NICE National Institute for Health and Care Excellence

NICE quality standard

Ovarian cancer

Quality standard
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This standard is based on CG122 and NG241.

This standard should be read in conjunction with QS13, QS15 and QS124.

Quality statements

Statement 1 Adults with a 5% or more total lifetime risk 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 newly diagnosed with non-mucinous high-grade epithelial ovarian cancer are offered panel germline genetic testing. **[new 2025]**

Statement 4 Adults newly diagnosed with stage 3 or 4 non-mucinous high-grade epithelial ovarian cancer are offered tumour genetic testing. **[new 2025]**

Statement 5 Adults with high-risk stage 1 ovarian cancer, or stage 2 to 4 ovarian cancer, have both surgery and chemotherapy discussed as a treatment option by a specialist gynaecological cancer multidisciplinary team. **[new 2025]**

In 2025 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 on ovarian cancer is available as a pdf.

Quality statement 1: Discussion about risk-reducing surgery

Quality statement

Adults with a 5% or more total lifetime risk 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 5% or more total lifetime risk. It is important that adults are supported to make informed decisions. This could be through discussion of genetics, cancer risk, and the impact of surgery (on reproductive choices and fertility and, in premenopausal adults, the impact of surgical menopause), including its benefits and risks. This will facilitate informed and shared decision making.

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 5% or more total lifetime risk 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 5% or more total lifetime risk 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 and genetics services) ensure that healthcare professionals are trained to discuss risk-reducing surgery with adults who have a 5% or more total lifetime risk of developing ovarian cancer. They ensure that healthcare professionals in these services are trained in shared decision making and information provision, which relates to genetics, cancer risk, reproductive choices, fertility, menopause (for premenopausal adults), and the benefits and risks of surgery. They also work with the National Disease Registration Service (NDRS) to ensure that genetic variants and family history are coded, to populate the NDRS's germline molecular data set.

Healthcare professionals (such as clinical nurse specialists, gynaecologists, geneticists and genetic counsellors) discuss risk-reducing surgery with adults when a 5% or more total lifetime risk of developing ovarian cancer has been identified. They attend training on shared decision making and information provision, which relates to genetics, cancer risk, reproductive choices, fertility, menopause (for premenopausal adults), and the benefits and risks of surgery. 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 total lifetime risk of developing ovarian cancer. They should ensure that services provide an opportunity to discuss genetics, cancer risk, reproductive choices, fertility, menopause (for premenopausal adults), and the risks and benefits of surgery, and provide information and support, to aid shared decision making.

Adults with an increased risk of ovarian cancer discuss risk-reducing surgery. This includes healthcare professionals discussing with them genetics, cancer risk and the benefits, impact and risks of surgery. 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, table 1 (information and support about familial ovarian cancer in all settings), table 2 (information and support about risk assessment and genetic testing in genetics services) and table 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]

5% or more total lifetime risk

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', which is 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) with ovarian cancer.

NICE's guideline on ovarian cancer, recommendations 1.6.3 and 1.6.5, describe how the risk of developing ovarian cancer is assessed. [NICE's guideline on ovarian cancer: identifying and managing familial and genetic risk, recommendations 1.6.3 and 1.6.5, 1.8.1, and glossary (pathogenic variant and strong family history of ovarian cancer)]

Risk-reducing surgery

Risk-reducing surgery could include:

- 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]

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 NICE recommendations.

A review in 2024 of recommendations on the recognition of suspected ovarian cancer in NICE's guideline on suspected cancer 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%of people are 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 the 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 NICE's guideline on suspected cancer: recognition and referral). As such, updated recommendations are expected to determine the focus of quality improvement for recognition, referral and safety netting.

Quality statement 3: Panel germline genetic testing for non-mucinous high-grade epithelial ovarian cancer

Quality statement

Adults newly diagnosed with non-mucinous high-grade epithelial ovarian cancer are offered panel germline genetic testing. **[new 2025]**

Rationale

Germline genetic testing identifies pathogenic variants present at birth that increase the risk of developing ovarian cancer. It also identifies the risk of developing other cancers and, for adults with stage 3 or 4 non-mucinous ovarian cancer, being tested as soon as possible after diagnosis can also influence first-line treatment options. Detection of germline pathogenic variants also enables testing to be offered to eligible blood relatives. Those found to carry pathogenic variants can then opt for screening or preventive interventions to minimise their cancer risk. Performing both tumour and panel germline testing is important because variants detected uniquely by each form of genetic testing can be identified.

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. Some localities may want to focus on equality of care depending on local needs, such as by comparing data on uptake stratified by ethnicity.

Process

a) Proportion of adults newly diagnosed with non-mucinous high-grade epithelial ovarian cancer who were offered panel germline genetic testing.

Numerator – the number in the denominator who were offered panel germline genetic testing.

Denominator – the number of adults newly diagnosed with non-mucinous 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.

b) Proportion of adults newly diagnosed with non-mucinous high-grade epithelial ovarian cancer who had panel germline genetic testing.

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

Denominator – the number of adults newly diagnosed with non-mucinous 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. The NDRS's germline molecular data set collects germline molecular data.

What the quality statement means for different audiences

Service providers (secondary and tertiary gynaecology services) ensure that panel germline genetic testing is offered to adults newly diagnosed with non-mucinous high-grade epithelial ovarian cancer in accordance with local pathways and protocols.

Healthcare professionals (members of gynaecology oncology multidisciplinary teams, clinical geneticists supporting mainstream services or genetic counsellors) have access to panel germline genetic testing and are aware of local pathways and protocols.

Commissioners ensure that they commission services that can provide panel germline genetic testing for adults newly diagnosed with non-mucinous high-grade epithelial ovarian cancer, in line with NHS England's national genomic test directory. They monitor providers to ensure that testing is offered, and when it is taken up, it is carried out as soon as possible after diagnosis.

Adults newly diagnosed with non-mucinous high-grade epithelial ovarian cancer are offered a blood or saliva test ('panel germline genetic testing') to detect variants they have been born with and may pass on. The results enable their risk of other cancers to be identified and the most beneficial form of treatment to be planned in the first-line setting. Information from this test also enables relatives to be tested if a variant is identified.

Source guidance

- National genomic test directory. NHS England (2025)
- 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

Panel germline genetic testing

A type of genetic test (a blood or saliva sample) that looks for inherited variants 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]

Equality and diversity considerations

Differences in uptake of genetic testing by ethnic group was identified as an equalities issue during development of the quality standard. It is important that information is provided to reduce barriers limiting understanding around genetic testing. This can be addressed by providing educational resources, in multiple languages, such as:

- genetic testing after cancer diagnosis: information for patients with cancer (written information)
- videos around genetic testing.

These resources have been developed by Ovarian Cancer Action's IMPROVE-UK programme Demonstration of Improvement for Molecular Ovarian Cancer Testing (DEMO)

in collaboration with Sandwell and West Birmingham NHS Trust, in conjunction with the Cancer Research UK Cambridge Centre. They have not been produced by NICE and are not maintained by NICE. We have not made any judgement about the quality and usability of the resources. Other resources may also be available.

Quality statement 4: Tumour genetic testing for stage 3 or 4 non-mucinous high-grade epithelial ovarian cancer

Quality statement

Adults newly diagnosed with stage 3 or 4 non-mucinous high-grade epithelial ovarian cancer are offered tumour genetic testing. **[new 2025]**

Rationale

Tumour genetic testing identifies gene variants that are present only in the tumour. This can help determine which treatments are the most effective. Offering tumour testing at the time of diagnosis means that results are available when they are clinically relevant to treatment options during first-line treatment. Performing both tumour and panel germline testing is important because variants detected uniquely by each form of genetic testing can be identified.

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. Some localities may want to focus on equality of care depending on local needs, such as by comparing data on uptake stratified by ethnicity.

Process

a) Proportion of adults newly diagnosed with stage 3 or 4 non-mucinous high-grade epithelial ovarian cancer who were offered tumour genetic testing.

Numerator – the number in the denominator who were offered tumour genetic testing.

Denominator – the number of adults newly diagnosed with stage 3 or 4 non-mucinous

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.

b) Proportion of adults newly diagnosed with stage 3 or 4 non-mucinous high-grade epithelial ovarian cancer who had tumour genetic testing.

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

Denominator – the number of adults newly diagnosed with stage 3 or 4 non-mucinous 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's National Disease Registration service.

What the quality statement means for different audiences

Service providers (secondary and tertiary gynaecology services) ensure that tumour genetic testing in adults newly diagnosed with stage 3 or 4 non-mucinous high-grade epithelial ovarian cancer is offered in accordance with local pathways and protocols.

Healthcare professionals (members of gynaecology oncology multidisciplinary teams, clinical geneticists supporting mainstream services or genetic counsellors) have access to tumour genetic testing and are aware of local pathways and protocols.

Commissioners ensure that they commission services that can provide tumour genetic testing for adults newly diagnosed with stage 3 or 4 non-mucinous high-grade epithelial ovarian cancer, in line the NHS England's national genomic test directory. They monitor providers to ensure that testing is offered, and when it is taken up, it is carried out at the time of diagnosis.

Adults newly diagnosed with stage 3 or 4 non-mucinous high-grade epithelial ovarian cancer are offered genetic testing of their tumour. The testing of tumour tissue enables

gene variants to be detected. Having the results soon after diagnosis means that the person has the best options available to them when considering first-line treatment.

Source guidance

- National genomic test directory. NHS England (2025)
- 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
- Several NICE technology appraisals refer to treatments that involve further testing to guide treatment options. See NICE's guideline on ovarian cancer: recognition and initial management, sections 1.5 and 1.6

Definitions of terms used in this quality statement

Tumour genetic 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 (around two-thirds) of variants detected in tumours are inherited (germline); around one-third are present in the tumour only. Details of tumour tests are available through NHS England's national genomic test directory. [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; British Gynaecological Cancer Society and British Association of Gynaecological Pathology's consensus for germline and tumour testing for BRCA1/2 variants in ovarian cancer in the United Kingdom, introduction; and expert opinion]

Equality and diversity considerations

Differences in uptake of genetic testing by ethnic group was identified as an equalities issue during development of the quality standard. It is important that information is provided to reduce barriers limiting understanding around genetic testing. This can be addressed by providing educational resources, in multiple languages, such as:

- genetic testing after cancer diagnosis: information for patients with cancer (written information)
- videos around genetic testing.

These resources have been developed by Ovarian Cancer Action's IMPROVE-UK programme Demonstration of Improvement for Molecular Ovarian Cancer Testing (DEMO) in collaboration with Sandwell and West Birmingham NHS Trust, in conjunction with the Cancer Research UK Cambridge Centre. They have not been produced by NICE and are not maintained by NICE. We have not made any judgement about the quality and usability of the resources. Other resources may also be available.

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

Quality statement

Adults with high-risk stage 1 ovarian cancer, or stage 2 to 4 ovarian cancer, have both surgery and chemotherapy discussed as a treatment option by a specialist gynaecological cancer multidisciplinary team. **[new 2025]**

Rationale

It is important that treatment with a combination of surgery and chemotherapy is discussed as an option by the specialist gynaecological cancer multidisciplinary team (MDT) when adults with ovarian cancer are reviewed for treatment. Surgery with chemotherapy is associated with improved survival or reduced risk of recurrence. The discussion of this treatment option by a team of healthcare professionals supports adults having the opportunity to be treated with a combination of surgery and chemotherapy. Some adults, however, may not benefit from a combination of surgery and chemotherapy, may be too unwell or may decline this treatment option.

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 outcome measures within equality groups, such as age and comorbidity.

Process

Proportion of adults with a diagnosis of high-risk stage 1, or stage 2 to 4, ovarian cancer who have surgery and chemotherapy discussed as a treatment option by a specialist gynaecological cancer MDT.

Numerator – the number in the denominator who have surgery and chemotherapy discussed as a treatment option by a specialist gynaecological cancer MDT.

Denominator – the number of adults with a diagnosis of high-risk stage 1, or stage 2 to 4, ovarian cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, from patient records and records of multidisciplinary team meetings. The Cancer Outcomes and Services Data set (COSD) sets out standards for data to be collected on MDT meetings and care planning.

Outcome

a) Proportion of adults with a diagnosis of high-risk stage 1, or stage 2 to 4, ovarian cancer who received surgery.

Numerator – the number in the denominator who received surgery.

Denominator – the number of adults with a diagnosis of high-risk stage 1, or stage 2 to 4, ovarian cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. Data is collected by NHS England, in the National Cancer Registration Dataset (NCRD)'s data on cancer treatments and Hospital Episode Statistics (HES) Admitted Patient Care (APC) dataset. The National Ovarian Cancer Audit collects data on the percentage of patients with stage 2 to 4 and unstaged non-borderline ovarian cancer who received surgery within 1 to 9 months of diagnosis.

b) Proportion of adults with a diagnosis of high-risk stage 1, or stage 2 to 4, ovarian cancer who received chemotherapy.

Numerator – the number in the denominator who received chemotherapy.

Denominator – the number of adults with a diagnosis of high-risk stage 1, or stage 2 to 4, 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 chemotherapy for all stages of ovarian cancer is collected by NHS England, in the HES APC and outpatient (OPC) datasets and the NDRS's data on cancer treatments and systemic Anti-Cancer Therapy (SACT) dataset. The National Ovarian Cancer Audit collects data on the percentage of patients with stage 2 to 4 and unstaged non-borderline ovarian cancer who received chemotherapy within 1 to 9 months of diagnosis.

c) Proportion of adults with a diagnosis of high-risk stage 1, or stage 2 to 4, ovarian cancer who received surgery and chemotherapy.

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

Denominator – the number of adults with a diagnosis of high-risk stage 1, or stage 2 to 4, 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 chemotherapy for all stages of ovarian cancer is collected by NHS England, in the HES APC and outpatient (OPC) datasets and the NDRS's data on cancer treatments and SACT dataset. The National Ovarian Cancer Audit collects data on the percentage of patients with stage 2 to 4 and unstaged non-borderline ovarian cancer who received surgery and chemotherapy within 1 to 9 months of diagnosis.

What the quality statement means for different audiences

Service providers (secondary and tertiary gynaecology services) ensure that referral and management pathways and network policies are in place so that adults with high-risk stage 1, or stage 2 to 4, ovarian cancer have both surgery and chemotherapy discussed as a treatment option by a specialist gynaecological cancer MDT. They ensure that referral pathways are in place so that adults are referred to a specialist gynaecological cancer centre for surgery and, depending 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, or stage 2 to 4, ovarian cancer have both surgery and chemotherapy discussed as a treatment option by a specialist gynaecological cancer MDT. They are aware of local protocols to ensure referral

to a specialist gynaecological oncology centre for surgery and, depending on local arrangements and resource, chemotherapy.

Commissioners have clinical protocols and network policies in place to ensure that adults with high-risk stage 1, or stage 2 to 4, ovarian cancer have both surgery and chemotherapy discussed as a treatment option by a specialist gynaecological cancer MDT. They commission services that can offer surgical procedures and recommended chemotherapy regimens, depending on the type, stage and grade of ovarian cancer.

Adults with high-risk stage 1, or stage 2 to 4, ovarian cancer are given the opportunity to decide whether they are treated with a combination of surgery and chemotherapy through review by a team of healthcare professionals.

Source guidance

- Ovarian, tubal and primary peritoneal cancer guidelines: recommendations for practice update 2024. British Gynaecological Cancer Society (2024), recommendations on page 85 ('approach to surgery', first recommendation listed); page 95 ('borderline tumours', first recommendation listed); page 97 ('germ cell tumours', first recommendation listed); page 100 ('sex-cord stromal tumours', first recommendation listed)
- Management of epithelial ovarian cancer. Scottish Intercollegiate Guidelines Network (SIGN) guideline 135 (2013, updated 2018), recommendation page 21, section 5.4.2
- Ovarian cancer: recognition and initial management. NICE guideline CG122 (2011, updated 2023), recommendations 1.2.2.1

Definitions of terms used in this quality statement

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
- cytoreductive primary or secondary (debulking) surgery.

[NICE's guideline on ovarian cancer: recognition and initial management, recommendation 1.4.1.1, 1.4.1.2 and 1.5.1.1; 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 (GCT) recommendations; GCT surgery, GCT systematic therapy and GCT follow-up (commentaries); sex-cord stromal tumours (SCST) recommendations; and management of suspected early-stage disease and management of advanced-stage and recurrent SCST (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 1.4.1.1, 1.4.1.2 and 1.5.1.1, and British Gynaecological Cancer Society's ovarian, tubal and primary peritoneal cancer guidelines: recommendations for practice update 2024, GCT recommendations; GCT surgery, GCT systematic therapy and GCT follow-up (commentaries); SCST recommendations; and management of suspected early-stage disease and management of advanced-stage and recurrent SCST (commentaries)].

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.

Minor changes since publication

April 2025: Source guidance references were updated to align with changes to NICE's guideline on ovarian cancer: recognition and initial management.

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 products 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.

For all quality statements where information is given, it is important that people are provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter if needed. People should also have access to an advocate, if needed, as set out in NICE's guideline on advocacy services for adults with health and social care needs.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

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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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Gynaecological Cancer Society (BGCS)
- Royal College of Pathologists
- Institute of Biomedical Science (IBMS)
- UK Cancer Genetics Group