

# Dyspepsia and gastro-oesophageal reflux disease

## NICE quality standard

### Draft for consultation

February 2015

## Introduction

This quality standard covers the investigation and management of dyspepsia and gastro-oesophageal reflux disease (GORD) symptoms in adults 18 years and older. It does not include the diagnosis and management of oesophagogastric cancer; this will be covered by a separate quality standard. For more information see the [Dyspepsia overview](#).

### ***Why this quality standard is needed***

Dyspepsia describes a range of symptoms arising from the upper gastrointestinal (GI) tract. Symptoms, which typically are present for 4 weeks or more, include upper abdominal pain or discomfort, heartburn, gastric reflux, and nausea or vomiting. The causes of dyspepsia symptoms include gastric and duodenal ulcers (strongly associated with the bacterium *Helicobacter pylori* [*H pylori*]), GORD, oesophagitis and oesophageal or gastric cancers. In many cases, the cause is unknown (functional dyspepsia). In addition, certain foods and medicines (such as non-steroidal anti-inflammatory drugs) are believed to contribute to the symptoms and underlying causes.

GORD is a chronic condition in which gastric juices from the stomach (usually acidic) flow back up into the oesophagus. It can lead to an abnormality of the cells in the lining of the oesophagus (Barrett's oesophagus), which is itself considered the most important risk factor for oesophageal adenocarcinoma. There are several risk factors for GORD, including hiatus hernia, certain foods, heavy alcohol use, smoking, and pregnancy, but there is also a genetic component. There is some evidence to

suggest that GORD is more likely to occur in socially disadvantaged people, and its prevalence increases with age.

The prevalence of dyspepsia depends on the definition used and is estimated to be between 12% and 41% of the general population and the approximate prevalence of GORD is between 10% and 20%.

Almost all causes of dyspepsia are recurrent and intermittent in nature. The only definitive treatments for dyspepsia symptoms are *H pylori* eradication therapy if the person has peptic ulcer disease and *H pylori*, and surgery if the person has GORD. Other treatments such as proton pump inhibitors (PPI) do not address underlying reasons for dyspepsia; once treatment stops, symptoms may return.

Dyspepsia accounts for between 1.2% and 4% of all consultations in primary care in the UK, half of which are for functional dyspepsia, in which the cause cannot be determined. There has been an upward trend in prescribing for dyspepsia and GORD, particularly proton pump inhibitors. The use of endoscopy has also increased considerably over the past decade, as awareness of its value in diagnosing dyspepsia and GORD has grown. Some of the costs associated with treating dyspepsia and GORD are decreasing, but the overall use of treatments is increasing. As a result, the management of dyspepsia and GORD continues to have potentially significant costs to the NHS.

This quality standard focuses on improving the overall care of adults with dyspepsia and GORD and the management of their condition, in order to promote self-management, support people with severe and frequent symptoms and improve consistency of referral for endoscopy and testing for *H pylori*.

The quality standard is expected to contribute to improvements in the following outcomes:

- prevention of oesophagogastric cancer
- detection of oesophagogastric cancer
- dyspepsia and GORD medication prescribing rates
- *H pylori* antimicrobial resistance rates
- health-related quality of life

- patient experience of primary care.

### ***How this quality standard supports delivery of outcome frameworks***

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of care – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2015–16](#)
- [Public Health Outcomes Framework 2013–2016](#).

Tables 1–2 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](#)**

<b>Domain</b>	<b>Overarching indicators and improvement areas</b>
1 Preventing people from dying prematurely	<p><b><i>Overarching indicator</i></b></p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults</p> <p>1b Life expectancy at 75</p> <p>i Males ii Females</p> <p><b><i>Improvement area</i></b></p> <p><b>Reducing premature mortality from the major causes of death</b></p> <p>1.4 Under 75 mortality rate from cancer (PHOF 4.5*)</p>

<p>2 Enhancing quality of life for people with long-term conditions</p>	<p><b>Overarching indicator</b>  2 Health-related quality of life for people with long-term conditions (ASCOF1A<sup>**</sup>)</p> <p><b>Improvement areas</b></p> <p><b>Ensuring people feel supported to manage their condition</b>  2.1 Proportion of people feeling supported to manage their condition</p> <p><b>Improving functional ability in people with long-term conditions</b>  2.2 Employment of people with long-term conditions (PHOF 1.8*, ASCOF 1E<sup>**</sup>)</p>
<p>3 Helping people to recover from episodes of ill health or following injury</p>	<p><b>Overarching indicator</b>  3a Emergency admissions for acute conditions that should not require hospital admission</p> <p><b>Improvement area</b></p> <p><b>Improving outcomes from planned treatments</b>  3.1 Total health gain as assessed by patients for elective procedures  <i>i Physical health-related procedures</i></p>
<p>4 Ensuring that people have a positive experience of care</p>	<p><b>Overarching indicator</b>  4a Patient experience of primary care  <i>i GP services</i>  4b Patient experience of hospital care  4c <i>Friends and family test</i>  4d <i>Patient experience characterised as poor or worse</i>  <i>i Primary care</i>  <i>ii Hospital care</i></p> <p><b>Improvement area</b></p> <p><b>Improving people's experience of outpatient care</b>  4.1 Patient experience of outpatient services</p>
<p><b>Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework</b></p> <p>* Indicator is shared with Public Health Outcomes Framework (PHOF)</p> <p>** Indicator is complementary with Adult Social Care Outcomes Framework (ASCOF)</p> <p><i>Indicators in italics are in development</i></p>	

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

Domain	Objectives and indicators
Vision: To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest	<p><b>Outcome measure</b></p> <p>Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life</p> <p>Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)</p>
1 Improving the wider determinants of health	<p><b>Objective</b></p> <p>Improvements against wider factors that affect health and wellbeing and health inequalities</p> <p><b>Indicators</b></p> <p>1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services (NHSOF 2.2*, ASCOF 1E**)</p> <p>1.9 Sickness absence rate</p>
2 Health improvement	<p><b>Objective</b></p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p><b>Indicators</b></p> <p>2.19 Cancer diagnosed at stage 1 and 2</p> <p>2.23 Self-reported well-being</p>
4 Healthcare public health and preventing premature mortality	<p><b>Objective</b></p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p><b>Indicators</b></p> <p>4.3 Mortality rate from causes considered preventable (NHSOF 1a***)</p> <p>4.5 Under 75 mortality rate from cancer (NHSOF 1.4*)</p> <p>4.13 Health-related quality of life for older people</p>
<p><b>Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework</b></p> <p>* Indicator is shared with NHS Outcomes Framework (NHSOF)</p> <p>** Indicator is complementary with Adult Social Care Outcomes Framework (ASCOF)</p> <p>*** Indicator is complementary with NHS Outcomes Framework (NHSOF)</p>	

### ***Patient experience and safety issues***

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to dyspepsia and GORD.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and are supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that impact on patient experience and are specific to the topic are considered during quality statement development.

### ***Coordinated services***

The quality standard for dyspepsia and GORD specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole dyspepsia and GORD care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults with dyspepsia and GORD.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality.

Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality dyspepsia and GORD service are listed in Related quality standards.

### **Training and competencies**

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating adults with dyspepsia and GORD should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and

competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

### **Role of families and carers**

Quality standards recognise the important role families and carers have in supporting adults with dyspepsia and GORD. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

### **List of quality statements**

[Statement 1](#). Adults with dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms are given advice about making lifestyle changes, taking medicines and when to consult their GP.

[Statement 2](#). Adults with dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms are referred for endoscopy to take place within 2 weeks if they have alarm symptoms.

[Statement 3](#). Adults with dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms who are being tested for *Helicobacter pylori* (*H pylori*) have a carbon-13 urea breath test, a stool antigen test or a locally validated laboratory-based serology test.

[Statement 4](#). Adults with persistent, unexplained dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms that have not responded to treatment discuss referral to a specialist service with their GP.

## Questions for consultation

### ***Questions about the quality standard***

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

**Question 2** If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

**Question 3** For each quality statement what do you think could be done to support improvement and help overcome barriers?

### ***Questions about the individual quality statements***

**Question 4** For draft quality statement 1: Would it be possible to measure whether advice is provided by community pharmacists to people presenting with dyspepsia or GORD symptoms? Please explain your answer.

**Question 5** For draft quality statement 3: Are laboratory-based serology tests that are not locally validated currently being used to test for *H Pylori*? Can you provide examples of current practice in this area?

**Question 6** For draft quality statement 4: For how long should treatment be tried before a referral to a specialist service is discussed with a patient with persistent unexplained dyspepsia or GORD symptoms? Please explain your answer.



## Quality statement 1: Advice to support self- management

### ***Quality statement***

Adults with dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms are given advice about making lifestyle changes, taking medicines and when to consult their GP.

### ***Rationale***

Adults with symptoms of dyspepsia or GORD can often alleviate and manage their symptoms by making changes to their lifestyle (eating healthily, losing weight if they are overweight, stopping smoking) and taking over-the-counter medicines. It is also important that people receive advice about how to take prescribed medicines for dyspepsia and GORD and when they should consult their GP.

### ***Quality measures***

#### **Structure**

Evidence of local arrangements that ensure adults presenting with dyspepsia or GORD symptoms are given advice about making lifestyle changes, taking medicines and when to consult their GP.

**Data source:** Local data collection.

#### **Process**

a) Proportion of presentations of adults with dyspepsia or GORD symptoms to their community pharmacist where advice is received about making lifestyle changes, taking medicines and when to consult their GP.

Numerator – the number in the denominator where advice is received about making lifestyle changes, taking medicines and when to consult their GP.

Denominator – the number of presentations of adults with dyspepsia or GORD symptoms to their community pharmacist.

**Data source:** Local data collection.

b) Proportion of presentations of adults with dyspepsia or GORD symptoms to their GP where advice is received about making lifestyle changes, taking medicines and when to consult their GP.

Numerator – the number in the denominator where advice is received about making lifestyle changes, taking medicines and when to return to see their GP.

Denominator – the number of presentations of adults with dyspepsia or GORD symptoms to their GP.

**Data source:** Local data collection. Data on dietary and smoking cessation advice are included in the 'care.data' extract for the [Health and Social Care Information Centre](#) (not specific to adults with dyspepsia or GORD).

### **Outcome**

Adults with dyspepsia or GORD symptoms who are able to self-manage their condition.

**Data source:** Local data collection.

### ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (community pharmacists, GPs) ensure that written protocols are in place so that adults presenting with dyspepsia or GORD symptoms receive advice about making lifestyle changes, taking medicines and when to consult (or return to) their GP. This may include providing information leaflets when over-the-counter or prescribed medicines are dispensed.

**Healthcare professionals** provide advice to adults with dyspepsia or GORD symptoms about making lifestyle changes, taking medicines and when to consult (or return to) their GP.

**Commissioners** (NHS England area teams and clinical commissioning groups [CCGs]) ensure that that they commission services that provide advice to people with dyspepsia or GORD symptoms about making lifestyle changes, taking medicines and when to consult (or return to) their GP. Commissioners should work

collaboratively where minor ailment schemes are in place to ensure that advice to people with dyspepsia or GORD is included in any relevant service specifications.

### ***What the quality statement means for patients, service users and carers***

**Adults with indigestion or heartburn** receive advice from their pharmacist or GP about what they can do to relieve their symptoms. This should include advice about eating healthily, losing weight if they are overweight and stopping smoking. They should also receive information about medicines that can be bought 'over-the-counter' without a prescription, how to take medicines that are prescribed by the GP, and when people should make an appointment to see their GP. This information will help adults with indigestion or heartburn to manage their condition themselves.

### ***Source guidance***

- [Dyspepsia and gastro-oesophageal reflux disease](#) (2014) NICE guideline CG184, recommendations 1.1.1, 1.2.1, 1.2.2, and 1.2.3.

### ***Definitions of terms used in this quality statement***

#### **Advice about lifestyle changes**

Adults with dyspepsia or GORD symptoms should be given simple lifestyle advice including:

- Healthy eating, weight loss for people who are overweight and smoking cessation for people who smoke.
- Avoiding known causes that may be associated with symptoms, including smoking, alcohol, coffee, chocolate, fatty foods and being overweight.
- Other factors that might help, such as raising the head of the bed and having a main meal well before going to bed. [[Dyspepsia and gastro-oesophageal reflux disease](#) (NICE guideline CG184) recommendations 1.2.1 and 1.2.2]

#### **Advice about using medication**

Adults with long term dyspepsia or GORD symptoms should be advised:

- to reduce their use of prescribed medication by using the effective lowest dose on an 'as-needed' basis if possible
- to return to self-treatment with antacid and/or alginate therapy unless there is an underlying condition or comedication that needs continuing treatment
- to avoid long-term, frequent dose, continuous antacid therapy, because it only relieves symptoms in the short-term rather than preventing them. [[Dyspepsia and gastro-oesophageal reflux disease](#) (NICE guideline CG184) recommendations 1.2.5 and 1.8.7]

### **Advice about when to consult or return to their GP**

Adults with dyspepsia or GORD should be advised to see their GP if their symptoms have persisted for several weeks, get worse over time, do not improve with medication, or if they have any additional symptoms that may be a cause for concern, including chronic gastrointestinal bleeding, dysphagia, progressive unintentional weight loss or persistent vomiting. [Adapted from [Dyspepsia and gastro-oesophageal reflux disease](#) (NICE full guideline CG184) section 4.1.2.1, [Referral guidelines for suspected cancer](#) (NICE guideline CG27) recommendation 1.4.2 and expert opinion]

### ***Equality and diversity considerations***

Healthcare professionals should offer prescriptions for adults who cannot afford to buy over-the-counter medicines for dyspepsia or GORD symptoms.

Healthcare professionals should take into account cultural and communication needs when providing advice.

Not all adults will want to self-manage their dyspepsia or GORD symptoms, or be able to do so, and healthcare professionals should identify any vulnerable people who may need additional support.

### ***Question for consultation***

Would it be possible to measure whether advice is provided by community pharmacists to people presenting with dyspepsia or GORD symptoms? Please explain your answer.

## Quality statement 2: Endoscopy referral

### ***Quality statement***

Adults with dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms are referred for an endoscopy to take place within 2 weeks if they have alarm symptoms.

### ***Rationale***

There is currently wide geographical variation in referral rates for endoscopy for adults with dyspepsia or GORD. This geographical variation is associated with missed detection of cancer in areas with a low referral rate, and an inefficient use of resources if too many referrals are made. While many adults with dyspepsia or GORD symptoms will not need an endoscopy, it is important that those with alarm symptoms that may indicate cancer are referred for endoscopy in order to investigate the cause and inform management of the condition.

### ***Quality measures***

#### **Structure**

Evidence of local arrangements to ensure that adults with dyspepsia or GORD symptoms are referred for an endoscopy to take place within 2 weeks if they have alarm symptoms.

**Data source:** Local data collection.

#### **Process**

Proportion of adults with dyspepsia or GORD symptoms and alarm symptoms who are referred for an endoscopy to take place within 2 weeks.

Numerator – the number in the denominator who are referred for an endoscopy to take place within 2 weeks.

Denominator – the number of adults presenting with dyspepsia or GORD and alarm symptoms.

**Data source:** Local data collection.

## Outcome

a) Early oesophagogastric cancer detection rate.

**Data source:** Local data collection. [Clinical Commissioning Group outcomes indicator set](#) (CCG 1.17) includes data on record of stage of cancer at diagnosis.

b) Patient satisfaction with investigation of dyspepsia and GORD symptoms.

**Data source:** Local data collection.

## ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (general practices, community healthcare providers and hospitals) ensure that processes and resources are in place so that adults with dyspepsia or GORD are referred for an endoscopy to take place within 2 weeks if they have alarm symptoms. Endoscopy services should record and report inappropriate referrals for adults with dyspepsia or GORD.

**Healthcare professionals** ensure that adults with dyspepsia or GORD are referred for an endoscopy if they have alarm symptoms.

**Commissioners** (clinical commissioning groups [CCGs] and NHS England area teams) ensure that they commission services that refer adults with dyspepsia or GORD and alarm symptoms for an endoscopy. Commissioners should monitor inappropriate referrals for endoscopy for adults with dyspepsia or GORD as well as investigate particularly low rates of referral.

## ***What the quality statement means for patients, service users and carers***

**Adults with indigestion or heartburn** may be referred for an endoscopy. An endoscopy is a procedure that is sometimes carried out to investigate indigestion symptoms and find out what is causing them. It involves using an endoscope (a narrow, flexible tube with a camera at its tip), to see inside the oesophagus and stomach. The person may be offered sedation before the procedure, and/or given a local anaesthetic to numb the throat. The endoscope is then guided down the

person's throat and into their stomach. Not everyone with indigestion or heartburn will need an endoscopy.

### **Source guidance**

- [Referral guidelines for suspected cancer](#) (2005) NICE guideline CG27, recommendations 1.4.2 and 1.4.3.

### **Definitions of terms used in this quality statement**

#### **Alarm symptoms**

Adults in the following groups should be identified as having alarm symptoms that may be a cause for concern:

- aged 55 years and older with unexplained, persistent, recent-onset dyspepsia or GORD symptoms
- any age with additional symptoms or indications including chronic gastrointestinal bleeding, dysphagia, progressive unintentional weight loss, persistent vomiting, iron deficiency anaemia, epigastric mass or suspicious barium meal result
- any age with unexplained worsening of their dyspepsia with known risk factors including Barrett's oesophagus; known dysplasia, atrophic gastritis and intestinal metaplasia; or peptic ulcer surgery more than 20 years ago. [[Referral guidelines for suspected cancer](#) (NICE guideline CG27) recommendations 1.4.2, 1.4.3 and 1.4.11]

Please note: the content and definitions of the final version of the quality statement will be amended in line with the updated NICE CG27.

## Quality statement 3: Testing for *Helicobacter pylori*

### **Quality statement**

Adults with dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms who are being tested for *Helicobacter pylori* (*H pylori*) have a carbon-13 urea breath test, a stool antigen test or a locally validated laboratory-based serology test.

### **Rationale**

It is recommended that carbon-13 urea breath tests or stool antigen tests are used to identify *H pylori*. Laboratory-based serology is less specific and therefore should only be used where its performance has been locally validated. Laboratory-based serology does not differentiate between active and past infections and so does not always provide an accurate diagnosis, with a larger number of positive results than other tests. As treatment for *H pylori* is complex there is concern that treatment without an accurate diagnosis may lead to increasing antimicrobial resistance. Treatment for *H pylori* can also be unpleasant for the patient and has a risk of *Clostridium difficile*. It is therefore important to ensure treatment is only given if needed.

### **Quality measures**

#### **Structure**

Evidence of local arrangements to ensure that adults with dyspepsia or GORD symptoms who are being tested for *H pylori* have a carbon-13 urea breath test, a stool antigen test or a locally validated laboratory-based serology test.

**Data source:** Local data collection.

#### **Process**

a) Proportion of adults with dyspepsia or GORD symptoms who are tested for *H pylori* with a carbon-13 urea breath test.

Numerator – the number in the denominator who are tested with a carbon-13 urea breath test.



Denominator – the number of adults with dyspepsia or GORD who are tested for *H pylori*.

**Data source:** Local data collection.

b) Proportion of adults with dyspepsia or GORD who are tested for *H pylori* with a stool antigen test.

Numerator – the number in the denominator who are tested with a stool antigen test.

Denominator – the number of adults with dyspepsia or GORD who are tested for *H pylori*.

**Data source:** Local data collection.

c) Proportion of adults with dyspepsia or GORD who are tested for *H pylori* with a locally validated laboratory-based serology test.

Numerator – the number in the denominator who are tested with a locally validated laboratory-based serology test.

Denominator – the number of adults with dyspepsia or GORD who are tested for *H pylori*.

**Data source:** Local data collection.

## **Outcome**

*H pylori* antimicrobial resistance rate.

**Data source:** Local data collection.

## ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (general practices, laboratory services and hospitals) ensure that adults with dyspepsia or GORD symptoms who are being tested for *H pylori* have either a carbon-13 urea breath test, a stool antigen test or a locally validated laboratory-based serology test. Service providers should ensure that laboratory-

based serology is only used where its performance has been locally validated and that all relevant data is made available for inspection and monitoring.

**Healthcare professionals** ensure adults with dyspepsia or GORD symptoms who are being tested for *H pylori* are tested with either a carbon-13 urea breath test, a stool antigen test or a locally validated laboratory-based serology test. Healthcare professionals should check that the performance of serology has been locally validated before using it.

**Commissioners** (clinical commissioning groups [CCGs] and NHS England area teams) ensure that they commission services that test for *H pylori* with either a carbon-13 urea breath test, a stool antigen test or a locally validated laboratory-based serology test. Commissioners should monitor the use of laboratory-based serology tests and request evidence of local validation of performance where it is being used.

### ***What the quality statement means for patients, service users and carers***

**Adults with indigestion or heartburn** may need to have a test for an infection called *Helicobacter pylori* (*H pylori* for short), which can cause stomach ulcers. *H pylori* infection is detected using a breath test or a stool test, or sometimes a blood test.

### ***Source guidance***

- [Dyspepsia and gastro-oesophageal reflux disease](#) (2014) NICE guideline CG184, recommendation 1.9.1.

### ***Definitions of terms used in this quality statement***

#### **Local validation of performance for laboratory-based serology**

If laboratory-based serology is to be used its performance should be locally validated. Validation is an evidence-based assessment of how a test performs in the laboratory, and demonstrates suitability for intended purpose. Local validation will provide documentary evidence that a commercial serology kit is performing within the manufacturer's specifications. This will include results of experiments to

determine its accuracy, sensitivity, reliability and reproducibility. Local validation should meet the requirements set out in the [UK Standards for Microbiology Investigations](#).

The sensitivity and specificity of serology varies in different populations. Since most laboratories receive samples from wide geographical areas it is likely that they will be covering populations that vary considerably in terms of age, social class and ethnicity, making local validation difficult. [Adapted from [Dyspepsia and gastro-oesophageal reflux disease](#) (2014) NICE full guideline CG184 and [UK Standards for Microbiology Investigations – SMI Q1: Commercial and in-house diagnostic tests: evaluations and validations](#) (2014) Public Health England Quality Guidance]

### ***Equality and diversity considerations***

Serological tests are less reliable in older patients and therefore, where laboratory-based serology tests have been locally validated, their suitability for use with people over 65 should be carefully considered.

It is important to use an accurate test for *H pylori* for people from ethnic minority groups as resistance rates are higher than the general population. Where laboratory-based serology tests have been locally validated, their suitability for use with people from ethnic minority groups should be carefully considered.

### ***Question for consultation***

Are laboratory-based serology tests that are not locally validated currently being used to test for *H Pylori*? Can you provide examples of current practice in this area?

## Quality statement 4: Referral to a specialist service

### ***Quality statement***

Adults with persistent, unexplained dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms that have not responded to treatment discuss referral to a specialist service with their GP.

### ***Rationale***

Adults with persistent, unexplained dyspepsia or GORD symptoms that have not responded to recommended treatments should discuss referral to a specialist service with their GP so that treatment and potential causes can be reviewed. If symptoms are not reviewed there is a risk of complications developing, including scarring of the oesophagus and pylorus that can lead to oesophageal stricture, pyloric stenosis and Barrett's oesophagus, which is a risk factor for cancer. The discussion should include individual risk factors and preferences. If a referral is made to a specialist service it should help to reduce symptom burden and reduce the risk of further complications developing.

### ***Quality measures***

#### **Structure**

Evidence of local arrangements to ensure that adults with persistent, unexplained dyspepsia or GORD symptoms that have not responded to treatment discuss referral to a specialist service with their GP.

**Data source:** Local data collection.

#### **Process**

a) Proportion of adults with persistent unexplained dyspepsia or GORD symptoms that have not responded to treatment who have a documented discussion with their GP about referral to a specialist service.

Numerator – the number in the denominator who have a documented discussion with their GP about referral to a specialist service.

Denominator – the number of adults with persistent unexplained dyspepsia or GORD symptoms that have not responded to treatment.

**Data source:** Local data collection.

b) Proportion of adults with persistent unexplained dyspepsia or GORD symptoms that have not responded to treatment who are referred to a specialist service.

Numerator – the number in the denominator who are referred to a specialist service.

Denominator – the number of adults with persistent unexplained dyspepsia or GORD symptoms that have not responded to treatment.

**Data source:** Local data collection.

### **Outcomes**

a) Incidence of Barrett's oesophagus.

**Data source:** Local data collection.

b) Incidence of oesophageal stricture.

**Data source:** Local data collection.

c) Incidence of pyloric stenosis in adults.

**Data source:** Local data collection.

d) Patient-reported health outcomes for people with dyspepsia or GORD.

**Data source:** Local data collection.

### ***What the quality statement means for service providers, healthcare professionals and commissioners***

**Service providers** (general practices ensure that policies and processes are in place so that all recommended treatment options are tried for adults with persistent, unexplained dyspepsia or GORD symptoms, but if there is no response to treatment there is a discussion with the patient about referral to a specialist service.

**Healthcare professionals** ensure that all recommended treatment options are tried for adults with persistent, unexplained dyspepsia or GORD symptoms, but if there is no response to treatment they have a discussion with the patient about referral to a specialist service.

**Commissioners** (clinical commissioning groups [CCGs] and NHS England) ensure that they commission services that discuss referral to a specialist service with adults with persistent, unexplained dyspepsia or GORD symptoms that have not responded to treatment. Commissioners should also ensure a suitable specialist service is available.

### ***What the quality statement means for patients, service users and carers***

**Adults with unexplained indigestion or heartburn** that does not go away and has not improved with medication should talk to their GP about the possibility of being referred to see a specialist.

### ***Source guidance***

- [Dyspepsia and gastro-oesophageal reflux disease](#) (2014) NICE guideline CG184, recommendation 1.11.1 (key priority for implementation) and 1.6.10.

### ***Definitions of terms used in this quality statement***

#### **Persistent, unexplained dyspepsia or gastro-oesophageal reflux disease (GORD) symptoms**

Adults of any age with ongoing dyspepsia or GORD symptoms that are not explained by a previous endoscopy. [Expert opinion]

#### **Not responded to treatment**

Adults with severe and frequent dyspepsia or GORD symptoms may need to try a high dose proton pump inhibitor (PPI), an alternative PPI or H<sub>2</sub> receptor antagonist (H<sub>2</sub>RA) therapy in order to manage their symptoms (in line with current guidelines for specific conditions). If all medication options have been tried and there is still no improvement in symptoms it should be concluded that the patient has not responded

to treatment. [Adapted from [Dyspepsia and gastro-oesophageal reflux disease](#) (NICE guideline CG184) recommendations 1.4.6, 1.6.5, 1.6.8, 1.6.10, 1.7.10, 1.8.5]

### **Specialist service**

A consultant led medical or surgical service. [Adapted from [Dyspepsia and gastro-oesophageal reflux disease](#) (NICE full guideline CG184) review question 4.9.1]

### ***Question for consultation***

For how long should treatment be tried before a referral to a specialist service is discussed with a patient with persistent unexplained dyspepsia or GORD symptoms?  
Please explain your answer.

## Status of this quality standard

This is the draft quality standard released for consultation from 27 February to 27 March 2015. It is not NICE's final quality standard on dyspepsia and GORD. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 27 March 2015. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the [NICE website](#) from July 2015.

## Using the quality standard

### *Quality measures*

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its [Indicators for Quality Improvement Programme](#). If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [What makes up a NICE quality standard?](#) for further information, including advice on using quality measures.

### *Levels of achievement*

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of



100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

### ***Using other national guidance and policy documents***

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources.

## **Diversity, equality and language**

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between healthcare practitioners and adults with dyspepsia or GORD is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with dyspepsia or GORD should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

## **Development sources**

Further explanation of the methodology used can be found in the quality standards [Process guide](#).

## ***Evidence sources***

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Dyspepsia and gastro-oesophageal reflux disease](#) (2014) NICE guideline CG184.
- [Referral guidelines for suspected cancer](#) (2005) NICE guideline CG27.

## ***Policy context***

It is important that the quality standard is considered alongside current policy documents, including:

- Public Health England (2014) [Helicobacter pylori: diagnosis and treatment guide for primary care](#)
- Department of Health (2005) [National service framework: long-term conditions](#)

## ***Definitions and data sources for the quality measures***

- Health and Social Care Information Centre (2014) [Care.data](#)
- Health and Social Care Information Centre (2014) [Clinical Commissioning Group outcomes indicator set \(CCG OIS\)](#)
- Public Health England Quality Guidance (2014) [UK Standards for Microbiology Investigations - SMI Q1: Commercial and in-house diagnostic tests: evaluations and validations.](#)

## **Related NICE quality standards**

### ***Published***

- [Acute upper gastrointestinal bleeding](#) (2013) NICE quality standard 38
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15
- [Alcohol dependence and harmful alcohol use](#) (2011) NICE quality standard 11
- [Smoking cessation: supporting people to stop smoking](#) (2013) NICE quality standard 43.

***In development***

- [Managing medicines in care homes](#). Publication expected March 2015.

***Future quality standards***

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Community pharmacy: promoting health and wellbeing
- Effective antimicrobial stewardship
- Gastro-oesophageal reflux (children)
- Hernia (including femoral and inguinal)
- Long-term conditions, people with comorbidities, complex needs
- Managing symptoms with an uncertain cause
- Medicines management: managing the use of medicines in community settings for people receiving social care
- Medicines optimisation (covering medicines adherence and safe prescribing)
- Oesophagogastric cancers
- Referral for suspected cancer

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

## **Quality Standards Advisory Committee and NICE project team**

### ***Quality Standards Advisory Committee***

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

#### **Ms Deryn Bishop**

Public Health Behaviour Change Specialist, Solihull Public Health Department

#### **Dr Alastair Bradley**

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#### **Jan Dawson**

Registered Dietitian

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Co-Director, Ageing Society Grand Challenge Initiative, Coventry University

#### **Ms Margaret Goose**

Lay member

#### **Dr Madhavan Krishnaswamy**

Consultant Clinical Oncologist, Southend University Hospital NHS Trust

#### **Mrs Geeta Kumar**

Clinical Director, Women's Services (East) Betsi Cadwaladr University Health Board

#### **Mrs Rhian Last**

Clinical Lead, Education For Health

#### **Dr Hugh McIntyre (Chair)**

Consultant Physician, East Sussex Healthcare Trust

**Ms Ann Nevinson**

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**Dr Jane O'Grady**

Director of Public Health, Buckinghamshire County Council

**Mrs Jane Orr-Campbell**

Director, Orr-Campbell Consultancy, Bedfordshire

**Professor Gillian Parker**

Professor of Social Policy Research and Director, Social Policy Research Unit,  
University of York

**Mr David Pugh**

Independent Consultant, Gloucestershire County Council

**Dr Eve Scott**

Head of Safety and Risk, The Christie NHS Foundation Trust, Manchester

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Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

**Mr Darryl Thompson**

Registered Nurse (Mental Health), South West Yorkshire Partnership NHS  
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**Mrs Julia Thompson**

Health Improvement Principal, Sheffield City Council

**Mrs Sarah Williamson**

Clinical Quality Assurance and Performance Manager, NHS Stockport Clinical  
Commissioning Group

The following specialist members joined the committee to develop this quality  
standard:

**Professor Hugh Barr**

Consultant Upper Gastrointestinal Surgeon, Gloucestershire Hospitals NHS Trust

**Dr Mark Follows**

GP, St James Medical Practice, Norfolk

**Mrs Ann Harding**

Lay member

**Professor Janusz Jankowski**

Consultant Physician and Honorary Professor, University Hospitals Coventry & Warwickshire NHS Trust

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**Rachel Neary-Jones**

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**Jenny Mills**

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## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathway on [dyspepsia and gastro-oesophageal reflux disease](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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