NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1. Quality standard title

Renal and ureteric stones

Date of quality standards advisory committee post-consultation meeting:   
16 January 2020

1. Introduction

The draft quality standard for renal and ureteric stones was made available on the NICE website for a 4-week public consultation period between 6 November and 4 December 2019. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 10 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

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

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

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

4. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard and data collection.

* Be explicit about what “good” looks like
* Be explicit about who should keep the data
* Data accuracy will be determined by hospital administration systems.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Adults with suspected renal colic have low-dose non-contrast CT within 24 hours of presentation.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

Statement

* Support for the statement as it will avoid unhelpful additional investigations
* Be clearer that pregnant people should not have CT
* Not all patients with symptoms of ureteric colic should have a non-contrast CT, such as patients who recently had one and young thin patients
* CT is more likely to be negative in female patients, so female patients under 50 years without both flank pain and haematuria should have a pelvic ultrasound before CT
* The 24 hour timeframe will be difficult to achieve from presentation in primary care without new referral processes, or in sites with single or few scanners. Suggested wording change to “within 24 hours of presentation to secondary care” or “after referral has been received from primary care”.

Measures

* Data collection should be straightforward
* Exclude patients who should not have a CT from the denominator in the process measure
* Is outcome a about time to CT being performed, the stone showing on the CT report or informing the patient of the stone?
* Outcome b assumes all patients with suspected renal stones have had urea and electrolytes tests.

Audience descriptors

* Any adequately trained CT specialist radiographer should be able to perform this
* The referrer needs to provide enough data to the practitioner, such as diagnostic information or medical records, so they can decide whether there will be enough benefit to the patient of the exposure, in line with regulations.

Definitions

* More detail is needed in the definition of suspected renal colic
* The definition of “low dose” will vary. Protocols should be optimised in collaboration with the medical physics advisor
* National Diagnostic Reference Levels were highlighted by a stakeholder.
  1. Draft statement 2

People with suspected renal colic receive a non-steroidal anti-inflammatory drug (NSAID) as first-line treatment.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* Support for the statement as it will avoid the use of other unnecessary and inappropriate medications
* NSAIDs can be administered by patients, relatives, GPs or hospital doctors
* Add “if tolerated and not contraindicated”
* Data collection will be substantial. Recommendations on how to do this centrally or automatically would be helpful if keeping continuous data for every patient with possible ureteric colic is expected.
  1. Draft statement 3

Adults with ureteric stones and renal colic have surgical treatment within 48 hours of diagnosis or readmission, if pain is ongoing and not tolerated, or the stone is unlikely to pass.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

Statement

* Achieving the statement within the timeframe could be difficult, for example due to access to emergency lithotripsy and on call urologists over the weekend
* Availability of machines for shockwave lithotripsy treatment is an issue, with patients having to travel long distances for treatment, and sometimes having to make repeat visits
* Timing and patient experience begin when pain is registered
* Include dealing with timings for decompression (either nephrostomy or ureteric stenting) in patients with obstruction and sepsis (6hrs) or AKI/Solitary kidney (12hrs)

Measures

* Outcome a: how is “stone-free” defined and at what time point is this after treatment?
* It will be difficult to automate the data collection for all patients with ureteric colic, but the data could be gathered through a trial or snapshot
* There will be costs associated with delivering the measures.

Definitions

* It is difficult to define “unlikely to pass” as it depends on judgement
* Should percutaneous nephrostomy be used to manage ureteric colic?
  1. Draft statement 4

Adults with renal or ureteric stones have their serum calcium measured.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* Support for the statement as part of routine care and to detect causes of hypercalcaemia
* This can be done at the time of colic or at follow-up
* State a timeframe by which serum calcium should be tested, such as “within 3 months of presentation”
* Data collection will need to be automated to ascertain the number of blood tests sent on such a large demographic
* Does this include all incidental stones, and how would these patients get flagged for calcium testing?
  1. Draft statement 5

People with renal or ureteric stones are given advice on diet and fluid intake.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

Statement

* Support for the statement as a cost-effective intervention that isn’t consistently done
* Does this include patients with incidental stones? These patients will be difficult to identify, and they are unlikely to follow the advice if they don’t have symptoms
* Advice should be available in different languages, in written format and electronically
* A national steer is needed to ensure proper information is used and there is a consistent approach
* There could be cost implications if consultation times increase to allow time to give advice, and if there is no current dietetic service provision.

Measures

* The process measure should be patients with symptomatic stones instead of diagnoses of stones
* It will be difficult to collect the data for the numerator in the process measure in a continuous form. A snapshot audit would work better
* Giving advice should be recorded in patient records for audit.

Audience descriptors

* Doctors and healthcare workers dealing with renal stone patients need education on this. It is not feasible to train all health professionals about dietary advice
* This advice can be given by GPs, physicians or specialist nurses, or cases that need more tailored advice can be referred to dietitians.

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* Employment problems, such as loss of employment, sick pay and sick leave.

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| **ID** | **Stakeholder** | **Statement number** | **Comments[[1]](#footnote-1)** |
| --- | --- | --- | --- |
| 1 | British Association of Urological Surgeons | General | In general, it would be useful to make it explicit who is to keep the data regarding these standards, and what “good looks like” as a target for each… |
| 2 | Royal College of Nursing | General | Thank you for the opportunity to contribute to this quality standard, we do not have any comments from the RCN on this occasion. |
| 3 | Royal College of Paediatrics and Child Health | General | Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the draft quality standard for renal and ureteric stones.  Please note that we did not receive any responses for this consultation. |
| 4 | Society and College of Radiographers | Question 2 | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? Data accuracy will be determined by the consistent use of standardised protocol names on the hospital administration system, radiology information system, during justification and protocolling of the exposure and on the CT scanner. In addition to this the referrer must supply the practitioner with sufficient medical data (such as previous diagnostic information or medical records) relevant to the exposure requested by the referrer to enable the practitioner to decide whether there is a sufficient net benefit as required by regulation 11(1)(b) of The Ionising Radiation (Medical Exposure) Regulations 2017. |
| 5 | British Association of Urological Surgeons | Statement 1 | Not all patients who present with symptoms of ureteric colic need or should have a Non-Contrast CTKUB. The denominator is stated to be “the number of presentations of adults with suspected renal colic”. Excluding patients in whom a CT is “unsuitable” will appropriately reduce the numerator but not apparently the denominator. Patients who are pregnant should not have a CT; patients who have recently had a CT and re-present might not need another, and young thin patients may be reasonably imaged with KUB US in the first instance. Should this be reflected by the denominator not including these patients? |
| 6 | British Society for Interventional Radiology | Statement 1 | Should the description of ‘suspected renal colic be more detailed’ or are the clinical features beyond the scope of this document |
| 7 | British Society for Interventional Radiology | Statement 1 | It is well know that CT is more likely to be negative if female patients, personally I think that female patients <50 that do not have both flank pain and haematuria (rather than pelvic pain and haematuria or just abdominal pain) should have a pelvic US before CT. Female patients with flank pain and haematuria can go straight to CT. Should the statement reflect this? I worry that the statement as is will increase the number of negative CTs, and hence radiation burden, in the younger female population. |
| 8 | Renal Association | Statement 1 | The availability of CT scan (non contrast) should be feasible and will prevent many additional investigations that may not be helpful (e.g. plain AXR, USS). This is a vital first line investigation. Collecting data on this measure should be straightforward. |
| 9 | Royal College of General Practitioners | Statement 1 | Can the committee consider changing this to read ‘non-pregnant adults with suspected renal colic’ |
| 10 | Royal College of General Practitioners | Statement 1 | Currently to gain access to a low dose non contrast CT scan in 24 hours requires referral to an ambulatory care unit or A&E. From primary care, to order a CT scan can take at least 24 hours for the request itself to be processed and so to achieve this quality standard will be difficult without new referral processes being developed.  Given this is the case, the committee may wish to consider changing the quality statement to make this more feasible e.g. ‘within 24 hours of presentation to secondary care or after referral has been received from primary care’ |
| 11 | Royal College of General Practitioners | Statement 1 | Is this time to the CT being performed, the stone being shown on the CT scan report or a clinician informing the patient of the stone? From primary care, the CT result may take time to reach the surgery (often days-week) and then the patient needs to be contacted adding further delay. Clarification of what “time to diagnosis means” would be useful here. |
| 12 | Royal College of General Practitioners | Statement 1 | This assumes all patients with suspected renal stones has a U&E completed. |
| 13 | Society and College of Radiographers | Statement 1 | SCoR welcomes the inclusion of the statement “Adults with suspected renal colic have low-dose non-contrast CT within 24 hours of presentation”. Not all sites will have CT services available 24/7 and there should be well defined local procedures for scheduling these patients appropriately. CT protocols should be optimised in collaboration with the medical physics advisor as the definition of “low dose” varies considerably. We draw your attention to the National DRLs for kidneys-ureters-bladder for stones/colic <https://www.gov.uk/government/publications/diagnostic-radiology-national-diagnostic-reference-levels-ndrls/ndrl#national-drls-for-computed-tomography-ct>. |
| 14 | Society and College of Radiographers | Statement 1  Question 2 | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? Data accuracy will be determined by the consistent use of standardised protocol names on the hospital administration system, radiology information system, during justification and protocolling of the exposure and on the CT scanner. In addition to this the referrer must supply the practitioner with sufficient medical data (such as previous diagnostic information or medical records) relevant to the exposure requested by the referrer to enable the practitioner to decide whether there is a sufficient net benefit as required by regulation 11(1)(b) of The Ionising Radiation (Medical Exposure) Regulations 2017. |
| 15 | Society and College of Radiographers | Statement 1  Question 3 | SCoR believes most CT services will already be achieving the 24 hour target however formal adoption of the standard may result in challenges for sites with single or few scanners. Assuming appropriate optimisation of the protocol has been assured (see point 1), this is not a technically challenging CT examination and is therefore one which any adequately trained CT specialist radiographer should be able to perform. |
| 16 | British Association for Paediatric Nephrology | Statements 2 and 5 | I did not receive any comments with regard to standard 2 or 5 which include children. |
| 17 | British Association of Urological Surgeons | Statement 2 | Data collection for this will be substantial. Recommendations as to how this should be centrally / automatically collected would be helpful, unless “snapshot” audits are to be taken. If this is to be kept as continuous data on every patient who attends with possible ureteric colic, an automated system will be needed… |
| 18 | Renal Association | Statement 2 | NSAIDs as first line is sensible and can be administered by patient or relative, GP or hospital doctor. It may avoid unnecessary opiate use and other inappropriate medications. |
| 19 | Royal College of General Practitioners | Statement 2 | Can the committee consider adding: “if tolerated and not contraindicated”  Many patients will not be able to tolerate NSAIDs or have contraindications. E.g. the NICE guidance states paracetamol should be given if NSAIDs are contraindicated |
| 20 | Beat Kidney Stones | Statement 3 | Understandably times are measured from time of arrival or time of interface with medical staff. Could Beat Kidney Stones remind NICE in general that patient experience starts with the registering of pain. The aspect of this we wish to emphasise is the following:  The geography of the U.K. and the obvious solution of providing the best services at sites that serve the largest groups of people is sensible and practicable but please do not forget the peripheries of the U.K. This Charity was asked to fund the journey of a patient needing to travel from North West Devon to North Bristol for Lithotripsy treatment. He had lost his job due to the intermittent and irregular aspects of passing a kidney stone. To get to Bristol from his home was 110 miles and took 2.75 hours. It is the distances and road quality I would like to remind people of. For example Penzance to London is almost the same as Carlisle to London.  I am confident both NICE and Commissioners are fully aware of the distances involved but this Charity is just seeking to remind all concerned.  One issue raised by sufferers is the availability of SWL machines, hence my comment above.  Furthermore, after further emergency treatments for acute renal colic, a repeat visit by the patient for SWL treatment for the same stone is sometimes necessary due to one of the following:  Only flakes or parts of a stone coming away.  The SWL operator not finding an anvil so not being so effective in breaking up the stone. |
| 21 | British Association of Urological Surgeons | Statement 3 | This is the most challenging standard, both to define and to deliver. In particular, the definition “stone unlikely to pass” is intrinsically imprecise as it depends on judgment.  Is “unlikely to pass” a 10% spontaneous stone passage rate? Or a 49% likelihood of spontaneous passage?  The numerator also brings a stone clearance assessment (as opposed to simply timing) as the outcome. How is stone free to be defined? Total absence of any stone? By CT? At what time point after treatment?  The denominator is “the number of patients who have had treatment for ureteric stones”. This standard therefore requires data on every patient with ureteric colic, both in terms of timing, the imprecise definition of “whether likely to pass”, their stone free rate (ie follow up data) and a quality of life assessment. This could be delivered in a trial, or possibly a snap-shot, but I do not think this can be made automated (as judgment over the likelihood of stone passage is needed). We are currently a long long way from having the infrastructure to deliver this for every patient with ureteric colic from now on… |
| 22 | British Society for Interventional Radiology | Statement 3 | Are NICE saying percutaneous nephrostomy (as it is not mentioned) has no place in the management of ureteric colic – or should it still be used a bridge to surgery within 24hrs in selected patients? Nephrostomy is still used in many centres when surgical treatment is delayed, septic patients or patient unfit for GA. |
| 23 | British Society for Interventional Radiology | Statement 3 | Does the statement need to include a subsection dealing with timings for decompression (either nephrostomy or ureteric stenting) in patients with obstruction and sepsis (6hrs) or AKI/Solitary kidney (12hrs). |
| 24 | Renal Association | Statement 3 | I am not sure how acheiveable this recommendation is. If a person is admitted on a Friday afternoon I am not sure most hospitals would perform surgery within 48 h if pain was not settling or stone was immobile. There may be costs associated with delivering this measure. Emergency access to lithotripsy would also be required universally as this may prevent surgery. Access to oncall urologists may also be a concern to deliver this measure within 48 h as urologists may be performing transplant surgery or not available for other reasons. |
| 25 | British Association of Urological Surgeons | Statement 4 | The timeframe by which the serum calcium should be tested should be stated. Many patients will not have had a Calcium sent in A/E (the diagnosis has often not been made at the time that bloods are sent). Should it be “within 3 months of presentation” to allow the tests to be sent from clinic review? The data collection will need to be automated to ascertain the number of blood tests sent on such a large demographic as all future patients who have renal or ureteric stones. In particular, does the denominator include all incidental stones found on abdominal imaging? How are these patients to get flagged for Calcium testing?? Or should incidental diagnoses (e.g a 3mm stone on oncological cross-sectional follow up imaging) not be included? Stating this in the exclusion criteria would be helpful. |
| 26 | Renal Association | Statement 4 | The performance of blood tests (including a serum calcium measure) should be part of routine care and I don’t see any issues with implementing this. If a calcium test is not performed at the time of colic then it can be performed at follow up. This intervention will detect significant numbers of patients with primary hyperparathyroidism and other causes of hypercalcaemia |
| 27 | British Association of Urological Surgeons | Statement 5 | Do patients with incidental stones need dietary advice? This would mean all such patients need to be referred as it will not be feasible to train all health professionals about this, let alone identifying these patients. It is also highly unlikely that patients with asymptomatic incidental stones will follow the advice. Perhaps this should be about patients with Symptomatic stones, as opposed to “the number of diagnoses of renal or ureteric stones”. The numerator will be difficult to collect in a continuous form – this aspect would be well studied in a focused snapshot audit. |
| 28 | British Dietetic Association (Renal Nutrition Group) | Statement 5 | People with renal or ureteric stones are given advice on diet and fluid intake.  We support the inclusion of a QS on diet and fluid intake as we feel it is an important and potentially cost-effective intervention. In many cases the advice can be given (with some training or supportive literature) by the healthcare professional – GP, physician, specialist nurse. Alternatively, patients could be referred to a dietitian who can tailor dietary advice, this would be preferable for those requiring more complex information e.g. those with calcium oxalate stones, those who have to balance the renal stone dietary advice with other therapeutic diets. Referral to specialist services for weight management may be indicated, in some cases.  We feel there is a need for improvement in this area as it is unclear if advice on fluid intake and diet is consistently given to patients.  When dietary / fluid advice is given it should be recorded in patient medical records which could be audited  Potentially there may be resource implications if consultation times need to increase to allow time to give the dietary advice. If there is no provision for a dietetic service and it is deemed necessary for the cohort of patients this would have cost implications. If weight management is required there should be local services – although it is possible that these are under resourced. |
| 29 | Renal Association | Statement 5 | Diet and fluid advice should be given to all. The quality of the written advice should be good, with translations into foreign languages. This alone may prevent many stone recurrence episodes. One problem is that each hospital trust will adopt a different approach. A national steer from NICE is required for the proper information to be used. Many doctors will still advocate a low calcium diet for stone formers if this message is not communicated properly and sufficient education is given to doctors and healthcare workers dealing with renal stone patients. In the climate of Paper-lite this information should be in App or electronic form (pdf via QR code or similar) as well as a written paper version.  The availability of information and dietary advice is already established as a means to reduce recurrent stones (the stone clinic effect) and this needs to be adopted by all carers of renal stone formers. |
| 30 | Beat Kidney Stones | Additional area | I would like to comment on one aspect of your Briefing Paper in the following paragraph.  “2.3 Incidence and prevalence  Epidemiological data suggest that the incidence and prevalence of renal and ureteric stones is increasing. The number of hospital episodes increased by 71% over an 18- year period between 2000 and 2018, from 51,035 episodes to 87,347 episodes. The lifetime prevalence of renal stone disease is 13%. Renal and ureteric stones affect about 3 in 20 men and 2 in 20 women at some stage in their lives. Consequently, the direct costs of treatment are increasing as well as the indirect socioeconomic burdens of reduced quality of life, sickness leave and medical follow-up.”  This Charity has been told by a number of kidney stone sufferers that because employers do not appreciate the possible intermittent nature of passing a stone,  the levels of pain involved and the consequences of having a stent fitted; all have more serious consequences.  Your comment about sickness leave is only the tip of the iceberg. Some lose their jobs and many others are penalised in more subtle ways.  Would NICE consider inserting after sickness leave, employment problems and medical.......  A large portion of the population do not get sick pay or sick leave.  Then coming to the Renal and ureteric Stones, the consequences of having a stone are endless visits to the loo and infrequent bouts of acute colic, neither of which are conducive to happily being at the workplace.  I am told it is even worse having a stent fitted. |

## Registered stakeholders who submitted comments at consultation

* Beat Kidney Stones
* British Association for Paediatric Nephrology
* British Association of Urological Surgeons
* British Dietetic Association (Renal Nutrition Group)
* British Society for Interventional Radiology
* Renal Association
* Royal College of General Practitioners
* Royal College of Nursing
* Royal College of Paediatrics and Child Health
* Society and College of Radiographers

1. PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees. [↑](#footnote-ref-1)