The Lancet Commission into Liver Disease in the UK

Report of the launch meeting of the report “Disease burden and costs from excess alcohol consumption, obesity and viral hepatitis: fourth report of the Lancet Standing Commission on Liver Disease in the UK”
The Kohn Centre, Royal Society of London, Wednesday 29th November 2017

Dr Richard Horton, editor of The Lancet, opened the meeting with a reflection on the particular strength of the Commission in comparison with other public health initiatives, in that it is bringing together the voices and expertise of both public health experts and clinicians. He welcomed to the meeting Dame Sally Davies, Chief Medical Officer for England, who has been an advocate on many public health matters during her period as CMO, particularly the issue of antimicrobial resistance but also warning of the perils of the rising levels of liver disease, the importance of which she first flagged up in her annual report of 2011. Professor Roger Williams joined RH in thanking Dame Sally for her continuing support and hailed the UK Supreme Court decision on the introduction of Minimum Unit Pricing in Scotland as an example of the change that can be achieved through concerted efforts.

Dame Sally echoed RW and RH in stating that the flag has been raised on the importance of public health issues such as obesity and liver disease and that her role to a large extent is to encourage and enable coalitions of stakeholders. She cautioned that action on smoking took 40-50 years to achieve and an important lesson learned was the need to actively sell change to both politicians and public and to keep the evidence base up to date and relevant. She welcomed the 2nd Atlas of Variation produced by Public Health England as an invaluable source of data to inform the conversations that are needed.

In the following Roundtable Discussion the panel were asked how to get Public Health England and NHS England to work more closely together and Dame Sally bemoaned the apparent disconnect in effort and direction between the two organisations. In answer to a question from Professor Nick Sheron she urged the Commission to focus hard on salience which she defined as the efforts of champions, media coverage and patient power in combination to get an issue onto the political agenda. A simple, clear and strong voice is required. Professor Matthew Cramp highlighted the continuing stigma associated with liver disease and both panel and audience agreed that there is a need to widen the message and talk more about associated harm and impacts, such as crime. Professor Harry Rutter suggested the need to re-frame the problem, moving away from failure of individuals and consequent stigmatising attitudes, towards a more up-stream focus on societal and market level problems. Richard Horton summarised the discussion as a need to identify partners to form an even more broadly based coalition and to widen the message about impacts and where real changes can be achieved.

Professor Martin McKee (London School of Hygiene and Tropical Medicine), spoke next and praised the excellent data in the Lancet report, as well as in the Financial Case on Liver Disease report published in July 2017, which make an overwhelming case for action. He pointed out that liver disease accounts for many times more deaths per annum in the UK than terrorism and yet the latter captures the media attention. He suggested that the reason why, is that the so-called experts employed by those with entrenched interests argue that the problem is too ‘complex’ to be tackled. In reality, the key factors are those of a classic commercial marketing plan: Price, Availability and Marketing, and it is time that the Commission used the same tactics in structuring and delivering their own message. He concluded that the predicted 63,000 preventable deaths over the next 5 years is the greatest argument for change.

Katherine Brown (Institute of Alcohol Studies), began her presentation with some stark facts on obesity in the UK: 63% of adults aged 16 years and over are overweight or obese; 1-in-3 primary school leavers are overweight or obese; hospital admission episodes related to obesity increased 150% in the 5 year period 2010/11 – 2015/16. The cost impact is equally shocking: £6.1bn of cost to the NHS per year; £352m a year
in social care costs; £5.6bn in lost productivity costs; welfare costs of £6bn – in total, an annual cost to society of £27bn - £46bn. The figures for alcohol are equally dramatic: alcohol-related liver disease accounts for 84% of liver-related deaths, with 21,000 alcohol related deaths a year; 1.1 million hospital admissions each year are related to alcohol and there are 1 million alcohol related crimes. 167,000 working years of life lost, each year. The costs: £3.5bn NHS costs per year; £2.8bn in child services costs; £7.3bn lost productivity; £13bn criminal justice costs.

The Institute of Alcoholic Studies has been looking at new ways to get over messages on the harm caused and the true ‘victims’, and the recent White Cider campaign has been an example of how this can be achieved. The campaign included the story of a teenage girl’s death due to binge drinking of cheap white cider and her mother’s plea for changes in availability of “pocket money” priced cheap alcohol. The IAS has also surveyed pub managers who do support a change in taxation which would reduce high consumption of cheap alcohol at home and bring people back into the more controlled environment of social drinking in pubs. KB stressed that the message should not be one of prohibition but of more sensible drinking. Professor Nick Sheron, (University of Southampton), followed this presentation with data on the years of working life lost and the relationship between cirrhosis mortality and consumption of spirits and wines in the UK. There is clear evidence that mortality for cirrhosis is directly related to per capita consumption and this has been known for a long time. Data on alcohol affordability and the impact of the duty escalator are very clear and based on this data, there will be an estimated 1,700 preventable deaths if there is a delay in implementation of MUP in England until 2022. NS also highlighted the other aspect of the taxation argument – the loss of income to the Treasury by failing to raise tax on alcohol. RH thanked both speakers for their presentations and commented that in their White Cider campaign, the IAS had clearly achieved the salience that Dame Sally Davies had called for but the overarching message from these speakers is that more champions are needed.

Professor Julia Verne (Public Health England) spoke on Tackling Variations in Outcomes and the wealth of data that has been collated in the 2nd Atlas of Variation in Risk Factors and Healthcare for Liver Disease in England. Liver disease is killing young people and the age of death in the UK is lower than two European countries also known for high alcohol consumption, France and Sweden. The Atlas exposes the huge variation in disease burden and inequality both in terms of specific sectors of society affected and their access to treatment. She cautioned that in interpreting and using the data, it is important to understand the variation at local level. For alcoholic liver disease, there is wide variation in access of patients to specialist services, in hospital admissions and in successful outcomes following structured treatment interventions. Similarly for non-alcoholic fatty liver disease, hepatitis C-related end-stage liver disease and hepatocellular carcinoma, there are wide variations in availability of services and excess mortality.

The take-home messages from Professor Verne were that liver disease mortality is not reducing, hospital admissions are increasing and that there is statistically significant geographical variation in every indicator. Deprivation drives some of the geographical variation in liver disease and alcohol related morbidity drives much of the variation in mortality but not all. Geographical variation in obesity and Hepatitis B&C are also important and there are wide variations in services for patients with risk factors for liver disease. CCGs, Local Authorities and STPs need to use the data to improve outcomes.

The next speaker was Professor Graham Foster (Bart’s Health), on Meeting Elimination Goals for Viral Hepatitis B and C. The introduction of universal childhood vaccination for hepatitis B means that new infections will eventually reduce and over the next 20 years it will be increasingly a situation of case finding and treatment. The situation with hepatitis C is not so reassuring and evidence from New York shows that there the virus is in fact spreading through increasing rates of harmful drug use: 17,000 pregnant women in New York are living with hepatitis C infection. In the UK at the moment there are 100,000 cases requiring treatment and at a rate of 12,500 treated a year the UK could be the first to eliminate the virus. When it comes to delivering treatment, the lesson from Germany is that treatment rates are tailing off, probably because there is no financial incentive to prescribers for case finding. In Australia, experience shows that a
very effective treatment blitz delivering 40,000 treatment in 9 months, will need to be followed by a screening blitz as patients may not prioritise therapy. In addition, an HCV treatment drive might increase treatment rates but quality of service may suffer. Finally, access to treatment does not result in elimination; elimination needs case-finding and new tricks.

Professor Foster proposed that an attitude shift is now needed in the UK. The strategy so far has been to focus on sicker patients until the price of treatment comes down but as we move into the elimination phase, the focus needs to be on case finding and access to care through the HCV ODN model, with any doctor, drug worker, pharmacist or nurse approved to deliver treatment locally. GF echoed a point made throughout the meeting, that there is a disconnect between the organisations involved and diagnosis is not enough, it must result in treatment. To achieve success, ODNs must establish links to prisons, drug services etc and set up ‘local plans’ to eliminate, and PHE must start sharing data and working with the ODNs – reports of numbers are not enough.

The next speaker, Professor Matthew Cramp (Peninsula Schools of Medicine and Dentistry, Plymouth), had been asked to speak on Outstanding Challenges in the Hospital Sector. The reality is that 2454 patients a year are dying with ARLD: 25% were never seen by a hepatologist or gastroenterologist and there are frequently missed opportunities to change the outcome. There is very variable access to endoscopy, many hospitals being without 24/7 cover, and very variable expertise in dealing with bleeding, especially from varices. There is also a lack of formal referral arrangements for when endoscopic therapy fails. There have, however, been successes such as the introduction of the Decompensated Cirrhosis Care Bundle, the implementation of ODNs for delivery of HCV treatment, and the increased availability of fibro-scanners. The challenges that remain are a wide variability in care and outcomes and a need to raise standards in areas falling behind. For liver transplantation services, the challenge remains one of geographical inequality and across all liver services, training and workforce issues need to be addressed. The Commission continues to argue the case for establishment of acute liver services in district general hospitals linked with regional specialist centres for more complex investigations and treatment, together with increased provision of medical and nursing training in hepatology. Professor Cramp concluded by referring to the launch of the new IQUILs accreditation scheme which, though not mandatory, will raise professional standards of best practice and identify sub-optimal practice.

The first session of the afternoon ended with a general discussion. Professor Nick Bosanquet (Imperial College London) spoke briefly about the potential for scientific and political consensus and how to build this. His message echoed earlier speakers on the need to widen the message from a focus on liver disease to bring in the associated impact of crime and other societal harms. He also suggested that the message needs to be one of safer behaviours such as responsible drinking rather than being heard as a call for prohibition. He asked the speakers to address the question of how to raise the profile of at risk groups with primary care providers and queried the feasibility of every District General Hospital having a liver service. JV suggested that one approach was the hub and spoke model which has been used with success in cancer care but all agreed with the conclusion that at present, the volume of disease is exceeding the resources available for provision of services.

Professor Philip Newsome (University of Birmingham) addressed the topic of Rising Obesity Levels and Consequences. The United Kingdom now has the 7th highest rate of adult obesity and data shows that the highest rates of excess weight are predominantly in the most deprived areas. The same pattern is seen in children. The Lancet Commission strongly supports the various measures included in the Health Select Committee Recommendations but disappointingly some, such as strong controls on price promotions of unhealthy foods and drinks, have not been included in the Government’s Child Obesity Plan. PN referred to two studies, one in Berkeley, USA, which showed that introduction of a cent per ounce Sugar Sweetened Beverage (SSB) excise tax reduced consumption of these products (Silver et al. Plos Med 2017), and a
second study in Australia which showed that introduction of a 20% SSB tax reduced the mean weight of men across all age groups but the greatest benefit was seen amongst the most disadvantaged groups (Lal et al. Plos Med 2017). Turning to the issue of non-alcoholic fatty liver disease, it is estimated that 25% of the UK population now has this condition and 0.5-1% will have Non-alcoholic Steatohepatitis (NASH) and significant fibrosis. There are pharmacological treatments available which can produce significant weight loss which will significantly reduce levels of NAFLD. Bariatric surgery is also extremely effective but less than 0.3% of the eligible population are receiving this treatment. He ended his talk on a positive note, referring to the introduction of new guidelines for the management of abnormal liver blood tests.

The next speaker, Dr Helen Jarvis (Royal College of GPs) spoke on the topic of Earlier Detection of Liver Disease in General Practice. More than 90% of all liver disease is preventable and currently three quarters of people are diagnosed in hospital when they already have cirrhosis. Even moderate drinkers can develop liver damage and it is asymptomatic up until the late stages. As mentioned by the previous speaker, up to 30% of adults in the UK have NAFLD and up to 50% of patients with HBV and HCV are unaware they are infected. In response to this rising tide of illness, there is a need to make liver disease prevention, detection and treatment a central part of routine healthcare amongst the UK’s 43,000 GPs. Liver Disease is now a Clinical Priority Programme for the RCGP and HJ is working with Dr Jez Thompson, the RCGP/British Liver Trust funded Champion for Liver Disease, to introduce a variety of measures including raising awareness of the key risk factors for liver disease in primary care and guidance on early identification and management of cirrhosis; promotion of an understanding of the effectiveness of primary care interventions; support for effective primary/secondary pathways and joined up work; clear guidelines, toolkits, resources and learning materials for GPs; and input into undergraduate and postgraduate training for GPs. Overarching this is the aim to influence commissioners and policy makers in their decision making about service provision.

Dr Joanne Morling (University of Nottingham) had been asked address the issue of Screening Programmes for Liver Disease and she outlined details of The Scarred Liver Project, a Nottingham based project to introduce a novel diagnostic pathway for detection of significant liver disease in the community. The aim has been to focus on risk factors and early detection through community testing, in a cost effective way. A three step pathway has been introduced, beginning with identification of patients with risk factors (hazardous alcohol use, type 2 diabetes, obesity) and introduction of Point of Care diagnostics and Brief Interventions delivered in the community by nurses. The third step was review by specialists in primary care hepatology clinics. The outcomes of the pilot study have been very encouraging with increased detection of significant liver disease: 20% of those having a community Fibroscan were found to have significant liver disease and notably 73.1% of patients with proven cirrhosis were found to still have normal liver function enzymes.

In conclusion, The Scarred Liver Project has successfully piloted a community based risk stratification pathway for chronic liver disease which is now commissioned within the local area. The pathway integrates primary and secondary care enabling patients with liver disease to be diagnosed earlier where interventions could reduce, stop or even reverse the progression of disease. Patient satisfaction is consistently high and there has been a high rate of patient engagement – the attendance rate for community Fibroscan appointments was 95%. Furthermore, the pathway has been shown to be cost effective.

The final speaker of the meeting was Tim Baxter (Department of Health) who outlined the measures that the Government is taking. The Government is aiming to focus on harmful consumption of alcohol and is tackling alcohol misuse through preventing below cost selling, tightening the rules on irresponsible promotions and introducing new powers to deal with anti-social behaviour, as well as a commitment to a new tax band to target cheap and high strength ‘white’ ciders. Local Authorities are supported by Public
Health England in the commissioning of high quality, evidence based treatment services for their local population’s needs and the Government promotes informed choice, underpinned by the UK Chief Medical Officers’ new low risk drinking guidelines. There is an outstanding commitment to do more to support children living with alcohol-dependent parents and the Department of Health are considering what more could be done. The Department is promoting screening and brief advice through the Preventing Ill health by Risky Behaviours CQUIN which focuses on identifying and influencing inpatients who are increasing or higher risk drinkers; and inpatients who are continuing to smoke. It applies to community and mental health trusts in 2017-18 and extends to acute trusts in 2018-19. The primary deliverable is alcohol identification and brief advice (IBA) and tobacco brief advice. IBA targets are to screen 50% of all adult inpatients and to deliver a relevant intervention (i.e. brief advice or referral) to 80% of patients identified as drinking above low risk. The estimated NHS cost saving is £27 per patient receiving brief advice, each year over four years. From April 2013, an alcohol risk assessment has been a mandatory component in the NHS Health Check, so that people are given brief advice on cutting down if their drinking is putting their health at risk. Brief advice for newly registered patients became part of the GP core contract from April 2015.

TB also outlined ways in which the Department of Health is supporting specialist treatment services and referred to the measures of the Childhood Obesity Plan and the wide-ranging programme to tackle viral hepatitis. He concluded that total consumption of alcohol has fallen but there are some worrying trends in health harms, highlighted by the Lancet Liver Commission’s work and he recommended that going forward the Commission should think about the narrative of its message to Government and policy makers, and specifically consider the electoral implications of the measures it recommends and how this influences Government policy.

In summing up the meeting Richard Horton said that he felt extremely optimistic about what has been achieved to date: elimination of hepatitis C infection in the country is a realistic possibility, the Scarred Liver Project in Nottingham demonstrates a new and cost-effective way to earlier diagnosis and influence behaviour change and GPs are engaging more with liver disease and their input at primary care level. In many ways the Lancet Commission and the organisations it is working with are getting the message right but some aspects of the message need to be refined, such as how to focus on high risk groups and how to incentivise CCGs.

RH thanked Roger Williams and members of the Commission for their hard work and commitment and he also thanked the Kohn Foundation for supporting the meeting. He concluded by announcing that in addition to Lancet 5 in the UK, in 2018 there will be a new Lancet Commission on Liver Disease in Europe, to be set up in association with the European Association for Study of the Liver.