

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Gallstone disease

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for gallstone disease. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source(s) referenced in this briefing paper is:

- [Gallstone disease](#) (2014) NICE guideline CG188
- [Single-incision laparoscopic cholecystectomy](#) (2014) NICE guideline IPG508
- Royal College of Surgeons (2013) [Commissioning guide: gallstone disease](#)

2 Overview

2.1 Focus of quality standard

This quality standard will cover identifying, diagnosing and managing gallstone disease in adults.

2.2 Definition

Gallstone disease is the term used in this quality standard to refer to the presence of stones in the gallbladder or common bile duct and the symptoms and complications they cause.

2.3 Incidence and prevalence

About 15% of adults are thought to have gallstone disease with around 80% of these having asymptomatic gallbladder stones, meaning the stones are confined to the gallbladder and they do not have any symptoms. The disease is identified coincidentally as a result of investigations for other conditions. People with asymptomatic gallbladder stones may never go on to develop symptoms or complications.

For the remaining 20% of people the condition is symptomatic. The symptoms of gallstone disease range from mild, non-specific symptoms that can be difficult to diagnose, to severe pain and/or complications which are often easily recognised as gallstone disease by health professionals.

2.4 *Management*

There is variation within the NHS in how people are managed once asymptomatic gallbladder stones have been diagnosed. Some patients are offered treatments to prevent symptoms and complications developing, and others are offered a watch and wait approach so that active treatment only begins once the stones begin to cause symptoms.

People with mild, non-specific symptoms of gallstone disease may attribute their symptoms to other conditions, or may be misdiagnosed and undergo unnecessary investigations and treatment. This has a detrimental effect on quality of life and has an impact on the use of NHS resources. Thus, there is a need to identify whether there are any specific signs, symptoms or risk factors for gallstone disease and to identify the best method for diagnosing the condition so that patients can be managed appropriately.

There are a range of endoscopic, surgical and medical treatments available to treat gallstone disease. Surgery to remove the gallbladder, known as cholecystectomy, is the most common way to treat biliary pain or cholecystitis caused by gallstones and is one of the most commonly performed surgical procedures in the NHS. About 66,660 cholecystectomies are performed every year in the UK, costing about £111.6 million, around 61,220 of these are laparoscopic cholecystectomies.

See appendix 1 for the associated care pathway and algorithms from NICE clinical guideline 188.

2.5 *National Outcome Frameworks*

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [NHS Outcomes Framework 2015–16](#)

Domain	Overarching indicators and improvement areas
3 Helping people to recover from episodes of ill health or following injury	<p>Overarching indicator 3b Emergency readmission within 30 days of discharge from hospital (PHOF 4.11*)</p> <p>Improvement areas Improving outcomes from planned treatments 3.1 Total health gain as assessed by patients for elective procedures i <i>Physical health-related procedures</i></p>
4 Ensuring that people have a positive experience of care	<p>Overarching indicator 4b Patient experience of hospital care 4c <i>Friends and family test</i> 4d <i>Patient experience characterised as poor or worse</i> ii <i>Hospital care</i></p> <p>Improvement areas Improving people’s experience of outpatient care 4.1 Patient experience of outpatient services Improving hospitals’ responsiveness to personal needs 4.2 Responsiveness to in-patients personal needs Improving people’s experience of accident and emergency services 4.3 Patient experience of A&E services</p>
<p>Alignment across the health and social care system * Indicator is shared <i>Indicators in italics are in development</i></p>	

Table 2 [Public health outcomes framework for England, 2013–2016](#)

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	<p>Objective Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p>Indicators 4.11 Emergency readmissions within 30 days of discharge from hospital (NHSOF 3b*)</p>
<p>Alignment across the health and social care system * Indicator shared</p>	

3 Summary of suggestions

3.1 Responses

In total 5 stakeholders responded to the 3-week engagement exercise 06/03/15 – 27/03/15.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

NHS England's patient safety division did not submit any data for this topic.

Full details of all the suggestions provided are given in appendix 4 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Diagnosing gallstone disease <ul style="list-style-type: none"> • Prompt diagnosis • Endoscopic ultrasound (EUS) 	BH, NHSE, SCM
Managing gallbladder stones <ul style="list-style-type: none"> • Acute cholecystitis • Non-surgical management 	BH, BSG & PSGBI, RCGP, SCM
Managing common bile duct stones <ul style="list-style-type: none"> • Endoscopic retrograde cholangiopancreatography (ERCP) • Biliary stenting 	BSG & PSGBI, BSIR, SCM
Patient, family member and carer information <ul style="list-style-type: none"> • Dietary patterns • Post-surgery 	RCGP, SCM
Single-incision laparoscopic cholecystectomy	BH
Additional areas <ul style="list-style-type: none"> • Prevention with pharmaceutical interventions • Audit of complications 	
BH, Barts Health NHS Trust BSG & PSGBI, British Society of Gastroenterology and the Pancreatic Society of Great Britain and Ireland BSIR, British Society of Interventional Radiology NHSE, NHS England RCGP, Royal College of General Practitioners SCM, Specialist Committee Member	

4 Suggested improvement areas

4.1 *Diagnosing gallstone disease*

4.1.1 Summary of suggestions

Prompt diagnosis

Stakeholders highlighted that use of ultrasound and liver test functions will enabled prompt diagnosis of gallstone disease. Quick access to these diagnostic tests is not widely available and is not always considered for some patients.

Endoscopic ultrasound (EUS)

Stakeholders stated that the EUS can detect common bile duct stones if a magnetic resonance cholangiopancreatography (MRCP) does not make a diagnosis. EUS could also enable an Endoscopic retrograde cholangiopancreatography to take place without a repeat appointment. Stakeholders felt that availability of EUS was not as widespread as MRCP and was variable across the health service.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 4 to help inform the Committee’s discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Prompt diagnosis	Diagnosing gallstone disease NICE CG188 Recommendation 1.1.1
Endoscopic ultrasound (EUS)	Diagnosing gallstone disease NICE CG188 Recommendation 1.1.3

Prompt diagnosis

NICE CG188 – Recommendation 1.1.1

Offer liver function tests and ultrasound to people with suspected gallstone disease, and to people with abdominal or gastrointestinal symptoms that have been unresponsive to previous management.

Endoscopic ultrasound (EUS)

NICE CG188 – Recommendation 1.1.3

Consider endoscopic ultrasound (EUS) if MRCP does not allow a diagnosis to be made.

4.1.3 Current UK practice

Prompt diagnosis

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Endoscopic ultrasound (EUS)

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.2 *Managing gallbladder stones*

4.2.1 Summary of suggestions

Acute cholecystitis

Stakeholder stated the need to prevent and quickly treat patients with acute cholecystitis. They highlighted that this would reduce length of hospital stay and readmission rates, with some trusts not prioritising these patients which result in a delay to treatment.

Non-surgical management

A stakeholder felt that non-surgical management should be prioritised, though no supporting information was provided.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the Committee’s discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Acute cholecystitis	Managing gallbladder stones NICE CG188 Recommendation 1.2.4 (KPI)
Non-surgical management	Managing gallbladder stones NICE CG188 Recommendation 1.2.5

Acute cholecystitis

NICE CG188 – Recommendation 1.2.4 (key priority for implementation)

Offer early laparoscopic cholecystectomy (to be carried out within 1 week of diagnosis) to people with acute cholecystitis.

Non-surgical management

NICE CG188 – Recommendation 1.2.5

Offer percutaneous cholecystostomy to manage gallbladder empyema when:

- surgery is contraindicated at presentation and

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- conservative management is unsuccessful.

4.2.3 Current UK practice

Acute cholecystitis

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Non-surgical management

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.3 **Managing common bile duct stones**

4.3.1 **Summary of suggestions**

Endoscopic retrograde cholangiopancreatography (ERCP)

Stakeholders highlighted that ERCP is the most common method to manage common bile duct stones. However it was felt that it is a technically challenging method and current services require improvement and access is limited across the health service.

Biliary stenting

A stakeholder suggested that the use biliary stenting as a second line treatment when ERCP has failed was required provide a complete range of treatment. Facilities and expertise vary across the health service and may not be available in a timely manner.

4.3.2 **Selected recommendations from development source**

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the Committee’s discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Endoscopic retrograde cholangiopancreatography (ERCP)	Managing common bile duct stones NICE CG188 Recommendation 1.3.2 (KPI)
Biliary stenting	Managing common bile duct stones NICE CG188 Recommendation 1.3.2 (KPI)

Endoscopic retrograde cholangiopancreatography (ERCP)

NICE CG188 – Recommendation 1.3.3 (key priority for implementation)

Clear the bile duct:

- surgically at the time of laparoscopic cholecystectomy **or**
- with endoscopic retrograde cholangiopancreatography (ERCP) before or at the time of laparoscopic cholecystectomy.

Biliary stenting

NICE CG188 – Recommendation 1.3.3 (key priority for implementation)

If the bile duct cannot be cleared with ERCP, use biliary stenting to achieve biliary drainage only as a temporary measure until definitive endoscopic or surgical clearance.

4.3.3 Current UK practice

Endoscopic retrograde cholangiopancreatography (ERCP)

The British Society of Gastroenterology produced a standards framework for the use of ERCP. In the current context they found that in practice availability can be suboptimal. As well as the fact that availability was not widespread they also found that performance of ERCP required improvement, comparing it to the previous scenario for colonoscopy, and that ERCP should follow suit by accepting the need to improve services¹.

Biliary stenting

While not specifically addressing biliary stenting the Royal College of Radiologists review into the provision of interventional radiology services found many services across the NHS have limited or no direct access to interventional radiology (of which biliary stenting is one). In out of hour care less than one third of units are able to provide comprehensive interventional radiology care².

¹ British Society of Gastroenterology (2014). [ERCP – The Way Forward, A Standards Framework](#)

² Royal College of Radiologists (2014). [Provision of interventional radiology services](#)

4.4 *Patient, family member and carer information*

4.4.1 Summary of suggestions

Dietary patterns

Stakeholders highlighted that dietary patterns should be discussed with patients both before and after diagnosis including after any intervention. This includes preventative measures as well as checking if any issues remain after an intervention.

Post-surgery

A stakeholder suggested that patients experience post-surgery should be addressed. This will help to prevent further complications and any readmissions. This should take place in primary care.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Dietary patterns	<p>Patient, family member and carer information</p> <p>NICE CG188 Recommendation 1.4.1 to 1.4.3</p> <p>Primary care management</p> <p>Royal College of Surgeons. Commissioning guide: gallstone disease 1.1.</p>
Post-surgery	<p>Patient, family member and carer information</p> <p>NICE CG188 Recommendation 1.4.3</p>

Dietary patterns

NICE CG188 – Recommendation 1.4.1

Advise people to avoid food and drink that triggers their symptoms until they have their gallbladder or gallstones removed.

NICE CG188 – Recommendation 1.4.2

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Advise people that they should not need to avoid food and drink that triggered their symptoms after they have their gallbladder or gallstones removed.

NICE CG188 – Recommendation 1.4.3

Advise people to seek further advice from their GP if eating or drinking triggers existing symptoms or causes new symptoms to develop after they have recovered from having their gallbladder or gallstones removed.

Royal College of Surgeons. Commissioning guide: gallstone disease 1.1.

Further episodes of biliary pain can be prevented in around 30% of patients by adopting a low fat diet. Fat in the stomach releases cholecystokinin, which precipitates gallbladder contraction and might result in biliary pain.

Post-surgery

NICE CG188 – Recommendation 1.4.3

Advise people to seek further advice from their GP if eating or drinking triggers existing symptoms or causes new symptoms to develop after they have recovered from having their gallbladder or gallstones removed.

4.4.3 Current UK practice

Dietary patterns

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Post-surgery

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.5 *Single-incision laparoscopic cholecystectomy*

4.5.1 Summary of suggestions

A stakeholder, while supporting the use of single-incision laparoscopic (SILS) cholecystectomy felt that they should be limited to those with a track record of performing SILS frequently and well.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the Committee’s discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Single-incision laparoscopic cholecystectomy	Single-incision laparoscopic cholecystectomy NICE IPG508 Recommendation 1.1 and 1.2

Single-incision laparoscopic cholecystectomy

NICE IPG508 – Recommendation 1.1

Current evidence on the safety and efficacy of single-incision laparoscopic cholecystectomy is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.

NICE IPG508 – Recommendation 1.2

Single-incision laparoscopic cholecystectomy is technically challenging and should only be carried out by experienced laparoscopic surgeons who have had specific training in the procedure.

4.5.3 Current UK practice

Single-incision laparoscopic cholecystectomy

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

4.6 *Additional areas*

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 05/05/15.

Prevention with pharmaceutical interventions

A stakeholder suggested that the prevention of gallstones using pharmaceutical interventions, including statins and ezetimibe could potentially be an improvement area. This area is not contained within any of the development sources identified.

Audit of complications

A stakeholder felt it was important that complications are appropriately audited as the recorded incidence of complications is lower than incidence in practice. This area is not contained within any of the development sources identified.

Appendix 1: Key priorities for implementation (CG188)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

- Reassure people with asymptomatic gallbladder stones found in a normal gallbladder and normal biliary tree that they do not need treatment unless they develop symptoms.
- Offer early laparoscopic cholecystectomy (to be carried out within 1 week of diagnosis) to people with acute cholecystitis.
- Reconsider laparoscopic cholecystectomy for people who have had percutaneous cholecystostomy once they are well enough for surgery.
- Clear the bile duct:
 - surgically at the time of laparoscopic cholecystectomy or
 - with endoscopic retrograde cholangiopancreatography (ERCP) before or at the time of laparoscopic cholecystectomy.
- If the bile duct cannot be cleared with ERCP, use biliary stenting to achieve biliary drainage only as a temporary measure until definitive endoscopic or surgical clearance.

Appendix 2: Glossary

Gallbladder empyema Build-up of pus in the gallbladder, as a result of a blocked cystic duct.

Laparoscopic cholecystectomy Removal of the gallbladder through 'keyhole' surgery.

Percutaneous cholecystostomy A procedure to drain pus and fluid from an infected gallbladder.

Appendix 3: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
4.1 Diagnosing gallstone disease					
001	Barts Health NHS Trust	Key area for quality improvement 4 Have diagnostic ultrasound available 24/7 in A&E units	Often patients with upper abdominal/chest pain have ECG and Troponin done in the A&E department, and when those exclude an MI, they are sent home on a PPI. It is only after several such attacks that an ultrasound gets done and gallstones are diagnosed	It will enable earlier diagnosis	
002	NHS England	Key area for quality improvement 1:- Gallstone disease is adequately considered in primary care, particularly in dyspeptic patients in whom nausea and vomiting are particular features	The Gallstone Clinical Guideline is thorough with regard to the management of gallstones once they are known about, but less so about diagnosis. This needs to be emphasised, over and above the emphasis other guidance	Although many people have asymptomatic gallstones for years, they can lead to years of troublesome symptoms, and can evade diagnosis if too much emphasis is placed on managing dyspepsia	http://pathways.nice.org.uk/pathways/dyspepsia-and-gastro-oesophageal-reflux-disease#path=view%3A/pathways/dyspepsia-and-gastro-oesophageal-reflux-disease-overview.xml&content=view-index This pathway does not specifically lead to performing an ultrasound examination when the diagnosis is not clear

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
003	SCM 1	Use of Endoscopic ultrasound (EUS) with the option to proceed to ERCP in patients at moderate risk of common bile duct stones	EUS and MRCP are both recommended in the NICE guidance. With the right skill mix it may be possible to proceed to ERCP and stone removal following EUS detection of a stone under the same sedation. EUS	Availability of EUS is much lower than that of MRCP in the UK. The technique is very much operator dependent.	Please see NICE Gallstones guidance
004	SCM 2	Access to endoscopic ultrasound (EUS) to diagnose	EUS is an important tool to diagnose CBD calculi. It is more sensitive and specific for diagnosing small CBD stones than MRCP. It has an important role for diagnosing CBD stones where there is clinical / biochemical suspicion of CBD calculi, but where MRCP is non-diagnostic. It has an important role where magnetic resonance imaging is contraindicated (pacemakers, other metal implants in certain circumstances and claustrophobia).	The role of EUS in the diagnosis of CBD stones is described in the NICE guidance on gallstones. The current UK availability of access to this test is not well documented, but I am aware that it is variable across different regions. Need to ensure pathways in place to allow access for patients who present to an institution which does not offer an EUS service.	NICE guidance on gallstone disease.
4.2 Managing gallbladder stones					
005	Barts Health NHS Trust	Key area for quality improvement 1 Support hospitals in providing rapid access to theatres for early cholecystectomy in acute	Despite evidence that early cholecystectomy in acute cholecystitis is safe in expert hands and reduces length of	Doing this will: Reduce the length of hospital stay Curtail the suffering of patients Reduce the number of re-admissions	

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ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		cholecystitis	hospital stay and re-admissions, many NHS Trusts fail to prioritise these patients onto CEPOD lists	Reduce antibiotic usage	
006	British Society of Gastroenterology and the Pancreatic Society of Great Britain and Ireland	Key area for quality improvement 1	Operative treatment of patients with acute cholecystitis on index admission	Very variable practice amongst surgeons. Failure to treat on index admission often leads to further admissions / complications	http://www.nice.org.uk/guidance/CG188
007	SCM 3	Key area for quality improvement 1	Abdominal pain (gallstones)	Different hospitals admit patients with abdominal pain either under surgeons or physicians. Once patient is on a medical ward and diagnosed with CBD stones/gallstones it can be difficult to have surgical review in a timely manner and vice versa. There is a delay to treatment with many patients not being operated on within a week as stipulated in NICE Guideline on Gallstones.	Anecdotal; talking to different consultants in various Trusts
008	The Royal College of General Practitioners	Prevention of cholecystitis in a person know to have asymptomatic gallstones			
009	The Royal College of General Practitioners	Non surgical treatment of gallstone disease			

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
4.3 Managing common bile duct stones					
010	British Society of Gastroenterology and the Pancreatic Society of Great Britain and Ireland	Key area for quality improvement 2	Patients with gallstone pancreatitis to have their gallbladder removed or if unfit an ERCP an sphionterotomy on the index admission or within 4 weeks.	Several audits have shown that in the UK and across Europe that patient do not get a timely lap chole (LC) / ERCP after their index gallstone pancreatitis. This can often lead to further episodes of pancreatitis	Evidence to show poor outcome of interval LC vs index LC Van Baal, Annals of Surgery 255,5,2012 Early intervention supported in IAP/APA guidelines IAP/APA evidence based guidelines for the management of acute pancreatitis Pancreatology 13(2013) e1 - e15
011	British Society of Interventional Radiology	Availability of ERCP and sphincterotomy/ stenting as a therapeutic measure to clear common bile duct stones and performing this in a timely fashion	Common bile duct stones may be missed at the time of cholecystectomy and, if impacted in the distal duct, can result in significant morbidity.	Facilities and expertise vary between trusts and may not always be available locally or be available in an appropriate timeframe.	See 'BSG Quality and Safety Indicators for Endoscopy' (Joint Advisory Group on GI Endoscopy 2007). http://www.thejag.org.uk/downloads%5CUnit%20Resources%5CBSG%20Quality%20and%20Safety%20Indicators.pdf Also see 'The role of ERCP in benign diseases of the biliary tract' (ASGE

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					guidelines 2015). http://www.asge.org/uploadedFiles/Publications_(public)/Practice_guidelines/ERCP_benign_diseases_biliary_tract.pdf
012	British Society of Interventional Radiology	Availability of percutaneous biliary drainage for temporary drainage in biliary obstruction secondary to gallstones for the small number of cases where ERCP has failed or is not possible	To provide the complete range of treatment options for all patients who may need them.	Facilities and expertise vary between trusts and may not always be available locally or be available in an appropriate timeframe. This service could be provided locally or through a formal networked arrangement (both in and out of hours).	See 'Provision of interventional radiology services' (RCR/BSIR 2014). https://www.rcr.ac.uk/sites/default/files/publication/BFCR(14)12_POIR.pdf Also see 'Standards for providing a 24-hour interventional radiology service (RCR 2008). https://www.rcr.ac.uk/sites/default/files/publication/Stand_24hr_IR_provision_1.pdf
013	SCM 2	Improve quality of ERCP services in the UK.	ERCP is the most common method to manage common bile duct stones and their clinical consequences in the UK. ERCP is a technically challenging technique with a long learning curve. It carries the risk of significant complications. Evidence that outcomes are	Recognition by the British Society of Gastroenterology that there is room for quality improvement in the delivery of ERCP services in the UK. The BSG ERCP Working Party have suggested performance and quality should be guided by key performance indicators (such as technical success rates and procedural complication rates).	ERCP – The way forward, a standards framework. Document published by the British Society of Gastroenterology, June 2014.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			improved when ERCP performed in high volume centres by those with appropriate training.		
014	SCM 2	Improve access to ERCP in the UK, especially at weekends.	ERCP is an essential tool in the management of acutely unwell patients with gallstone disease (severe acute pancreatitis, cholangitis and post cholecystectomy bile leaks). Prompt access to quality ERCP services is important for patient outcomes.	Recognition by the BSG ERCP working party that access to ERCP is an issue in the UK. Will likely require more collaborative working and greater adoption of 7 day working. Low volume units may be insufficiently responsive, unless there is collaboration with larger regional units. In my own region (Greater Manchester) there is not a single Trust that offers a dedicated weekend ERCP service. Evidence that access at weekends reduces length of patient stay also.	ERCP – The way forward, a standards framework. Document published by the British Society of Gastroenterology, June 2014. Inpatient weekend ERCP is associated with a reduction in patient length of stay. Am J Gastroenterol. 2014 Apr;109(4):465-70. doi: 10.1038/ajg.2013.362. Parikh ND et al.
4.4 Patient, family member and carer information					
015	SCM 4	Collection of data regarding changes to diet both before and after diagnosis and then after surgery. With this in mind what arrangements are in place for a dietician to input on discussions?	Because some internet forums suggest avoiding surgery if possible.		
016	SCM 4	Longer term follow up post surgery. Areas such	Lack of available data.		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		as whether patients have any remaining or different dietary problems or problems with the site of incision, etc.			
017	SCM 3	Key area for quality improvement 2	Patient experience post cholecystectomy and increased contact with GP with concerns	Knock on effect (if any) to primary care providers due to acute Trust pressures of early discharge	CD Briggs and GB Irving et al (2009). Introduction Of Day case Laproscopic Cholecystectomy Service in the UK: a critical analysis of factors same day discharge and contact with primary care providers. Ann R Coll Surgery Oct 91(7); 583-590.
018	The Royal College of General Practitioners	Prevention of gallstones by lifestyle means, including dietary patterns			
019	The Royal College of General Practitioners	Correlation of gallstone disease with dietary patterns and sugar sweetened beverages			
4.5 Single-incision laparoscopic cholecystectomy					
020	Barts Health NHS Trust	Key area for quality improvement 3 Limit SILS only to individual units/surgeons	I think the benefits of SILS are overstated and the technical	A single incision is not necessarily better,	

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ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		who have a track record of doing it frequently and doing it well	difficulties are considerable	especially if it increases the risks.	
4.6 Additional areas					
021	Barts Health NHS Trust	Key area for quality improvement 2 Audit complications of cholecystectomy especially biliary injuries and leaks	As a tertiary HPB surgeon I find that the recorded incidence of biliary injuries and leaks is lower than the actual incidence in practice	Some primary surgeons (especially the few who have caused several biliary injuries) tend to manage biliary injuries themselves and are loath to transfer the patient. This leads to poor outcomes. When they do transfer, they transfer late, often send patients to different hospitals on different occasions, thus scattering the light that would otherwise be shone on their suboptimal outcomes.	
022	The Royal College of General Practitioners	Prevention of gallstones by pharmaceutical interventions, including statins and ezetimibe			
N/A					
023	Royal College of Nursing	This is to inform you that the Royal College of Nursing had no comments to submit to inform on the above topic engagement at this time			
024	Royal College	RCP wishes to endorse			

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ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	of Physicians	the submission of the British Society of Gastroenterology and the Pancreatic Society of Great Britain and Ireland's on this topic engagement.			