All Party Parliamentary Hepatology Group (APPHG) Inquiry
Institute of Alcohol Studies response

The Institute of Alcohol Studies (IAS) is pleased to submit the following responses to questions raised as part of the APPHG inquiry. The IAS is an independent organisation whose broad aim is to increase awareness of alcohol-related issues in society. It does not depend on the Government or the alcohol industry for funding and, in consequence, can provide a truly independent opinion on alcohol policy.

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

A. There is considerably ***more information*** in the public domain now than pre 2010 on both the antecedents of liver disease and on liver disease itself from a variety of sources e.g.

(i). NICE

a. Clinical Guidelines

CG98	Neonatal jaundice	May 2010
CG100	Alcohol-use disorders: physical complications	June 2010
CG115	Alcohol dependence and harmful alcohol use	February 2011
CG141	Acute upper GI bleeding	June 2012
CG165	Hepatitis B (chronic)	June 2013

b. Public Health Guidance

PH24	Alcohol-use disorders - preventing harmful drinking	June 2010
PH35	Preventing type 2 diabetes - population and community interventions	May 2011
PH38	Preventing type 2 diabetes - risk identification and interventions for individuals at high risk	July 2012
PH42	Obesity - working with local communities	November 2012
PH43	Hepatitis B and C - ways to promote and offer testing	December 2012

c. Quality Standards

QS11	Alcohol dependence and harmful alcohol use	Aug 2011
QS38	Acute upper gastrointestinal bleeding	July 2013

d. Interventional Procedures Guidance

IPG392	Stent insertion for bleeding oesophageal varices	April 2011

IPG459	Selective internal radiation therapy for primary cholangiocarcinoma	July 2013
IPG460	Selective internal radiation therapy for primary hepatocellular carcer	July 2013
e. Technology appraisal guidance		
TA253	Hepatitis C (genotype 1) - boceprevir	April 2012
TA252	Hepatitis C (genotype 1) - telaprevir	April 2012
TA189	Hepatocellular carcinoma (advanced and metastatic)-sorafenib (1st line)	May 2010
TA200	Hepatitis C - peginterferon alfa and ribavirin	September 2010

(ii). DEPARTMENT OF HEATH

a. **Alcohol**

- A Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Alcohol Harm Reduction Interventions October 2011
- Alcohol strategy March 2012
- *See also* Government response to the House of Commons Health Select Committee inquiry on the Government's Alcohol Strategy. September 2012
- DoH commissioning guidance for alcohol services
  - *Alcohol learning Centre, Ready Reckoner* http://www.alcohollearningcentre.org.uk/
  - *Signs for improvement: commissioning interventions to reduce alcohol-related harm*, July 2009
  - *Creating Strong, Safe and Prosperous Communities*, http://www.communities.gov.uk/publications/

b. **Obesity**

- Strategic High Impact Changes: Childhood Obesity: April 2011
- Healthy Lives, Healthy People: A Call to Action on Obesity in England October 2011

c. **Liver disease**

- Living Well for Longer: A call to action to reduce avoidable premature mortality March 2013

(iii) RightCare NHS

- NHS Atlas of Variation: Liver Disease 2011

(iv) BRITISH SOCIETY FOR GASTROENTEROLOGY

- Moriarty K J, Alcohol-Related Liver Disease: Meeting the challenge of improved quality of care and improved quality of care and better use of resources. 2010. A Joint Position Paper

on behalf of the British Society of Gastroenterology, Alcohol HealthAlliance UK, British Association for Study of the Liver http://www.bsg.org.uk/clinical/general/publications.html

- Published on behalf of the British Society of Gastroenterology and Bolton NHS Foundation Trust, Quality and Productivity: Alcohol Care Teams: reducing acute hospital admissions and improving quality of care. 2012. http://www/evidence.nhs.uk/qipp

- Commissioning Evidence-based Care for Patients with Gastrointestinal and Liver Disease (with others) http://www.bsg.org.uk/images/Commissioning_report/BSG_Commissioning%20Report.pdf

(v) NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND DEATH (NCEPOD)

- Bariatric Surgery: Too Lean a Service? (2012)
- Alcohol Related Liver Disease: Measuring the Units (2013)

B. There is greater public and professional ***awareness*** of the problems of liver disease.

C. There has been more widespread ***implementation*** of Alcohol Specialist Services and Alcohol Care Teams across the country although the service is still patchy in some parts of the country and still under funded in others. However, the Government's complete U-Turn on minimum pricing, which was one of the main tenets of NICE Public Health Guidance (PH24), has removed the single, most effective, proposed measure for combating not only alcohol misuse *per se* but also alcohol—related liver disease.

Some initiatives directed at improving services for liver disease *per se* have been implemented at local levels e.g. Liverpool PCT-CCG has promoted risk assessment and early recognition of liver disease through the use of a locally enhanced service payment to minimise late diagnosis while in Nottingham all CCG referrals from individual practices are screened by a general practitioner with an interest in gastroenterology and only referred onwards if indicated. However, there is no easily accessible, coherent national plan for liver services since the abandonment of the promised Liver Strategy. Thus, although a focus on local solutions is important, an overarching national framework for action on liver disease is urgently required.

2. Looking at the reforms to health and social care, what are

a. the biggest opportunities for tackling liver disease?

This is very difficult to gauge at present and it is possible that many of the opportunities will be lost in a bureaucratic quagmire. How this might happen is best illustrated by the Government's response to the House of Commons Health Select Committee (HSC) Report on the Alcohol Strategy.

HSC recommendation:

The Committee believes that an Alcohol Strategy should be seen as part of a wider public health strategy, and should contain some key quantified, alcohol-specific objectives which will provide both a framework for policy judgements and an accountability framework. It seems logical that Public Health England should oversee this process, given its overarching responsibility for public health matters. It also seems logical that Public Health England should devise the national measures against which the strategy can be tested.

Government's response:

It is for the Government rather than Public Health England, to set national objectives for public health, together with the Public Health Outcomes Framework.

Thus, even logical assumptions, such as those made by the HSC, may be incorrect as it is unclear who is actually pulling what strings. Very little is known or has been published about the various strands of the commissioning for liver services. In an ideal world there would be transparent declarations of what is planned so that stakeholders could be more directly involved in the process

b. the biggest threats to tackling liver disease?

(i) The abandonment of the Liver Strategy

(ii) The removal of the Liver Czar.

Dr Mike Glyn has been appointed as National Clinical Director for Gastroenterology and Liver Diseases at the National Commissioning Board. This is a substantial undertaking and will clearly mean that liver services will not receive undivided attention.

(iii) The very real possibility that PHE and NHS England will not work together effectively.

The three main causes of liver disease in the UK are alcohol, obesity and infection with the hepatitis B and C. In each instance there is a need for major and significant public health input to tackle the underlying issues in addition to a major health service input to tackle the associated liver disease. It would now appear likely, mainly in consequence of the health and social care reforms, that three entirely separate 'liver disease lobbies' will emerge, each vying for the available funds. This is reflected in the current landscape and well illustrated by the following.

Public Health England:
Local authorities and CCGs will require support in the form of a national service framework which could be adapted to local needs, backed up opportunities to share best practice. These frameworks could be directed by PHE, with established experts setting out, and supporting the implementation of principles for action rather than prescriptive plans. However, there is already clear evidence of significant and unacceptable disparity

in the level and quality of the approach to the three main areas associated with liver disease.

Obesity: PHE has an established Obesity Review Group.

Viral hepatitis: PHE has produced a comprehensive guide to the management of HBV (Chapter 18 in the Green Book) and also has recently published

- Hepatitis C in the UK 2013 report.
- An audit of hepatitis C services in a representative sample of English prisons, 2013

It also has an Advisory Group on Hepatitis

Alcohol: Although it is stated that PHE has an alcohol remit this is not evident. It is not specifically mentioned for action in its stated mission to reduce premature deaths *viz*:

- Support people to live healthier lives by implementing NHS Healthchecks
- Accelerate efforts to promote tobacco control and reduce the prevalence of smoking.
- Report on premature mortality and the Public Health Outcomes Framework.
- Enable improved integration of care, to support local innovations to find alternatives to hospital-based care, especially for our frail older population.

In addition the only document posted on its website is the Government's responses to its consultation on the Alcohol Strategy which contained no reference to liver disease or indeed to any alcohol-related morbidities.

There is no Advisory Group on Alcohol.

Difficulties will clearly arise if PHE follow the lead taken by NICE PH24 in recommending minimum pricing for alcohol but are prevented from pursing this because it is now contrary to Government wishes.

NHS England.

NHS England should provide local commissioning groups with guidance on the best practice for commissioning comprehensive treatment services, based, where available, on the NICE guidance and published quality standard. They should hold commissioning consortia to account on their performance against a set of indicators relating to treatment services, linking to the shared mortality improvement area to reduce the under 75 mortality rate for liver disease in the NHS Outcomes Framework.

The Prescribed Specialist Services Advisory Group (PSSAG) for liver disease, which is the ministerial group which will advise the Secretary of State for Health on commissioning, has only just been convened and it is not known when it will make its recommendations.

A number of Specialist Commission Groups have been set up to develop service specifications for what they expect to be in place for providers to offer evidence-based, safe and effective services. There are four which are relevant to liver disease. The main one, which falls under the internal medicine section, is the most important (A02); within liver disease it covers

- acute liver failure
- complicated chronic liver disease e.g. variceal haemorrhage, intractable ascites; hepatorenal syndrome; multiorgan failure
- complicated viral hepatitis e.g. co-morbid HIV or haemophilia
- primary cancers of the liver and biliary tree

The other three Commissioning Guides in this area concentrate on Liver Transplantation; Cancer Services; and the use of Internal Ionising Radiation for Hepatobiliary Cancers.

These specialist commissioning guide are only relevant to the practices of the small number of specialist liver and transplant units in England. Vastly more patients are managed in primary and secondary care and commissioning for these services are not at present nationally guided.

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

The requirements for support will differ at every service level and so no specific formulation can be provided. However, it is essential that there is a national framework for liver disease to ensure consistency of service provision across the country. There should in addition be local area appointees for liver services, one clinical and one public health. These local champions could be responsible for ensuring that local services match national requirements, are modified as needed to take account of local conditions and could monitor service provision and outcomes. They could also ensure that service delivery in the community, primary and secondary care is fully integrated

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

Clearly preventing and limiting alcohol misuse; preventing and managing obesity; and, where possible, preventing infection with hepatitis B and C and effectively treating those who are already infected. This will mean screening and effective early intervention and long-term follow-up. These opportunities could be provided if PHE and NHS England work effectively together. Reversing the Government's decision on minimum pricing would have a significant beneficial effect on preventing and limiting alcohol-related liver disease.

5. How can we avoid unwarranted variation in liver disease outcomes across England?

Knowing what causes the inequalities and dealing with them. The NHS Atlas of Variation: Liver Disease 2011 provides information on where the inequalities exist and provides examples of best practice. These data should be updated on an annual basis. The DoH published a useful document in October 2011 entitled A Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Alcohol Harm Reduction Interventions. Stipulated best service specifications which include community and public health are needed

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

The Atlas of Variation: Liver Disease 2011 provides examples of areas where service provision is good and areas where services are in need of significant improvement. Likewise the recent NCEPOD report identifies areas where practice needs to be improved. Overall the provision of service is not optimal. Examples of good practice in one area may not be easily transferable elsewhere as they often depend on the expertise and enthusiasm of a single practitioner.

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