British Society of Gastroenterology response to the APPG on Hepatology Liver Inquiry

The British Society of Gastroenterology (BSG) is pleased to respond to this consultation. The BSG is a specialist medical society representing over 3500 doctors, nurses and scientists working in the fields of gastroenterology and hepatology, many of whom are dealing with the rising problem of liver disease.

1. What is your assessment of progress in tackling liver disease since 2010?

Whilst there appears to be greater awareness that liver disease is a rising problem, and there have been some positive moves in Primary and Secondary care settings as well as amongst commissioners, there is no overarching, coherent national plan to tackle it. In this regard the absence of the publication of the National Liver Strategy, announced with some fanfare in 2009-10, is deeply disappointing for the BSG and its members. In addition, the Government’s u-turn on the introduction of a minimum unit price for alcohol amounts to the single biggest missed opportunity to reduce alcohol-related liver disease admissions and mortality. A ban on below cost-selling, on the contrary, which the Government intends to introduce, is a largely ineffective measure which the latest research suggests will reduce alcohol consumption by approximately 0.04%.

There has been some welcome progress on local initiatives; however, this progress is inconsistent and there is effectively, at present, a “postcode lottery” for liver disease services, as evidenced in the NHS Atlas of Variation in Healthcare for People with Liver Disease. Work on the implementation of Alcohol Specialist Nurses (implementation up from 42% of Trusts in 2009 to 79% in 2011) and Alcohol Care Teams (ACTs) (23%), are examples of highly effective and evidence-based service interventions which should be rolled out more widely.

Despite the lack of a joined up framework, a wealth of evidence exists on how to tackle the current liver disease epidemic, to which the BSG has contributed significantly. Indeed, the BSG has produced its own Commissioning guidance document, in conjunction with other professional societies and patient groups, which has been sent to all Clinical Commissioning Groups. This comprehensive document includes sections on chronic liver disease; viral hepatitis; alcohol dependence and harmful alcohol use; physical complications related to alcohol-use disorders; and preventing harmful drinking. There is also NICE guidance either published, in development or referred on preventing harmful drinking; alcohol dependence and harmful alcohol misuse; Cirrhosis, Hepatitis B, Liver disease (non-alcoholic), Obesity, Pancreatitis (including acute pancreatitis) & preventing harmful alcohol use.

The BSG has also produced a paper alongside the Alcohol Health Alliance (AHA) and the British Association for the Study of the Liver (BASL) on how to improve alcohol related services. The recent

1. Atlas of Variation for Liver Disease
2. Impact of nurse-led ALS – Steve Ryder et al, Clinical Medicine, 2010
3. Alcohol Care Teams: reducing acute hospital admissions and improving quality of care – NHS Evidence QIPP paper, BSG and Bolton Hospital NHSFT
4. BSG Commissioning Guidance Document
NCEPOD Report into alcohol-related liver disease was also particularly effective in highlighting both the scale of the problem faced and measures to tackle it.

The BSG welcomes measures such as the inclusion of liver disease in NHS and public health outcomes frameworks, the recognition of liver disease in Public Health England’s (PHE) “Longer Lives Map” of preventable mortality, the inclusion of liver disease in the Department of Health’s call to action on reducing premature mortality, the appointment of Dr Michael Glynn as National Clinical Director for GI and Liver at NHS England and previously Prof. Martin Lombard at the Department of Health.

Although a focus on local solutions is important, an overarching national framework for action on liver disease is urgently required and Clinical Commissioning Groups and local authorities need much more guidance than they are currently receiving.

2. Looking at the reforms to health and social care, what are (a) the biggest opportunities and (b) the biggest threats for tackling liver disease?

The separation of public health from the NHS through the creation of PHE is both a potential opportunity for, and a threat to, liver disease; it is essential that the two organisations work in a coordinated manner. PHE can work with the NHS to help tackle liver disease, for example through joint training in public health for hospital consultants (and vice versa to some extent), and joint training in gastroenterology and hepatology in substance misuse. The BSG welcomed Lord Darzi’s suggestions in the NHS Next Stage Review report ‘High Quality Care for All’ that there should be opportunities for doctors to train jointly in a clinical specialty and public health. For example, in a team of ten cardiologists or gastroenterologists, it would be sensible to have at least one team member taking a population-wide view and prioritising preventative measures. Some continuing clinical commitment to individual patients for trained public health doctors would help their perspective too. The benefits of an integrated approach would quickly become clear as interventions in secondary care help to identify people who need support and those at risk. Public health training with a special focus on alcohol and obesity would help to promote effective and robust pathways within local health systems.

There is also an opportunity for primary care to make significant advances in the early identification of liver diseases; there is good evidence that tests are available which do permit early identification of severe liver disease in the community/primary care (fibrosis markers). However, knowledge of the presence of liver disease, risk factors for it and the use of these tests is poor. Using approaches such as that piloted by Dr Nick Sheron and colleagues at University of Southampton and Southampton General Hospital in the creation of a new “traffic light” system for liver disease risk should be generalised across the UK. Better use could also be made of the QOF payments framework in primary care for liver disease. There are currently no indicators for liver diseases despite high incidence and mortality.

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6 NCEPOD report - Alcohol Related Liver Disease: Measuring the Units (2013) – again shows poor performance
The “integration pilots” scheme launched by DH is a step in the right direction in terms of better integration of services at the primary, secondary and community care level; better integration in liver services will save lives and reduce financial pressures faced by Hospitals. This could present an opportunity to embed ACTs which are highly recommended by an NHS Evidence QIPP paper (referenced Q1). ACTs are led by a hospital-based consultant to coordinate policies of care across acute departments, establishing links to community services through a 7-day Alcohol Specialist Nurse Service. The wider rollout of these teams would ensure a more integrated approach to care for alcohol-related liver disease patients.

There is also a significant opportunity to tackle viral hepatitis, where recent technological advances mean that this is completely curable and open up the prospect of completely eradicating the disease.

3. **What support do different organisations need in improving liver disease outcomes?** [For example, commissioners, providers, GPs, prisons, drug action teams].

As stated above, a national framework for liver services is essential given the varied quality of services across the country; however, on a local level there needs to be a named clinical lead for liver disease, responsible for composing, and monitoring the outcomes of, a local “liver plan” to meet liver disease needs. These could be established in England along the lines of the Local Area Team geographies. The BSG would be able to assist in suggestions of members to approach in each area but a national framework must exist for guidance. PHE should also have a lead for liver disease and local authority Directors of Public Health should appoint leads for liver disease, to liaise with the Local Area Team liver lead. The BSG Commissioning Guidance document (referenced earlier) also provides a useful evidence base and commissioning framework for improved joint working.

4. **What opportunities do you see for early diagnosis and/or prevention of liver disease?**

Improved primary care for liver diseases through the earlier identification of those with unsuspected liver disease is crucial. ACTs also have a significant role to play, in ensuring that those at risk of liver disease don’t simply become “revolving door patients” who return to hospital frequently rather than receive intervention at an earlier stage in the community or after discharge from hospital.

As stated earlier, from a policy point of view, the introduction of a minimum unit price for alcohol is a huge opportunity for beginning to tackle alcohol-related liver disease. It is a targeted, effective policy which would reduce alcohol-consumption levels. The Government needs to follow in the footsteps of the Scottish, Irish (both North and South) and Welsh devolved governments who are all either introducing a minimum unit price for alcohol or giving the policy serious consideration.

Liver disease is one of the top 3 causes of preventable mortality; this in itself shows how much of an opportunity there is to tackle it.

5. **How can we avoid unwarranted variation in liver disease outcomes across England?**
As set out above, the BSG supports a national framework of guidance and interventions based on local need and led by local leads on liver disease. This is in addition to improved training and better collaboration between the NHS and PHE, including the creation of a liver disease-lead at PHE and within local authorities.

The BSG’s Commissioning Guidance document provides a best practice commissioning guide for all CCGs. Again, the NICE publications (also referenced earlier) offer a guide to any future national plan, however, the implementation of these guidelines, as well as the measurement of outcomes are not being monitored or enforced adequately.

6. Can you give examples of where a part of the pathway is working well in an area, or where it is not?

The NHS Atlas of Variation helps to identify examples of best practice and areas where liver services are in need of significant improvement. However, this work has not been properly embedded or scrutinised and needs further attention; a CQC “Keogh-style” review of liver services within LAT geographies across the country would be one possible way of improving both the local variation and pathways. The NCEPOD report highlights areas where practice has been poor.

The BSG would be willing to lead service based reviews for liver disease where mortality is high or an outlier, in a similar vein to the work Prof Sir Mike Richards is conducting as Chief Inspector of Hospitals. A key problem is the lack of detailed service and outcomes data in liver disease. The BSG would support the establishment of improved data collection methods and is willing to play a leading role in driving this. The BSG and partners recently launched the Inflammatory Bowel Disease Registry to support service quality improvement and research. A similar model could be adopted with liver disease.

NICE publications have been helpful but their remit for guidelines and quality standards is extremely vast and the need for improvements to liver disease services is urgent. We believe NHS England has a role here to do more to measure adherence to guidelines & quality standards. However, more needs to be done by the clinical community to improve interactions/hand-offs between organisations and different parts of the health system (eg. acute to mental health or acute to primary care & social services). The earlier point about improvement in primary care diagnosis is also relevant here.