

→ Background

CholeQuIC-ER launched in July 2019 with the aim of radically improving outcomes for patients with gallstone disease by reducing time to surgery for this patient group. The project expands on the learning from **CholeQuIC**, the successful 13 site collaborative, where sites demonstrated significant improvement ([see associated publications](#)).

Prior to COVID-19, the 23 participating sites had been making good progress in achieving the project's aims. Most sites were collecting data and implementing improvement plans within the first three months; changes were introduced and improvements with time to surgery were being demonstrated by the six month point; see Chart 1, showing the average time to surgery across the full cohort.

The project was due to close June 2020, however due to COVID-19 and the temporary suspension of laparoscopic surgery, the project was extended by 6 months, and we will continue to work with our teams until December 2020.

We are currently supporting teams on the ground as they restart their emergency gallstone services.

→ Key themes

- **Initial impact of COVID-19**
 - » All sites, with the exception of **The Royal Bournemouth and Christchurch NHS Foundation Trust**, outlined that that COVID-19 has had a significant impact on the way they deliver care to patients with gallstone disease.
 - » At the start of the UK pandemic (March 2020), admission numbers dropped markedly, and with the majority of sites following the **Intercollegiate General Surgery Guidance on COVID-19**, most sites stopped laparoscopic surgery (see yellow and purple lines on Chart 2). The guidance at the time stated that surgeons should 'consider laparoscopy only in selected individual cases' and that 'where non-operative management is possible and reasonable (such as for early appendicitis and acute cholecystitis) this should be implemented'. Therefore the sites stopped laparoscopic surgery and managed patients conservatively using drains or antibiotics.

Recent communication with CholeQuIC-ER teams



On 16 June 2020, a CholeQuIC-ER re-launch webinar was held.

19 of the 23 CholeQuIC-ER sites attended the webinar.

3 of the remaining 4 who did not attend articulated their local situation via telephone call or email.



Chart 1: Average time to surgery – week

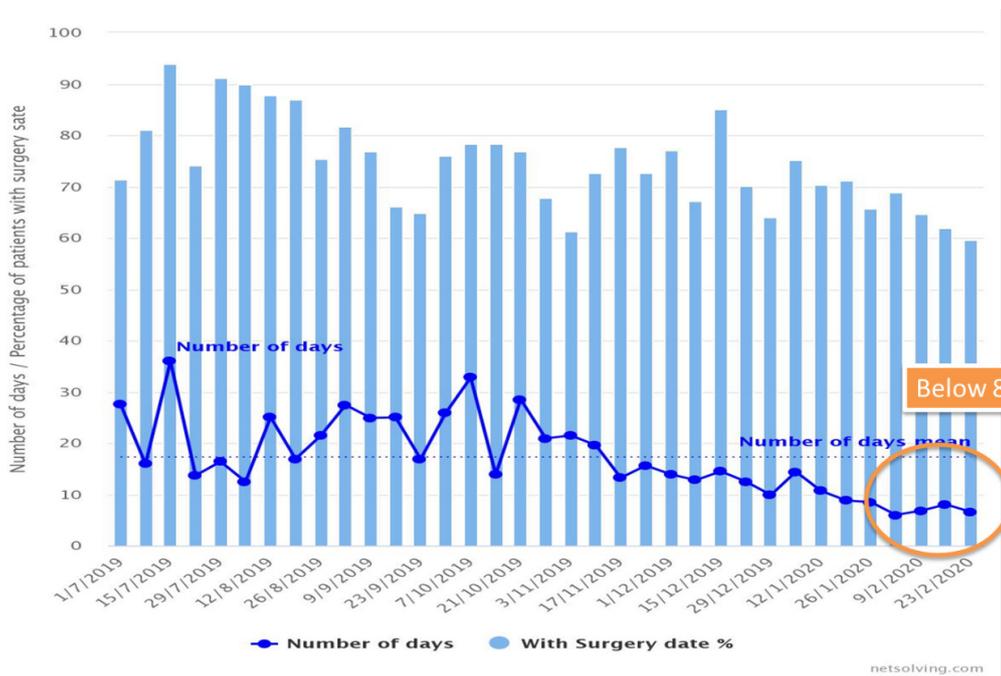
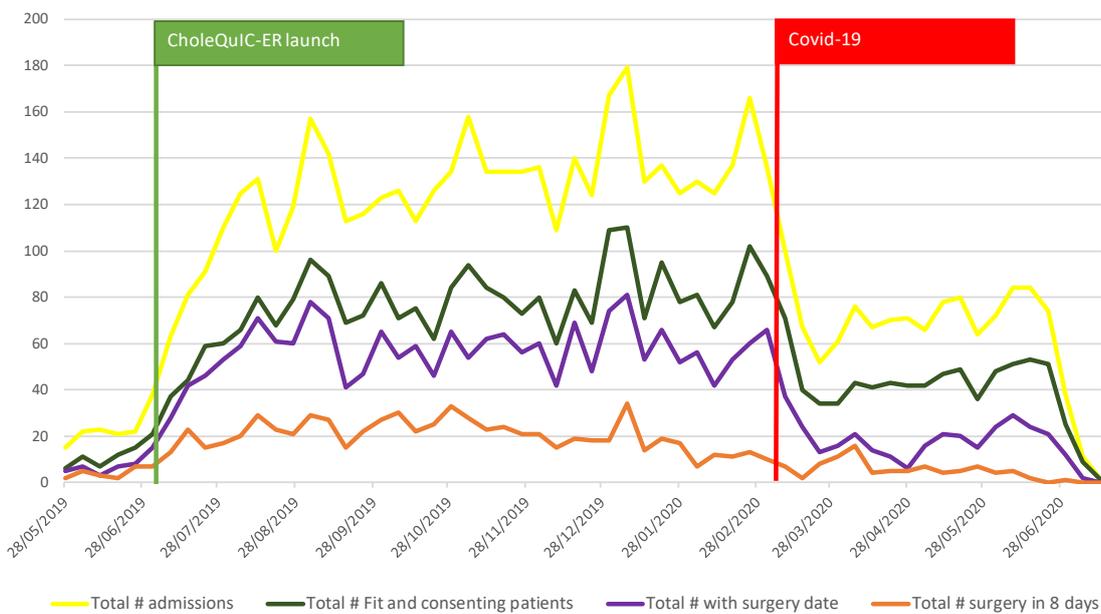


Chart 2: Number of admissions and surgery numbers across CholeQuIC-ER cohort



→ Key themes continued

- **Impact of revised guidance and approach**
 - » Although the **NHS Clinical guide to surgical prioritisation during the coronavirus pandemic** has identified ‘cholecystectomy – post acute pancreatitis’ as Priority 3 surgery that can be delayed for up to three months and ‘cholecystectomy – after biliary colic/cholecystitis’ as Priority level 4 surgery that can be delayed for more than 3 months, all national and international guidelines advocate emergency surgery within 72 hours as the optimal treatment. We would recommend that the ideal treatment is within 72 hours and therefore the priority should be re-graded to Priority level 1b Urgent (operation needed with 72 hours). However, we recognise that during this phase of the pandemic, surgery for both ‘...acute pancreatitis’ and ‘...biliary colic/cholecystitis’ may need to be delayed for up to 4 weeks, so it may be appropriate to re-grade it to Priority 2 (can be deferred for up to 4 weeks).
- » The **Intercollegiate General Surgery Guidance** on COVID-19 was updated on 30 May 2020 and now supports hospitals restarting laparoscopic surgery, provided all risks are mitigated against.
- » As a result of this, sites have restarted their acute gallbladder services and are beginning to carry out laparoscopic cholecystectomies.
- **Utilisation of private hospitals**
 - » Some sites have been able to use private hospitals to carry out laparoscopic cholecystectomies, while others have not.
- **Equipment used to mitigate risks**
 - » Some sites have been using CONMEDs AirSeal. Teams have found it is difficult to gain access to the machine as many teams are competing to use it.
 - » Some sites have not been using AirSeal and have mitigated risks by using a smoke extraction device, and wearing PPE3.
- **Prioritisation and guidance from CholeQuIC-ER project team**
 - » Patient outcomes are improved by reducing their total exposure time in hospital. Where possible emergency patients presenting with acute biliary pain should have a laparoscopic cholecystectomy straight away as they can be sent home the following day, whereas if they are discharged before an operation they will have to self-isolate for 14 days before their surgery.
 - » We are working on proposed updates to both the **Intercollegiate General Surgery Guidance on COVID-19** and **NHS Clinical guide to surgical prioritisation during the coronavirus pandemic**. We hope to get the guidance documents updated so they better meet the needs of patients with gallstone disease.
 - » There is a need to balance waiting lists against emergency patients.
 - » Patients with acute pancreatitis or acute cholecystitis should be prioritised.

¹AUGIS, 2015, Pathway for the management of acute gallstone diseases www.augis.org/wp-content/uploads/2014/05/Acute-Gallstones-Pathway-Final-Sept-2015.pdf

British Society of Gastroenterology, 2019, Practical guide to the management of acute pancreatitis <https://fg.bmj.com/content/10/3/292>

International Association of Pancreatology /American Pancreatic Association, 2013, Evidence-based guidelines for the management of acute pancreatitis www.mdl.nl/sites/www.mdl.nl/files/richlijnen/IAP-APA_Evidence-based_Guidelines_Management_Acute_Pancreatitis_-_Pancreatology_2013.pdf

National Institute for Health and Care Excellence, 2014, Gallstone disease: Clinical guideline [CG188] www.nice.org.uk/guidance/cg188



Case study – The Royal Bournemouth and Christchurch NHS Foundation Trust

The Royal Bournemouth and Christchurch NHS Foundation Trust was not impacted by COVID-19 as much as they originally anticipated they would be. They suspended elective surgery, theatre capacity reduced, and team members were re-deployed, but the trust were able to continue to carry out hot laparoscopic cholecystectomies. The team collaborated with Spanish and Italian colleagues who carried on performing laparoscopic surgery throughout the pandemic. The trust took the approach that they the safest way to treat biliary patients presenting as an emergency, was to reduce their total exposure time in hospital. Therefore, they decided not to treat patients conservatively with drains or antibiotics, as this would increase the time they would spend in hospital. Instead, they operated on patients and then discharge them as soon as they could. They utilised the trust's contract with a private hospital and carried out laparoscopic cholecystectomies there. When carrying out laparoscopic surgery, they mitigated against the risks by using a smoke evacuator, sucked out all the gas before removing the gallbladder and used PPE3.

The team have been able to make a marked improvement on their average time to surgery during the pandemic. The mean time to surgery from March 2020 – May 2020 was below 3 days, as opposed to a mean of 16 days from July 2019 – March 2020.

The team continue to prioritise patients and balance acute patients with elective patients who have been waiting for an operation. They expect that they will gain access to more theatre capacity and this will help them to continue to build on their excellent progress. The project lead for Bournemouth shared their experience to date with the rest of the CholeQuIC-ER cohort at the 16 June 2020 webinar. This provided valuable information for trusts and health boards who had stopped laparoscopic cholecystectomies and are in the process of re-starting their services.

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