

community pharmacies. This service is available to people who are injecting drugs but not on opiate substitution therapy. We surveyed operational delivery network (ODN) staff across England to understand the current implementation of the NHSE advanced service.

Method Service leads and key stakeholders within each ODN in England were identified by the Hepatitis C Trust. The survey was designed using Microsoft Forms. It was advertised through the NHSE HCV newsletter and distributed by HCV Action. Results were analysed using Microsoft Excel.

Results We received 22 responses from 20 out of 23 ODNs (87%). We analysed the results per ODN (n=20). In two ODNs there were two respondents, if the answers matched we included the answer once; if one respondent had a definitive answer and the other an unknown response, the definitive answer was used; and if there were contradictory answers, the response from this ODN was excluded.

Fourteen (70%) ODNs had met with a representative from the local pharmaceutical committee and 95% of ODNs had pharmacies that had registered interest in the advanced service, with more than ten pharmacies registering interest in the majority of ODNs (12 (63%)). Four (20%) ODNs had arranged additional training for pharmacies. Fourteen (70%) respondents were aware of their referral pathway. Two (10%) ODNs reported that the pharmacist would perform a dry blood spot test to check RNA status if a client was antibody positive. Only three (15%) ODNs reported that testing had started in their region, despite eight (40%) ODNs reporting a prior pilot of pharmacy-based HCV testing.

16/22 (73%) of respondents wanted further guidance on the implementation of the service, this included guidance with the initial set up and how to effectively communicate between clinicians and pharmacists. Qualitative feedback about the service was varied, however, a consistent theme was the need to expand the eligible population for the service.

Conclusions The NHSE HCV antibody testing service has started in a small number of community pharmacies in a minority of ODNs. Many ODNs have had prior successful pilot testing programme. There is therefore an opportunity to learn from these experiences to support the implementation of the national service.

P032 INCREASING BURDEN OF ALCOHOL-RELATED LIVER DISEASE IN THE UK ASSOCIATED WITH THE CORONAVIRUS PANDEMIC

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During the first UK national coronavirus pandemic lockdown (Mar-Jul 2020), alcohol sales increased 30% in supermarkets. Surveys reported that 20% of people increased their alcohol consumption and numbers of high-risk drinkers increased by 13%. Post-lockdown, clinicians noted high numbers of alcohol-related liver disease (ArLD)-related admissions. We hypothesised that greater alcohol consumption in high-risk drinkers

contributed to this increase. We conducted a national service evaluation to document the number and severity of unplanned ArLD hospital admissions pre- and post-lockdown.

We performed a retrospective service evaluation in 28 UK hospitals of all unplanned admissions during a one-week period in August 2019 and the same period in August 2020. The protocol was approved by the lead site's Clinical Audit Department and registered at participating sites. We applied a validated coding algorithm that more accurately identifies ArLD admissions than using only ArLD codes in the primary diagnosis.¹ Eligible cases were manually reviewed and data extracted into a pre-designed collection tool. Data collected included demographics, diagnosis, alcohol use and liver disease severity scores, which were compared between evaluation periods.

There was an 18% absolute increase in unplanned hospital admissions for patients with ArLD in the evaluation period in 2020 compared to 2019 (263 vs 223). Demographics were similar between the two periods (mean age 55; 37% female). In-hospital mortality was similar (9.0% vs 7.2%) and there were no differences between proportions of patients with complications of liver disease including variceal bleeding and alcoholic hepatitis. Patients in both evaluation periods had similar severity of liver disease with mean Child Pugh score of 8 and MELD 14. Those with alcoholic hepatitis had mean MELD 20 (SD 7.5) and discriminant function 90 (SD 70).

In the post-lockdown period, there were more active alcohol drinkers (151 vs 196; 75% vs 68%) than pre-lockdown. Mean consumption per patient was higher (154 vs 127 units alcohol/week; p=0.02). More patients reported drinking spirits post- vs pre-lockdown (31% vs 22%; p=0.06).

This national service evaluation demonstrates an increase in unplanned ArLD hospital admissions post-lockdown with patients reporting heavier alcohol use. Although there were no differences in clinical presentations or outcomes, these patients have advanced liver disease with high short-term mortality. These data suggest the pandemic has disproportionately affected high-risk drinkers and demonstrate the heavy burden of ArLD in the UK. There is an ongoing need to develop long-term strategies to improve these patients' outcomes.

REFERENCE

1. Kallis, et al. *Aliment Pharm Therap* 2020;**52**:182–95.

P033 DELIVERY OF LIVER SERVICES WITHIN PRIMARY CARE CAN IMPROVE TREATMENT OUTCOMES IN PERSONS EXPERIENCING HOMELESSNESS

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Background Persons experiencing homelessness (PEH) often have complex health needs compounded by difficulty accessing healthcare. Liver disease is the third commonest cause for death in PEH after accidents and suicides. Some studies have identified chronic hepatitis C (CHC) in up to 50% of this population. Alcohol disorders are also extremely common.