



**Clinical Standards ~ March 2008**

**Management of ovarian cancer services**

NHS Quality Improvement Scotland is committed to equality and diversity. We have assessed this area of work for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. An equality and diversity impact assessment report has been published along with these standards and is available online or in hardcopy upon request.

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## 1 Introduction

Cancer services are provided by a wide range of individuals and organisations (statutory and voluntary), throughout Scotland: from primary care, through secondary and tertiary care, regional centres such as the Beatson Oncology Centre in Glasgow and local hospices/specialist palliative care units. Cancer treatment and care is highly dependent on other core NHS services, such as diagnostics and imaging, and therefore cannot be planned or managed in isolation. The role and importance of others in the delivery of cancer care and the provision of cancer services should also be noted, for example, community pharmacists and dentists.

In July 2001, the then Scottish Executive Health Department (SEHD), now the Scottish Government Health Directorates (SGHD), published its cancer strategy, *Cancer in Scotland: Action for Change*<sup>1</sup>. This document sets the context in which NHSScotland should plan activity to improve the services for people across Scotland. The commitment of the then SEHD to tackle cancer in Scotland was emphasised by the new resources that accompanied the cancer strategy, and were allocated specifically to improve cancer services. These funds were distributed through Regional Cancer Advisory Groups (RCAGs), supported by Regional Cancer Networks. Each Regional Cancer Network reports to the Scottish Cancer Group (SCG) via its RCAG.

### Objective

In May 2004, *Cancer in Scotland: Sustaining Change*<sup>2</sup> was published by SEHD to highlight progress made since the original strategy was published in 2001, and to identify new challenges facing the service. To support NHSScotland in the continuous improvement of cancer services, NHS Quality Improvement Scotland (NHS QIS) agreed to revise and update the four tumour specific cancer standards: breast, colorectal (bowel), lung and gynaecological (ovarian) cancer, first developed in 2001.

## **2 Development of the clinical standards for management of ovarian cancer services**

In 2001, the Clinical Standards Board for Scotland (CSBS, one of the organisations drawn together to form NHS QIS) produced standards for breast, colorectal, gynaecological (ovarian) and lung cancer. Peer review visits to assess performance against the four cancer standards were carried out throughout Scotland during 2001. Findings from these reviews were published by CSBS in 2002, in the form of local NHS board reports and a national overview.

The standards for core cancer services draw together common elements of service provision covered by the original standards, and these have been updated in light of developments in the service. NHS QIS began revisions of the four original tumour specific cancer standards in 2006, with the clinical standards for ovarian cancer services forming part of this work.

The revision of clinical standards for ovarian cancer services has been the responsibility of NHS QIS, taking into account advice from SGHD and in consultation with NHS organisations.

Under the direction of the core cancer services working group established by NHS QIS, a clinical adviser was appointed to oversee the revision of the ovarian cancer standards. A small working group was then convened to re-examine the evidence base on which the 2001 gynaecological (ovarian) cancer standards were developed, and to revise the standards in light of changes in current best practice and clinical advancements.

### **Evidence base**

During the revision of the clinical standards for management of ovarian cancer services, the working group considered a wide range of evidence, which is fully referenced in Chapter 4 (References).

The following standards, local reports and national overview formed the core evidence reviewed by the project group.

- **Clinical standards: ovarian cancer**<sup>3</sup>
- **Local reports: ovarian cancer services**<sup>4</sup>
- **National overview: ovarian cancer**<sup>5</sup>
- **National Standards: Clinical Governance and Risk Management: Achieving Safe, Effective, Patient-Focused Care and Services**<sup>6</sup>
- **Draft core standards for cancer services**<sup>7</sup>

**Relevance to standards development:** A review of these documents determined the scope of the clinical standards, to establish equity of care and the best possible condition management for patients, no matter where they live. The group considered how these standards should be applied at an operational level, and ensured that duplication would not occur across the above standards.

- **NHS HDL(2007)21: Strengthening the role of managed clinical networks**<sup>8</sup>
- **Quality assurance frameworks for north of Scotland cancer network (NOSCAN)<sup>9</sup>, south east Scotland cancer network (SCAN)<sup>10</sup> and west of Scotland cancer network (WOSCAN)<sup>11</sup>**

**Relevance to standards development:** The frameworks provide quality assurance measures for all staff involved in the delivery of care in cancer services and are tailored on a regional basis. The frameworks for the three regional cancer networks were reviewed to prevent duplication within the standards.

- **Cancer Scenarios: An aid to planning cancer services in Scotland in the next decade**<sup>12</sup>
- **Cancer in Scotland: Action for Change**<sup>1</sup>
- **Cancer in Scotland: Sustaining Change**<sup>2</sup>
- **Cancer waiting times: National delivery plan**<sup>13</sup>

**Relevance to standards development:** These documents guide operating divisions and clinicians to implement the measures necessary to improve cancer services. Awareness of the recognised processes across NHSScotland is important when developing standards. It helped the working group to develop a practical tool for supporting continuous quality improvement, taking into account how services are delivered and monitored. Further guidance to support the introduction of Cancer in Scotland: Action for Change is available in two Health Department Letters, HDL(2001)54<sup>14</sup> and HDL(2001)71<sup>15</sup>.

### **Standards development**

To take forward the revision of the standards, NHS QIS appointed a working group to review the evidence and use it to inform the revision of the clinical standards. The group was chaired by Dr Jo Davis, Consultant Gynaecological Oncologist, NHS Greater Glasgow and Clyde. Full membership of the group can be found in Appendix 3.

### **Consultation**

Following publication of the Draft Clinical Standards for Ovarian Cancer<sup>16</sup> in October 2007, consultation was undertaken. During this period professional groups, health service staff, voluntary organisations and individuals were given the opportunity to influence the development of the standards.

### **Finalising the standards**

Following consultation each written comment and all feedback on the draft standards were used by the working group to produce final standards.

### **3 Clinical standards for management of ovarian cancer services**

**Standard 1 Referral process**

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**Standard 2 Investigations and assessment**

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**Standard 3 Multidisciplinary working**

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**Standard 4 Audit**

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**Standard 5 Preoperative preparations**

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**Standard 6 Surgical treatment**

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**Standard 7 Postoperative management**

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**Standard 8 Postoperative management - pathology**

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## Standard 1: Referral process

### Standard Statement 1a

Where the referring physician is suspicious of ovarian cancer, there is an agreed urgent referral pathway to the local gynaecological department.

#### Rationale

When ovarian cancer is suspected, rapid referral to the gynaecological department is essential.

References: 17, 18, 19, 20, 21, 22, 23, 24

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#### Essential Criteria

- 1a.1 There are formal referral arrangements, including electronic referral, jointly agreed between general practitioners (GPs) and gynaecologists working within the multidisciplinary team (MDT), for patients with suspected ovarian cancer.
- 1a.2 For intra-departmental referrals where ovarian cancer is suspected, there are formal arrangements agreed to ensure urgent referral to specialists working within the MDT.
- 1a.3 The referral protocol includes the following circumstances which require urgent investigation:
  - a clinically palpable pelvic mass
  - ascites
  - a pelvic mass diagnosed by ultrasound/computed tomography(CT)/magnetic resonance imaging (MRI).
- 1a.4 Where ovarian cancer is suspected, first review of urgent cases by the gynaecologist occurs within 10 working days of referral.

#### Desirable Criteria

- 1a.5 Where there is a suspicion of ovarian cancer, there is a system in place for the GP to request urgent abdominal and pelvic ultrasound in parallel with referral to the gynaecologist so that results are available to the gynaecologist at the time of first review.
- 1a.6 If abdominal and/or pelvic ultrasound suggests the possibility of ovarian cancer then direct referral from the radiology/ultrasound department is made to the gynaecology department.

## Standard 2: Investigations and assessment

### Standard Statement 2a

Once ovarian cancer is suspected, standard investigations are undertaken and results made available so that first treatment can be offered within a stated maximum time.

#### Rationale

Early confirmation of ovarian or primary peritoneal cancer enables urgent treatment to be arranged.

References: 24, 25, 26, 27

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#### Essential Criteria

- 2a.1 The following basic investigations are undertaken once ovarian cancer is suspected or an ovarian mass is identified:
- Cancer antigen (CA) 125, and
  - abdominal and pelvic ultrasound (unless prior imaging by CT).
- 2a.2 Abdominal and pelvic ultrasound reports include sufficient information to enable the risk of malignancy index (RMI) to be calculated, including the presence or absence of the following ultrasound features associated with an ovarian mass:
- multilocular cyst
  - solid areas
  - bilateral lesions
  - ascites, and
  - intra-abdominal metastases.
- 2a.3 The RMI is calculated using preoperative CA125 level, menopausal status and abdominal and pelvic ultrasound findings.
- 2a.4 If the RMI exceeds 200 and ultrasound indicates the presence of a complex mass and/or extra ovarian disease, the following investigations are undertaken:
- CT scan of abdomen and pelvis (to include lung bases), and
  - carcinoembryonic antigen (CEA).
- 2a.5 Assessment, investigations, treatment planning and first treatment are completed within 62 days of first referral and in accordance with SGHD guidelines.

## Standard 3: Multidisciplinary working

### Standard Statement 3a

The management of patients with ovarian cancer is multidisciplinary.

#### Rationale

Patients with cancer have complex needs, which cannot be addressed by a single speciality. To ensure co-ordination and appropriate management of these needs, it is essential that there is structured local and regional multidisciplinary working.

References: 8, 18, 19, 24, 28

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#### Essential Criteria

- 3a.1 In the NHS board area, there is a named lead clinician with responsibility for gynaecological cancer.
- 3a.2 Multidisciplinary management protocols are in place for ovarian cancer which:
  - have an implementation date set
  - are approved by the local/regional managed clinical network (MCN)
  - cover systems for referral, investigation, surgical and chemotherapy treatment and follow-up, and
  - are reviewed annually, considering any new evidence, using a process agreed by the MCN.
- 3a.3 There is a weekly MDT meeting at which all new patients with raised RMI and imaging showing a complex mass or extra ovarian disease are reviewed and discussed.
- 3a.4 All patients confirmed to have ovarian cancer after surgery are discussed at the MDT meeting and follow-up treatment organised.
- 3a.5 The following minimum constitution of the gynaecological cancer MDT meeting is:
  - consultant clinical oncologist with specialist interest in gynaecological cancer
  - consultant gynaecological oncologist
  - consultant medical oncologist with specialist interest in gynaecological cancer
  - consultant clinical pathologist with specialist interest in gynaecological cancer
  - consultant clinical radiologist with specialist interest in gynaecological cancer
  - clinical nurse specialist (CNS) in gynaecological oncology from each NHS board within the MDT, and
  - designated consultant lead gynaecologist, recognised by the regional MCN, from each NHS board within the MDT.

- 3a.6 There is a documented policy for the working and decision-making process of the MDT meeting to include:
- frequency of meetings and meeting times
  - chair and membership
  - referral process
  - decision and data recording
  - communication with hospital clinicians, GPs and patients
  - data management
  - organisational and managerial responsibilities, and
  - IT and technical support.
- 3a.7 A printed record of the MDT decision is made for each patient, filed in the patient's notes and is sent to all involved clinicians, including the patient's GP, within 1 working day of the MDT meeting.
- 3a.8 There are locally agreed standards of care for ovarian cancer covering all aspects of cancer nursing practice.

**Desirable Criteria**

- 3a.9 There is radiology and pathology specialisation within the NHS board.
- 3a.10 The national generic clinical system is used for ovarian cancer.
- 3a.11 There is more than one representative of each specialty present at the MDT meeting to aid discussion.

## **Standard 4: Audit**

### **Standard Statement 4a**

Prospective clinical audit is an integral part of ovarian cancer services.

#### **Rationale**

Clinical audit is a continuing process that helps to identify clinically important variations in practice and encourages examination of the reasons for these. It identifies the changes required to effect improvements. It is, therefore, integral to the process of implementing guidelines and standards.

References: 29, 30

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#### **Essential Criteria**

- 4a.1 There is a continuous collection of the nationally agreed ovarian cancer core datasets to facilitate audit.
- 4a.2 There is annual reporting of case-mix and outcome including 1, 2, and 5-year survival rates for ovarian cancer.

## Standard 5: Preoperative preparations

### Standard Statement 5a

All ovarian cancer patients undergoing surgery have appropriate preoperative preparation and planning.

#### Rationale

Patients undergoing gynaecological surgery may benefit from a High Dependency Unit and an Intensive Therapy Unit.

Preoperative preparation is necessary to minimise complications.

References: 24, 31, 32, 33, 34

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#### Essential Criteria

5a.1 Preparation for surgery includes:

- chest X-ray
- preoperative deep vein thrombosis (DVT) prophylaxis
- antibiotic prophylaxis as determined by local unit policy and the principles of SIGN Guideline 45
- advice and preparation for colostomy if bowel involvement is suspected, and
- dedicated theatre time allocated in advance.

5a.2 All gynaecological units operating on patients with ovarian cancer have access to both a High Dependency Unit (HDU) and an Intensive Therapy Unit (ITU).

#### Desirable Criterion

5a.3 Epidural service is available for intra and postoperative pain control.

## Standard 6: Surgical treatment

### Standard Statement 6a

All patients with a suspected diagnosis of ovarian cancer are operated on by a designated and trained gynaecological surgeon.

#### Rationale

Specialist surgery improves outcome.

References: 24, 35

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#### Essential Criteria

- 6a.1 The NHS board has trained gynaecologists who deal with ovarian cancer and are recognised by the MCN advisory board.
- 6a.2 All patients with clinical, radiological or histological evidence of extra ovarian disease are operated on by a gynaecological oncologist.

#### Desirable Criterion

- 6a.3 All ovarian cancer patients are operated on by a gynaecological oncologist.

### **Standard Statement 6b**

In young women, aged 30 years or less, the possibility of germ cell tumours is considered.

#### **Rationale**

Primary surgical procedure is different in this group of women.

Reference: 36

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#### **Essential Criteria**

- 6b.1 Young women suspected of having ovarian cancer have specific tumour markers taken and are referred to MDT:
- alpha-fetoprotein ( $\alpha$ FP)
  - human chorionic gonadotropin (hCG)
  - lactate dehydrogenase (LDH), and
  - CA125.
- 6b.2 Following discussion at MDT, young women suspected of having a germ cell tumour are referred preoperatively to the regional gynaecological oncology centre.
- 6b.3 Fertility-conserving surgery is planned and performed at laparotomy.
- 6b.4 If germ cell tumour is confirmed, the patient is referred to the MDT for the planning of postoperative treatment.

#### **Desirable Criterion**

- 6b.5 Frozen section assessment of cystic lesions are available at the time of laparotomy.

## Standard 6: Surgical treatment

### Standard Statement 6c

All ovarian cancer patients undergoing laparotomy have an appropriate surgical procedure carried out to ensure complete staging can be made.

#### Rationale

Surgery is a major part in the management of ovarian cancer. The timing of surgical intervention is dependent on initial assessment, which includes fitness and disease resectability. Some patients are now offered delayed primary surgery to improve outcome.

References: 24, 31

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#### Essential Criteria

- 6c.1 A vertical incision is made.
- 6c.2 Washings are taken or ascitic fluid sent for cytology examination.
- 6c.3 Optimal cytoreductive surgery is attempted and includes a hysterectomy and bilateral salpingo-oophorectomy (if not performed, the reason to be recorded in the patient's records).
- 6c.4 Infracolic omentectomy is performed.
- 6c.5 A record of residual disease is made in the operation notes.
- 6c.6 All surgically-removed specimens are sent labelled for pathological assessment.
- 6c.7 International Federation of Gynecology and Obstetrics (FIGO) surgical stage is recorded in the operation notes.
- 6c.8 The final FIGO surgical pathological stage is recorded in the clinical notes.

## Standard 7: Postoperative management

### Standard Statement 7a

Where surgical services for ovarian cancer are provided there are specialist staff working in a designated facility.

#### Rationale

Patients requiring major surgery for ovarian cancer have specialist needs in the postoperative period.

Reference: 37

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#### Essential Criteria

- 7a.1 Patients are nursed postoperatively by nurses with training in gynaecological oncology.
- 7a.2 Patients have access to a specialist palliative care team.

#### Desirable Criteria

- 7a.3 Within gynaecological oncology centres, gynaecology oncology patients have designated ward areas.
- 7a.4 Within gynaecological oncology centres, patients are reviewed daily by a gynaecological oncologist.

## Standard 8: Postoperative management - pathology

### Standard Statement 8a

A standard minimum pathological report based on careful macroscopic and microscopic examination, description and sampling is issued.

#### Rationale

A standard minimum pathological report is issued.

References: 31, 38, 39, 40

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#### Essential Criteria

- 8a.1 Macroscopic features sufficient to inform FIGO surgical/pathological staging are recorded (eg capsule rupture, surface tumour, adhesions).
- 8a.2 Microscopic examination is based on adequate samples of the primary tumour, other submitted pelvic organs, and any metastatic deposits.
- 8a.3 Histological type, sub-type (where appropriate) and grade of disease are recorded.
- 8a.4 All cases of ovarian cancer and borderline ovarian tumours are reviewed at regional gynaecological oncology MDT meetings.

#### Desirable Criteria

- 8a.5 Fluid cytology is reported with the main resection specimen.
- 8a.6 Tumour histopathology is undertaken, or reviewed at the MDT, by a consultant pathologist who specialises in gynaecological pathology.

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## **5 Appendices**

**Appendix 1 About NHS Quality Improvement Scotland**

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**Appendix 2 NHS Quality Improvement Scotland standards development methodology**

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**Appendix 3 Membership of the clinical standards for management of ovarian cancer services working group**

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**Appendix 4 Glossary**

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## Appendix 1: About NHS Quality Improvement Scotland

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland.

We achieve our objectives through five key functions that link together:

- providing clear advice and guidance on effective clinical practice
- setting clinical and non-clinical standards of care
- reviewing and monitoring the performance of NHS services
- supporting NHS staff in improving services, and
- promoting patient safety and implementation of clinical governance.

We deliver our commitments to the public and to NHSScotland by following an approach that is:

- **independent** – we reach our own conclusions and report on what we find
- **open and transparent** – we explain what we do, how and why we do it, and what we find, using language and formats that are easy to understand and to access
- **sensitive and professional** – we recognise needs, beliefs and opinions and respect and encourage diversity.

Our work is:

- **partnership-focused** – we work with patients and the public, NHSScotland and many organisations to improve the quality of care and avoid duplication
- **evidence-based** – we base our conclusions and recommendations on the best evidence available as indicated in Chapter 2 (Development of the clinical standards for management of ovarian cancer services : evidence base).
- **quality-driven** – we make sure our own work is monitored and evaluated, internally and externally.

## Appendix 2: NHS Quality Improvement Scotland standards development methodology

### Basic principles

A major part of our remit is to develop and run a national system of quality assurance of clinical services. Working in partnership with healthcare professionals and members of the public, we set standards for clinical services, assess performance throughout NHSScotland against these standards, and publish the findings. The standards are based on the patient's journey as he or she moves through different parts of the health service. A wide range of conditions and services have already been addressed, including asthma services for children and young people and bowel screening programme.

In fulfilling our responsibility to develop and run a system of quality assurance, we take account of the principles set out in Fair for All<sup>41</sup> and Partnership for Care<sup>42</sup>, to ensure that 'our health services recognise and respond sensitively to the individual needs, background and circumstances of people's lives'.

We will ensure that consideration of equality and diversity issues feature prominently in the design, development and delivery of all our functions and policies.

The standards are developed in accordance with the commitments of the National Health Service Reform (Scotland) Act 2004<sup>43</sup> which state that 'individual patients receive the service they need in the way most appropriate to their personal circumstances and all policy and service developments are shown not to disadvantage any of the people they serve'.

### Process

For each set of standards we develop, we appoint a group representing a range of stakeholders, including healthcare professionals and members of the public, to:

- oversee the development of, and consultation on, the standards and self-assessment framework, and
- recommend an external peer review process.

The way in which standards are developed is a key element of the quality assurance process. Project groups working on our behalf are expected to:

- adopt an open and inclusive process involving members of the public, voluntary organisations and healthcare professionals
- work within NHS QIS policies and procedures, and
- test the measurability of draft standards by undertaking pilot reviews.

The standards are clear and measurable, based on appropriate evidence, and written to take into account other recognised standards and clinical guidelines. The standards are:

- written in simple language and available in a variety of formats
- focused on clinical issues and include non-clinical factors that impact on the quality of care
- developed by healthcare professionals and members of the public, and consulted on widely
- regularly reviewed and revised to make sure they remain relevant and up to date, and
- achievable but stretching.

### Format of standards and definition of terminology

All our standards follow the same format.

- Each standard has a **title**, which summarises the area on which that standard focuses.
- This is followed by the **standard statement**, which explains the level of performance to be achieved.
- The **rationale** section provides the reasons why the standard is considered to be important.
- The standard statement is expanded in the section headed **criteria**, which states exactly what must be achieved for the standard to be reached. Criteria are **essential**, in that it is expected that they will be met wherever a service is provided. Other criteria are **desirable**, in that they are being met in some parts of the service and demonstrate levels of quality, which other providers of a similar service should strive to achieve. The criteria are numbered for the sole reason of making the document easier to work with, particularly for the assessment process. The numbering of the criteria is not a reflection of priority.

### Clinical governance and risk management standards

Every patient using healthcare services should expect these to be safe and effective. The NHS QIS standards for clinical governance and risk management<sup>6</sup> will ensure NHS boards can provide assurance that clinical governance and risk management arrangements are in place, and are supporting the delivery of safe, effective, patient-focused care and services.

These standards underpin all care and services delivered by NHSScotland and provide the context within which NHS QIS service and condition-specific standards apply. They should be read in conjunction with all our standards.

The clinical governance and risk management standards are available on request from NHS QIS or can be downloaded from the website ([www.nhshealthquality.org](http://www.nhshealthquality.org)).

### Assessment of performance against the standards

The framework for the NHS QIS review process is as follows.

- Once the current cancer standards have been finalised, these will link into the accreditation of regional managed clinical networks for cancer.
- With the need for a cohesive and comprehensive approach to continual improvement based on these standards, the subsequent measurement, and assessment and reporting of the standards from a local, regional and nationwide perspective will be adopted, with support provided by Information Services Division, NHS National Services Scotland.
- Ongoing monitoring of the standards will be a function of the networks with NHS QIS intervening if there were concerns regarding data. Occasional visits may be undertaken by NHS QIS on a regional basis to test the system.

Our processes are subject to internal and external evaluation, to help improve the quality assurance system.

### Revision of the standards

NHS QIS standards are considered for revision and updating every 3 years. If a revision of a set of standards is undertaken the original standards will be withdrawn and the revised standards would be considered for further updating every 3 years thereafter. Please check the status of these standards with the Standards Development Unit if they are past the 3 years revision date.

### Appendix 3: Membership of the clinical standards for management of ovarian cancer services working group

Name	Title	NHS board area/ organisation
Dr Jo Davis (Chair)	Consultant Gynaecological Oncologist	NHS Greater Glasgow and Clyde
Dr Sonia Devereux	Macmillan Lead Cancer GP	NHS Tayside
Dr Donna Edwards	Consultant Radiologist	NHS Lanarkshire
Mrs Diane Fleming	Managed Clinical Network Co-ordinator (retired)	
Dr Rosalind Glasspool	Consultant Medical Oncologist	NHS Greater Glasgow and Clyde
Miss Jennifer Godsman	Cancer Audit Manager	NHS Highland
Mrs Linda Johnston	Gynaecology/Oncology Specialist Nurse	NHS Forth Valley
Dr Clare McKenzie	Consultant Gynaecologist	NHS Tayside
Mrs Fiona Mitchell	Director of Operations (Medical & Associated Services)	NHS Lothian
Dr Graeme Walker	Gynaecological Oncology Fellow	NHS Lothian

Support from NHS QIS in developing these clinical standards was provided by the Standards Development Unit: Mrs Anne Coote (Project Administrator), Ms Hilary Davison (Head of Standards Development Unit), Ms Clare Echlin (Senior Project Officer), Miss Ali McAllister (Project Officer) and Mrs Stacey Moffat (Project Officer) until January 2008.

## Appendix 4: Glossary

<b>acute care</b>	Refers either to a pattern of healthcare in which a patient is treated for an acute (immediate and severe) episode of illness, or to the subsequent treatment of injuries related to an accident or other trauma, or care during recovery from surgery. Acute care is usually given in a hospital by specialised personnel using complex and sophisticated technical equipment and materials, and is often necessary for only a short time.
<b>alpha-fetoprotein (αFP)</b>	A human protein that can be used as a tumour marker. The level produced by certain tumours permits monitoring of the response to treatment of these tumours.
<b>antibiotic prophylaxis</b>	The administration of antibiotics to reduce the prospect of infection.
<b>ascites</b>	Accumulation of fluid in the abdominal cavity.
<b>audit</b>	The measuring and evaluation of care against best practice with a view to improving current practice and care delivery.
<b>bilateral (lesions)</b>	On both sides.
<b>bilateral salpingo-oophorectomy</b>	Removal of both (bilateral) ovaries and tubes at a surgical procedure.
<b>bowel</b>	A tube-like structure running in its upper part from the stomach to the anus. It allows digestion of food and the discharge of waste products.
<b>cancer</b>	The name given to a group of diseases that can occur in any organ of the body, and in blood, and which involve abnormal uncontrolled growth of cells.
<b>cancer antigen (CA) 125</b>	A tumour marker measured by a blood test.
<b>cancer centres</b>	Cancer services are based in cancer centres. Such centres provide the entire spectrum of cancer care – both on-site and to associated cancer units.
<b>carcinoembryonic antigen (CEA)</b>	A special type of protein, it can be found in the blood of patients suffering from certain diseases. CEA is otherwise normally found in fetal gut tissue.
<b>case-mix</b>	Population of patients with different prognostic factors.
<b>clinical governance</b>	Ensures that patients receive the highest quality of care possible, putting each patient at the centre of his or her care. This is achieved by making certain that those providing services work in an environment that supports them and places the safety and quality of care at the top of the organisation's agenda.  Management of clinical risk at an organisational level is an important aspect of clinical governance. Clinical risk management recognises that risk can arise at many points in a patient's journey, and that aspects of how organisations are managed can systematically influence the degree of risk.
<b>clinical nurse specialist</b>	A clinical nurse specialist is a registered nursing professional who has acquired additional knowledge, skills and experience, together with a professionally and/or academically accredited post-registration qualification (if available) in a clinical specialty. They practice at an advanced level and may have sole responsibility for a care episode or defined client/group.

<b>Clinical Standards Board for Scotland (CSBS)</b>	The Clinical Standards Board for Scotland was a statutory body, established as a Special Health Board in April 1999. Its role was to develop and run a system of quality control of clinical services designed to promote public confidence that the services provided by the NHS met nationally agreed standards, and to demonstrate that, within the resources available, the NHS was delivering the highest possible standards of care. On 1 January 2003, CSBS was merged, along with four other clinical effectiveness bodies, to form NHS Quality Improvement Scotland (NHS QIS).
<b>colostomy</b>	An opening created by a surgeon into the colon from the outside of the body; provides a new path for waste material to leave the body. The colostomy may be temporary, eventually being closed after weeks or months to restore continuity; or permanent, usually when the rectum or lower colon has been removed. An appliance is worn over the colostomy opening (stoma) to collect the faeces and to prevent soiling of clothes.
<b>computed tomography (CT)</b>	An X-ray imaging technique used in diagnosis that can reveal many soft tissue structures not shown by conventional radiography. A computer is used to assimilate multiple X-ray images into a two-dimensional cross-sectional image.
<b>cytology</b>	The study of the structure and function of cells under the microscope, and of their abnormalities (cytopathology).
<b>cytoreductive surgery</b>	Removal of the major portion of the material composing a lesion.
<b>dataset</b>	A list of required and specific information relating to a single disease.
<b>deep vein thrombosis (DVT) prophylaxis</b>	Measures taken to reduce the prospect of the formation of blood clots in the deep veins of the legs or pelvis after an operation.
<b>generic clinical system</b>	A tool kit for the development of specialist clinical applications.
<b>germ cell tumours</b>	Tumours of the reproductive cells.
<b>guidelines (non-clinical)</b>	A document which presents operational good practice in a way that can guide day-to-day activities within an organisation.
<b>gynaecologist</b>	A medical doctor who specialises in gynaecology.
<b>gynaecology</b>	A branch of medicine dealing with the diagnosis and treatment of disorders affecting the female reproductive organs.
<b>Health Department Letter (HDL)</b>	A formal communication from the former Scottish Executive Health Department (SEHD) to NHSScotland, previously known as a Management Executive Letter - MEL.
<b>high dependency unit (HDU)</b>	Intensive care: advanced and highly specialised care provided to medical or surgical patients whose condition is life-threatening and who need comprehensive care and constant monitoring. It is usually administered in specially equipped units of a health care facility.
<b>histological grade</b>	The degree of similarity of the cancer cells to normal cells when examined under the microscope.
<b>histology/histopathology</b>	The study of the structure, composition and function of tissues under the microscope, and of their abnormalities (histopathology).
<b>human chorionic gonadotropin (hCG)</b>	A hormone made by cells in the placenta.
<b>hysterectomy</b>	Surgical removal of the uterus and cervix, performed either through the abdominal wall or through the vagina.
<b>Information Services Division (ISD)</b>	Part of NHS National Services Scotland. Health service activity, manpower and finance data are collected, validated, interpreted and distributed by ISD. These data are received from NHS boards and general practices. Website address: <a href="http://www.isdscotland.org">www.isdscotland.org</a>

<b>infracolic omentectomy</b>	The removal of part of the omentum, which is a membrane connecting the stomach with other abdominal organs.
<b>intensive therapy unit (ITU)</b>	An area of a hospital to which patients are admitted for treatment of actual or impending organ failure or with life-threatening complications.
<b>International Federation of Gynecology and Obstetrics (FIGO)</b>	An organisation which brings together professional societies of obstetricians and gynaecologists on a global basis. Its mission is to promote the wellbeing of women and to raise the standard of practice in obstetrics and gynaecology. Website address: <a href="http://www.figo.org">www.figo.org</a>
<b>lactate dehydrogenase (LDH)</b>	An enzyme with various forms depending on where it is produced in the body. Testing blood levels of LDH is useful in the evaluation of many disease processes.
<b>laparotomy</b>	General term for abdominal surgery. The operation is done to examine the abdominal organs as a help to diagnosis; for example, to establish the spread of a growth.
<b>lesion</b>	Any structural change in a bodily part resulting from injury or disease.
<b>lymph</b>	Almost colourless fluid that travels through the lymphatic system, bathing body tissues and carrying cells that help fight infection.
<b>lymph nodes</b>	Small bean-shaped organs located along the lymphatic system. Nodes filter bacteria or cancer cells that are travelling through the body.
<b>magnetic resonance imaging (MRI)</b>	An imaging technique used to image the internal structures of the body. The technique uses a large magnet to excite and then monitor atoms within cells, and is particularly useful for detecting some cancers and monitoring their progress
<b>managed clinical network (MCN)</b>	A formally organised network of clinicians. The main function is to audit performance on the basis of standards and guidelines, with the aim of improving healthcare across a wide geographic area, or for specific conditions.
<b>metastases</b>	The spread of tumour cells from one part of the body to another unrelated part of the body by the way of the bloodstream or lymphatics.
<b>multidisciplinary team (MDT)</b>	A multiprofessional group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The makeup of multidisciplinary teams will vary according to many factors. These include: the specific condition; the scale of the service being provided; and geographical/socio-economic factors in the local area.
<b>multilocular cyst</b>	A cyst containing several compartments formed by membranous septa.
<b>NHS board</b>	There are 21 NHS boards of two types: 14 territorial boards responsible for healthcare in their areas and seven special health boards which offer supporting services nationally.
<b>oncologist</b>	A doctor who specialises in the treatment of cancer patients. A clinical oncologist, or radiotherapist, specialises in treating cancer with radiation or drugs, and a medical oncologist specialises in treating cancer with drugs.
<b>oncology</b>	The branch of medicine devoted to the study of cancer and its diagnosis and treatment.
<b>outcome</b>	The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment, and/or rehabilitation.

<b>ovary</b>	The female organ that produces and stores the eggs required for reproduction.
<b>palliative care</b>	Palliative care is the active total care of patients and their families by a multiprofessional team when the patient's disease is no longer responsive to curative treatment.
<b>pathologist</b>	A specialist medical doctor who examines and diagnoses disease through studying cells and tissues.
<b>pathology</b>	The study of disease processes with the aim of understanding their nature and causes. This is achieved by observing samples of fluid and tissues obtained from the living patient by various methods, or at post mortem.
<b>peer review</b>	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the NHS QIS approach, all members of a review team are equal.
<b>policy</b>	The highest-level statement of intent and objectives within an organisation. A policy can also be a required process or procedure within an organisation.
<b>primary care</b>	The conventional first point of contact between a patient and the NHS. This is the care given to patients outside hospitals and is typically, though not always, delivered through general practices. Other providers include dentists, pharmacists, optometrists and ophthalmic medical practitioners. Primary care services are the most frequently used of all services provided by the NHS. See acute and secondary care.
<b>primary cytoreductive surgery</b>	An operation planned as an initial treatment to reduce the amount of cancer present. Usually refers to an operation for ovarian cancer.
<b>primary peritoneal cancer</b>	A cancer of the cells lining the peritoneum, or abdominal cavity.
<b>primary tumour</b>	Original site of the cancer. The mass of tumour cells at the original site of abnormal tissue growth.
<b>procedure</b>	Set operational instructions to regulate activity.
<b>prophylaxis</b>	Preventative treatment for a disease.
<b>prognosis</b>	An assessment of the expected future course and outcome of a person's disease.
<b>protocol</b>	Operational instructions which regulate and direct activity. Protocols may be national, or agreed locally to take into account local requirements.
<b>radiologist</b>	A qualified doctor trained in the technique of diagnosing disease by means of X-rays and other imaging methods.
<b>radiology</b>	The use of X-rays in the diagnosis, treatment and monitoring of disease.
<b>referral</b>	The process by which a patient is transferred from one professional to another, usually for specialist advice and/or treatment.
<b>Regional Cancer Advisory Groups (RCAGS)</b>	There are three Regional Cancer Advisory Groups – North, West and South East Scotland, each providing a strategic, advisory and planning focus for their respective locality cancer services and NHS boards.
<b>risk of malignancy index (RMI)</b>	A measure of the risk of a harmful tumour, based on combining the results of transvaginal ultrasound examination (U), with menopausal status (M), and blood levels of the ovarian cancer marker CA125.

<b>Scottish Cancer Group (SCG)</b>	Leads and directs the cancer services reconfiguration programme in Scotland. The SCG is a multidisciplinary group which advises Ministers, the Chief Medical Officer and the Scottish Government on the strategic priorities and objectives for the development of cancer services, including service quality, research and audit, clinical trial, and clinical effectiveness. The group also provides advice on trends in incidence and mortality, scientific advances and on the implementation of nationally agreed initiatives for the delivery of cancer services, programmes of prevention and screening. Website address: <a href="http://www.show.scot.nhs.uk/sehd/cancerinscotland/pages/SCgroupmeetings.htm">www.show.scot.nhs.uk/sehd/cancerinscotland/pages/SCgroupmeetings.htm</a>
<b>Scottish Government Health Directorates (SGHD)</b>	The SGHD is responsible for both NHSScotland and for the development and implementation of health and community care policy. It is also responsible for social work policy and for community care and voluntary issues. Website address: <a href="http://www.show.scot.nhs.uk/sghd">www.show.scot.nhs.uk/sghd</a>
<b>secondary care</b>	Hospital-based (acute) health services which are provided on an inpatient or outpatient basis. See acute care.
<b>staging</b>	The process of determining whether cancer has spread. Staging involves clinical, surgical, radiological and pathological assessment.
<b>tertiary care</b>	Specialised care, usually on referral from primary or secondary medical care personnel, by specialists working in a centre that has the personnel and facilities for special investigation and treatment.
<b>tumour</b>	An abnormal mass of tissue. A tumour may be either benign (not cancerous) or malignant (cancerous). Also known as a neoplasm.
<b>ultrasound</b>	An imaging test that bounces sound waves off tissues and converts the echoes into pictures.
<b>vertical incision</b>	An incision used in abdominal surgery. The incision is described as vertical because it runs lengthways, rather than across the abdomen.
<b>X-ray</b>	An imaging technique that uses energy beams of penetrating electromagnetic energy. This is the most common imaging technique used in clinical practice, with the image captured on photographic film or digitally.