

National Ovarian Cancer Audit (NOCA) Outlier Response 2026

NOCA Performance Indicator 7a	Case-mix adjusted one year survival (repeat alert: greater than two standard deviations from national average in three consecutive years)		
NHS Provider	Provider Response to NOCA Outlier Notification	Outlier in 2026 report	Outlier in 2025 report
<p>Sheffield Teaching Hospitals NHS Foundation Trust</p>	<p>Re: Potential Outlier Notification</p> <p>Thank you for your letter regarding the National Ovarian Cancer Audit (NOCA) analysis undertaken for the forthcoming <i>State of the Nation Report</i> to be published on 11 June 2026. We welcome the opportunity to review and respond to the findings and to contribute constructively to the quality-improvement aims of the audit process.</p> <p>We would like to emphasise at the outset that this response reflects a collective and collaborative effort from across the gynaecological oncology multidisciplinary team (MDT) within our cancer system. The data validation, case reviews, contextual analysis, and quality-improvement considerations outlined below have been undertaken with input from consultant gynaecological oncologists, oncology colleagues, specialist nurses, audit and data teams, and colleagues from our partner cancer units. This work has therefore not been undertaken in isolation, but represents a shared, system-wide review and response to the NOCA findings.</p> <p>We have carefully considered the notification that our gynaecological cancer system has been identified as a potential 'repeat alert' outlier for the indicator <i>one-year survival (case-mix adjusted)</i>. Our responses to your specific questions are set out below.</p>	<p>YES</p>	<p>NO (repeat alert not included in outlier policy)</p>
	<p>1. Accuracy of NOCA data compared with hospital records</p> <p>We have undertaken an initial review of the NOCA data submission against locally held hospital records and cancer registry data.</p> <p>As part of our detailed validation of the NOCA dataset for our gynaecological cancer system, we have identified two significant data-related issues that are likely to affect the accuracy and interpretation of the reported one-year survival outcomes.</p>		

	<ul style="list-style-type: none"> • Firstly, a number of patients included within the NOCA dataset do not have a confirmed histological diagnosis of ovarian cancer. Following multidisciplinary team (MDT) review, these patients have been classified locally as either Cancer of Unknown Primary (CUP) or as having metastatic disease from a non-gynaecological primary, such as lower gastrointestinal or breast cancer. In our view, inclusion of these cases within the ovarian cancer audit cohort is inappropriate and may adversely affect survival metrics. You have already indicated that these patients can be excluded from the dataset. We have reviewed the data extract provided by NOCA and annotated the relevant cases that, based on MDT classification, we believe should be excluded from the audit dataset. This annotated data sheet is enclosed for your consideration. • Secondly, we have identified 27 patients from affiliated cancer units in 2022 and 31 patients in 2023 within our wider cancer system who were not referred to, nor managed by, Sheffield Teaching Hospitals. Following discussions with each of the cancer units within our gynaecological cancer system, the NOCA team should now have received separate reports from each unit detailing patients whom they believe should be excluded from their respective datasets. These exclusions are in addition to those cases that we have already identified and highlighted within the annotated Sheffield Teaching Hospitals (STH) data sheet submitted to you. <p>The basis for these proposed exclusions is consistent across units and relates primarily to the absence of a confirmed histological diagnosis of ovarian cancer or classification as an alternative primary malignancy or cancer of unknown primary. We believe that exclusion of these cases is clinically appropriate and necessary to ensure accurate representation of ovarian cancer outcomes within the audit.</p> <p>If all of the proposed exclusions from the individual cancer units, together with those identified within the STH dataset, are upheld, then based on our initial local review and preliminary calculations, we anticipate that this would be sufficient to bring our gynaecological cancer system out of outlier status for the one-year survival indicator. We acknowledge that these local calculations are necessarily crude, as they are based on survival outcomes alone and do not incorporate formal adjustment for case-mix, comorbidity, or age. Nevertheless, they strongly suggest that inappropriate cohort inclusion has had a material impact on the reported results.</p>		
--	---	--	--

	<p>We would therefore respectfully request that these exclusions are fully considered and that the analysis is re-run following cohort correction, as this is likely to substantially alter the interpretation of our system's performance.</p> <ul style="list-style-type: none"> In addition, we recognise that survival outcomes are dependent on accurate and timely linkage between clinical records, cancer registry data, and mortality data. We are aware that delays in case ascertainment, updates to staging information, or post-diagnosis transfers of care may influence reported outcomes within national datasets. We therefore consider it possible that some elements of the data, while directionally correct, may not fully capture the clinical context of individual cases or subsequent patient management across organisational boundaries. We are undertaking further reconciliation with registry submissions and trust-level mortality data to ensure completeness and accuracy. <p>Taken together, we feel that these issues raise important concerns regarding cohort definition and case inclusion, which may have materially influenced the apparent survival outcomes for our gynaecological cancer system.</p> <p>We are continuing a more detailed case-level validation exercise to confirm staging, treatment intent, and survival status, and we will notify the audit team should any material discrepancies be identified.</p>		
	<p>2. Potential justifiable reasons for variation in one-year survival</p> <p>Subject to confirmation that the data are accurate, we believe there are several contextual factors that may reasonably contribute to the observed variation in one-year survival and which merit consideration when determining outlier status:</p> <ul style="list-style-type: none"> Late stage at diagnosis: A higher-than-average proportion of patients are diagnosed at FIGO stage III–IV, which is known to significantly impact short-term survival, even after case-mix adjustment. (See below for improvement projects in process). Population characteristics and data quality: With respect to population characteristics, we note that Sheffield has a recognised historical issue with the completeness and quality of data collection and clinical coding, particularly in relation to comorbidity and deprivation metrics. It is therefore likely that comorbidity burden and socioeconomic deprivation within our cohort may be 		

	<p>under-recorded or inadequately captured within national datasets. This may limit the effectiveness of case-mix adjustment and, consequently, the extent to which the reported survival figures accurately reflect the underlying clinical risk profile of our patient population.</p> <ul style="list-style-type: none"> • Treatment limitations aligned with informed patient choice and national guidance: Treatment outcomes within our population are significantly influenced by informed patient choice, which we recognise to be a particularly prominent feature across South Yorkshire. A reasonable proportion of our patients with advanced ovarian cancer decline cytoreductive or ultra-radical surgery following detailed discussion within the specialist gynaecological oncology multidisciplinary team. <p>These decisions are made in accordance with NICE guidance, including <i>Ovarian cancer: recognition and initial management (CG122)</i> and the principles set out in <i>Shared decision making (NG197)</i>. Patients are provided with comprehensive, individualised information regarding the potential benefits, risks, and likely impact of surgery, including peri-operative morbidity, prolonged hospitalisation, the possibility of permanent stomas, and effects on functional status and quality of life.</p> <p>Consistent with NICE standards, patient values and preferences are central to decision-making. Many patients explicitly prioritise quality of life over length of life and choose to avoid extensive surgical intervention, particularly where the likelihood of achieving meaningful cytoreduction is uncertain or where the anticipated morbidity is high. These decisions are fully documented, supported by the MDT, and represent appropriate, patient-centred care rather than limitations in access to or delivery of treatment.</p> <p>While clinically appropriate and ethically robust, such treatment choices may reasonably be expected to influence short-term survival outcomes and are not fully accounted for within routine audit metrics, including those used for case-mix adjustment.</p>		
<p>3. Quality improvement measures in place</p>			

	<p>Notwithstanding the above, we recognise the importance of ongoing quality improvement and have already implemented, or are in the process of implementing, the following measures:</p> <ul style="list-style-type: none"> • Participation in clinical trials: We actively participate in national research aimed at improving decision-making and outcomes in ovarian cancer. In particular, we are involved in the IMPRESS2 project, which is evaluating a structured support tool to enable more consistent, evidence-based, and patient-centred decision-making regarding surgical management in ovarian cancer. • We have also agreed to participate in the GOTYou trial, for which Professor Sundar is the Chief Investigator. Engagement in this study reflects our commitment to contributing to high-quality research and to embedding research-informed practice within our clinical pathways. <p>Local Initiatives:</p> <ul style="list-style-type: none"> • We are currently undertaking a detailed analysis of our 2024 ovarian cancer cohort, with a specific focus on patients presenting as emergency admissions. This work aims to identify modifiable factors within the diagnostic and referral pathways, including opportunities for enhanced primary care education, earlier referral, and improved utilisation of urgent and non-specific symptom pathways. • We are developing a standardised algorithm for the management of patients admitted under other specialties or departments with suspected ovarian cancer, with the aim of improving early diagnostics, nutritional assessment, prehabilitation, and timely specialist involvement. • In parallel, we are establishing an advanced ovarian cancer MDT, with particular emphasis on centralised specialist radiology reporting and the use of a structured radiological scoring system. This is intended to support more consistent identification of patients who are suitable candidates for surgery and to optimise treatment sequencing. <p>Inpatient chemotherapy provision:</p> <ul style="list-style-type: none"> • The absence of an inpatient chemotherapy service is recognised as a potential contributor to poorer outcomes within our system, particularly for patients diagnosed following emergency admission. NOCA data highlights that our region has a higher-than-average rate of emergency 		
--	--	--	--

	<p>diagnoses, and this cohort includes patients who may benefit most from timely inpatient systemic therapy.</p> <ul style="list-style-type: none"> Historically, progress in this area has been limited by the absence of a medical oncologist within the gynaecological oncology service, with care currently provided by clinical oncologists. Nonetheless, this issue has been escalated within the Trust, and we are actively exploring viable models for establishing an inpatient chemotherapy service. Improving access to inpatient systemic treatment for this high-risk patient group remains a strategic priority, with the aim of improving both short-term outcomes and overall patient experience. <p>These actions form part of a continuous improvement programme aimed at improving both short- and long-term outcomes for women with ovarian cancer within our system.</p>		
	<p>We remain fully committed to transparency, high-quality patient care, and active engagement with the NOCA process. We would welcome further dialogue with the audit team should additional clarification or information be helpful.</p> <p>NOCA Project Team comment:</p> <p><i>The NOCA project team reviewed and re-analysed results for Sheffield Teaching Hospitals NHS Foundation Trust's gynaecological cancer system based on information on data inaccuracies for diagnoses in 2022 and 2023 provided by its trusts during the outlier process. Following the review:</i></p> <ul style="list-style-type: none"> <i>The NOCA team determined that results for case-mix adjusted one year survival for diagnoses in 2023 (2026 SotN report) and 2022 (2025 SotN report) remained below the lower 95% control limit (two standard deviations) for both years.</i> 		
<p>NOCA Performance Indicator 7a</p>	<p>Case-mix adjusted one year survival (repeat alert: greater than two standard deviations from national average in two consecutive years)</p>		

NHS Provider	Provider Response to NOCA Outlier Notification	Outlier in 2026 report	Outlier in 2025 report
<p>Norfolk and Norwich University Hospitals NHS Foundation Trust</p>	<p>Thank you for reviewing the data of the patients that were diagnosed with ovarian cancer from 01/01/2022 – 31/12/2023 and updating the treatment outcomes for Norfolk and Norwich University Hospital. Following this process we identified the following issues:</p> <ol style="list-style-type: none"> 1. The patient’s frailty data were not collected and recorded appropriately by the local team. 2. There were issues with the definition of ovarian cancer diagnosis. The cohort included patients that had a different histology (and not ovarian cancer) and patients that were wrongly diagnosed based on clinical and imaging findings. <p>For the purposes of future audits, we will engage the local teams to ensure that all the registered diagnosis of ovarian cancer are confirmed by the gynaecology oncology team. Also, we need to validate our local data prior to future publications of the ovarian cancer audit.</p> <p>NOCA Project Team comment:</p> <p><i>The NOCA project team reviewed and re-analysed results for Norfolk and Norwich University Hospitals NHS Foundation Trust’s gynaecological cancer system based on information on data inaccuracies provided by its trusts during the outlier process. Following the review:</i></p> <ul style="list-style-type: none"> • <i>The NOCA team determined that results for case-mix adjusted one year survival for diagnoses in 2023 (2026 SotN report) and 2022 (2025 SotN report) did NOT fall below the lower 95% control limit (two standard deviations) for either year.</i> • <i>The outlier process closed at step 4 (outlier policy table 1) and no notification of CQC, HQIP and NHS England was required.</i> • <i>Results for performance indicators 7a and 7b (one and two year survival) will not be reported for Norfolk and Norwich University Hospitals NHS Foundation Trust’s gynaecological cancer system in the 2026 State of the Nation report.</i> 	<p>NO</p>	<p>NO (repeat alert not included in outlier policy)</p>