**Abstract P18 Figure 1** Proportion and number of patients starting treatment in the community

Key to implementation was regular reiteration, evaluation and feedback across the network, utilising Plan, Do, Study, Act (PDSA) cycles to evolve solutions to the needs of each provider and their clients.

We forged a common purpose, combined with a supportive culture to overcome challenges as they emerged. We focused on the positive impacts of our work and the values the nursing team have established to connect and build strong relationships with the staff of our partner organisations.

We focused on a number of areas including training, development, patient and staff needs; working collaboratively to find solutions and establishing working groups where needed. A data dashboard, ‘one version of the truth,’ was shared across all organisations, to inspire discussion about further improvements.

**Results** Community locations increased from six in 2017–2018 to 17 in 2019–2020 resulting in a five fold increase in the number of patients treated in the community (n=34 vs. n=154) (figure 1). Currently 50% of our HCV treatment is community-based compared to 12% prior to our initiative.

**Conclusion** Working collaboratively with stakeholders can substantially scale up community-based HCV treatment by delivering an integrated and personalised service. Wider adoption of such models through a collaborative and reiterative approach could help achieve HCV elimination.

**P19 PATIENT ASSESSMENT AND CHARACTERISTICS IN A SINGLE-CENTRE FONTAN-ASSOCIATED LIVER DISEASE COHORT**

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**Background** The Fontan operation is performed in individuals born with a single functional ventricle. The procedure separates venous return from the heart and allows normal arterial oxygen saturations. It extends the life span of these patients, who are now surviving into adulthood. However, the Fontan circulation results in chronic hepatic congestion and reduced portal blood flow. Fontan-associated liver disease (FALD) is an increasingly recognized complication, and can lead to cirrhosis, portal hypertension (PHT) and hepatocellular carcinoma. Screening for liver disease is a critical part of long-term follow-up, although assessment of fibrosis in this cohort is not clear-cut. Here we describe a model for outpatient hepatology review, and report baseline parameters of liver disease in new referrals.

**Methods** All patients referred to hepatology at the Royal Infirmary of Edinburgh from Dec 2017 to Aug 2019 were included. Demographic data, blood tests and echocardiogram results were recorded in a database at the time of clinic review.

**Results** 21 patients were included. Mean age was 29 years old, 62% were male. Average age at the time of Fontan completion was 9 years. Median Fontan duration was 20 years (range 8–34). 5/21 patients had evidence of moderate LV impairment. The most common liver enzyme abnormality was isolated raised GGT (87.1U/l, range 30–326). 20/21 had abdominal ultrasound, 9 had normal liver appearance. Transient elastography (Fibroscan) results were available in 18 patients. Median liver stiffness was 15.4 kPa (range 7.9–34.3). 11/21 patients had clinical features suggestive of possible PHT (varices/ascites/splenomegaly/thrombocytopenia). None of the patients had features of decompensated cirrhosis. Serum bilirubin was higher in patients with features of PHT (29.2 μmol/l vs.16.9 μmol/l p<0.0167). There was no significant correlation between the presence of features of portal hypertension and liver stiffness or Fontan duration. Serum hyaluronic acid was only mildly elevated in a single patient (mean 35.2, range 20–73) and was not affected by the presence of features of PHT or LV impairment.

**Conclusions** Individuals with Fontan physiology are surviving longer with the current literature suggesting almost universal development of FALD. Evaluation of FALD is challenging with traditional markers of liver fibrosis being unreliable. We recommend assessment for FALD 10-years post-Fontan including clinical assessment, abdominal ultrasound, laboratory investigations, calculation of fibrosis scores and elastography. Following these individuals over time, and development of a UK registry, would help to improve our understanding of how best to assess fibrosis and predict severity of FALD in unbiased cohorts.

**P20 OBETICHLIC ACID IMPROVES EXPERIMENTAL NON-INVASIVE MARKERS OF NON-ALCOHOLIC STEATOHEPATITIS AND ADVANCED FIBROSIS: RESULTS OF A SECONDARY ANALYSIS FROM THE MONTH-18 INTERIM ANALYSIS OF THE REGENERATE STUDY**

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In the REGENERATE 18-month interim analysis, obeticholic acid (OCA) improved surrogate endpoints of liver fibrosis in patients with non-alcoholic steatohepatitis (NASH). New biomarker indices are being developed, including FibroMeter (FM), which is designed to predict fibrosis stage ≥2 using age, gender, alpha-2-macroglobulin, international normalized ratio, platelets, urea, and gamma-glutamyltransferase. FM Vibration-Controlled Transient Elastography (VCTE) uses the same biomarkers (excluding urea) with liver stiffness (LS). The FibroScan AST (FAST™) score uses LS by VCTE, Controlled Attenuation Parameter score, and aspartate aminotransferase to identify patients with NASH and NAFLD Activity Score (NAS) ≥4 and fibrosis stage ≥2.