SCHEDULE 2 – THE SERVICES

A. Service Specifications

1. Service name	Specialised Hepatobiliary and Pancreas (HPB) Services (Adults).
2. Service specification number	**A02/S/a - 250501**
3. Date published	May 2025
4. Accountable Commissioner	Internal Medicine Programme of Care https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-a/

5. Population and/or geography to be served

5.1 Population covered

The service outlined in this specification is for patients ordinarily resident in England; or otherwise as identified as the commissioning responsibility of the NHS in England (as defined in 'Who Pays? Determining responsible payments to providers' and other guidance relating to patients entitled to NHS care or exempt from charges).

Deaths from liver disease are increasing in England, unlike most other Western European countries, where liver disease deaths are falling. Liver disease is amongst the commonest causes of premature (working age) mortality with a disproportionate risk in lower socioeconomic class populations.
Deaths from liver disease have steadily risen over the last four decades in contrast to other major causes of disease where age-standardised mortality has fallen. The most common causes of liver disease are potentially preventable. Whilst approximately 5% is attributable to autoimmune disorders (diseases characterised by abnormal functioning of the immune system), the majority of liver disease is due to three main risk factors: alcohol, obesity and viral hepatitis. https://fingertips.phe.org.uk/profile/liver-disease.

Acute pancreatitis has an incidence of approximately 56 cases per 100,000 people per year in the UK. In 25% of cases, acute pancreatitis is severe and associated with complications such as organ failure, or the development of abdominal fluid collections. In such severe cases, people often require critical care and the mortality rate rises to 25% in this cohort.

The incidence of chronic pancreatitis in western Europe is around 5 new cases per 100,000 people, although this is probably an underestimate. Many affected people live with chronic pain and the effects of diminished pancreatic function including malabsorption and diabetes as well as a heightened risk of pancreatic cancer[1].

[1] NICE NG104 (September 2018)

This service is for adults requiring medical and /or surgical treatment for one or more of the following conditions:

- Acute or chronic liver failure requiring escalation to Level 2 or Level 3 dependency care.
- Complications of acute or chronic liver disease.
- Management of complex portal hypertension requiring transjugular intrahepatic portosystemic stent shunting (TIPSS) insertion.
- Chronic or complicated hepatitis C viral infection.
- Patients with chronic hepatitis B or C infection and/or hepatitis D viral super-infection receiving drug therapies.
- Rare or complex autoimmune, or inherited liver diseases.
- Complex vascular disease of the hepatic or portomesenteric circulation.
- Non-cancer related complex hepatobiliary surgery.
- Liver, biliary or pancreatic trauma.
- Strictures of the bile ducts and pancreatic ducts requiring surgery or complex biliary interventions.
- Benign pancreatic disease including complications of acute and chronic pancreatitis requiring endoscopic, radiological and/or surgical intervention.

Separate specifications cover management of malignancy, including cancers of the pancreas, biliary tract, duodenum and ampulla including pancreatic cancer, neuroendocrine tumours, colorectal liver secondaries and cystic neoplasms [link].

The Hepatobiliary & Pancreas services will also work with specialised operational delivery networks focussing on treatments for people with Hepatitis C, for which there is a separate specification [https://www.england.nhs.uk/wp-content/uploads/2024/05/PRN231105-hepatitis-c-network-specification-2023-.pdf].

In particular, this service specification covers specialised liver medicine (hepatology), specialised HPB surgery and interventional radiology relating to these specialised areas.

- People with serious complications of cirrhosis (approx 11,000 cases each year).
- Services for people needing complex liver, biliary and pancreatic surgery (approx 5,000 cases each year).
- People with complex acute, chronic or hereditary pancreatitis requiring specialist management (approx. 6000 cases each year)
- Pancreatic cystic tumours, including intraductal papillary mucinous neoplasms (IPMN).

5.2 Minimum population sizes

Specialised liver (hepatology) centres offering non-surgical specialist care should serve populations of at least 600,000 to 1 million, given the wide variations in incidence of cirrhosis across the country [Ref: 2nd Atlas of Variation in Risk Factors and Healthcare for Liver Disease in England, 2017] http://tools.england.nhs.uk/images/LiverAtlas17/atlas.html.

Specialised HPB-surgical centres covering liver, biliary and pancreatic surgery typically serve a population of 2 - 4 million.

Specialised hepatology and HPB-surgical centres are expected to establish a networked model of care, adopting a population health approach including secondary and primary care.

Where an ICS does not contain a designated specialised hepatology or HPB-surgical centre they are expected to create a local clinical network linking to the specialist centres within a neighbouring ICS.

6. Service aims and outcomes

6.1 Service aims

1) To ensure that all patients with liver, biliary or pancreatic disorders that may require complex interventions have access to specialist care, and are managed according to national and international guidelines to reduce the risk of complications arising.

2) To ensure that clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences.

3) To ensure equitable access to high quality care for all patients with complex or advanced liver disease who are predicted to benefit from specialised intervention.

4) To ensure that all patients with complications of portal hypertension are assessed appropriately at an early stage and that those who might benefit from a transjugular intrahepatic portosystemic shunt (TIPSS) procedure have timely access to the specialist centre and the expertise they offer.

5) To ensure that all patients with cirrhosis are reviewed regularly to ensure timely access to specialised centres for assessment of suitability for liver transplantation.

6) To facilitate local work up and long term follow up for people undergoing liver transplantation where possible.

7) To ensure all patients with complications of cirrhosis deemed unsuitable for aforementioned interventions are provided with options for supportive care appropriate to their needs and prognosis.

8) To ensure prompt specialist care for complications of acute pancreatitis.

9) To support the Hepatitis C ODNs to achieve Hepatitis C virus (HCV) elimination; optimise management of chronic Hepatitis B virus (HBV); and initiate and optimise management of Hepatitis D (HDV) super infection.

10) To lead early detection and prevention programme/strategies adopting a population health approach.

11) To establish clinical networks for liver and pancreaticobiliary disease to ensure patients receive the right care in the right place at the right time according to their needs.

12) To deliver ambulatory care for patients with HPB disease through developing day case services and virtual ward environments where patients can be assessed and offered interventions to avoid hospitalisation.

13) To ensure services are configured in such a way as to be able to deliver sufficient volumes of activity to enable centres of expertise and training to ensure development of the future workforce.

6.2 Outcomes

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

The full definition of the quality outcomes and metrics together with their descriptions including the numerators, denominators and all relevant guidance will be accessible at https://www.england.nhs.uk/commissioning/spec-services/npc-crg/spec-dashboards/ following the next scheduled quarterly refresh of the dashboard metadata document.

Service defined outcomes/outputs

Reference	Domain	Rationale	Indicator
HPB – P1	1, 3, 5	To ensure that patients are treated in a safe and effective manner, ensuring early diagnosis and treatment	30 day mortality rate post surgery for severe acute pancreatitis patients
HPB – P2	1, 3, 4, 5	To ensure that patients receive appropriate and effective intervention	30 day mortality rate following pancreatic necrosectomy
HPB – P3	2, 3, 4 ,5	To ensure that patients are discharged in a safe and effective manner	Non-elective readmission rate to the same centre within 30 days for patients with chronic pancreatitis
HPB – L1	1, 4, 5	This indicator measures the effectiveness of the care pathway for a patient admitted as an emergency	Percentage of in-hospital mortality within 30 days following emergency admission for variceal haemorrhage
HPB – L2	3, 4, 5	This indicator measures the effectiveness of the care pathway for a patient admitted as an emergency	Proportion of patients admitted to HDU/ITU following an emergency admission with a variceal haemorrhage
HPB – L3	3, 4, 5	In Hospital care and sepsis rates following emergency admission	Percentage of in-hospital mortality, following emergency admission with decompensated cirrhosis of the liver
HPB – L4	1, 3, 4, 5	Effectiveness of the care pathway for a patient admitted as an emergency. Early	Percentage of in-hospital mortality within 30 days following emergency

		intervention with evidence-based treatments for patients with the complications of cirrhosis can save lives.	admission with decompensated cirrhosis of the liver
HPB – L5	3, 4, 5	This indicator measures the effectiveness of the care pathway for a patient admitted as an emergency.	Percentage of unplanned readmissions within 30 days of discharge from an emergency admission for decompensated liver disease

Other National Standards.

For medical liver (hepatology) centres the following national standards apply:

- NICE Guidance for the management of cirrhosis advises that people who have, or are at high risk of developing, complications of cirrhosis should be referred to a specialist Hepatology centre. Such specialist centres should:
  - provide 24-hour support, 7 days per week from an appropriately trained and accredited consultant in Gastroenterology and/or Hepatology.
  - provide ready access to high dependency and intensive care beds.
  - ensure all providers in their network use the BSG-BASL decompensated cirrhosis care bundles to optimise management (See link at 7.9 below).

The Specialist centre should provide region wide Hepatology advice with access to specialised commissioned high cost medication including, but not limited to, antiviral drugs for Hepatitis C (NICE TA330,363,365,413,430,499) second line therapies, such as those for primary biliary cholangitis (NICE TA 443), and drugs for progressive familial intrahepatic cholestasis (NICE NST17) as available.

For specialist interventions, such as endoscopic ultrasound, ERCP, and trans-jugular intrahepatic portosystemic stent shunt (TIPSS) procedures, services should ensure their adherence to professional standards of care, including in relation to levels of activity to support development and maintenance of skills and training in these procedures. The British Society of Gastroenterology have published guidelines on minimum procedural numbers required for individual ERCP endoscopists and their provider units (see link below).

7 Service description

7.1 Service Model

The specialised Hepatobiliary services form part of a much larger patient pathway spanning from primary and community care through to transplantation services. This specification mainly deals with care in the yellow box in Figure 1 below. Additionally, the service will be responsible for developing networks with other secondary care providers within the designated geography (single ICS or multiple). They would also be expected to collaborate with primary care networks on early detection and surveillance programmes in community settings.

Services will provide a multi-disciplinary approach to diagnosis and treatment and care, delivered through a network model, which will link the whole patient pathway.

Specialised centres may offer one or more of: medical hepatology; hepatic, pancreatic or biliary (HPB) surgery; or liver transplantation, depending on local configuration. Transplant services are subject to separate service specifications [https://www.england.nhs.uk/publication/liver-transplantation-service-adults/] but there is a need to improve networks for referral and longer term management of this group of patients.

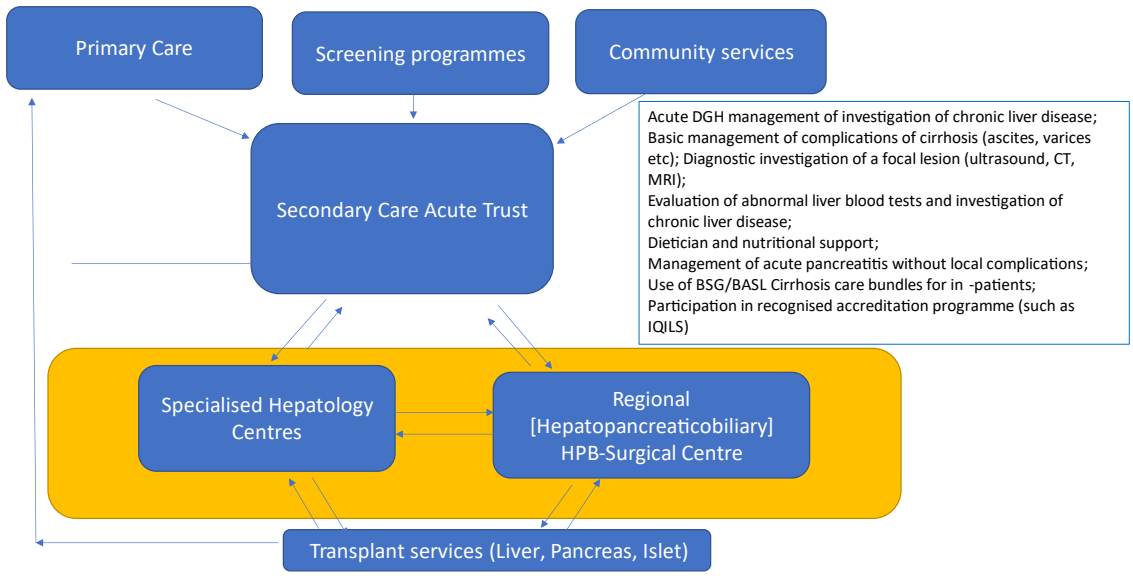

Fig 1 – hepatobiliary patient pathways.

Specific criteria are outlined below for designation as a Hepatology or HPB-Surgical Centre. Integral to these criteria is the requirement to establish local referral 'liver' networks including systems for the monitoring of clinical outcomes and effectiveness.

Non-specialist providers in secondary care would typically provide:

- Initial assessment and management of liver, pancreas and biliary disorders.
- Community pathways and guidance for assessment of abnormal liver blood tests in primary care.
- Fibrosis risk assessment for chronic liver conditions including alcohol related and metabolic dysfunction associated liver disease.
- Surveillance of patients at risk of hepatocellular carcinoma in accordance with national guidelines.
- Surveillance and initial management of people at risk of clinically significant portal hypertension including varices.
- Initial emergency care of people admitted with complications of cirrhosis, acute pancreatitis or chronic pancreatitis.
- Participation in recognised accreditation programmes such as Improving Quality in Liver Services (IQILS) and/or the JAG Endoscopy services accreditation programme.
- An Alcohol Care Team, either employed directly or from an in-reach service, with defined links to community support services
- Access to dietetic and nutrition support for people with liver, pancreatic and biliary disorders.

- Linkage with clearly defined pathways into networked specialist services outlined below.
- Local hepatology services should support and utilise local liver referral networks established by Specialised Hepatology centres, particular for scenarios including (but not confined to) elective or emergency TIPSS, incomplete response to initial treatment of Primary Biliary Cholangitis (PBC), specially commissioned antiviral agents, vascular/thrombotic disease, decompensated cirrhosis likely to require transplant assessment and complex acute or chronic pancreatitis.

Specialised Hepatology Centres should provide the following services, as well as provide robust pathways to access these services:

- Specialised Hepatology centres should establish formal local liver referral networks, including establishing uniform network referral procedures, so that non-specialised centres can engage, be supported, and refer patients for particular scenarios, including (but not confined to) elective or emergency TIPSS, incomplete response to initial treatment of Primary Biliary Cholangitis, specially commissioned antiviral agents, vascular/thrombotic disease, decompensated cirrhosis likely to require transplant assessment and complex acute or chronic pancreatitis. Patients should also be returned to local non-specialised centres for routine care that enables patients to be treated as close to home as possible.
- Advice for district general hospitals on the management of complex liver disease.
- An accessible referral pathway for other specialties needing complex hepatobiliary advice such as respiratory (e.g. supporting patients with cystic fibrosis), maternity services, rheumatology or dermatology.
- Diagnosis and management of rare or complex liver diseases including vascular liver disease.
- MDTs for the discussion of complex cases open to networked referral from secondary care including delivery of anti-viral therapy for chronic viral hepatitis or complex autoimmune disease such as second line therapies for Primary Biliary Cholangitis.
- A formal relationship (through Memorandum Of Understanding (MOU) or Service Level Agreement (SLA)) with a liver transplantation centre for initial local work-up of patients as well as long-term post-transplant follow-up.
- Interventional radiology for complications of portal hypertension including TIPSS (for variceal haemorrhage or ascites).
- On-site renal support, if indicated, for patients with hepatorenal syndrome.
- Level 2 and level 3 critical care, including availability for plasma exchange for acute liver failure where indicated.
- 24-hour support, 7 days per week from appropriately trained and accredited consultants in Gastroenterology and/or Hepatology.
- Specialist endoscopy services including endoscopic retrograde. cholangiopancreatography (ERCP), endoscopic ultrasound (EUS) and cystgastrostomy (see also NHS England gastro intestinal endoscopy networks. development framework https://www.england.nhs.uk/long-read/gastro-intestinal-endoscopy-networks-a-development-framework/).
- Specialist hepatology nurses, pharmacists and dieticians.
- A 7 day a week alcohol care team with capability for outpatient “detox”.

- A daycase paracentesis service for ascites.
- Participation in a recognised accreditation programme (such as IQILS).
- Involvement in research initiatives to advance the management of liver and pancreatic disease.
- Links to specialised services for young adults and adolescents transitioning from paediatric care.

The specialised hepatology centre must be capable of managing patients with complex or decompensated cirrhosis requiring category 2 or category 3 level care (i.e. patients with a need to be managed by specialists providing 24-hour cover, 7 days per week, consultant led care with ready access to on-site high dependency or intensive care units and fully trained allied health professionals).

Regional HPB Surgical Centres should provide the following:

- Work closely with hepatology colleagues to deliver the above services as well as those outlined below.
- 24-hour, 7 days a week, consultant led care by specialist HPB surgeons
- Clearly defined pathways across the region to facilitate discussion or referral of patients with severe pancreatitis.
- Surgical expertise in managing liver and pancreatic trauma.
- Specialist radiologists with appropriate facilities including cross-sectional imaging (CT, MRI), functional imaging (FDG PET) and fluoroscopy.
- Specialist interventional radiology service including TIPSS.
- Specialist endoscopy services including endoscopic retrograde cholangiopancreatography (ERCP), endoscopic ultrasound (EUS) and cystgastrostomy.
- Consultant histopathologists with subspecialty HPB interest and facilities for assessment of fine needle aspiration cytology samples by cytopathologists, urgent intra-operative assessment by frozen section histology and protocols for rapid assessment of potential malignancy.
- Surgical treatment for chronic and acute pancreatitis with fluid collection and/or necrosis.
- Expertise in managing complex benign biliary disease (e.g. complex gallbladder disease, Caroli's disease, cystic liver disease, choledochal cysts).
- Diagnosis facilities for recurrent, chronic, autoimmune, hereditary and idiopathic pancreatitis including IgG4 disease.
- Availability of counselling and genetic testing for hereditary pancreatitis.
- Pathways for long term monitoring of patients with chronic pancreatitis including HbA1c testing, bone densitometry and consideration of cancer surveillance (as per NICE guideline).
- Facilities for the investigation and management of pancreatic cystic lesions.
- Access to specialist MDT for management of pancreatic duct obstruction, pseudocysts or other complications of acute and chronic pancreatitis including clearly defined pathways for ERCP, EUS and pancreatic surgery.
- Access to MDTs for referring hospitals of at least weekly frequency.
- Dietetic and nutrition team serving both inpatients and outpatients.
- Supportive care including specialist nurses with expertise in hepatobiliary & pancreatic disease.

Specialised Hepatology centres and HPB surgical centres should be based on a defined geographical area with linked, named regional hospitals ('referring sites'). The services provided by the specialised hepatology and HPB centre and the individuals involved in providing those services should be clearly defined and that information should be readily available to both referring sites and to patients that may be referred to that service.

The criteria for referral and the mode of referral for each service provided must be available and a memorandum of understanding between the hospitals should be in place. Criteria for referral should be reviewed regularly.

Regional hospitals ('referring sites'), specialised hepatology centres and HPB surgical centres should have agreed processes in place to refer to their regional Adult Critical Care Transfer Services (ACCTS), for patients requiring transfer who are critically ill in line with the NHS England ACCTS Service Specification https://www.england.nhs.uk/wp-content/uploads/2021/06/Adult-critical-care-transfer-service-specification-2023-v0.6-FINAL.pdf.

This should include for 'Escalation of Care' transfers into a specialist centre and 'Repatriation' transfers following completion of a specialist episode of care.

Viral Hepatitis (including HCV Operational Delivery Networks)
Ensure HCV infected individuals with complex infections including:

- Those with cirrhosis, decompensated liver disease or hepatocellular cancer (HCC).
- Those with co-infection with other blood borne viruses (BBVs) such as Human Immunodeficiency Virus (HIV) or HBV.
- Those with other liver diseases such as MaSLD*, autoimmune liver disease, or alcohol-related liver disease.
- Those who have previously been treated with anti-viral treatments

are supported to access and use treatment and care in order to reduce health inequalities in accessing antiviral therapy for hepatitis C and in order to improve morbidity and mortality

Provide a consistent, comprehensive, effective and appropriate outpatient service for patients with complex HCV. This includes:

- Providing assessment in a specialist HCV clinic staffed by trained specialists and viral hepatitis nurses within 4 weeks (HCV Elimination Programme standards, developed for CQUIN).
- Providing access to appropriate specialists as required.
- Conducting appropriate assessment and diagnostics on patients to determine appropriate, safe antiviral therapy for patients with complex HCV as advised by the local HCV Operational Delivery Network Clinical Lead.
- Providing consistent and equitable decision making and access to NICE approved drug therapies provided by appropriately trained and supported health care professionals in an environment that meets the needs of the patient.
- Providing tailored and personalised support to individuals and empowering them to manage their HCV through appropriate information and

support. Patients should have information about their condition, their medication, how to contact services out of hours, and about local third sector organisations that can provide support. The aim is to help patients enact and maintain behaviour change to stay healthy and avoid onward transmission, to maintain optimal adherence to therapy, and to access primary / community and third sector services to support in the management of the HCV or related conditions. A multi-disciplinary approach is key;

- Ensuring clear pathways / network arrangements are in place, publicised and implemented in respect of referral for liver transplantation.
- Increasing the proportion of patients with complex Hepatitis C achieving a sustained virological response and to minimise the side effect of therapy.
- Providing enhanced care for patients presenting with reinfection, which takes account of their additional support needs to be able to maintain their post-treatment viral response over time.

* MaSLD – Metabolic dysfunction-associated steatotic liver disease – a long-lasting liver condition characterised by excessive fat in the liver.

Transition to Adult Services

All services are required to deliver developmentally appropriate healthcare to patients and families. Children and young people with ongoing healthcare needs may present direct to adult services or may be required to transition into adult services from children's services.

Transition is defined as a "purposeful and planned process of supporting young people to move from children's to adults' services". Poor planning of transition and transfer can result in a loss in continuity of treatment, patients being lost to follow up, patient disengagement, poor self-management and inequitable health outcomes for young people. It is therefore crucial that adult and children's NHS services, in line with their core responsibilities, plan, organise and implement transition support and care (for example, holding joint annual review meetings with the child/young person, their family/carers, the children's and adult service). This should ensure that young people are equal partners in planning and decision making and that their preferences and wishes are central throughout transition and transfer. NICE guidelines recommend that planning for transition into adult services should start by age 13-14 years at the latest, or as developmentally appropriate and continue until the young person is embedded in adult services.

Specialised centres and regional networks should have clearly defined arrangements for the care of young people with liver and pancreatic conditions including transition from paediatrics and provision of support for young adults. This should include direct access for patients, parents and health care providers and include signposting to services providing patient and peer support, education and employment guidance and health promotion.

7.2 Pathways

Overall patient care settings

Regular MDTs linking all hospitals in the network must be in place to discuss the management of patients. Each specialised centre (both hepatology centres and HPB surgical centres) must hold regular MDTs for the referring hospital to discuss complex cases (including those close to liver on pancreas transplantation).

Liver Cirrhosis - Patients admitted to hospital with acute deterioration should be managed by specialists with the appropriate experience working in properly constituted units offering a comprehensive consultant led 24-hour, 7 days per week service. The BSG/BASL cirrhosis admission care bundle is a useful tool to assist in early management and identification of patients requiring escalation of care.

7.3 Clinical Networks

All providers, whether designated a specialist centre or not, should participate in a networked model of care to enable services to be delivered as part of a coordinated, whole system approach. There should be collaborative working with regional ACCTS and regional Adult Critical Care Networks to ensure transfer and specialist critical care provision are considered in the development of regional patient pathways. This should enable rapid escalation of care where needed, and also return patients to local non-specialised centres for routine care, when appropriate, which enables patients to maintain their ongoing care as close to home as possible.

Clinical leadership of local liver networks should be appointed through an inclusive, transparent and accountable appointments process with a defined term of office. Leadership opportunities should be advertised and available to members from all network sites. Regular network user meetings should be scheduled to encourage collaboration, share data and develop service improvements.

7.4 Essential Staff Groups

Each specialised hepatology centre and HPB surgical centre must hold regular MDTs for referring hospitals to discuss complex cases. These MDTs should include:

- hepatologist and/or gastroenterologists
- clinical nurse specialists,
- specialist pharmacists

and, where appropriate,

- surgeons,
- intensivists,
- radiologists,
- dietetics.

HPB cancer MDTs should be fully constituted under the Cancer Networks, and are covered in a separate service specification.

7.5 Essential equipment and/or facilities

Supporting facilities as listed above in Section 7.1: Service Model.

7.6 Inter-dependant Service Components – Links with other NHS services

For specialised hepatology centres:

Co-located services

- Interventional radiology,
- Intensive care,
- Renal medicine,
- Gastroenterology & nutrition,
- Services for the specialist management of autoimmune liver disease unresponsive to first line therapy including primary biliary cholangitis.

Accessible services

- Hospital based and primary care groups caring for those with diabetes mellitus,
- Infectious disease and/or sexual health services for people with blood-borne viruses,
- Palliative Care,
- Addiction services,
- Obesity services,
- Clinical genetics services for patients with benign hereditary hepatobiliary disorders,
- Specialist Dietetic services that can provide support on the management of Pancreatic Enzyme Replacement Therapy (PERT), dietary modification, Enteral Nutrition and Parenteral Nutrition,
- Adult Critical Care Transfer Service.

Consideration should be given to a multidisciplinary approach to rare complex metabolic disorders, such as Wilson's disease where for example there may be a need for combined hepatological, neurological and psychiatric care and other uncommon disorders, such as obstetric liver disease, where experience is critical to satisfactory outcomes.
Services may undertake to work towards protocols for shared care, Patient Group Directions (PGDs) and expanded prescriber permissions, within current medicines access rules and limitations.

All staff working in the hepatology and viral hepatitis services who are in direct contact with patients should be aware of the Infected Blood Inquiry: The Report and its consequences, and recognise the impact it may have on specific groups or individual patients.

Specialised hepatology and HPB-surgical centres must have clearly defined links with a liver transplant centre and a clearly defined role in the assessment and management of patients pre and post liver transplantation. Joint staff appointments to the transplant and specialist liver centre are encouraged, as are “satellite clinics” and other outreach models of care.

Specialised hepatology and HPB centres may also be commissioned for liver cancer or pancreatic cancer related work, and there are separate service specifications for these [2325-hpb-pancreatic-service-specification.pdf] and [2260-hpb-liver-service-specification.pdf], although some aspects of the patient pathway overlap.

7.7 Additional requirements

NHS England is directed by the Secretary of State to hold a registry of all implantable devices (see https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notices/secretary-of-state-directions/outcomes-and-registries-directions-2024). Where a device is implanted into a patient, healthcare providers are mandated to submit details about the patient, the clinician, the date of the implantation and supporting device information into the Medical Devices Outcome Registry and / or clinical registry.

7.8 Commissioned providers

The list of commissioned providers for the services covered by this specification will be published in due course. [LINK TO THE COMMISSIONED PROVIDER LIST TO BE ADDED ONCE AVAILABLE] .

7.9 Links to other key documents

- Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland. The provision of services for upper gastrointestinal surgery (2016). https://www.augis.org/Guidelines/AUGIS-Guidelines.

- British Society of Gastroenterology & British Association for the Study of the Liver. A time to act: Improving liver health and outcomes in liver disease (2009). Microsoft Word - National Liver Plan 2009.doc.

- British Society of Gastroenterology. Transjugular Intrahepatic Portosystemic Stent-Shunt (TIPSS) in the management of portal hypertension (2020). https://www.bsg.org.uk/clinical-resource/transjugular-intrahepatic-portosystemic

- British Society of Gastroenterology Endoscopic Retrograde Cholangiopancreatography (ERCP) Quality Improvement Programme: minimum service standards and good practice statements. *Frontline Gastroenterology* 2024;15:445-471 https://fg.bmj.com/content/15/6/445

- BSG-BASL Decompensated cirrhosis care bundle – first 24 hours (2014). https://www.bsg.org.uk/clinical-resource/bsg-basl-decompensated-cirrhosis-care-bundle-first-24-hours/.

- British Society of Gastroenterology. Diagnosis and treatment guidelines for cholangiocarcinoma bsg-guidelines-cholangiocarcinoma.

- Endoscopic transluminal pancreatic necrosectomy (IPG567) https://www.nice.org.uk/guidance/ipg567.

- Getting it Right First Time (GIRFT) – Gastroenterology GIRFT National Specialty Report (NHS 2021) https://gettingitrightfirsttime.co.uk/medical_specialties/gastroenterology/#:~:text=GIRFT%20gastroenterology%20report%20recommends%20more,outcomes%20and%20increase%20surgical%20outputs.

- National Confidential Enquiry into Patient Outcome and Death. Acute Pancreatitis: Treat the Cause (2016). https://www.ncepod.org.uk/2016ap.html

- National Confidential Enquiry into Patient Outcome and Death. Alcohol Related Liver Disease: Measuring the Units (2013) https://www.ncepod.org.uk/2013arld.html.

- National Confidential Enquiry into Patient Outcome and Death. Gastrointestinal Haemorrhage: Time to Get Control? (2015) https://www.ncepod.org.uk/2015gih.html

- NHS England. Gastro-intestinal endoscopy networks: A development framework (2023) https://www.england.nhs.uk/long-read/gastro-intestinal-endoscopy-networks-a-development-framework/.

- NICE guideline [NG50]. Cirrhosis in over 16s: assessment and management (2016) https://www.nice.org.uk/guidance/ng50.

- NICE IPG [IPG204]. Laparoscopic distal pancreatectomy (2007). https://www.nice.org.uk/guidance/ipg204

- NICE guideline [NG104]: Pancreatitis (2018). https://www.nice.org.uk/guidance/ng104.

- NICE highly specialised technologies guidance [HST17]. Odevixibat for treating progressive familial intrahepatic cholestasis https://www.nice.org.uk/search?q=NST17.

- NICE Quality Standard QS152 – Liver Disease (2017). https://www.nice.org.uk/guidance/qs152.

- NICE technology appraisal [TA106]. Elafibranor for previously treated primary biliary cholangitis. https://www.nice.org.uk/guidance/ta1016.

- NICE technology appraisal [TA443]. Obeticholic acid for treating primary biliary cholangitis https://www.nice.org.uk/guidance/ta443.

- NICE technology appraisal [TA896]. Bulevirtide for treating chronic hepatitis D https://www.nice.org.uk/guidance/ta896.

- NICE. Endoscopic ultra-sound guided biliary drainage for biliary obstruction. Interventional procedures guidance [IPG761]. April 2023 available at Overview | Endoscopic ultrasound-guided biliary drainage for biliary obstruction | Guidance | NICE.

- NICE. Endoscopic ultra-sound guided gallbladder drainage for acute cholecystitis when surgery is not an option. Interventional procedures guidance [IPG764]. June 2023 available at Overview | Endoscopic ultrasound-guided gallbladder drainage for acute cholecystitis when surgery is not an option | Guidance | NICE.

- Office for Health Improvement and Disparities. Official statistics: Liver disease profile, April 2024 update. https://www.gov.uk/government/statistics/liver-disease-profile-april-2024-update/liver-disease-profile-april-2024-update.

- Operational Delivery Networks for Hepatitis C Care in Adults [PRN231105]: https://www.england.nhs.uk/wp-content/uploads/2024/05/PRN231105-hepatitis-c-network-specification-2023-.pdf.

- Infected Blood Inquiry https://www.infectedbloodinquiry.org.uk/reports/inquiry-report.

- UK Provision of Interventional Radiology Services (POIRS) position statement by the British Society of Interventional Radiology (BSIR) and the Royal College of Radiologists (RCR) 2023 https://link.springer.com/content/pdf/10.1007/s00270-023-03600-0.pdf?pdf=core.

- Williams R, Aspinall R, Bellis M et al. Addressing liver disease in the UK: a blueprint for attaining excellence in health care and reducing premature mortality from lifestyle issues of excess consumption of alcohol, obesity, and viral hepatitis. *Lancet*. 2014 Nov 29;384(9958):1953-97. doi: 10.1016/S0140-6736(14)61838-9. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61838-9/abstract.

Please refer to the https://www.england.nhs.uk/publication/manual-for-prescribed-specialised-services/ for information on how the services covered by this specification are commissioned and contracted for.

Please refer to the Identification Rules tool for information on how the activity associated with the service is identified and paid for.

Please refer to the relevant Clinical Reference Group https://www.england.nhs.uk/commissioning/spec-services/npc-crg/ for NHS England Commissioning Policies which define access to a service for a particular group of service users.

Glossary:

ACC – Adult Critical Care.
ACCTS – Adult Critical Care Transfer Service.
ERCP - Endoscopic retrograde cholangiopancreatography.
EUS - Endoscopic ultrasound.
FDG-PET Fluorodeoxyglucose (FDG)-positron emission tomography (PET).
HbA1c - Glycosylated haemoglobin.
HBV – Hepatitis B viral infection.
HCV – hepatitis C viral infection.
HDV – Hepatitis D viral infection.
HIV – Human Immunodeficiency Virus.
HPB – Hepato-pancreato-biliary – service covering the liver, biliary and pancreatic systems.
IgG4 – Immunoglobulin G4.
IQILS - Improving Quality in Liver Services (accreditation programme).
MaSLD - Metabolic dysfunction-associated steatotic liver disease – a long-lasting liver condition characterised by excessive fat in the liver.
MDT - Multidisciplinary team.
MOU - Memorandum of understanding.
PERT - Pancreatic Enzyme Replacement Therapy.
SLA - Service level agreement.
TIPSS - Transjugular intrahepatic portosystemic stent shunt.