NICE National Institute for Health and Care Excellence

NICE quality standard

Liver disease

Quality standard
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Contents

This standard is based on NG49, CG165 and NG50.

This standard should be read in conjunction with QS140, QS127, QS111, QS94, QS83, QS65, QS38, QS13 and QS11.

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Quality statement 1: Advice on physical activity, diet and alcohol

Quality statement

People with non-alcoholic fatty liver disease (NAFLD) are given advice on physical activity, diet and alcohol.

Rationale

Adopting a healthy lifestyle can help to reduce the rate of progression of NAFLD. Providing lifestyle advice to people with NAFLD can encourage them to consider changes they can make that might help them avoid more serious liver disease.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

Evidence of local arrangements to provide advice on physical activity, diet and alcohol to people with NAFLD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols.

Process

a) Proportion of people with NAFLD who are given advice on physical activity.

Numerator – the number in the denominator who are given advice on physical activity.

Denominator – the number of people with NAFLD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

b) Proportion of people with NAFLD who are overweight or obese who are given advice on diet.

Numerator – the number in the denominator who are given advice on diet.

Denominator – the number of people with NAFLD who are overweight or obese.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

c) Proportion of people with NAFLD who drink alcohol who are given advice on alcohol.

Numerator – the number in the denominator who are given advice on alcohol.

Denominator – the number of people with NAFLD who drink alcohol.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

Outcome

a) Awareness of people with NAFLD that lifestyle changes may help them to avoid more serious liver disease.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey.

b) Rate of disease progression among people with NAFLD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

What the quality statement means for different audiences

Service providers (general practices, community healthcare providers, hospitals and specialist liver units) ensure that they give advice on physical activity, diet and alcohol to people with NAFLD. Providers ensure that their staff know where people with NAFLD can get support if they want to make lifestyle changes, such as lifestyle weight management programmes.

Healthcare professionals (such as GPs, practice nurses, hepatologists, gastroenterologists and specialist nurses) give advice on physical activity, diet and alcohol to people with NAFLD and ensure that they know where they can get support to make lifestyle changes, such as lifestyle weight management programmes.

Commissioners commission services that provide advice on physical activity, diet and alcohol to people with NAFLD. Commissioners ensure that information is available to healthcare professionals on the support available locally to help people with NAFLD to make lifestyle changes, such as lifestyle weight management programmes.

People with NAFLD, and their parents or carers if appropriate, are given advice on diet (if they need to lose weight), physical activity and alcohol consumption (if they drink alcohol), and are told where they can get support to make lifestyle changes. Following this advice can help to improve NAFLD or stop it from getting worse.

Source guidance

Non-alcoholic fatty liver disease (NAFLD): assessment and management. NICE guideline NG49 (2016), recommendations 1.2.12, 1.2.13 and 1.2.16

Definitions of terms used in this quality statement

Advice on physical activity, diet and alcohol

People diagnosed with NAFLD should:

- be offered advice on physical activity and diet if they are overweight or obese, in line

with NICE's guideline on overweight and obesity management.

- be advised that there is some evidence that exercise reduces liver fat content
- be advised that, if they drink alcohol, it is important to stay within the government's recommended limits for alcohol consumption.

[NICE's guideline on non-alcoholic fatty liver disease, recommendations 1.2.12, 1.2.13 and 1.2.16]

Quality statement 2 (developmental): Testing for advanced liver fibrosis

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

Quality statement

People with non-alcoholic fatty liver disease (NAFLD) are offered regular testing for advanced liver fibrosis.

Rationale

There is a risk that NAFLD will progress to fibrosis and then to cirrhosis. Regular testing for advanced liver fibrosis for people with NAFLD will enable those at high risk of disease progression to be identified so that they can receive advice, treatment and regular monitoring. Regular testing will also reduce unnecessary referrals or further testing for people who are at low risk of disease progression.

Young people and adults with NAFLD should be offered testing in primary care, and referred to a specialist in hepatology if advanced liver fibrosis is diagnosed. Children with NAFLD who are diagnosed with advanced liver fibrosis should already be supported by a paediatric specialist in hepatology in tertiary care.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

a) Evidence of local referral pathways to ensure that people with NAFLD are offered regular testing for advanced liver fibrosis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols.

b) Evidence that GP practices and paediatric hepatology services have arrangements to offer regular testing for advanced liver fibrosis to people with NAFLD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols.

Process

a) Proportion of people newly diagnosed with NAFLD who are tested for advanced liver fibrosis.

Numerator – the number in the denominator who are tested for advanced liver fibrosis.

Denominator – the number of people newly diagnosed with NAFLD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

b) Proportion of adults with NAFLD identified as having a low risk of advanced liver fibrosis (such as an enhanced liver fibrosis [ELF] score below 10.51) who were tested for advanced liver fibrosis within the past 3 years.

Numerator – the number in the denominator who were tested for advanced liver fibrosis within the past 3 years.

Denominator – the number of adults with NAFLD identified as having a low risk of advanced liver fibrosis (such as an ELF score below 10.51).

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

c) Proportion of children and young people with NAFLD identified as having a low risk of advanced liver fibrosis (such as an ELF score below 10.51) who were tested for advanced liver fibrosis within the past 2 years.

Numerator – the number in the denominator who were tested for advanced liver fibrosis within the past 2 years.

Denominator – the number of children and young people with NAFLD identified as having a low risk of advanced liver fibrosis (such as an ELF score below 10.51).

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

Outcome

a) Inappropriate referrals to a specialist for young people and adults with NAFLD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

b) Incidence of advanced liver fibrosis in people with NAFLD.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

What the quality statement means for different audiences

Service providers (such as general practices and tertiary paediatric hepatology services) ensure that processes are in place to offer regular testing for advanced liver fibrosis to people with NAFLD. They should ensure that young people and adults diagnosed with advanced liver fibrosis are referred to a specialist in hepatology, and that children diagnosed with advanced liver fibrosis are cared for by a tertiary paediatric hepatology service.

Healthcare professionals (such as GPs and paediatric hepatologists) offer regular testing for advanced liver fibrosis to people with NAFLD. GPs refer young people and adults

diagnosed with advanced liver fibrosis to a specialist in hepatology. Paediatric hepatologists continue to care for children diagnosed with advanced liver fibrosis.

Commissioners commission testing for advanced liver fibrosis for people with NAFLD. Commissioners ensure that providers offer testing and re-testing for advanced liver fibrosis to young people and adults with NAFLD and that there is sufficient capacity in hepatology services to meet expected demand for referrals for people diagnosed with advanced liver fibrosis. Commissioners ensure that tertiary paediatric hepatology services have capacity to support children diagnosed with advanced liver fibrosis.

People with NAFLD have a test to check if their liver is scarred every 3 years, or every 2 years if they are aged under 18. If the test shows that their liver is scarred, they are referred to a specialist in hepatology for further advice, treatment and check-ups, or cared for by a paediatric specialist in hepatology if they are under 16.

Source guidance

Non-alcoholic fatty liver disease (NAFLD): assessment and management. NICE guideline NG49 (2016), recommendations 1.2.1 and 1.2.7

Definitions of terms used in this quality statement

Regular testing for advanced liver fibrosis

Testing for advanced liver fibrosis, for example with the enhanced liver fibrosis (ELF) test, should be offered to adults every 3 years and to children and young people every 2 years. [NICE's guideline on non-alcoholic fatty liver disease, recommendations 1.2.2, 1.2.7 and 1.2.8]

Advanced liver fibrosis

A grade of F3 or above using the Kleiner (NASH-CRN) or the steatosis, activity and fibrosis (SAF) score. This is referred to as bridging fibrosis (the presence of fibrosis linking hepatic veins to portal tracts). [NICE's guideline on non-alcoholic fatty liver disease]

Children, young people and adults

Children are aged under 16. Young people are aged 16 and 17. Adults are aged over 18. [NICE's guideline on non-alcoholic fatty liver disease]

Quality statement 3 (developmental): Non-invasive testing for cirrhosis

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

Quality statement

Young people and adults with risk factors for cirrhosis are offered non-invasive testing for cirrhosis.

Rationale

Cirrhosis may cause few or no symptoms and may not be identified until serious complications arise. Young people and adults with risk factors for cirrhosis should therefore be tested to find out if they have cirrhosis. Diagnosing cirrhosis will ensure that they get the treatment and support they need to manage their condition. Non-invasive testing is more acceptable to people than a liver biopsy and can be done in an outpatient setting with the results available immediately.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

a) Evidence of local availability of non-invasive testing for cirrhosis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service specification.

b) Evidence of local arrangements to ensure that young people and adults with risk factors for cirrhosis are offered non-invasive testing for cirrhosis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols.

Process

a) Proportion of young people and adults who have been drinking alcohol in a harmful way for several months (for measurement purposes this could be at least 3 months) who receive non-invasive testing for cirrhosis.

Numerator – the number in the denominator who receive non-invasive testing for cirrhosis.

Denominator – the number of young people and adults who have been drinking alcohol in a harmful way for several months (for measurement purposes this could be at least 3 months).

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

b) Proportion of young people and adults diagnosed with hepatitis C virus infection who receive non-invasive testing for cirrhosis.

Numerator – the number in the denominator who receive non-invasive testing for cirrhosis.

Denominator – the number of young people and adults diagnosed with hepatitis C virus infection.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

c) Proportion of adults newly referred for assessment for hepatitis B virus infection who receive non-invasive testing for cirrhosis.

Numerator – the number in the denominator who receive non-invasive testing for cirrhosis.

Denominator – the number of adults newly referred for assessment for hepatitis B virus

infection.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

d) Proportion of young people and adults diagnosed with alcohol-related liver disease who receive non-invasive testing for cirrhosis.

Numerator – the number in the denominator who receive non-invasive testing for cirrhosis.

Denominator – the number of young people and adults diagnosed with alcohol-related liver disease.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

e) Proportion of young people and adults diagnosed with non-alcoholic fatty liver disease (NAFLD) with advanced liver fibrosis who receive non-invasive testing for cirrhosis.

Numerator – the number in the denominator who receive non-invasive testing for cirrhosis.

Denominator – the number of young people and adults diagnosed with NAFLD with advanced liver fibrosis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

Outcome

Incidence of cirrhosis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

What the quality statement means for different audiences

Service providers (such as general practices and hospitals) ensure that they offer non-invasive testing for cirrhosis to young people and adults with risk factors for cirrhosis and give them information about the accuracy, limitations and risks of the different tests for diagnosing cirrhosis.

Healthcare professionals (such as GPs, gastroenterologists and hepatologists) offer non-invasive testing for cirrhosis to young people and adults with risk factors for cirrhosis, and discuss the accuracy, limitations and risks of the different tests for diagnosing cirrhosis with them.

Commissioners commission non-invasive testing for cirrhosis and ensure that providers offer it to young people and adults with risk factors for cirrhosis. They also ensure that providers give young people and adults with risk factors for cirrhosis information about the accuracy, limitations and risks of the different tests for diagnosing cirrhosis.

Young people and adults who have a risk of cirrhosis either because they drink alcohol in a harmful way, or they have hepatitis B or C, alcohol-related liver disease or NAFLD with advanced fibrosis, are offered a scan to check for cirrhosis. If cirrhosis is found, they are offered advice and treatment.

Source guidance

- Cirrhosis in over 16s: assessment and management. NICE guideline NG50 (2016, updated 2023), recommendations 1.1.3 and 1.1.4
- Hepatitis B (chronic): diagnosis and management. NICE guideline CG165 (2013, updated 2017), recommendation 1.3.3

Definitions of terms used in this quality statement

Young people and adults

Young people are aged 16 and 17. Adults are aged over 18. [NICE's guideline on non-

alcoholic fatty liver disease]

Risk factors

Young people and adults have risk factors for cirrhosis if they:

- drink alcohol in a harmful way, defined as more than 50 units of alcohol per week for men and more than 35 units per week for women, and have done so for several months or
- have hepatitis C virus infection or
- have been newly referred for assessment for hepatitis B virus infection (adults only) or
- have been diagnosed with alcohol-related liver disease or
- have been diagnosed with NAFLD with advanced liver fibrosis.

[NICE's guideline on cirrhosis in over 16s, recommendations 1.1.3 and 1.1.4, and NICE's guideline on hepatitis B (chronic), recommendation 1.3.3]

Non-invasive testing for cirrhosis

Non-invasive testing for cirrhosis includes:

- transient elastography (for all people with risk factors for cirrhosis) or
- acoustic radiation force impulse imaging (for young people and adults with NAFLD and advanced liver fibrosis).

[NICE's guideline on cirrhosis in over 16s, recommendations 1.1.3 and 1.1.4, and NICE's guideline on hepatitis B (chronic), recommendation 1.3.3]

Equality and diversity considerations

Community outreach services should support young people and adults with risk factors for cirrhosis who are experiencing homelessness or who inject drugs to enable them to have non-invasive testing for cirrhosis. This support may be available from the homelessness multidisciplinary team (for more information, see NICE's guideline on integrated health and social care for people experiencing homelessness, recommendations 1.3.2 and 1.5.15).

Prisons should ensure that prisoners who have risk factors for cirrhosis are offered non-invasive testing for cirrhosis.

Quality statement 4: Surveillance for hepatocellular carcinoma

Quality statement

Adults with cirrhosis are offered 6-monthly surveillance for hepatocellular carcinoma.

Rationale

Cirrhosis is a substantial risk factor for hepatocellular carcinoma. Hepatocellular carcinoma develops quickly and may be asymptomatic until it is advanced. Regular surveillance of adults with cirrhosis at 6-month intervals helps to ensure that it is detected early. Treatment can then begin promptly, which can improve the person's chances of survival.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that adults with cirrhosis are offered 6-monthly surveillance for hepatocellular carcinoma.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols.

Process

Proportion of adults with cirrhosis who received ultrasound surveillance for hepatocellular carcinoma within the past 6 months.

Numerator – the number in the denominator who received ultrasound surveillance for

hepatocellular carcinoma within the past 6 months.

Denominator – the number of adults with cirrhosis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

Outcome

a) Proportion of adults with cirrhosis who are diagnosed with hepatocellular carcinoma at an early stage.

Numerator – the number in the denominator who are diagnosed with hepatocellular carcinoma at an early stage.

Denominator – the number of adults with cirrhosis who are diagnosed with hepatocellular carcinoma.

Data source: National Cancer Registration and Analysis Service cancer outcomes and services dataset. Early-stage diagnosis may be based, for example, on stages 0 or A of the Barcelona Clinic Liver Staging classification.

b) Hepatocellular carcinoma survival rates.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records. Hepatocellular carcinoma is included within liver cancer in the Office for National Statistics' cancer survival for adults in England.

What the quality statement means for different audiences

Service providers (such as hospitals, and specialist liver centres) have recall systems in place to ensure that adults with cirrhosis are offered 6-monthly surveillance for hepatocellular carcinoma.

Healthcare professionals (such as gastroenterologists and hepatologists) ensure that

adults with cirrhosis are routinely offered 6-monthly surveillance for hepatocellular carcinoma.

Commissioners commission services that have recall systems in place to offer 6-monthly surveillance for hepatocellular carcinoma to adults with cirrhosis.

Adults with cirrhosis should have a check for liver cancer every 6 months. This will ensure that they can be offered treatment as early as possible if liver cancer develops.

Source guidance

- Cirrhosis in over 16s: assessment and management. NICE guideline NG50 (2016, updated 2023), recommendation 1.2.4
- Hepatitis B (chronic): diagnosis and management. NICE guideline CG165 (2013, updated 2017), recommendation 1.7.1

Definitions of terms used in this quality statement

Adults with cirrhosis

Adults aged over 18 diagnosed with cirrhosis, excluding people who are receiving end of life care. [NICE's guideline on cirrhosis in over 16s, recommendations 1.2.4 and 1.2.6]

6-monthly surveillance for hepatocellular carcinoma

Ultrasound surveillance with or without measurement of serum alpha-fetoprotein. Surveillance for adults with cirrhosis who have hepatitis B should include alpha-fetoprotein testing. [NICE's guideline on cirrhosis in over 16s, recommendation 1.2.4, and NICE's guideline on hepatitis B (chronic), recommendation 1.7.1]

Equality and diversity considerations

Adults with cirrhosis who are experiencing homelessness or who inject drugs may need additional support from community outreach services to ensure that they attend for 6-monthly surveillance for hepatocellular carcinoma. This support may be available from

the homelessness multidisciplinary team (for more information, see NICE's guideline on integrated health and social care for people experiencing homelessness, recommendations 1.3.2 and 1.5.15).

Prisons should ensure that prisoners with cirrhosis are offered 6-monthly surveillance for hepatocellular carcinoma.

Quality statement 5: Prophylactic intravenous antibiotics for upper gastrointestinal bleeding

Quality statement

Young people and adults with cirrhosis and upper gastrointestinal bleeding are given prophylactic intravenous antibiotics at presentation.

Rationale

People with cirrhosis and upper gastrointestinal bleeding are prone to have bacterial infections during or soon after a bleeding episode. Those who develop bacterial infections have a higher risk of death and early rebleeding. Giving prophylactic intravenous antibiotics at presentation reduces bacterial infections. Giving antibiotics intravenously also overcomes the difficulties of oral administration in people with haematemesis and critical illness.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that young people and adults with cirrhosis and upper gastrointestinal bleeding are given prophylactic intravenous antibiotics at presentation.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols.

Process

Proportion of presentations of young people and adults with cirrhosis and upper gastrointestinal bleeding in which the person receives prophylactic intravenous antibiotics at presentation.

Numerator – the number in the denominator in which the person receives prophylactic intravenous antibiotics at presentation.

Denominator – the number of presentations of young people and adults with cirrhosis and upper gastrointestinal bleeding.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

Outcome

a) Rate of bacterial infection in young people and adults with cirrhosis and upper gastrointestinal bleeding.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

b) Length of hospital stay for young people and adults with cirrhosis and upper gastrointestinal bleeding.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records. NHS Digital Hospital episode statistics includes length of stay data.

c) Emergency hospital re-admission rate within 30 days of discharge for young people and adults with cirrhosis and upper gastrointestinal bleeding.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records. NHS Digital Hospital episode statistics can be analysed to identify re-admissions.

d) Mortality rate in young people and adults with cirrhosis and upper gastrointestinal

bleeding.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from audit of patient health records.

What the quality statement means for different audiences

Service providers (such as hospitals, including emergency departments and specialist liver centres) have processes in place to ensure that young people and adults with cirrhosis and upper gastrointestinal bleeding are given prophylactic intravenous antibiotics at presentation. Providers should ensure that the choice of antibiotics is determined by local microbiological practices and that intravenous antibiotics are reviewed in line with NICE's guideline on antimicrobial stewardship.

Healthcare professionals (such as emergency consultants, gastroenterologists and hepatologists) give prophylactic intravenous antibiotics to young people and adults with cirrhosis and upper gastrointestinal bleeding at presentation. Healthcare professionals ensure that the choice of antibiotics is determined by local microbiological practices and that intravenous antibiotics are reviewed in line with NICE's guideline on antimicrobial stewardship.

Commissioners commission services that give prophylactic intravenous antibiotics to young people and adults with cirrhosis and upper gastrointestinal bleeding at presentation.

Young people and adults with cirrhosis who are vomiting blood or passing blood in their stools should be given antibiotics through a drip to stop them getting an infection.

Source guidance

Cirrhosis in over 16s: assessment and management. NICE guideline NG50 (2016, updated 2023), recommendation 1.3.9

Definitions of terms used in this quality statement

Young people and adults

Young people are aged 16 and 17. Adults are aged over 18. [NICE's guideline on non-alcoholic fatty liver disease]

Update information

Minor changes since publication

January 2025: Changes have been made to align this quality standard with the NICE guideline on overweight and obesity management. The link in the definition for advice on physical activity, diet and alcohol was updated in statement 1.

September 2023: The source guidance recommendation number in statement 5 has been updated in line with the updated NICE guideline on cirrhosis in over 16s.

March 2022: The equality and diversity considerations sections for statements 3 and 4 were updated in line with NICE's guideline on integrated health and social care for people experiencing homelessness.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and

equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Association for the Study of the Liver
- Foundation for Liver Research
- Primary Care Society for Gastroenterology
- Royal College of Pathologists
- Royal College of General Practitioners (RCGP)
- British Liver Trust