



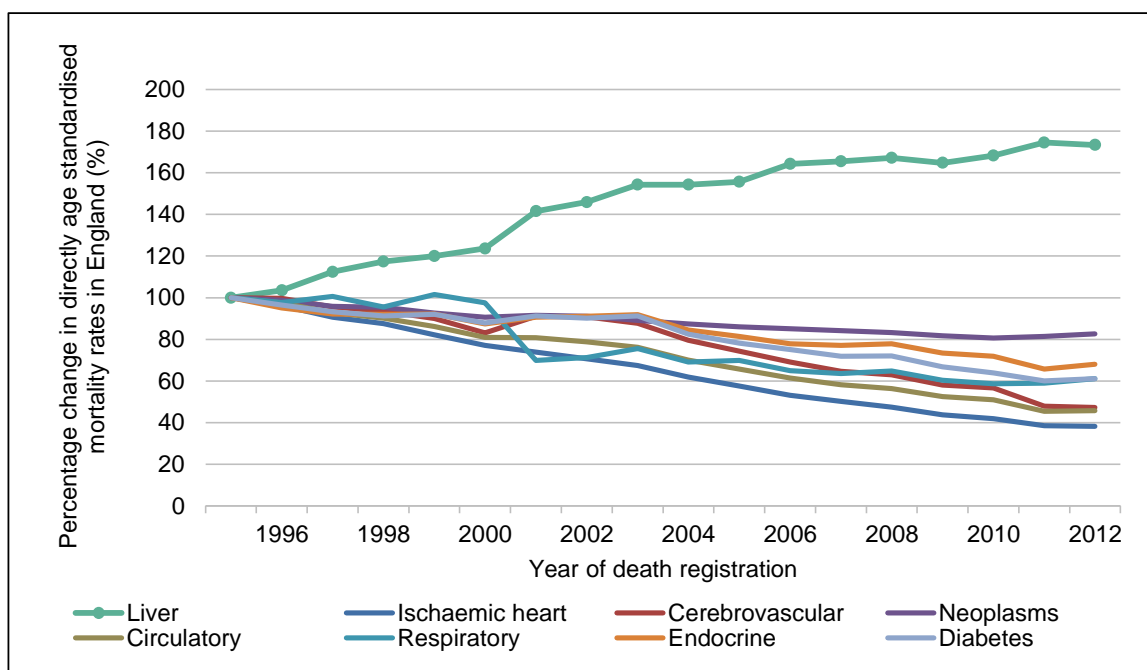
Local Authority Liver Disease Profiles

North East Lincolnshire

Introduction

Death rates from liver disease are increasing in England. This is in contrast to most EU countries where liver disease death rates are falling. Between 2001 and 2012 the number of people who died with an underlying cause of liver disease in England rose from 7,841 to 10,948. This represents a 40% increase in liver deaths during this period and is in contrast to other major causes of disease which have been declining (figure 1). Liver disease is largely preventable. Whilst approximately 5% of liver disease is attributable to autoimmune disorders (diseases characterised by abnormal functioning of the immune system), most liver disease is due to three main risk factors: alcohol, obesity and viral hepatitis.

Figure 1 - Percentage change in mortality rates, England 1995 - 2012



Key messages for North East Lincolnshire

In North East Lincolnshire, between 2010 and 2012, the average number of years of life lost* in people aged under 75 from liver disease is 41 per 10,000 persons. This compares to 42 for breast cancer, 20 for stroke and 6 for road traffic accidents.

In North East Lincolnshire the rate of premature mortality from liver disease between 2010 and 2012, is similar to the England average for males and similar to the England average for females.

Between 2001-03 and 2010-12, the average number of people per year who died with an underlying cause of liver disease in North East Lincolnshire, increased from 28 to 39.

The rate of alcohol specific hospital admissions in 2012/13 in North East Lincolnshire is similar to the England average for males and significantly lower than the England average for females.

* YLL is an estimate of the average years a person would have lived if they had not died prematurely. It is therefore a measure of premature mortality. As a method it is an alternative to death rates that gives more weight to deaths amongst younger people.

Alcohol Related Liver Disease

Key Facts

Alcohol is the most common cause of liver disease in England. Alcoholic liver disease accounts for over a third of liver disease deaths. The more someone drinks above the lower-risk guideline, the higher their risk of developing liver disease. The UK is one of the few European countries where alcohol consumption has risen in the last 50 years.

- Between 2010 and 2012, in those under 75 years, an average of 13 men and 3 women died each year in North East Lincolnshire from alcoholic liver disease. In 2012/13, there were 55 hospital admissions in North East Lincolnshire (39 male and 16 female) where alcoholic liver disease was the primary diagnosis.

- There were 555 alcohol specific hospital admissions in North East Lincolnshire in 2012/13 (402 male and 153 female). The rate of alcohol specific hospital admissions in North East Lincolnshire is similar to the England average for males, and significantly lower than the England average for females.

- There are currently 513 premises licensed to serve alcohol in North East Lincolnshire. This equates to one licensed premises for every 244 adults. There are 10 premises with 24 hour alcohol licenses.

Prevention

The most effective way for an individual to prevent alcohol related liver disease is to drink within the lower-risk guideline. There is strong evidence that opportunistic early identification of people whose health is being damaged by alcohol and brief advice is effective in reducing alcohol consumption and related problems, particularly when delivered in Primary Care and Emergency Departments.

There is good evidence that population level interventions which limit availability and affordability of alcohol through licensing restrictions, minimum pricing and taxation that is proportionate to the volume of alcohol are effective in reducing alcohol consumption.

Questions you should ask locally

1. Has alcohol and its links with liver disease been included in your Joint Strategic Needs Assessment (JSNA)?
2. Do you have a local multi-agency alcohol strategy which considers public health and community safety?
3. Are the links between availability of alcohol and alcohol related harm explicitly considered in local licensing policy, and when reviewing new licensing applications?
4. Are local health and social care staff trained to routinely provide early identification of problem drinking and provide brief alcohol advice?
5. Do local alcohol services have sufficient capacity to meet current and future alcohol treatment needs?

Resources

- Health First: An evidence-based alcohol strategy for the UK.
<http://www.stir.ac.uk/media/schools/management/documents/Alcoholstrategy-updated.pdf>
- Local Alcohol Profiles for England <http://www.lape.org.uk/>
- Longer Lives: <http://longerlives.phe.org.uk/>
- National Institute for Health and Care Excellence. Public health guidance Alcohol-use disorders - preventing harmful drinking. <http://www.nice.org.uk/guidance/PH24>
- National Confidential Enquiry into Patient Outcome and Death: Alcohol Related Liver Disease: Measuring the Units: <http://www.ncepod.org.uk/2013arld.htm>
- The Alcohol Learning Centre <http://www.alcohollearningcentre.org.uk/>

Non-Alcohol Related Fatty Liver Disease

Key Facts

Obesity is an important risk factor for liver disease because of its link to non-alcoholic fatty liver disease (NAFLD), which is the term used to describe accumulation of fat within the liver that is not caused by alcohol. It is usually seen in people who are overweight or obese.

Although the great majority of people with NAFLD never experience any symptoms from the condition, a minority may progress to a more serious form of the disease known as non-alcoholic steatohepatitis, which may ultimately lead to fibrosis and, in a small number of cases, cirrhosis.

• The proportion of Year 6 children classified as overweight or obese in North East Lincolnshire in 2012/13 is 34%, which is similar to the England average of 33%.

• In North East Lincolnshire, the proportion of adults classified as overweight or obese in 2012 is 66%, which is similar to the England average of 63%.

Prevention

The best way for an individual to prevent becoming overweight or obese is by eating healthily and exercising regularly.

The problem of obesity cannot be solved by individual behaviour change alone. Obesity is a complex problem that requires action at all levels, from individual to societal, and across all sectors, to create environments that promote and support physical activity and healthy eating.

Questions you should ask locally

1. Has obesity and its links with liver disease been included in your Joint Strategic Needs Assessment (JSNA)?
2. Are there plans and processes in place to assess (ideally by doing a health impact assessment) the affect of local planning policies and other local decisions on the ability of the community to be physically active and eat a healthy diet? For example is the proximity to schools, colleges, leisure centres and other places where children gather considered when reviewing applications for fast food outlets
3. Are local health and social care staff trained and confident to make every contact count and raise the issue of weight management routinely?
4. Are there weight management services across the obesity care pathway in place locally with sufficient capacity to meet current and future need?
5. Are nutritional standards (including government buying standards) for food applied in local schools and colleges, hospitals and local employers?

Resources

- Obesity Knowledge and Intelligence Team: <http://www.noo.org.uk/>
- National Institute for Health and Care Excellence: Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children; <http://publications.nice.org.uk/obesity-cg43>
- Longer Lives: <http://longerlives.phe.org.uk/>
- Healthy weight, healthy lives: A toolkit for developing local strategies http://www.fph.org.uk/healthy_weight,_healthy_lives%3A_a_toolkit_for_developing_local_strategies
- Academy of Medical Royal Colleges Measuring Up: The Medical Profession's Prescription For The Nation's Obesity Crisis: http://www.aomrc.org.uk/doc_download/9673-measuring-up

Hepatitis B

Key Facts

Hepatitis B is a virus which is transmitted through contact with infected blood or other body fluids. Acute infection can lead to chronic disease and during the acute phase of infection the majority of people including children are asymptomatic; only a third of adults develop symptoms which may include cold-like symptoms, nausea, fever and jaundice. Most acute infections are acquired through adult risk behaviours such as injecting drug use and sexual contact. The risk of developing chronic hepatitis B infection depends on the age at which infection is acquired. Chronic infection occurs in up to 90% of children who acquire the infection under the age of 5 years and up to 10% of people infected as adults. Those who are chronically infected are at risk of developing chronic liver disease and liver cancer. In the UK, annually the majority (95%) of newly identified chronic hepatitis B infections are acquired overseas at birth or at a young age. The prevalence of chronic hepatitis B infection in the UK is estimated to be 0.3% (approximately 180,000 people).

- In North East Lincolnshire, no data was submitted on the proportion of babies vaccinated who were born to mothers infected with hepatitis B in 2012/13. Without a completed course of vaccinations these infants are at risk of chronic infection and cirrhosis.

- In North East Lincolnshire in 2012/13 the proportion of people, in their latest treatment journey at specialist drug services, being offered and completing a course of hepatitis B vaccine is 30%.

Prevention

Hepatitis B is a vaccine preventable disease. Immunisation is recommended for high risk groups including children born to hepatitis B positive mothers, those who change sexual partners frequently and people who inject drugs. Other groups are detailed in 'Immunisation against Infectious Disease'. Actions that prevent hepatitis B infection also include:

- Follow-up of close household and sexual contacts of hepatitis B positive individuals, ensuring testing and vaccination
- Education and promoting increased awareness of the infection, offering testing to those at increased risk and promoting safer sex and condom use
- Harm reduction services for people who inject drugs e.g. needle and syringe programmes and opioid substitution therapy

Questions you should ask locally

1. Are local services available to ensure that babies born to hepatitis B positive mothers, are followed up to ensure they have been fully vaccinated and tested for infection in line with national policy?
2. Are local provisions in place to ensure close household and sexual contacts of cases of hepatitis B are followed up appropriately (that is tested and vaccinated)?
3. Are local services in place to ensure prisoners, people who attend genitourinary medicine clinics and people who inject drugs are immunised against hepatitis B in line with national recommendations?
4. Is there local provision to ensure that people and particular vulnerable groups at increased risk of hepatitis B infection, such as people with links to high prevalence countries, are offered testing according to NICE guidance?
5. Are other prevention strategies such as needle and syringe programmes and condom provision readily accessible to those at risk of hepatitis B?
6. Is there adequate specialist service provision to ensure diagnosed cases are managed appropriately?

Resources

- NICE public health guidance PH 43. Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection. <http://www.nice.org.uk/guidance/ph43>
- NICE clinical guidelines CG165. Hepatitis B (chronic): Diagnosis and management of chronic hepatitis B in children, young people and adults. <http://www.nice.org.uk/guidance/cg165>
- Department of Health. Immunisation against Infectious Disease (The Green Book) 2013. <https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18>
- NICE quality standards QS65. Quality standards for hepatitis B: <http://www.nice.org.uk/guidance/qs65>

Hepatitis C

Key Facts

Hepatitis C virus is mainly transmitted through contact with infected blood. Injecting drug use is the most important risk factor for infection within the UK. People born or brought up in a country with high prevalence of chronic hepatitis C are also at risk (especially those in Africa and Asia, including Egypt, China and Pakistan), as are those who received blood transfusions in the UK prior to the introduction of HCV testing in 1991. The prevalence of chronic Hepatitis C infection in England is estimated to be 0.4% of adults (approximately 160,000 people).

Hepatitis C is often asymptomatic, and symptoms may not appear until the liver is severely damaged. Around 20-30% of infected people clear their infection naturally within the first six months of infection. For the remainder, hepatitis C is a chronic infection which can lead to liver disease. Data from the Unlinked Anonymous Monitoring survey of people who inject psychoactive drugs suggest that levels of infection in this group are high at around 50% in England with around 1 in 7 sharing needles/syringes. Around one in 20 of those who inject image and performance enhancing drugs (such as anabolic steroids and melanotan) have also been infected with hepatitis C.

• In North East Lincolnshire in 2012/13, the proportion of people who inject drugs, who are in their latest treatment episode at specialist drug services, being offered and taking up a hepatitis C test is 63%.

• In 2012 it is estimated that 38% of those people who inject drugs in North East Lincolnshire have been infected with hepatitis C; with 0.54% of the population of North East Lincolnshire estimated to be injecting heroin and/or crack cocaine (2011/12).

Prevention

Education and awareness programmes are needed to prevent drug misuse. Treatment services and needle and syringe programmes for people who inject drugs are particularly important to minimise ongoing transmission of Hepatitis C. Actions to prevent Hepatitis C infection include:

- Interventions to reduce initiation of injecting drug use and to help people to stop injecting
- Harm reduction services for people who inject drugs e.g. needle and syringe programmes and substitution therapy
- Increasing awareness, testing and diagnosis of those at risk of infection
- Getting diagnosed individuals into treatment and care. NICE approved therapies exist for the treatment of hepatitis C that will clear the virus in the majority of cases.

Questions you should ask locally

1. Can you describe current service provision (and gaps) and is there a locally agreed multi-agency strategy to prevent and control hepatitis C infection?
2. Has the PHE commissioning template been used to estimate HCV prevalence and numbers eligible for treatment in your local area?
3. Is local provision in place to promote and offer testing to people at risk of hepatitis C infection, as recommended by NICE?
4. Are care pathways in place to ensure that diagnosed individuals can access NICE recommended treatments and care, particularly for those BME groups at increased risk of infection and those diagnosed in drug services and prisons?
5. Do the needle and syringe programmes in your local area provide an appropriate range of services with sufficient coverage, as recommended by NICE?
6. Has Chronic Hepatitis C and its links to liver disease been included in your Joint Strategic Needs Assessment (JSNA)

Resources

- Hepatitis C in the UK - 2014 report. <https://www.gov.uk/government/publications/hepatitis-c-in-the-uk>
- Commissioning template for estimating HCV prevalence and numbers eligible for treatment by Drug Action Team Area. <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HepatitisC/EpidemiologicalData/>
- NICE public health guidance PH 43. Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection. <http://www.nice.org.uk/guidance/ph43>
- NICE public health guidance PH52. Needle and syringe programmes guidance. <http://www.nice.org.uk/guidance/PH52>

Liver disease profiles - North East Lincolnshire

Liver disease indicators

Indicator		Local no per year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Demography	1 -% in most deprived quintile	60,813	38.1	20.4	83.8		0
	2 - Persons who inject drugs	563	5.5	2.5	8.7		0.3
All liver disease	3 -Hospital admissions (males)	74	98.8	142.8	337.4		47.5
	4 -Hospital admissions (females)	80	98.7	85.1	228.5		30.4
	5 -Premature mortality (males)	20.3	29.9	23.7	58.4		13.0
	6 -Premature mortality (females)	9.0	12.9	12.6	25.0		6.9
Alcohol	7 -Alcohol specific hospital admissions (males)	402	528.4	506.9	1,477		178.1
	8 -Alcohol specific hospital admissions (females)	153	192.8	232.3	682.6		86.8
	9 -Hospital admissions (males)	39	50.5	44.3	158.5		7.0
	10 -Hospital admissions (females)	16	20.8	19.8	81.9		0
	11 -Premature mortality (males)	13.3	19.4	12.0	38.2		1.9
	12 -Premature mortality (females)	3.7	5.3	5.9	15.2		0
Hepatitis B	13 -Vaccination coverage - Hep B (2 Yrs)	n/a	n/a	n/a	9.1		100
	14 -Drug users - Hep B Vaccination	43	30.5	17.9	0		70.4
	15 -Hospital admissions (persons)	0	0	1.0	5.1		0
	16 -Premature mortality (persons)	0.3	0.2	0.2	1.0		0
Hepatitis C	17 -Drug users - With Hep C test	443	63.6	70.3	27.5		97.3
	18 -Persons starting HCV treatment	-	-	-	-	Placeholder Indicator - No data currently available	-
	19 -Hospital admissions (persons)	0	0	3.5	13.6		0
	20 -Premature mortality (persons)	1.7	1.1	0.5	2.8		0
Obesity	21 -Excess weight - Adults	277	66.2	63.8	74.4		45.9
	22 -Excess weight - 10-11 year olds	558	34.3	33.3	44.2		24.1
	23 -Hospital admissions (persons)	*	n/a	2.9	12.7		0
	24 -Premature mortality (persons)	1.0	0.7	0.7	6.7		0

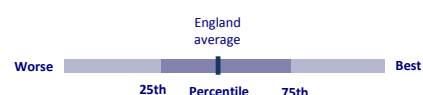
Indicator - unit of measure

Indicator - Percentage (%)

Indicator - Crude Rate per (1,000 or 100,000)

Indicator - Directly age standardised rate per 100,000

- Significantly Worse than England average
- Significantly Better than England average
- Not significantly different from England average
- No significance available



* Hospital admission figure suppressed to avoid potential disclosure (between 1 and 5 events)

n/a - Data not available for this Local Authority/England

1. Deprivation - Percentage of people in this area living in the 20% most deprived areas in England, IMD2010, population estimates 2012. 2. Persons who inject drugs (PWID) - estimated number of persons who inject (heroin and/or crack cocaine) aged 15 – 64, per 1,000 population, 2011/12. 3,4. Hospital admissions for liver disease - males, females - directly age-standardised rate per 100,000 population, 2010-12. 5,6. Premature mortality from liver disease – males, females - directly age-standardised rate in less than 75 year olds, per 100,000 population, 2010-12. 7,8. Alcohol specific hospital admissions - admitted to hospital due to alcohol-specific conditions - males, females - directly age-standardised rate per 100,000 population, 2012/13. 9,10. Hospital admissions for alcoholic liver disease - males, females - directly age standardised rate per 100,000 population, 2012/13. 11,12. Premature mortality from alcoholic liver disease - males, females - directly age standardised rate in less than 75 year olds per 100,000 population, 2010-12. 13. Percentage of children at age 24 months who have received the complete course (4 doses) of hepatitis B vaccine as a % of the eligible population as defined in the hepatitis B chapter of the immunisation against infectious diseases "Green Book" (have maternal Hep B positive status 2012/13). 14. Persons in their latest treatment journey at specialist drug services, who have completed a course of hepatitis B vaccinations - the proportion of persons beginning a journey in structured drug treatment who were offered and had accepted a course of hepatitis B vaccinations who completed the course, 2012/13. 15. Hospital admissions for hepatitis B related end-stage liver disease or hepatocellular carcinoma - persons - crude rate per 100,000 population, 2012/13. 16. Premature mortality from hepatitis B related end-stage liver disease/hepatocellular carcinoma - persons less than 75 years, crude rate per 100,000 population, 2010-12. 17. Proportion of persons who inject or have previously injected drugs who have had a Hepatitis C test - number of individuals with a Hepatitis C test as a proportion of the number of individuals in their most recent treatment episode in structured treatment services who reported that they were currently injecting or had previously injected drugs, 2012/13. 18. Number of individuals commencing HCV treatment (Placeholder - No data is currently available for this indicator). 19. Hospital admissions for hepatitis C related end-stage liver disease/hepatocellular carcinoma - persons - crude rate per 100,000 population, 2012/13. 20. Premature mortality from hepatitis C related end-stage liver disease/hepatocellular carcinoma - persons - crude rate in less than 75 year olds per 100,000 population, 2010-12. 21. The proportion of adults who are considered of excess weight or obese - % of adults, modelled estimate using Health Survey for England, 2012. 22. The proportion of school children in Year 6 (age 10-11) classified as overweight or obese, 2012/13. 23. Hospital admissions for non-alcoholic fatty liver disease - persons - crude rate per 100,000 population, 2012/13. 24. Premature mortality from non-alcoholic fatty liver disease - persons - crude rate in less than 75 year olds per 100,000 population, 2010-2012.

For further information, accompanying documentation and to download the data in this profile, please visit:

<http://fingertips.phe.org.uk/profile/liver-disease>

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