side effects and self-management during therapy. Patient information is delivered with the support of guide-nurses in accordance with a documented procedure. Radiotherapy treatment data, including technique, dose and treatment duration, are recorded in the ARIA system in line with guidelines, and a clinical summary is integrated into the patient record. Any deviation from the prescribed dose is documented and reviewed. Treatment toxicities and complications are systematically recorded in the patient record and discussed at department and national levels, with regular learning and quality review activities, including routine reporting and review of near-misses and incidents, supporting continuous quality improvement.

The radiotherapy department is sufficiently staffed, resourced and effectively managed.

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

Standard 50: Radiotherapy equipment

Auditors findings
The radiotherapy department has adequate capacity to deliver radiotherapy to all patients requiring treatment. The CCCC has 22 megavoltage linear accelerators, of which two are MR-Linacs (one each for HGH and RH). A structured maintenance programme is in place, including routine servicing, scheduled calibrations and safety checks performed by qualified personnel. Equipment performance is regularly monitored, and medical devices used for treatment undergo periodic certification by authorised authorities.

The radiotherapy department is sufficiently equipped and medical equipment is safe, efficient and accurate.

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

Standard 51: Radio-chemotherapy

Auditors findings
Chemo-radiation therapy is delivered in accordance with established standard procedures, and in accordance with clinical guidelines. The unit has a defined SOP covering both sequential and simultaneous radio-chemotherapy. Blood count monitoring and relevant laboratory tests are routinely performed and documented throughout treatment. Treatment-related side effects and toxicities are systematically recorded in the patient record and reviewed at department level, supporting ongoing evaluation of safety, tolerance and quality of combined modality therapy.

Chemo-radiation therapy follows appropriate standard procedures.

#	Standard	Score	Auditor score
1	The unit has an SOP for sequential / simultaneous radio-chemotherapy.	Yes	Yes
2	Blood count monitoring and laboratory tests are documented during radio-chemotherapy.	Yes	Yes
3	The side effects of radio-chemotherapy are recorded and evaluated.	Yes	Yes

Standard 52: Palliative radiotherapy

Auditors findings
Palliative radiotherapy is provided every day except on Sundays and can also be delivered in the evenings when needed.

Palliative radiotherapy is offered.

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

Standard 53: Medical oncology (oncology and haemato-oncology)

Auditors findings
Staffing levels are regularly adjusted based on monthly reports monitoring waiting times and adherence to cancer-package timelines. Training sessions and educational activities in medical and clinical oncology, as well as haematology, are offered to doctors, nurses and other healthcare professionals. Waiting times are monitored at national level as part of quality control.

The medical oncology and haemato-oncology departments are sufficiently staffed, resourced and effectively managed.

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

Standard 54: Medical oncology, anti-cancer drugs: prescription and pharmacy preparation

Auditors findings	
Systemic treatment plans are managed via the EPIC BEACON module. All the necessary information is consolidated in the personalised BEACON treatment plan, covering medication prescription, pharmacy ordering and administration. Treatments preparations are centralized at the Capital Region Pharmacy which has two production units (RH and HDH) working according to GMP and common SOP's (with a few exceptions, which are prepared by specialist nurses in the department's preparation rooms, under the direct supervision of a qualified pharmacist). Parts of the anticancer drugs pathway still depend on paper-based processes, creating an avoidable vulnerability in a largely digital system.	

There is a system for the prescription, preparation, distribution and administration of anti-cancer drugs.

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

Standard 55: Medical oncology, anti-cancer drugs: administration

Auditors findings	
The "Medical Cancer Treatment" manual, available online, contains SOPs relating to the administration of anticancer drugs. All treatments are administered in day-care units or oncology wards, with a few exceptions where necessary (preparation is carried out by specialist nurses in intensive care units). Nurses follow structured training modules consisting of a 5-day theoretical module and a 5-day practical training, followed by a "chemotherapy practical exam". Patients receive a medical consultation prior to the initiation of systemic treatment. Unexpected adverse effects are reported via the national digital reporting system, which is accessible online. No assessment of quality management and risk management practices for anticancer drugs is currently provided.	

Administering of anti-cancer drugs is controlled and effectively managed.

#	Standard	Score	Auditor score
1	CORE There are SOPs for the administration of anti-cancer drugs.	Yes	Yes
2	Anti-cancer drugs are administered only in oncology or haemato-oncology wards (for inpatients).	Mostly	Mostly
3	There are dedicated day-care units for the administration of anti-cancer drugs.	Yes	Yes
4	CORE Anti-cancer drugs are administered by nurses who have completed a specific training programme for chemotherapy administration.	Yes	Yes
5	CORE Each patient has a medical consultation prior to the commencement of systemic therapy.	Yes	Yes
6	The relevant data (dosage and total treatment time) are recorded in line with the guidelines.	Yes	Yes
7	A specific procedure for reporting unexpected side effects of anti-cancer drugs is implemented.	Yes	Yes
8	Quality and risk management practices for anti-cancer drugs are regularly evaluated.	Mostly	Partially

Standard 56: Nursing, tasks and responsibilities of oncology nurses

Auditors findings
The centre employs nurses who are formally educated in oncology across all technical, clinical and outpatient departments where cancer patients are treated, ensuring appropriate expertise for the tumour types managed within the centre. Oncology nursing specialisation is a 1.5-year programme, with specific training offered in areas such as the administration of SACT and brachytherapy, ensuring alignment between nursing competencies and the clinical needs of each service. Clinical Nurse Specialists with advanced responsibilities are present, and each subunit has a Head Nurse who provides clinical and organisational leadership. Nursing tasks and responsibilities are clearly defined according to their level of education and competency, supported by structured job descriptions organised across three levels and seven domains of competence. The centre employs Advanced Practice Nurses, aligned with the EONS definition, who demonstrate expert oncology knowledge, advanced clinical skills and complex decision-making capabilities. In addition, roles and responsibilities for nurses with specialised expertise, such as palliative care, clinical nurse specialists, care pathway coordination and other focused functions, are clearly describe. These roles strengthen multidisciplinary care delivery.

The cancer centre employs nurses formally educated in oncology whose tasks and responsibilities are defined according to the level of their education.

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

Standard 57: Pain service

Auditors findings
Pain management within the cancer centre is supported by national clinical guidelines, trained clinical oncologists providing basic supportive care, and access to specialist palliative care teams for complex symptom management. Pain and symptom burden are assessed as part of routine clinical care. While these tools capture pain-related symptoms, there is no evidence of a consistently implemented, validated pain-specific assessment tool (e.g. numerical rating scale or standardised pain screening instrument) used systematically across all stages of the patient pathway.

A protocol for pain control is implemented in the cancer centre.

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

Standard 58: Referral to supportive disciplines

Auditors findings	
There is a local and national standard policy for access to supportive disciplines, supported by clear guidelines defining referral indications and types of intervention, including nutrition, psychosocial support, rehabilitation, late-effects and palliative care. In practice, most patients are referred to municipal services for supportive care, and those meeting defined criteria are subsequently referred to and reviewed by the late-effects clinic. While supportive disciplines contribute through referral pathways, MDT input and palliative care involvement, in-house supportive care services are not routinely or consistently integrated into regular clinical sessions across all pathways in both hospitals. From the patient perspective, supportive care delivered by municipalities is experienced as variable in standard and primarily focused on general rather than specialised cancer care, with some patients expressing frustration when responsibility is transferred to general practitioners who may be less familiar with cancer-specific needs. This highlights an opportunity to strengthen integration and consistency of supportive care across the patient pathway.	

There is a standard policy concerning access of patients to supportive disciplines.

#	Standard	Score	Auditor score
1	CORE There are guidelines which define the indications for referral and the types of intervention from supportive disciplines.	Yes	Yes
2	In appropriate cases, supportive disciplines are regularly part of clinical sessions.	Yes	Partially

Standard 59: Psycho-oncology

Auditors findings	
Cancer patients have access to psycho-oncology support primarily through regional referral pathways, with psycho-oncology services delivered outside the cancer centre. Procedures exist for referral of patients experiencing psychological distress, typically initiated by clinicians and coordinated with regional or municipal services. Services are provided in the community setting or through the Danish Cancer Society, who will visit inpatients when needed. However, it is not clear that a dedicated in-house psycho-oncology service with oncology-specific psychiatric or psychological expertise is consistently available within the centre, nor that systematic screening using validated assessment tools for psychological distress is routinely applied across all patient pathways. Referral processes are present but rely on identification through clinical judgement rather than structured, standardised screening, indicating the need for stronger integration and formalisation of psycho-oncology services.	

Cancer patients have access to psycho-oncology services.

#	Standard	Score	Auditor score
1	CORE There is a psycho-oncology service with competence in oncology psychiatry and/or clinical psychology.	Yes	Partially
2	CORE Structured screening with validated assessment tools is systematically used.	Mostly	Partially
3	Procedures are defined about the way to refer patients to the psycho-oncology service, including patients in psychological distress.	Mostly	Partially

Standard 60: Rehabilitation

Auditors findings	
There is timely access to rehabilitation services for cancer patients and survivors through a multidisciplinary approach. A clearly defined referral procedure is in place, initiated digitally via the electronic patient record (EPIC), enabling referral to rehabilitation services both within the centre and externally, most commonly to municipal rehabilitation programmes, with clear pathways in place to support continuity of care. Rehabilitation plans are developed following clinical review and are shared with relevant providers, and patients with more complex or persistent needs are referred to specialised services, including late-effects clinics, ensuring appropriate, coordinated rehabilitation support throughout survivorship.	

There is access to rehabilitation services for cancer patients.

#	Standard	Score	Auditor score
1	CORE There is timely access to rehabilitation services with multidisciplinary interventions for cancer patients and survivors.	Yes	Yes
2	There is a defined procedure for referral to cancer rehabilitation services within and outside the centre.	Yes	Yes

Standard 61: Social counselling

Auditors findings	
Social counselling for cancer patients is provided in accordance with established guidelines and is accessible to all patients throughout the cancer pathway. These services are delivered externally, with clear referral pathways enabling patients to access support as needed.	

Social counselling for cancer patients is provided according to guidelines.

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

Standard 62: Nutrition

Auditors findings	
Cancer patients have access to nutrition specialists throughout the patient pathway, with dietitians involved in assessment and management whenever nutritional needs are identified. However, access to dietetic support is not consistently available across all departments and supportive care settings, resulting in some variation in provision. Patients are referred in a timely manner when nutritional concerns are recognised, particularly within surgical oncology and supportive care pathways. Identification of patients who may benefit from nutritional support is currently based on local practices, including use of the VIP SOP. All newly referred outpatients are screened at their first or second visit, and inpatients are screened within 24 hours. However, there is no evidence that a validated nutritional screening tool is systematically applied across the cancer centre.	

There is access to nutrition specialists for cancer patients.

#	Standard	Score	Auditor score
1	There are screening tools which are used to identify patients who will benefit from support of nutrition specialists.	Yes	Partially
2	There is timely access to nutrition specialists for cancer patients throughout the patient pathway.	Yes	Yes

Standard 63: Involvement of caregivers

Auditors findings	
The cancer centre has clearly defined arrangements to support the involvement of caregivers throughout the patient journey. In agreement with the healthcare team, caregivers may participate in personal care activities such as meals and washing, when appropriate. Each inpatient ward provides dedicated rooms for meetings with caregivers; for example, the surgical ward includes designated family rooms to support private discussions and caregiver presence. Visiting time restrictions are applied flexibly based on patient and caregiver needs, including the possibility of overnight stays where necessary, supporting patient-centred and family-inclusive care.	

Arrangements for the involvement of caregivers are defined.

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

Standard 64: Survivorship support

Auditors findings	
The CCCC provides support to patients and caregivers throughout treatment and survivorship through clinical teams, patient schools, late-effects clinics, rehabilitation planning and collaboration with external organisations such as the Danish Cancer Society. Patients receive written and verbal information on healthy living, including diet, exercise, smoking cessation and recognition of signs and symptoms, and are referred to appropriate programmes. Patients are informed about potential late effects of cancer and treatment, with guidance on self-management supported by nurse-led education and rehabilitation plans shared with municipalities. However, the delivery of this recurrence prevention support is not fully standardised across all pathways. Furthermore, the auditors were unable to identify any widespread or clear evidence of the use of a formal, personalised post-treatment follow-up plan, either during interviews with staff or with patients. Information on peer support groups and counselling services is routinely provided. It must be noted that primary prevention activities largely fall under municipal and broader public health responsibility. Within this context, the centre's role is focused on patient-level education and referral, while population-level prevention remains outside its direct remit.	

Advice and support is offered to all patients and caregivers during treatment and survivorship.

#	Standard	Score	Auditor score
1	CORE Advice and support is given to patients and caregivers on prevention of recurrence and overall healthy living in the fields of: diet; exercise; spotting signs and symptoms.	Yes	Partially
2	Information is given to patients on relevant peer groups for patients with similar cancers.	Yes	Yes
3	Information and support is given to patients about the potential late effects of their cancer.	Yes	Yes
4	Information and support is given to patients about self management.	Yes	Yes

Standard 65: Support to children and caregivers of cancer patients

Auditors findings	
Specific support for children of cancer patients is largely in place, delivered by trained cancer nurses with defined competencies in communication and family-centred care, and supported by access to relevant services when concerns are identified. However, provision of specialist, structured support (such as routine involvement of a dedicated family therapist or equivalent service) is not consistently available or formalised across all pathways.	

Support to children and caregivers of cancer patients is provided.

#	Standard	Score	Auditor score
1	Caregivers are given specific support and advice for helping patients.	Mostly	Mostly
2	Specific support for children of cancer patients is provided by trained staff (e.g. a family therapist).	Mostly	Mostly

Standard 66: Palliative care team

Auditors findings

The composition and tasks of the palliative care team are clearly defined, with one established multidisciplinary team at each hospital (RH and HGH). Each team is led by a physician with specialised training and expertise in palliative medicine and includes doctors and nurses providing palliative care across oncology and non-oncology conditions. All patients referred to palliative care are discussed within the palliative care team through scheduled meetings and internal review processes in line with established procedures, ensuring coordinated and consistent care. The palliative care teams provide education and guidance on palliative care and symptom control to patients and caregivers as part of routine clinical management. The teams also support healthcare professionals through clinical advice, collaboration, and in-house training, including input into end-of-life care and coordination with general practitioners and community nursing services.

The composition and tasks of the palliative care team are defined.

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

Standard 67: Palliative care

Auditors findings

Palliative care is included within patient pathways both inside the cancer centre and beyond, with coordination involving general practitioners, community nursing services and other external providers. However, this integration is not consistently or uniformly described in the same level of detail across all cancer pathways, and integration beyond the centre varies, particularly with primary care and community services. Support can vary depending on diagnosis, referral timing and available capacity. A dedicated helpline service is in place to address the immediate needs of palliative care patients, supporting timely symptom control and access to clinical advice.

Palliative care is organised according to written procedures.

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

Standard 68: End of life care

Auditors findings
End-of-life care is delivered in a patient-centred and sensitive manner, guided by policies that support discussion and documentation of patients' and relatives' wishes and preferences. End-of-life care is embedded within the care pathway for patients with incurable disease and is provided in collaboration with specialist palliative care teams, general practitioners, community nursing services and, where appropriate, home-based or hospice services. Patients and caregivers are informed about available end-of-life options within the centre and the local community. Access to spiritual care and bereavement support is available through chaplaincy services and palliative care follow-up, with referral to external support services when required.

End of life care is appropriately and sensitively arranged according to patients' needs and wishes.

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

8. Research

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 8														
Score audit team	23	43.4	13	24.5	13	24.5	4	7.5	0	0.0	0	0.0	53	100.0
Score centre	28	52.8	19	35.8	5	9.4	1	1.9	0	0.0	0	0.0	53	100.0

Standard 69: Strategic planning for oncology research

Auditors findings

The research strategic plan outlines several ambitions within the regional framework. However, it does not identify priority research areas, specific targets or operational plans. Developing a separate, dedicated research strategy with clearly defined KPIs and inclusion of fundamental research would strengthen integration of research activities across the university hospitals and provide a clearer vision and ambition for future CCCC research. Mapping of research groups is currently underway, and the development of a detailed scientific report covering all cancer research across the involved institutions will help identify key stakeholders and enhance collaboration and interdisciplinary work across the CCCC.

The research strategy plan is regularly updated.

#	Standard	Score	Auditor score
1	CORE There is a regularly updated research strategic plan covering at least three years, which is integrated in the overall strategy of the cancer centre.	Mostly	No
2	Specific aims for research performance are defined (publications, grants, innovations etc.).	Mostly	No
3	CORE The cancer centre research performance/activity is regularly evaluated and communicated in a scientific report.	Mostly	Partially
4	CORE ¹ The centre has research groups and output covering basic, translational and clinical research.	Mostly	Mostly

¹ This is only a core standard for an OECl Comprehensive Cancer Centre

Standard 70: Organisational structure

Auditors findings	
The research groups are currently organised within each university hospital. It remains to be defined how these groups will be brought together within a unified CCCC research structure under the leadership of the Scientific Director. The development of the Research Board will be an important step in establishing this structure. Responsibilities of research group leaders are defined at the university level only, including policies for the supervision of PhD students. A more extensive mapping of research groups will provide a better understanding of the CCCC research ecosystem and its vision. The Institute of Clinical Medicine provides a 3-day course to train in effective research supervision. However, responsibilities specific to the CCCC context are not yet outlined. A dedicated Phase I/II unit is in place, supporting early-phase clinical research.	

The organisational responsibilities within the research, innovation and development structure are clearly defined.

#	Standard	Score	Auditor score
1	CORE There is a defined organisational structure specifically for research and innovation related to cancer.	Yes	Partially
2	The individual research group structures are clearly defined.	Yes	Partially
3	The qualifications and responsibilities of research group leaders are clearly defined.	Yes	Partially
4	The centre has a dedicated phase I/II clinical research unit.	Yes	Yes

Standard 71: Means for conducting research activities

Auditors findings	
The research budget is not prospectively defined. Shared technological platforms and core facilities are available at RH, HGH and the Biotech Research & Innovation Centre (BRIC - a research centre at University of Copenhagen), with access funded primarily through external grant income. Internal funding is limited. Some financial support is available to support researchers applying for large scale coordinated grants (approximately 10k), allocated on a case-by-case basis. In addition, the development of clinical academic groups is supported through university or RH funding. Financial management is handled by the Capital Region or the university hospital finance departments. There is currently no evidence of financial stewardship or coordinated financial oversight at the CCCC level.	

A planned cycle for resourcing the infrastructure of research activities is defined.

#	Standard	Score	Auditor score
1	CORE The cancer research budget covering both external and internal funding for the cancer centre is defined each year.	Mostly	Partially
2	CORE The cancer centre provides access to shared technological platforms for research activities.	Yes	Yes
3	The cancer centre provides internal funding for research activities.	Mostly	Mostly
4	The use of financial resources and accounting of research activities is monitored and reported.	Yes	Yes

Standard 72: Periodical external site visit / review

Auditors findings
A Scientific Advisory Board is not yet in place. Research groups within the CCCC are currently not evaluated either externally or internally. At present, research projects undergo review only at the funder level. Research professors are evaluated by the University every five years as part of the appointment renewal process. The clinical trial unit is inspected by the DMA, most recently in January 2026, and trials are periodically audited by sponsors.

Periodical external site visits of research are organised.

#	Standard	Score	Auditor score
1	CORE An external Scientific Advisory Board (SAB) meets at regular intervals and advises the cancer centre on its cancer research strategy, organisation, infrastructure and overall performance.	No	No
2	CORE The performance of each research group is externally or internally reviewed at regular intervals.	Mostly	Partially
3	There is a periodical external site visit/review for research support facilities.	Mostly	Mostly

Standard 73: Research collaboration

Auditors findings
The cancer centre collaborates with a number of international research groups and networks. The centre coordinates several international projects.

The cancer centre is part of research networks.

#	Standard	Score	Auditor score
1	The cancer centre supports formalised collaborations with international research organisations and networks.	Mostly	Yes
2	The cancer centre co-ordinates international research projects.	Yes	Yes

Standard 74: Scientific interaction and integration

Auditors findings
There are many opportunities for interactions and knowledge sharing between clinicians and researchers. Protected research time for clinicians is provided via external grants and is not embedded in clinical contracts. Nevertheless, a substantial number of clinicians across specialties have dedicated research time, including haematology, oncology, radiology and pathology.

There is structured co-operation between researchers and clinicians.

#	Standard	Score	Auditor score
1	CORE Regular briefings on research activities, results and new opportunities are organised through information sharing and meetings for laboratory researchers and clinicians.	Mostly	Mostly
2	CORE There are funding mechanisms and/or programmes to give clinicians protected time for clinical and/or translational research.	Mostly	Mostly

Standard 75: Scientific dissemination programme

Auditors findings
There are multiple opportunities for knowledge sharing between clinicians and researchers. Establishing a CCCC-branded seminar series or research forum could further strengthen integration and foster collaboration across institutions. The research and innovation offices provide support for innovation activities, complemented by the services of the Technology Transfer Offices (TTO) at the University of Copenhagen and at the regional level.

A scientific knowledge transfer programme is present in the cancer centre.

#	Standard	Score	Auditor score
1	CORE There is a structured, documented and up-to-date scientific programme in the cancer centre through colloquia, seminars and theme-specific conferences.	Yes	Mostly
2	There are procedures in place to ensure that results from internal and external research are translated into new practice (e.g. diagnostic tools, treatment or prevention).	Yes	Yes

Standard 76: Research talent development

Auditors findings

There is currently no formal policy for research talent development. A structured PhD programme is in place, and BRIC offers a postdoctoral career development programme. This is not yet available to medical postdocs, but establishing such a programme is an explicit goal for the CCCC. Mentoring programmes and peer-support opportunities are available, providing additional support for early-career researchers.

There is a policy for research talent development.

#	Standard	Score	Auditor score
1	There is a programme in place for research talent development.	Yes	Mostly

Standard 77: Grant proposals

Auditors findings

Grant applications are not formally reviewed prior to submission, nor is there a systematic evaluation of grant-proposal success. Some regional support is available for EU grants, and training courses in grant writing are offered to students. Additional resources for identifying funding opportunities and supporting the preparation of applications would help increase both the number and quality of external funding proposals. Enhanced research support/grant support may also be beneficial to increase the level of large-scale projects being led or coordinated by CCCC researchers, building on the strengths observed during the peer-review visit.

There is a procedure for dealing with grant proposals.

#	Standard	Score	Auditor score
1	There is an internal review of grant proposals before submission to funding bodies.	Partially	Partially
2	There is an internal evaluation of the success of the grant proposals.	Partially	Partially
3	CORE The cancer centre has training programmes and supportive services for grant applicants.	Mostly	Mostly

Standard 78: Prevention and detection and handling of scientific misconduct

Auditors findings

The CCCC adheres to national policies and procedures regarding research integrity and scientific misconduct. The Danish Council for Scientific Fraud is established by law and operates under the Danish Ministry of Education and Research. PhD students are required to complete training in research integrity. An independent, designated individual is available to receive reports of suspected scientific misconduct.

Conduct of research is defined by core principles of research integrity.

#	Standard	Score	Auditor score
1	There is a code of conduct regarding good research practices, covering the research environment, data practices and management, publication and dissemination, such as those of the European Code of Conduct for Research Integrity.	Yes	Yes
2	There is a procedure to deal with violation of research integrity, such as research misconduct.	Yes	Yes

Standard 79: Intellectual property and innovation

Auditors findings
There are regional strategies in place to support innovation in health research. However, innovation should be incorporated into the overall CCCC strategy. Regional support guidelines for researchers are available, alongside a regional framework for intellectual property ownership (with IP owned by the region) and a regional TTO is available to provide support for the protection and utilisation of intellectual property. The National Center for Cancer Immune Therapy (CCIT) from HGH provides support for business development arising from research.

There are policies in place for protection of intellectual property and innovation.

#	Standard	Score	Auditor score
1	Innovation strategy is an explicit part of the strategic plan of the centre.	Yes	Partially
2	There are rules for ownership of intellectual property and patents.	Yes	Yes
3	There is a unit providing support for the protection and utilisation of intellectual property (Technology Transfer Office).	Yes	Yes
4	There is a unit (internal or external) providing support for business development arising from research.	Mostly	Mostly

Standard 80: Organisation of clinical research

Auditors findings
The CCCC utilises the Ethics Committee for the Capital Region. All trial proposals are discussed at local protocol meetings. Clinical trial management units are in place at both HGH and RH, with the expertise to run Phase I, II and III trials. The two units meet every six months to ensure strategic alignment. Open trials are listed on the CCCC website, although not in lay format. Trials are managed digitally on an individual basis, with no centralised overview available. Personal data protection follows the Capital Region's data protection policy. There is currently no annual plan or report available regarding clinical trial activity. Information on patient inclusion in clinical trials is accessible in EPIC.

Tasks of the Clinical Research Management unit and Institutional Review Board (IRB) are defined.

#	Standard	Score	Auditor score
1	CORE There is a Research Ethical Committee (internal or external) or Institutional Review Board (IRB) that evaluates ethical aspects of all research proposals on human subjects or material.	Yes	Yes
2	There is a scientific review board/committee that evaluates the quality, feasibility and priority of clinical trial proposals.	Mostly	Yes
3	CORE There is an institutional clinical research management unit dedicated to cancer patients.	Yes	Yes
4	The unit has an annual plan for its activities.	Partially	Partially
5	The cancer centre has a policy for promoting clinical trials, including internal and public information on trial availability.	Partially	Partially
6	The unit has dedicated personnel ensuring that clinical trials are conducted according to the trial protocols and Good Clinical Practice guidelines.	Yes	Yes
7	The unit ensures the process of administrative, scientific and ethical/legal review and approval as well as the feasibility of new clinical trials.	Yes	Yes
8	The unit co-ordinates and monitors the clinical research activities as well as their financial management.	Yes	Yes
9	CORE The cancer centre keeps an up-to-date database of clinical trials, including the accrual of patients.	Mostly	Partially
10	The cancer centre provides an annual report on clinical trial activities.	Mostly	No
11	Personal data protection is guaranteed for patients in clinical trials according to the appropriate legislation, including GDPR.	Yes	Yes
12	The inclusion of a patient in a clinical trial is immediately available in the medical file of the patient, including the signed informed consent.	Yes	Yes
13	The institutional clinical research management unit has specific resources (expertise and financial) to manage investigator-initiated trials.	Yes	Yes

Standard 81: Promotion of clinical research

Auditors findings
Open trials are listed on the website and are accessible to physicians, but they are not presented in a patient-friendly format. Information for patients is instead available through the Danish Society and clinicaltrials.gov. Promotion of trial participation is carried out verbally by clinicians. Trial results are shared internally through research days and publications. Patient-information videos explaining clinical research and trial processes are currently in preparation.

The cancer centre promotes and disseminates internally and externally clinical research projects and their results.

#	Standard	Score	Auditor score
1	The cancer centre publishes the ongoing clinical research trials on its website for patients and external physicians.	Partially	Partially
2	The cancer centre promotes the participation to clinical trials to the patients by means of brochures, website, etc.	Yes	Mostly
3	The researchers publish or participate in the publication of the results of the clinical trials, both in scientific and public papers.	Yes	Yes
4	The cancer centre organises internal meetings to share the results of the clinical and translational research realised in the centre among its research community.	Yes	Yes
5	The results of the clinical trials are communicated on the website.	Mostly	Mostly

Standard 82: Biobank

Auditors findings
Denmark has a national cancer biobank governed by national policies and regulations. The regional biobank is housed at HGH and has been operational since 2009, containing more than 90,000 specimens. Biobanking is integrated into routine clinical workflows. All samples are collected with informed consent, and patients retain the right to withdraw at any time. A defined process is in place to allow researchers to access samples for ethically approved studies.

Biobanking is conducted according to defined procedures.

#	Standard	Score	Auditor score
1	The cancer centre has a written policy for biobanking patient samples.	Mostly	Mostly
2	CORE There are SOPs defining the patient information, informed consent, collection, storage, registration, recovery and use of the biological samples.	Yes	Yes
3	CORE There is a centralised biobank database which provides linking to detailed clinical data.	Mostly	Mostly
4	The cancer centre biobank has facilities for long-term storage of paraffin blocks for research purposes.	Yes	Yes

9. Education and training

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 9														
Score audit team	12	63.2	2	10.5	5	26.3	0	0.0	0	0.0	0	0.0	19	100.0
Score centre	15	78.9	4	21.1	0	0.0	0	0.0	0	0.0	0	0.0	19	100.0

Standard 83: Analysing and providing for oncology training needs

Auditors findings

The CCCC has a training programme in oncology for resident doctors and nurses. During the visit, these programmes and their evaluation processes were presented. No evidence was provided of training programmes for supportive disciplines such as physiotherapists, psychologists, social workers, or volunteers. There are only a few exchange experiences with other countries, likely due to language barriers.

The cancer centre analyses the specific training and continuous education needs in oncology and defines training and educational programmes.

#	Standard	Score	Auditor score
1	The cancer centre analyses the specific training and oncological continuous education needs of its staff regularly (preferably annually, cross reference to Chapter 2, Standard 17).	Yes	Yes
2	CORE Relevant training is provided to all staff according to individual needs, institutional requirements, and regulatory requirements, including Good Clinical Practice and prevention and control of infections, including hand hygiene.	Yes	Mostly
3	Based on the analysis, the institution defines an annual or multi-annual oncology training programme for physicians.	Yes	Yes
4	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for researchers.	Yes	Yes
5	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for nurses.	Yes	Yes
6	Based on the analysis, the cancer centre defines an annual or multi-annual oncology training programme for supportive disciplines.	Yes	Partially
7	The centre ensures that all volunteers who work in the centre (whether with patients or not), are given appropriate training and support for their role (directly or by other bodies).	Mostly	Mostly
8	The cancer centre collects and analyses feedback about the quality of the continuous professional education and training programmes.	Yes	Yes

Standard 84: Undergraduate academic education in oncology

Auditors findings	
The centre provides comprehensive undergraduate oncology education for medical and nursing students, aligned with national curricula and university programmes. Medical undergraduate education includes structured oncology teaching, mandatory clinical rotations, supervised practice, formal assessments and regular trainee feedback, with external programme review conducted by the Danish Health Authority. Nursing undergraduate education supports a large cohort of students through structured clinical placements, trained supervisors, dedicated clinical educators and oncology-specific teaching. Feedback on education quality is routinely collected through trainee evaluations and appraisal processes. However, there is no clear evidence of a formal undergraduate oncology education programme for allied health or other supportive discipline students, as these groups are not consistently represented within education governance. International exchange opportunities are currently limited, as undergraduate oncology exchange programmes have been paused due to funding constraints, language barriers and reduced interest.	

The cancer centre provides oncology education for undergraduate degrees.

#	Standard	Score	Auditor score
1	CORE The cancer centre provides undergraduate oncology education.	Yes	Yes
2	The cancer centre provides undergraduate oncology education for medical students.	Yes	Yes
3	The cancer centre provides undergraduate oncology education for nursing students.	Yes	Yes
4	The cancer centre provides undergraduate oncology education for supportive discipline students.	Mostly	Partially
5	The cancer centre collects and analyses feedback about the quality of the undergraduate oncology education.	Yes	Yes
6	The cancer centre offers oncology education to medical/nursing/supportive discipline students from other countries, e.g. through exchange programmes.	Mostly	Partially

Standard 85: Postgraduate academic education in oncology

Auditors findings	
The centre provides structured postgraduate oncology education for medical and nursing staff, including palliative care. Postgraduate medical training follows national curricula and includes supervised clinical practice, mandatory rotations, formal assessments and regular feedback. Postgraduate nursing education includes oncology-specific and palliative care training, competency-based development, specialist education programmes and ongoing appraisal. However, it is not clearly evidenced that a defined postgraduate oncology education programme exists for supportive disciplines, as these are not consistently represented within education structures. Feedback on postgraduate education quality is routinely collected through trainee evaluations and supervision processes. There are currently no oncology exchange programmes or international postgraduate education activities, due to funding constraints, language barriers and limited uptake.	

The cancer centre provides oncology education of postgraduate students.

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

Part 2: General remarks, strengths, opportunities and conclusion

The second part of the final peer review report describes the general remarks, strengths and opportunities which have been identified by the audit team and approved by the OEI A&D Board.

Following the OEI accreditation visit, the audit team, and A&D Board, have identified many strong structures and programs. Some gaps were already acknowledged by the CCCC or were evident during the peer review visit and represent the opportunities for improvement. These are listed in the audit score (appendix 1) and described in this part of the report. The A&D Board expects to receive an improvement plan on these issues. Based upon this plan the OEI Accreditation and Designation certificate can be awarded.

A. General remarks

Responsibility for healthcare in Denmark is divided across three levels. The State sets national legislation, quality standards, and overall health policy through the Ministry of Health and national agencies. The five Regions are responsible for hospital services, specialist care, and implementation of national clinical pathways. The 98 municipalities manage prevention, rehabilitation, home care, and long-term social support. Citizens are registered with a general practitioner (GP), who acts as the main gatekeeper to specialist services and coordinates access to hospitals.

Cancer care is organised through a nationally coordinated but regionally delivered model that is strongly regulated. Since the introduction of the Danish Cancer Plans (5 since the 1990's), care has been structured around standardised "cancer courses packages" that define timelines and services from suspicion to diagnosis, treatment, and follow-up. These pathways aim to reduce delays and ensure uniform quality care across the country.

Specialised cancer treatment is concentrated in a limited number of university and regional hospitals to maintain expertise and quality. Major centres such as Rigshospitalet and Herlev Hospital provide medical oncology, radiotherapy, haematology, and highly specialised services. The delivery of complex cancer surgery within this CCCC is strictly designated as part of a national centralization model. Some less complex surgery such as breast cancer surgery is performed in aligned partner hospitals. Multidisciplinary team meetings guide treatment decisions, bringing together oncologists, surgeons, radiologists, pathologists, and specialist nurses.

National registries and digital health records support quality monitoring, research, and continuity of care. Rehabilitation and survivorship are shared between hospitals, municipalities, and primary care.

It is therefore within a highly hierarchical and regulated framework - one that is efficient but binding - that Rigshospitalet and Herlev-Gentofte hospitals decided in 2023 to join forces to establish a common Copenhagen Comprehensive Cancer Center (CCCC).

B. Strengths of the cancer centre with regard to the OECl quality standards

83,2% of the substandards are scored as 'yes' or 'mostly' by the audit team (Appendix 1). This means that for those indicators the standard has been implemented in the most critical places in the cancer centre and that the plan-do-check-act cycle (Deming-cycle) has been completed at least twice. The strengths described below relate to only the most significant of these high scored standards. The OECl A&D Board encourages the centre to maintain continuous quality improvement for these and other standards by running the Deming-cycle periodically.

Governance

1. **Adequate governance model and strong leadership.** The CCCC is overseen by a 13-member Board with responsibility for strategic direction, prioritisation, and quality oversight in cancer care. The Board includes leadership from both hospitals, with representatives from clinical and medical oncology, haematology, paediatric oncology, surgery, regional health advisory councils, and external stakeholders such as the Danish Cancer Society, University of Copenhagen, and Technical University of Denmark. Its terms of reference, composition, and meeting records confirm a clear strategic mandate across care, research, and quality. The governance structure was established and agreed in 2023. The Board is convinced of the added value of this project but also has a realistic understanding of the challenges posed by this development within Denmark's strongly regulated environment. Significant changes have been initiated, such as the merger of the haematology departments at Rigshospitalet, and the centralisation of breast surgery at Herlev-Gentofte Hospital.

Quality

2. **National driven quality dashboard - EPIC.** The dynamic national information system which encompasses clinical registries and digital health records, provides a wide range of indicators and dashboards that enable the monitoring of care delivery and outcomes throughout clinical pathways.

Patient involvement

3. **Patients school.** The CCCC has a very specific education programme that educates patients, called "patient school". This is a model where patients are educated for 5 days a week, half day each time, to accommodate for personal schedules or commitments of patients. Multi-disciplinary teams host the teaching sessions, which enables patients to understand their illness, diagnosis, and treatment options, and fosters a community between clinicians and patients.

Diagnosis

4. **Nuclear medicine - Imaging - Pathology.** The imaging and pathology services demonstrate a high level of organisation, expertise, and technological sophistication. Radiology and nuclear medicine departments at Rigshospitalet operate with robust staffing, regularly updated SOPs, strict monitoring of waiting times through EPIC, and compliance with Danish and European quality standards. Both departments are equipped with state-of-the-art technologies, including photon-counting CT, MR-PET, advanced PET-CT platforms, and radiotracer production facilities supporting cutting-edge oncological imaging and internationally recognised research programmes. There are also protected imaging resources for research and clinical trials. Strong collaboration with Herlev Hospital is ongoing and further supports CCCC integration.

The Pathology Department processes a very high volume of specimens within a mature quality framework based on national SOPs, inter-laboratory quality assurance, ISO 15189 standards, and an advanced governance platform (QualiWare). The associated biobank infrastructure is long established and was the pioneer of biobanking in Denmark, this represents a major resource that strongly supports translational research.

Overall, these services align strong clinical performance, advanced technology, rigorous quality processes, and exceptional scientific productivity, and represent a major strength of the CCCC ecosystem.

Treatments

5. **Radiotherapy.** The radiotherapy services are highly developed, well-staffed, and technologically advanced, ensuring safe and high-quality care across both hospital sites. Most oncologists across the CCCC are clinical oncologists, with relevant training and experience in both radiation and medical oncology. The Centre operates 22 linear accelerators, including two MR-Linacs, with strong expertise in adaptive, stereotactic, and combined chemo-radiotherapy.

Robust quality assurance, structured maintenance, comprehensive patient information, systematic toxicity monitoring, and effective incident-review processes support continuous improvement. Close collaboration between Rigshospitalet and Herlev Hospital further strengthens service integration and emergency radiotherapy provision.

6. **Surgical oncology (centralised model).** The surgical oncology services are well staffed, highly specialised and predominantly centralised, and supported by comprehensive multidisciplinary infrastructure. Integrated support disciplines and specialist nursing teams ensure high-quality perioperative care consistent with Copenhagen being to the fore internationally in perioperative medicine and enhanced recovery after surgery (ERAS) innovation and guidelines. Surgical planning is firmly embedded within multidisciplinary tumour boards, with weekly case discussions, rapid pathology turnaround, and systematic documentation of treatment decisions within EPIC.

The Danish nationally centralised model for complex cancer surgery represents a major strength, ensuring adequate procedure volumes and concentration of expertise for both common and rare cancers.

7. **Haematology.** The Department of Haematology at Rigshospitalet is a leading Nordic centre that combines advanced clinical care, research, and national referral functions for complex blood cancers. It treats patients with severe haematological malignancies and serves as a major hub for stem cell transplantation, CAR-T therapy, and other advanced immunotherapies. Closely linked to the University of Copenhagen, the department translates research findings rapidly into clinical practice and provides broad access to clinical trials. It integrates advanced diagnostics such as genomics and MRD monitoring and works in close multidisciplinary collaboration, including with paediatric oncology. The department has 42 inpatient beds, around 13,000 patient contacts annually, performs approximately 100 allogeneic transplants per year, and is staffed by 51 physicians and 16 postgraduates.

8. **Nurse leadership.** Nursing leadership demonstrates strong system-wide impact through active involvement in governance, quality monitoring, and operational management. Nursing has emerged as one of the professions showing the strongest levels of connection and collaboration across the hospitals within the CCCC. Prior to the centre merger, the hospitals operated with a degree of competition between them. However, the merger has shifted the culture towards greater collaboration, communication, and standardisation of practices. Through sustained knowledge exchange, shared best practices, and formalised collaboration, nursing teams have already driven meaningful changes with tangible impact across the entire centre.

The two chief nurses play a pivotal role in strengthening the interconnectedness between both hospitals within the centre, while head nurses are equally instrumental in translating shared knowledge into practice and fostering formal collaborations across sites.

One example is the Green Oncology collaboration, which was initially developed at Gentofte Hospital to improve cost-efficiency and optimise the use of equipment. Through this CCCC collaboration, the other hospital adopted the use of optic thermometers, replacing previous practices. This demonstrates how cross-site learning can lead to more efficient and standardised clinical practices.

Under strong nursing leadership, the centre has also been able to establish clearer career pathways and professional frameworks that support nurses in developing and progressing in areas aligned with their interests, including advanced practice nursing, research, education, and leadership.

Research

9. **Research ecosystem - Clinical trial Unit.** Cancer research within the University of Copenhagen-Capital Region ecosystem is organised as an integrated academic health network linking the University of Copenhagen with its major affiliated hospitals, Rigshospitalet and Herlev Hospital. The model combines basic science, translational research, and clinical investigation within a shared framework in which university laboratories, hospital departments, biobanks, and clinical trial units operate in close collaboration.

Basic research is primarily conducted in university-based institute Biotech Research & Innovation Centre (BRIC) and the Finsen Laboratory, where scientists study tumour biology, metastasis, immune regulation, and molecular mechanisms of treatment resistance. These discoveries are then connected to translational programmes embedded in hospital oncology and pathology departments, where molecular profiling, biomarker development, genomic analysis, and precision medicine are used to translate laboratory findings into clinical applications.

Clinical research is strongly developed at both hospital sites. Rigshospitalet hosts one of Scandinavia's largest early-phase oncology programmes, supporting phase I-III trials in solid tumours and haematological malignancies, while Herlev has internationally recognised expertise in cancer immunotherapy and personalised oncology. The Danish Cancer Biobank and national clinical registries provide a powerful infrastructure for linking biological samples with long-term outcomes, enabling population-based translational studies.

Education

10. **Education and training programme for doctors and nurses.** At undergraduate and postgraduate level, medical students, nurses, radiographers receive clinical training within the oncology departments of both hospitals. The two sites serve as major teaching hospitals where trainees participate in multidisciplinary cancer care while being supervised by senior specialists.

Herlev also hosts highly specialised educational programmes linked to translational research, particularly in cancer immunotherapy through the National Center for Cancer Immunotherapy, where clinicians and scientists are trained in experimental therapies and clinical trial methodology.

C. Opportunities for the cancer centre with regard to the OECl quality standards

16,8% of the sub-standards are scored as 'partially' or 'no' by the audit team (Appendix 1). This means that indicator is not yet implemented (plan) or implemented on a modest scale. According to the evidence seen by the audit team the Deming-cycle has not been completed for these sub-standards. The following opportunities were particularly identified by the audit team. These together with standards scored partially or no by the auditors should be addressed in the improvement plan.

Governance

1. **More integration in all domains.** Alongside the establishment of a sound and largely well-founded governance structure, the CCCC has also achieved greater visibility through a dedicated brand identity. Substantial progress has already been made toward centralisation, as shown in haematology and breast surgery. Furthermore, the CCCC operates within a well-regulated national framework that encompasses hospital specialty planning, cancer care pathways, surgery centralisation, and quality assurance systems. Collaboration between departments has likewise strengthened over time.

Despite these important advances, there remains scope for deeper integration across the centre's three core missions: patient care, research, and education. During the interviews and site visits, it became evident that, notwithstanding a clear commitment to bringing the two hospitals closer together, many teams continue to work primarily in the setting of their respective institutions rather than as part of a fully unified Comprehensive Cancer Centre.

Education illustrates this point clearly. Undergraduate and postgraduate teaching programmes are still organised separately by distinct teams at RH and HGH. These activities could be more effectively aligned through a single, coordinated educational strategy that fully embodies the shared vision of one integrated CCC.

2. **Strategic planning and reporting.** A key instrument for advancing the CCCC toward a more fully integrated model - while remaining aligned with national and regional regulatory requirements - would be the development of a more comprehensive strategic plan. Although the current document offers a valuable overarching direction, it remains largely conceptual and has not yet been translated into an operational roadmap with clearly defined SMART objectives, realistic timelines, and measurable outcomes spanning the full breadth of the CCCCs' activities.

It is therefore strongly recommended that such a plan be developed without delay. To ensure broad ownership and long-term impact, this process should be conceived as a collective institutional project, combining both top-down leadership and bottom-up engagement so that all stakeholders are meaningfully involved. This represents a critical step in giving tangible expression to the CCC vision, both within the organisation and in its external positioning

3. **Increase the university's visibility** . The outstanding contribution of BRIC and Finsen Laboratory are acknowledged, as well as the breadth and quality of basic, translational and clinical research. Notwithstanding, it was apparent during the peer review visit that there is limited integration of the "University" in its broadest sense in the new CCCC model, in particular in key domains such as governance, leadership, strategy including an integrated research plan, education, and support of academic investigators, in particular enabling protected academic time for clinicians. The CCCC is young, just in its foundation years, notwithstanding there is an evident opportunity for the University to have a better defined and expanded role through this accreditation process that will benefit both the CCCC and the University over time, closer integration now will likely reap dividends. In addition, the new Technical University of Denmark provides an enormous opportunity for the CCCC if positioned clearly within a strategic plan for research and innovation.

Quality

4. **Integration of quality systems at CCCC level.** The CCCC operates within a highly structured national and regional quality framework. At national level, the Danish Patient Safety Authority oversees patient safety, while the regional Oncology Health Advisory Council ensures consistency across oncology departments. Quality management is supported by the regional VIP system and the Centre's own Quality Management Programme (labs). Adverse events are reported through the national Danish URH system, and extensive clinical data are captured through national cancer groups, registries, and digital dashboards that monitor outcomes, activity, and key performance indicators. These data are regularly reviewed by hospital leadership, enabling follow-up actions and performance monitoring. Patient experience is systematically assessed through the national LUP survey, and specialised infrastructure such as MEDUSA and CIMT ensures safe management of medical technology. Competency controls are in place to ensure that specialised equipment is handled only by appropriately trained staff. However, the quality system remains largely dependent on national structures rather than a fully mature centre-based framework.

For this reason, it is recommended that the system be supplemented by establishing a formal quality management unit or group for the CCCC, which integrates the various components across both hospitals.

Furthermore, a systematic risk assessment policy - which has not yet been clearly established, a dedicated register of complications - the existence of which has not been confirmed, and greater transparency in the publication of inspection and accreditation results would strengthen the centre's internal quality governance.

Patient involvement and empowerment

5. **PROMs and PREMs implementation.** In Denmark, PREMs are collected nationally through the Landsdækkende Undersøgelse af Patientoplevelser (LUP), which evaluates patients' experiences of communication, coordination of care, waiting times, and involvement in treatment decisions. In parallel, disease-specific PROMs have been developed for some tumour groups, capturing symptoms, treatment toxicity, quality of life, and psychosocial wellbeing. These tools are progressively being integrated into electronic health records, allowing patients to complete questionnaires digitally before or between consultations. Clinicians can then use the information. Although implementation is ongoing, the routine use of PREM and PROM data for benchmarking and quality improvement remains limited, and uneven between tumour groups.

It is recommended that particular attention be paid to these developments and that steps be taken to speed up the implementation of PREMs and PROMs and to facilitate their use at local level.

6. **Patient involvement on the CCCC Board.** A 12-member Patient Advisory Panel meets four times a year; it enables patient representatives to provide support and advice on a voluntary basis to the organisation in the delivery of its services. Regarding the standard process for introducing new practices, patient representatives consider their involvement to be minimal, limited to providing advice on specific project-related issues, without being genuinely involved in the planning and development of changes to practices within the centre.

The centre has the opportunity to increase this level of involvement and could benefit from utilising or maximising patient participation in the planning and organisation of the integrated care centre. Subject to identifying a suitable profile, consideration could be given to having this patient advisory committee represented on the CCCC board of directors.

Multidisciplinary

7. **Harmonize and standardise MDT structures and processes.** General guidelines for multidisciplinary team (MDT) meetings were published in 2016 and are implemented at national level. Specific standard operating procedures (SOPs) are set out in the DMCG-MDT guidelines for each type of tumour. Nursing and support disciplines are not systematically represented. Patients eligible for MDT discussion are clearly defined, and all aspects of MDT meetings are detailed, including the inclusion of patients in clinical trials. Requirements regarding premises and infrastructure are met.

Several types of cancer, such as pancreatic and liver cancer, are treated surgically exclusively at the RH, whilst the 'leadership' of the programme within the CCCC organisational chart and from the evidence of the peer review visit is provided by the HGH. Cancers of the upper gastrointestinal tract, head and neck, as well as haematology, fall exclusively under the remit of the RH. However, prostate cancer, like colorectal cancer and certain others, is managed at both the HGH and the RH. Given this variability in arrangements depending on tumour type, it is not clear whether the process is fully harmonised across all MDT's.

There is an opportunity here to harmonise and develop uniform processes within the new structures and strategy of the CCCC, in particular dual MDTs (e.g. prostate, colorectal) must operate to identical standards, and MDTs and actions arising from MDT decision making where delivery of care is across both hospitals (e.g. pancreas/liver) must be clear and strictly defined

Moreover, an initiative to organise an annual meeting between the heads of the MDT's should be encouraged and continued to ensure full integration in the future.

Treatment

8. **To finalize the comprehensive digital management of the workflow for systemic treatments in the preparation units.** Systemic anticancer treatment within the CCCC is primarily managed through the EPIC BEACON module, which integrates prescribing, pharmacy ordering, and administration into an individualised digital treatment plan. Treatments preparations are centralized at the Capital Region Pharmacy which has two production units (RH and HDH) working according to GMP and common SOP's. Administration is supported by a comprehensive online manual of SOP's and take place in dedicated treatment rooms located in the Clinics Day care units. Treatment is delivered by nurses who complete structured competency-based training. Patients are medically reviewed before each treatment cycle, and unexpected adverse events are reported through the national digital reporting system (EPIC BEACON module).

Despite these strengths, parts of the anticancer drugs pathway still depend on paper-based processes, creating an avoidable vulnerability in a largely digital system. In addition, no formal evidence was provided of a specific quality or risk management framework for systemic anticancer drug handling.

The CCCC should quickly complete the full digitalisation of the systemic treatment pathway and formalize a dedicated quality and risk management programme for anticancer drug processes.

9. **Supportive care disciplines, connection with municipalities - Psychological support.** Supportive care for cancer patients in the Capital Region is delivered through a shared model between hospitals and municipalities, ensuring continuity across the care pathway. Hospitals retain responsibility for specialised supportive care during active treatment, while municipalities provide most rehabilitation and long-term support after discharge.

Within the CCCC, supportive care includes symptom management, nutritional assessment, pain control, palliative consultation, physiotherapy, and specialist nursing services, including a dedicated late-effects clinic. At both Rigshospitalet and Herlev Hospital, supportive care teams function separately but within a common framework of standard operating procedures and referral criteria. Needs are routinely assessed by physicians and cancer nurses, and patients with ongoing functional, psychological, or social needs are referred through the EPIC electronic patient record using established municipal pathways. The clinical team determines whether follow-up should be delivered through municipal rehabilitation, hospital-based specialised services, or a shared-care model.

While the framework is well defined, interviews indicated that implementation remains inconsistent at the local level. Access to follow-up services varies between municipalities, patients may struggle to navigate available services, and general practitioners do not always appear sufficiently informed about the supportive care pathways.

Three priorities for improvement emerge: stronger structural coordination between the supportive care teams at both hospitals (or better still, their merging, each professional retaining its own affiliation), enhanced access to psychological support, and a more robust process for needs assessment, patient information, and post-discharge follow-up to ensure greater continuity of care.

10. **Pain management.** Pain management is supported by national clinical guidelines, trained clinical oncologists providing basic supportive care, and access to specialist palliative care teams for complex symptom management. Pain and symptom burden are assessed as part of routine clinical care. While these tools capture pain-related symptoms, there is no evidence of a consistently implemented, validated pain-specific assessment tool (e.g. numerical rating scale or standardised pain screening instrument) used systematically across all stages of the patient pathway.

Systematic use of a pain assessment tool should be verified and, if needed, implemented across the patient pathways.

11. **Survivorship plan.** In line with the previous paragraph (9), the auditors were unable to identify any widespread or clear use of post-treatment follow-up plans, either during interviews with staff or amongst patients.

It is therefore recommended that the process for developing, communicating and ensuring the proper implementation of survivorship plans be thoroughly reviewed. It is suggested that this matter be discussed with the patient advisory committee. It is also the responsibility of the cancer centres of reference to explore and/or identify potential weaknesses in the system and to find ways to address them.

Research

11. **Strategic planning and reporting - SAB.** Cancer research associated with the CCCC is already highly developed and embedded within a particularly strong academic ecosystem. This environment brings together university laboratories such as the Biotech Research & Innovation Centre (BRIC), the research structures of Rigshospitalet and Herlev Hospital, clinical trials units, nationally coordinated biobanks, regional and national health registries, and a broad range of advanced research facilities. Collectively, these components support a dynamic and internationally recognised scientific output.

Each element of this ecosystem is well structured and operates within its own governance framework. With the recent establishment of the CCCC Cancer Research Forum, the next important step is to provide a comprehensive overview of the research that is partially or fully attributable to the CCCC, including its research groups, organisational framework, and the strategic vision guiding future development.

Therefore, it would now be highly valuable to develop a detailed and documented two- to three-year research strategy accompanied by an annual research report. Such a framework would strengthen visibility, improve coordination, and further consolidate the integration of research activities across the CCCC. Furthermore, in line with the recommendations made following the OECl's previous one-day visit, it is recommended to achieve the establishment of an international Scientific Advisory Board be established.

Education

12. **Educational programmes for supportive disciplines.** Educational and training programmes in cancer care are organised through a close partnership between the University of Copenhagen, Rigshospitalet, and Herlev Hospital. Together, these institutions provide a continuum of education that spans undergraduate teaching, specialist medical training, advanced nursing education, and research supervision.

However, there are currently no training programmes in the field of supportive care. Given the growing importance of this sector - particularly in the context of new treatments (immunotherapies) and the increasing number of cancer survivors - it would be advisable for the CCCC to consider introducing such a training programme.

D. Conclusion and Designation

Will be included in the final peer review report

Appendix 1: Overview of the auditor scores

§	Yes	%	Mostly	%	Partially	%	No	%	n/a	%	n/v	%	Sum Tot	Check
Chapter 1														
Score audit team	5	45.5	2	18.2	4	36.4	0	0.0	0	0.0	0	0.0	11	100.0
Chapter 2	Yes		Mostly		Partially		No		n/a		n/v		Tot	
Total	37	71.2	7	13.5	7	13.5	1	1.9	0	0.0	0	0.0	52	100.0
Chapter 3	Yes		Mostly		Partially		No		n/a		n/v		Tot	
Total	28	73.7	5	13.2	5	13.2	0	0.0	0	0.0	0	0.0	38	100.0
Chapter 4	Yes		Mostly		Partially		No		n/a		n/v		Tot	
Total	24	85.7	1	3.6	3	10.7	0	0.0	0	0.0	0	0.0	28	100.0
Chapter 5	Yes		Mostly		Partially		No		n/a		n/v		Tot	
Total	9	69.2	3	23.1	1	7.7	0	0.0	0	0.0	0	0.0	13	100.0
Chapter 6	Yes		Mostly		Partially		No		n/a		n/v		Tot	
Total	27	75.0	5	13.9	3	8.3	1	2.8	0	0.0	0	0.0	36	100.0
Chapter 7	Yes		Mostly		Partially		No		n/a		n/v		Tot	
Total	70	73.7	14	14.7	9	9.5	2	2.1	0	0.0	0	0.0	95	100.0
Chapter 8	Yes		Mostly		Partially		No		n/a		n/v		Tot	
Total	23	43.4	13	24.5	13	24.5	4	7.5	0	0.0	0	0.0	53	100.0
Chapter 9	Yes		Mostly		Partially		No		n/a		n/v		Tot	
Total	12	63.2	2	10.5	5	26.3	0	0.0	0	0.0	0	0.0	19	100.0
Total	235	68.1	52	15.1	50	14.5	8	2.3	0	0.0	0	0.0	345	100.0

Yes	The indicator has been on a wide scale in the cancer centre and the Deming-cycle has been completed at least twice (> in third cycle)
Mostly	The indicator has been implemented in most of the critical places in the cancer centre and the Deming-cycle has been completed at least once (> in second cycle)
Partially	The indicator has been implemented on project basis or on a modest scale in the cancer centre or the Deming-cycle has not been completed (Do)
No	The indicator does not get attention or there are plans to start working on the indicator (Plan)
Not applicable	The indicator is not applicable in the cancer centre / the centre is not responsible for this indicator due to the health care system
Not verified	The auditors have not addressed this indicator and are not able to provide a verified answer

Appendix 2: Peer review agenda

Will be included in the final peer review report