NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Ovarian cancer (update)

NICE quality standard

Draft for consultation

20 August 2024 (consultation)

21 May 2012 (first published date)

This quality standard covers the identification and management of familial and genetic risk and the recognition and management of ovarian, fallopian tube and primary peritoneal cancer or borderline ovarian cancer in women, trans men and non-binary people with female reproductive organs (ovaries, fallopian tubes and/or a uterus).

It describes high-quality care in priority areas for improvement. The quality standard does not cover risk management and decision-making support for men, trans women and non-binary adults born with male reproductive organs who have, or are at risk of having, a pathogenic variant associated with ovarian cancer.

This quality standard will update and replace the existing quality standard on ovarian cancer (published May 2012). The topic was identified for update following a review of quality standards. The review identified new guidance on ovarian cancer: identifying and managing familial and genetic risk.

For more information see update information.

This is the draft quality standard for consultation (from 20 August to 18 September 2024). The final quality standard is expected to publish in February 2025.

Quality statements

Statement 1 Adults with a total lifetime risk of 5% or more of developing ovarian cancer have a discussion about risk-reducing surgery. **[new 2025]**

Statement 2 (placeholder) CA125 blood test – age specific thresholds.

Statement 3 Adults with a new diagnosis of high-grade epithelial ovarian cancer have panel germline testing. **[new 2025]**

Statement 4 Adults with a new diagnosis of stage 3 or 4 high-grade epithelial ovarian cancer have tumour testing. **[new 2025]**

Statement 5 Adults who have high-risk stage 1 ovarian cancer, or stage 2 to 4 inclusive ovarian cancer, have both surgery and chemotherapy. **[new 2025]**

In 2024 this quality standard was updated and statements prioritised in 2012 were replaced **[new 2025]**. For more information, see update information.

The previous version of the quality standard for ovarian cancer is available as a pdf.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Can data for the proposed quality measures be collected locally? Please include in your answer any data sources that can be used or reasons why data cannot be collected.

Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Question 4: Please provide your comments on the equality and health inequalities assessment (EHIA) and the equality and diversity considerations section for each quality statement. Please confirm any issues that have been missed and how they can be addressed by health care services and practitioners.

Questions about the individual quality statements

Question 5: For draft quality statement 3 (panel germline genetic testing): Please state whether data can be collected to support monitoring take-up of panel germline testing by ethnicity.

Question 6: For draft quality statement 4 (tumour testing (stage 3, 4)): Please state whether data can be collected to support monitoring take-up of tumour testing by ethnicity.

Question 7: For draft quality statement 5 (treatment of high-risk stage 1, stage 2 to 4 (inclusive) ovarian cancer): Please state whether data can be collected to support monitoring the measures by age and comorbidity.

Implementing NICE guidelines

Question 8 What are the challenges to implementing the NICE guidance underpinning this quality standard? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives).

Quality statement 1: Discussion about risk-reducing surgery

Quality statement

Adults with a total lifetime risk of 5% or more of developing ovarian cancer have a discussion about risk-reducing surgery. **[new 2025]**

Rationale

Risk-reducing surgery is the most reliable way of substantially reducing the likelihood of developing ovarian cancer in adults who have a total lifetime risk of 5% or more. Discussing the risk of developing ovarian cancer, and the risks and benefits associated with surgery, facilitate informed and shared decision making. A key element of the discussion is to identify whether the adult has completed their family or is not planning to conceive naturally.

Quality measures

The following measure can be used to assess the quality of care or service provision specified in the statement. It is an example of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of adults who have a total lifetime risk of 5% or more of developing ovarian cancer who have a documented discussion about risk-reducing surgery.

Numerator – the number in the denominator who have a documented discussion about risk-reducing surgery.

Denominator – the number of adults who have a total lifetime risk of 5% or more of developing ovarian cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records, clinical genetics records or records from gynaecology oncology multidisciplinary team meetings.

What the quality statement means for different audiences

Service providers (such as secondary and tertiary gynaecology services, and genetics services) ensure that healthcare professionals are trained to discuss risk-reducing surgery with adults who have a 5% or more lifetime risk of developing ovarian cancer. They ensure that healthcare professionals in these services are trained in shared decision making and information provision which specifically relates to genetics and cancer risk.

Healthcare professionals (such as clinical nurse specialists, geneticists, and gynaecologists) discuss risk-reducing surgery with adults when a 5% or more lifetime risk of developing ovarian cancer has been identified. The discussion should include whether the adult has completed their family or does not plan to conceive naturally. They attend training on shared decision making and information provision which specifically relates to genetics and cancer risk. To facilitate discussion of risk-reducing surgery, they also provide information and support.

Commissioners ensure that they commission services that provide risk-reducing surgery for adults with a 5% or more lifetime risk of developing ovarian cancer who have completed their family or are not planning to conceive naturally. They should ensure that services provide an opportunity to establish that they have completed their family or are not planning to conceive naturally, discuss the risks and benefits and provide information and support.

Adults with an increased risk of ovarian cancer discuss risk-reducing surgery. This includes discussing whether they have completed their family or do not plan to conceive naturally. It also includes the impact of surgery, which for premenopausal adults will lead to early menopause. They are given information and support to facilitate this discussion and shared decision making.

Source guidance

Ovarian cancer: identifying and managing familial and genetic risk. NICE guideline NG241 (2024), recommendations 1.8.1 to 1.8.6

Definitions of terms used in this quality statement

Discussion about risk-reducing surgery

Topics, including information and support to aid shared decision making, are provided in NICE's guideline on ovarian cancer: identifying and managing familial and genetic risk, tables 1 (information and support about familial ovarian cancer in all settings) and 3 (information and support in specialist services).

When discussing risk-reducing bilateral salpingo-oophorectomy surgery with adults who are premenopausal, specialist menopause counselling should be offered before (and after) surgery.

[NICE's guideline on ovarian cancer: identifying and managing familial and genetic risk, recommendations 1.8.1, 1.8.3 and 1.8.4]

Total lifetime risk of 5% or more

This is calculated on the basis of:

- a pathogenic variant (presence of a genetic alteration that increases susceptibility or predisposition to a certain disease or disorder; or 'likely pathogenic variant' - a variant with strong evidence that suggests it is associated with an increased risk of ovarian cancer) associated with familial ovarian cancer; **or**
- a strong family history of ovarian cancer (1 or more first-degree relatives (for example, a grandmother, sister or daughter) on the same side of their family (the mother's or father's side of the family) with ovarian cancer.

[NICE's guideline on ovarian cancer: identifying and managing familial and genetic risk, recommendation 1.8.1, and glossary: pathogenic variant and strong family history of ovarian cancer]

Risk-reducing surgery

Risk-reducing surgery consists of:

- bilateral salpingo-oophorectomy - a surgical procedure to remove both (bilateral) fallopian tubes (salpingectomy) and the ovaries (oophorectomy)

- hysterectomy with bilateral salpingo-oophorectomy (to reduce the risk of endometrial cancer as well as ovarian cancer).

[NICE's guideline on ovarian cancer: identifying and managing familial and genetic risk, table 5, recommendations 1.8.6 to 1.8.11, and glossary]

Equality and diversity considerations

It is important that adults with additional communication needs are supported so that they can interact effectively with healthcare professionals.

If a need for advocacy is identified, healthcare professionals involved in the adult's care should support them to use an advocate. Healthcare professionals should also allow enough time for the advocate to help them prepare before any appointments or discussion and to ensure that they understand the outcome afterwards.

[Adapted from NICE's guideline on advocacy services for adults with health and social care needs, section 1.5]

NHS England's Accessible Information Standard or the equivalent standards for the devolved nations set out how additional communication and information provision needs relating to a disability, impairment or sensory loss can be supported to facilitate the discussion. Adults who do not speak or read English as their first language may need more support, such as:

- information available in multiple languages
- an interpreter for adults who do not read or understand English.

Quality statement 2 (placeholder): CA125 blood test – age specific thresholds

Placeholder statement

A placeholder statement is an area of care that has been prioritised by the quality standards advisory committee but for which there are currently no published recommendations.

A recent review of recommendations on the recognition of suspected ovarian cancer in NICE's guideline on suspected cancer: recognition and referral has identified that recommendations on thresholds for referral following CA125 testing should be updated. This placeholder statement will be reviewed following publication of the updated NICE guideline recommendations.

Rationale

Ovarian cancer is associated with late diagnosis (around 60% diagnosed at stages 3 and 4) and 30% of diagnoses were made through emergency presentation (NHS England's data on cancer incidence by stage and routes to diagnosis for 2020).

Age-specific CA125 thresholds may improve detection of both ovarian cancer and non-ovarian cancers in people with early symptoms of ovarian cancer that can be similar to those of other pelvic or abdominal conditions (2024 exceptional surveillance of suspected cancer: recognition and referral (NICE guideline NG12). As such, updated recommendations are expected to determine the focus of quality improvement for both recognition, referral and safety netting .

Statement 3: Panel germline genetic testing for high-grade epithelial ovarian cancer

Quality statement

Adults with a new diagnosis of high-grade epithelial ovarian cancer have panel germline testing. **[new 2025]**

Rationale

Pathogenic variants increase the risk of developing ovarian cancer; up to 20% arise due to an inheritable cause and it is estimated that 15% to 20% of people with high-grade epithelial ovarian cancer carry a pathogenic variant associated with increased risk of ovarian cancer. Performing panel germline testing in parallel with tumour testing, if appropriate, is important because variants detected uniquely by each form of genetic testing can be identified. Carrying out testing as soon as possible after the point of diagnosis means that results are available when they are clinically relevant to treatment options following first-line treatment; the results have prognostic and therapeutic value and enable appropriate treatment regimens to be offered. Detection of germline pathogenic variants also enables testing to be offered to eligible blood relatives; relatives found to carry pathogenic variants can then opt for screening or preventive interventions to minimise their cancer risk. Details of panel germline tests are available through NHS England's national genomic test directory.

Quality measures

The following measure can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly. Some localities may want to focus on equality of care depending on local needs, such as by comparing data on take-up stratified by ethnicity.

Process

Proportion of adults with a new diagnosis of high-grade epithelial ovarian cancer who had panel germline testing.

Numerator – the number in the denominator who had panel germline testing.

Denominator – the number of adults with a new diagnosis of high-grade epithelial ovarian cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers (secondary and tertiary gynaecology services, and laboratories) ensure that panel germline testing in adults with a new diagnosis of high-grade epithelial ovarian cancer is carried out, reported and recorded in accordance with local pathways and protocols. The testing is carried out, if appropriate, in parallel with tumour testing.

Healthcare practitioners (such as members of gynaecology oncology multidisciplinary teams such as surgical oncologists, medical oncologists, clinical nurse specialists; genetic counsellors, clinical geneticists supporting mainstream services, technicians) have access to panel germline testing and are aware of local pathways and protocols. The testing is carried out, if appropriate, in parallel with tumour testing.

Commissioners ensure that they commission services that can provide panel germline testing for adults with a new diagnosis of high-grade epithelial ovarian cancer. They monitor providers to ensure that testing is carried out, if appropriate, in parallel with tumour testing, and as near to the time of diagnosis as possible, so that results are available when they are clinically relevant to treatment options following first-line treatment.

Adults with a new diagnosis of high-grade epithelial ovarian cancer have ‘panel germline’ (a blood or saliva test) genetic testing to detect variants they have been born with and may pass on and it is carried out, if appropriate, alongside testing of tumour tissue. The results enable the most beneficial form of treatment following first-line surgery and chemotherapy to be planned. Information from this test also enables relatives to be tested if a variant is identified.

Source guidance

Ovarian cancer: identifying and managing familial and genetic risk. NICE guideline NG241 (2024), recommendation 1.4.6, 1.5.1 and 1.5.2

Definitions of terms used in this quality statement

High-grade epithelial ovarian cancer

This covers the following types, stage 1 to 4 inclusive:

- Carcinosarcoma.
- Clear cell.
- Endometrioid.
- Mucinous.
- Serous.
- Undifferentiated.

[NICE's guideline on ovarian cancer: identifying and managing familial and genetic risk, recommendation 1.4.6 and expert opinion]

Panel germline testing

A type of genetic test (a blood or saliva sample) that looks for inherited mutations that are present in the DNA of every cell of the body and have been present since birth. It enables inheritable pathogenic variants to be identified in relevant ovarian cancer genes.
[NICE's guideline on ovarian cancer: identifying and managing familial and genetic risk, glossary and expert opinion]

Question for consultation

Please state whether data can be collected to support monitoring take-up of panel germline testing by ethnicity.

Statement 4: Tumour testing for stage 3 or 4 high-grade epithelial ovarian cancer

Quality statement

Adults with a new diagnosis of stage 3 or 4 high-grade epithelial ovarian cancer have tumour testing. **[new 2025]**

Rationale

Pathogenic variants increase the risk of developing ovarian cancer, of which epithelial ovarian cancer is the most common form. Around one third of the variants in the tumour are present in the tumour only and absent from the germline (Sundar S, Manchanda R, Gourley C et al, 2021). Performing tumour testing in parallel with panel germline testing is important because variants detected uniquely by each form of genetic testing can be identified. Carrying out tumour testing at the time of histological diagnosis means that results are available when they are clinically relevant to treatment options following first-line treatment; the results have prognostic and therapeutic value and enable appropriate treatment regimens to be offered. Details of tumour tests are available through NHS England's national genomic test directory.

Quality measures

The following measure can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly. Some localities may want to focus on equality of care depending on local needs, such as by comparing data on take-up stratified by ethnicity.

Process

Proportion of adults with a new diagnosis of stage 3 or 4 high-grade epithelial ovarian cancer who had tumour testing.

Numerator – the number in the denominator who had tumour testing.

Denominator – the number of adults with a new diagnosis of stage 3 or 4 high-grade epithelial ovarian cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. Data on tumour testing by cancer site and by gene is collected by NHS England (data collected by the National Disease Registration service).

What the quality statement means for different audiences

Service providers (secondary and tertiary gynaecology services, and laboratories) ensure that tumour testing in adults with a new diagnosis of stage 3 or 4 high-grade epithelial ovarian cancer is carried out, reported and recorded in accordance with local pathways and protocols. The testing is carried out in parallel with panel germline testing.

Healthcare practitioners (such as members of gynaecology oncology multidisciplinary teams such as surgical oncologists, medical oncologists, clinical nurse specialists, radiologists, pathologists; genetic counsellors, clinical geneticists supporting mainstream services, technicians) have access to tumour testing and are aware of local pathways and protocols. The testing is carried out in parallel with panel germline testing.

Commissioners ensure that they commission services that can provide tumour testing for adults with a new diagnosis of stage 3 or 4 high-grade epithelial ovarian cancer. They monitor providers to ensure that testing is carried out at the time of histological diagnosis, and in parallel with panel germline testing, so that results are available when they are clinically relevant to treatment options following first-line treatment.

Adults with a new diagnosis of stage 3 or 4 high-grade epithelial ovarian cancer have genetic testing of their tumour. The testing of tumour tissue enables the presence of genetic variants to be detected and takes place alongside testing for variants they have been born with. The results enable the most beneficial form of treatment following first-line surgery and chemotherapy to be planned.

Source guidance

- Consensus for genetic testing in epithelial ovarian cancer in the United Kingdom. British Gynaecological Cancer Society and British Association of Gynaecological Pathology (2024), sections 4.1 and 9.1
- A number of NICE technology appraisals refer to treatments which involve further testing to guide treatment options [NICE's guideline on ovarian cancer: recognition and initial management, recommendation 1.4.3].

Definitions of terms used in this quality statement

Stage 3 or 4 high-grade epithelial ovarian cancer

This covers the following types, stage 3 and 4:

- Carcinosarcoma.
- Clear cell.
- Endometrioid.
- Mucinous.
- Serous.
- Undifferentiated.

[British Gynaecological Cancer Society and British Association of Gynaecological Pathology's consensus for genetic testing in epithelial ovarian cancer in the United Kingdom, section 4]

Tumour testing

DNA extracted from tumour tissue before systemic therapy (as part of surgical or radiological staging) which is tested for pathogenic variants and homologous recombination deficiency (HRD). A proportion of variants detected in tumours are inherited (germline).

[British Gynaecological Cancer Society and British Association of Gynaecological Pathology's consensus for genetic testing in epithelial ovarian cancer in the United Kingdom, section 1.1 and expert opinion]

Question for consultation

Please state whether data can be collected to support monitoring take-up of tumour testing by ethnicity.

Quality statement 5: Treatment of high-risk stage 1 or stage 2 to 4 (inclusive) ovarian cancer

Quality statement

Adults who have high-risk stage 1 ovarian cancer, or stage 2 to 4 inclusive ovarian cancer, have both surgery and chemotherapy. **[new 2025]**

Rationale

The most appropriate form of surgery (including staging) depends on histopathology, grade and stage of disease. Treatment with both chemotherapy and surgery is associated with improved survival or reduced risk of recurrence. It is important that the risks and benefits and possible implications on quality of life associated with treatment options are discussed to support informed and shared decision making around treatment choices.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly. Services may wish to monitor and compare unwarranted variation in achievement of the measures within equality groups, such as age and comorbidity.

Process

a) Proportion of adults with a diagnosis of high-risk stage 1 ovarian cancer who receive surgery and chemotherapy.

Numerator – the number in the denominator who receive surgery and chemotherapy.

Denominator – the number of adults with a diagnosis of high-risk stage 1 ovarian cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. Data on surgery and chemotherapy for all stages of ovarian cancer is collected by NHS

England, in Hospital Episode Statistics and the National Disease Registration Service's Systemic Anti-Cancer Therapy (SACT) dataset.

b) Proportion of adults with a diagnosis of stage 2 to 4 (inclusive) ovarian cancer who receive surgery and chemotherapy.

Numerator – the number in the denominator who receive surgery and chemotherapy.

Denominator – the number of adults with a diagnosis of stage 2 to 4 (inclusive) ovarian cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. Data on surgery and chemotherapy for all stages of ovarian cancer is collected by NHS England, in Hospital Episode Statistics and the National Disease Registration Service's Systemic Anti-Cancer Therapy (SACT) dataset.

What the quality statement means for different audiences

Service providers (secondary and tertiary gynaecology services) ensure that management protocols are in place so that adults with high-risk stage 1 ovarian cancer, and stage 2 to 4 (inclusive) ovarian cancer, receive both surgery and chemotherapy. They ensure that referral pathways are in place so that adults are referred to a specialist gynaecological centre for surgery and, dependent on local arrangements and resource, chemotherapy.

Healthcare professionals (gynaecological surgical oncologists and medical oncologists) are aware of local protocols to ensure that adults with high-risk stage 1 ovarian cancer, and stage 2 to 4 (inclusive) ovarian cancer, receive both surgery and chemotherapy. They are aware of local protocols to ensure referral to a specialist gynaecological oncology centre for surgery and, dependent on local arrangements and resource, chemotherapy.

Commissioners ensure that they commission services which can offer surgical procedures and recommended chemotherapy regimens, dependent on the type, stage and grade of ovarian cancer.

Adults with high-risk stage 1 ovarian cancer, and stage 2 to 4 ovarian cancer discuss both surgery and chemotherapy as treatment options with a healthcare professional who explains the risks and benefits of treatment options. The type of surgery, and timing of their chemotherapy relative to surgery, depends on the type, stage and grade of their cancer.

Source guidance

- Ovarian, tubal and primary peritoneal cancer guidelines: recommendations for practice update 2024. British Gynaecological Cancer Society (BGCS) (2024), germ cell tumours (GCT), recommendations, GCT surgery (commentary), GCT systematic therapy (commentary); sex-cord stromal tumours (SCST), recommendations, management of suspected early-stage disease (commentary), management of advanced-stage and recurrent SCST (commentary)
- Ovarian cancer: recognition and initial management. NICE guideline CG122 (2011, last updated 2023), recommendations 1.3.1.1, 1.3.2.1, 1.3.2.2 and 1.4.1.1
- Guidance on the use of paclitaxel in the treatment of ovarian cancer. NICE technology appraisal guidance 55 (2003, last updated 2005)

Definitions of terms used in this quality statement

High-risk stage 1 ovarian cancer

Adults at risk of recurrence following surgery because of the following subtypes of ovarian cancer:

- epithelial ovarian cancer, grade 3 or stage 1C
- germ cell tumours:
  - stage 1 tumours (except non-gestational choriocarcinoma) – discussion of benefits and toxicities of adjuvant chemotherapy compared to surveillance
  - unresectable tumours.
- sex-cord (stromal) tumours: the following types may benefit from adjuvant chemotherapy:
  - Sertoli-Leydig cell tumour, stage 1C grades 2 and 3 inclusive
  - juvenile granulosa cell tumours, stage 1C2
- borderline tumours, grade 3 or stage 1C.

[NICE's guideline on ovarian cancer: recognition and initial management, recommendations 1.3.2.1 and 1.3.2.2 and British Gynaecological Cancer Society's ovarian, tubal and primary peritoneal cancer guidelines: recommendations for practice update 2024, germ cell tumours, recommendations, GCT systematic therapy (commentary); sex-cord stromal tumours (SCST), recommendations, management of suspected early-stage disease (commentary).

Stage 2 to 4 ovarian cancer

- epithelial ovarian cancer, stage 2 to 4 inclusive
- germ cell tumours:
  - stage 2 to 4 inclusive
  - unresectable tumours.
- sex-cord tumours:
  - Sertoli-Leydig cell tumour, stage 2
  - juvenile granulosa cell tumours, stage 2
  - stage 3 and 4 inclusive, except granulosa cell tumours.
- borderline tumours, stage 2 to 4 inclusive.

[NICE's guideline on ovarian cancer: recognition and initial management, recommendations 1.3.2.1, and 1.3.2.2, and British Gynaecological Cancer Society's ovarian, tubal and primary peritoneal cancer guidelines: recommendations for practice update 2024, germ cell tumours, recommendations; sex-cord stromal tumours (SCST), recommendations, management of advanced-stage and recurrent SCST (commentary).

Surgery

The most appropriate form of surgery (including staging) depends on histopathology, grade and stage of disease. Age and reproductive choices are also factors if fertility-conserving surgery is an option. Surgery includes:

- surgical staging
- conservative surgery (also known as fertility-sparing surgery) which conserves the uterus and contra-lateral (opposite) ovary

- complete resection of all macroscopic disease as primary surgery (including maximal cytoreductive surgery, as defined NICE's interventional procedures guidance on maximal cytoreductive surgery for advanced ovarian cancer, section 2.3, and recommendations 1.1 to 1.4), or interval debulking surgery).

[NICE's guideline on ovarian cancer: recognition and initial management, recommendation 1.3.1.1, 1.3.1.2 and 1.4.1.1, NICE's interventional procedures guidance on maximal cytoreductive surgery for advanced ovarian cancer, section 2.3, and recommendations 1.1 to 1.4 and British Gynaecological Cancer Society's ovarian, tubal and primary peritoneal cancer guidelines: recommendations for practice update 2024, germ cell tumours, recommendations, surgery, GCT systematic therapy, follow-up (commentaries); sex-cord stromal tumours (SCST), recommendations, management of suspected early-stage disease, management of advanced ovarian cancer (commentaries)].

Chemotherapy

The most appropriate chemotherapy depends on histopathology, and the stage and grade of disease:

- adjuvant (post-operative) chemotherapy
- neoadjuvant chemotherapy.

[NICE's guideline on ovarian cancer: recognition and initial management, recommendation 1.3.1.1, 1.3.1.2 and 1.4.1.1, and British Gynaecological Cancer Society's ovarian, tubal and primary peritoneal cancer guidelines: recommendations for practice update 2024, germ cell tumours, recommendations, surgery, GCT systematic therapy, follow-up (commentaries); sex-cord stromal tumours (SCST), recommendations, management of suspected early-stage disease, management of advanced ovarian cancer (commentaries)].

Question for consultation

Please state whether data can be collected to support monitoring the measures by age and comorbidity.

Update information

February 2025: This quality standard was updated and statements prioritised in 2012 were replaced. The topic was identified for update following a review of quality standards. The review identified new guidance on ovarian cancer: identifying and managing familial and genetic risk.

Statements are marked as **[new 2025]** if the statement covers a new area for quality improvement.

The previous version of the quality standard for ovarian cancer is available as a pdf.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to

use the resource impact statement and resource impact template for NICE's guideline on ovarian cancer: identifying and managing familial and genetic risk to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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